Exploring The intersection of Nursing Home Culture, Improvement, and Documentation-Related attitudes

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ABSTRACT

EXPLORING THE INTERSECTION OF NURSING HOME CULTURE, IMPROVEMENT, AND DOCUMENTATION-RELATED ATTITUDES

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Background: Documentation of patient care and characteristics is an important part of nursing home operations, because it affects financial aspects, quality improvement efforts, inter-provider communication, and potential for dangerous medical errors. However, little is known about the relationships between workplace culture, quality improvement, and documentation-related attitudes. Purpose: The purpose of this study was to explore perspectives of a total of 10 nursing home staff and administrators on these variables within 8 Wisconsin facilities, based on a composite framework of Schein’s organizational culture typology and Shortell’s Quality Improvement Implementation Survey concepts. Methods: This qualitative interview study examined participant perspectives and emotions related to their facilities’ documentation quality, workplace culture, improvement efforts, and nursing staff turnover. Data quality measures taken included member checks, team-based transcript coding and analysis, and verbatim transcripts from a standardized interview guide. Thematic analysis was performed on data collected to construct a “storyline” and determine its fit within the originally proposed theoretical model. Results: Results indicated that the theoretical model was supported by sample data and that pairwise perceived relationships existed between nursing home culture, quality improvement,
and documentation. One of Schein’s culture types was not represented in the sample. Attitudes were predominantly negative, as were perceived influences on documentation quality and related attitudes. **Conclusions:** The results of this research contribute to knowledge on long-term care and could point future research in several directions: (1) similar work in dissimilar nursing homes to see whether results hold, (2) closer examination of staffing variability, (3) quantitative work on impacts of education and auditing on documentation-related attitudes, and (4) strategies to improve attitudes for quality improvement that does not increase staff stress levels.
EXPLORING THE INTERSECTION OF NURSING HOME CULTURE,
IMPROVEMENT, AND DOCUMENTATION-RELATED
ATTITUDES

BY

HANNAH JOY BAKER
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A DISSERTATION SUBMITTED TO THE GRADUATE SCHOOL
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DEDICATION

To the One who has given and sustains in me life, character, and all I have, be the glory!

“Do you see a man skillful in his work? He will stand before kings; he will not stand before obscure men.” (Proverbs 22:29)

“Great are the works of the LORD, studied by all who delight in them.” (Psalm 111:2)
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CHAPTER I
INTRODUCTION

Introduction

Long-term care quality improvement, and provider-related attitudes, matter to patients, providers, and the public for two key reasons. First, over 40% of U.S. residents spend time in a long-term care setting during their lifetime (Centers for Medicare and Medicaid Services, 2015). Second, the Quadruple Aim that guides health care focuses efforts on positive patient and provider experiences, per capita cost, and population health (Institute for Healthcare Improvement, 2019). Within reform efforts, much is already known about organizational culture and culture change, quality improvement, and various roles of providers’ documentation. However, since humans with emotions provide and document most health care, it is important to know more about the role of providers’ attitudes and their relationship with culture and quality improvement. This study focused on such relationships in long-term care settings, to begin to expand that knowledge base for more effective practice. The four research questions dealt with attitudes and perspectives of Wisconsin nursing home administrators and staff related to facility culture, documentation, and quality improvement.
Background of the Problem

Nursing Homes and the Quadruple Aim

Across the U.S., health care organizations strive to improve the health of populations, the experience of individual care recipients, and a lower per capita cost. A positive provider experience is often added to make this Triple Aim into the Quadruple Aim (Institute for Healthcare Improvement, 2019; Sikka, Morath, & Leape, 2015). In nursing home (NH) populations, examples of Quadruple Aim targets are prevention of health conditions, maintenance of patient rights and dignity, and ease of providers’ paperwork burden. Approximately 40% of the U.S. population lives in a NH for some length of time, as part of the long-term care continuum that also includes home health, hospice agencies, and assisted living facilities (Centers for Medicare and Medicaid Services, 2015; Lendon, Sengupta, Rome, Caffrey, Harris-Kojetin, & Melekin, 2019). Given the aging U.S. population, many older adults will likely use a NH. Common traits of NH residents include multiple medical and mental health conditions, inability to care for oneself at home, and vulnerability to financial and other types of abuse. For residents’ sake, it is important to maximize care quality and minimize provider burden, by means including quality improvement (QI).

Nursing Home Quality Improvement

The Center for Medicare and Medicaid Services (CMS) regulates long-term care providers and as part of this mandates QI or quality assurance/performance improvement (QAPI) (CMS, n.d. QAPI). It can help NHs improve resident satisfaction and reduce deficiency citations.
on annual surveys, impacting financial viability. QI targets generally relate to quality measures (QMs) such as incidence of falls and percent of residents with severe pain. Components of QI include a safety-based culture, actively involved leadership, strong data monitoring systems, performance improvement initiatives, and a mentality of continuous improvement (CMS, n.d. QAPI).

**Organizational Culture and Quality Improvement**

Many NHs have chosen to engage in culture change efforts as part of QI, to improve facility-wide teamwork, openness to change, commitment to best practices, and staffing stability. Taken together, these elements of organizational culture (OC) can increase resident satisfaction and medical and functional outcomes. However, whether aspects of culture need to be changed for better QI is not always clear. Schein’s 3-level model of cultural analysis (2017) helps to answer this question. This model enables researchers to describe and analyze an organization’s culture at a superficial (visible artifacts and behaviors), intermediate (stated beliefs and values), and deep level (hidden assumptions).

**Focus on Nurse Documentation**

One area with poor research coverage is the relationship between OC, QI, and nurses’ documentation in electronic health records (EHRs). Under the current Medicare payment model in particular, such documentation is a major determinant of reimbursement and thus financial viability of NHs. Required documentation in NHs is complex, and its quality can depend on the clinical environment and on staff attitudes toward it. NH operational constraints and leadership
can influence but not necessarily control environment and staff attitudes, however. Internal and external motivators can influence attitudes, which in turn influence behaviors. Several articles have explored the complexities of nurses’ documentation (e.g., Cheevakasemsook, Chapman, Francis, & Davies, 2006), but few have delved into the role of attitudes in how nurses approached their daily documentation requirements, nor to influences on attitudes.

The dissertation study explored nurses’ documentation-related attitudes, influences on those attitudes, and the relationship of both factors to OC in a NH context. Target participants were NH administrators and staff nurses because leaders are culture carriers (Schein, 2017). If they regularly talked with their frontline staff, they also were likely to have a good understanding of the facility culture. Floor-level staff were more likely than leaders to initiate successful culture change efforts (Mazur, McCreery, & Chen, 2012). Leaders who communicated more with their staff also experienced better outcomes during and after culture change (Arling, Abrahamson, Miech, Inui, & Arling, 2014; Zuidgeest, Strating, Luijkx, Westert, & Delnoij, 2012).

Statement of the Problem

Major Knowns

The topics of OC, QI, and skilled nursing facility (SNF) reform are well known individually and in pairwise combinations. Specifically, the Quality Improvement Implementation Survey (QIIS) is one research and QI tool developed for use in SNFs (e.g., Sawan, Jeon, & Chen, 2018). The question of OC change in SNFs remains a topic of interest. In the larger context of long-term care reform, QI and OC change are under thorough investigation
to determine what works, what does not, and how to tailor efforts toward the best possible changes. In a non-SNF-specific context, researchers have also documented the influence of attitudes on behavior.

**Major Unknowns**

Although the components of OC, QI, SNF reform, and attitude-behavior relationships are well studied, several aspects remain poorly known. First, studies have assumed but not necessarily known the attitudes that health care providers in SNFs adopt toward documentation. Second, in the field of behavior change, the role attitudes play in documentation process and quality is also unclear. Third, one can hypothesize that attitudes may influence behavior in a SNF documentation situation, but the relationship of these variables becomes more complex in an OC context.

**Study Objective**

Given these knowns and unknowns, the dissertation study relates to the larger goal of long-term care reform and associated knowledge base. In particular, it can inform questions of provider turnover and exit from health professions, effects of QI on SNF resident outcomes, and cost-effectiveness of past and future QI initiatives. The study objective was to explore attitudes and perceived attitude-documentation relationships of SNF staff at several levels, in order to inform OC and QI objectives and knowledge in individual SNFs and the industry as a whole.
Purpose of the Study

This study investigated attitudes and perceived attitude-documentation relationships expressed by NH administrators and RNs/LPNs in Wisconsin licensed facilities over a 6-month period in 2021, using qualitative thematic analysis techniques. Data uses included member checks, feedback to participating NHs, and groundwork for future qualitative and quantitative work about documentation-related attitudes.

Research Questions and Specific Aims

The dissertation addressed four research questions and two specific aims. The first specific aim addressed questions 1-3, and the second aim, question 4. Together, the questions and aims guided qualitative individual semi-structured interviews of a total of 10 participants, who were NH administrators, RNs, and LPNs in 8 Wisconsin facilities.

Aim 1

The first specific aim explored NH administrator and ground-level nursing staff perspectives on documentation and related attitudes with respect to QI, OC, and current COVID-19 influences. Policies and procedures in NHs often come down from the top, so a NH administrator was deemed to be a likely change agent regarding documentation practices and other processes. However, culture change efforts can just as often start at a grassroots level, so staff at multiple levels can have valuable perspectives (Mazur et al., 2012). In-depth individual interviews (see Table 4 for interview guide) were appropriate to ascertain these views in a
purposive sample. The interviewer used the four QIIS category descriptors in half of the interviews but an open-ended prompt in the other half to elicit participant descriptions of OC.

**Research question 1.** What are the perspectives of NH administrators and nurses on possible connections between OC and nurses’ documentation in their NHs?

**Research question 2.** What are the attitudes of NH administrators and nurses toward nursing documentation in their NHs?

**Research question 3.** What do NH administrators and staff perceive as influences on documentation-related attitudes in their NHs?

**Aim 2**

The second specific aim explored the perceived relationships between key variables of OC types, documentation-related attitudes, documentation quality initiatives, and QI efforts while considering influences of COVID-19. There is a clearly documented relationship between OC and QI, and some work on QI has targeted documentation (e.g., Karp, Freeman, Simpson, & Simpson, 2019). However, the role of and influences on documentation-related attitudes remained a literature gap. Personal work experience suggested that NH quality could relate closely to attitudes. Therefore, exploring themes and potential influences had the potential to yield rich insight into ways to improve documentation quality in a variety of NHs. Some culture change is deliberate, and some is determined by influences beyond an organization’s control. Themes from the Aim 1 interviews were analyzed to suggest relationships among the study variables that may be explored by post-dissertation work.
**Research question 4.** What themes connect the concepts of OC and QI to documentation-related attitudes?

**Significance of the Study**

The intended significance of this study was threefold. First, with an eye toward the knowledge base of literature related to OC, QI, and NHs, the work sought to deepen understanding of conceptual linkages. Second, with an eye toward the practical efforts to improve each NH, the study was the first step toward possible instrument development. Such an instrument would measure and facilitate addressing of attitudes in order to inform initiatives and technologies that improve documentation and quality in NHs. Finally, with an eye toward a global outcome, this study contributed to one facet of long-term care reform.

**Definition of Terms**

A complete alphabetical listing of terms with acronyms is in the front matter. However, here is a more organized set of definitions of key terms used in the study, grouped into (1) theoretical concepts and frameworks, (2) organizations, (3) personnel, and (4) structures and processes. Note that group (1) is intentionally broad because only one term was used outside of the literature review to inform interview guide development.
Group 1: Theoretical Concepts and Frameworks

**Competing Values Framework.** Management model developed by Robert Quinn that places four popular management styles into a quadrant with dimensions of external/internal and flexibility/control continua.

**Plan-do-study-act.** Quality improvement framework from outside of health care, composed of the four sequential steps emphasizing iterative evaluation of how organizational actions take effect.

**Quality Improvement Implementation Survey.** Research survey developed by Shortell and colleagues that examines NH culture at a surface level in relation to quality improvement.

**Total Quality Management.** Quality improvement framework from outside of health care; elements are ethics, integrity, trust, training, teamwork, leadership, communication, and recognition.

Group 2: Organizations

**Centers for Medicare and Medicaid Services.** Department of Health and Human Services agency responsible for administering Medicare and Medicaid health care/insurance programs.

**Department of Health Services.** Agency (here: in Wisconsin) responsible for overseeing licensure, compliance, and safety of smaller agencies that provide health care within the state.

**Nursing home.** Building comprised of long- (21+ days) and short-term (7-21 days) beds to provide nursing, therapy, and custodial care to individuals with complex health care needs but not enough acuity to require a hospitalization.
Group 3: Personnel

**Certified nursing assistant.** Direct care provider who has completed a state-determined number of training hours related to helping with personal care and basic nursing treatments.

**Director of nursing.** Head of nursing staff within a single NH; must hold an RN license.

**Interprofessional team.** In health care, a group of at least two types of providers that has shared language, goals, and knowledge while each profession contributes portions of treatment plans for better patient care.

**Licensed practical nurse.** Direct care provider with an LPN license, with more training than a CNA but less than an RN; qualified to administer medications and more complex treatments than a CNA can.

**Nursing home administrator.** Highest level of administrative staff within a single NH, with apprenticeship and licensure required. Qualified to oversee all aspects of NH operation and communicate with higher levels of administration.

**Registered nurse.** Direct care provider who has obtained an RN license; qualified to oversee LPNs and CNAs while providing advanced care ordered by patients’ physicians.

Group 4: Structures and Processes

**Electronic health record.** In any given health care facility or system, the software-housed record of each patient’s health conditions, treatment records, and identifying data. Often, “electronic medical record” or EMR is a connoted synonym.

**Quality assurance and performance improvement.** CMS requirement for all NHs for iterative, continuous care improvement. Its five elements are Design and Scope, Governance and

**Quality improvement.** Component of quality assurance/performance improvement (QAPI) that addresses consistency, integrity, and positive outcomes of care provided.

**Quality measure.** Benchmark area established by CMS for NHs. Examples include percentage of residents with new urinary incontinence or injurious falls in a time frame.

**Assumptions, Limitations, and Delimitations**

Assumptions of the study sprang from the researcher’s work experience and methodological standpoint. The investigator worked for 7 years full-time as a staff or senior physical therapist in two NHs in the Milwaukee, Wisconsin area, and assisted temporarily in other NHs in northern and central counties. Quality of these NHs varied widely per the CMS five-star rating system. Additionally, the investigator participated in QAPI efforts and IPT coordination especially in periods of interim rehabilitation director coverage. Methodologically, the investigator focused reading on qualitative interview and thematic analysis techniques to prepare for initial work in conducting the study.

Based on work experience, literature review, and methodological reading, the following biases of skepticism emerged: (1) NHs may not be able to be reformed as is; (2) attitudes may be hard to change due to mitigating factors; (3) attitudes may not be the main factor in addressing quality and culture issues in NHs; and (4) burnout may be inevitable. Because people filter data through biases, mitigation strategies were a diverse coding team and standardized interview
guide (Chapter 3). Study quality was anticipated to be good due to consistent use of accepted qualitative methodologies and techniques.

There were four limitations to the study. First, because the responses of NHs were voluntary, the sample might not parallel Wisconsin’s NHs overall. Second, in applying the results, state data may not represent the nation’s situation. Third, high turnover endemic to many NHs could have severely restricted sample size and caused higher-turnover facilities to be under-represented in the data. Fourth, NH administrators may have had a different view of their facilities’ culture than did floor-level staff. These limitations were addressed by thoughtful sampling, a comprehensive and balanced interview guide, adequate demographic data collection, clear explanation of potential benefits when recruiting, and use of member checks and procedure audits to increase the credibility, transferability, dependability, and confirmability required for effective qualitative research (Guba & Lincoln, 1989). It may be more profitable in future research to examine individual states’ NHs by the dissertation methodology, so that they can be compared in groups without losing distinctions between them.

Boundaries of this study were defined by the research questions and methodology. Thus, interview data explored individual NH employees’ thoughts about OC, QI, and documentation-related attitudes in a 20–40-minute interview time frame, which allowed for some probing but not as extensive as ideally envisioned due to participants’ time constraints. Due to its exploratory nature and sampling method, the study did not address issues in any specific NH and did not make quantitative or policy recommendations based on the dataset.
Conclusion

This study sought to fill a gap in knowledge and practice in the realm of long-term care reform. In the context of interactions between OC, QI efforts, and documentation-related attitudes of NH staff, it paved new ground in the unexplored nexus between all these concepts. It used qualitative interviews with thematic analysis to uncover rich insights that are the first step toward improvement in practice and conceptual development of complex interactions involved.
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This chapter outlines scholarly literature related to the concepts explored in this qualitative study. After the search description and conceptual and sketch of the theoretical framework, the recent and seminal research from the past 10 years is reviewed by concept or intersection of concepts. Each section will be introduced and summarized to help the reader trace the line of scholarly inquiry. In particular, conceptual relationships and intersections are reviewed to support the study framework of a heretofore-unexplored intersection of multiple concepts. The purpose of the review is to guide the reader through the logic of study development and completion.
Search Description

Databases used for articles and websites were Google Scholar and PubMed. Google Scholar was used initially to get a sense of the range of literature in non-science fields and locate full-text versions of references unavailable in other databases. PubMed was used for health-focused literature about nursing homes, quality improvement methods, and nurses’ documentation related to care of residents. Date ranges went 10 years back for theoretical and practical currency (2010-2020) except for seminal works previously read in coursework, and newer articles were sought following data gathering in 2021. Two iterations were completed in 2020 (April and August), with the second one just before submitting the proposal for defense. A third review of works related to organizational culture and behavior involved visually scanning university library shelves in May 2021, and a final update was performed in December 2021.

Search terms used in both databases were based on PubMed’s MeSH system and included “documentation,” “quality improvement,” “electronic health record,” “organizational culture,” and “nursing home.” Additional terms used in Google Scholar were “nursing documentation,” “communication,” “teams,” “IPE,” “telehealth,” “theory of constraints,” “care transition,” “leadership,” “turnover,” and “project management” based on preliminary references. Results were screened first by title, then by abstract, then by full text if available through either affiliated institution (Northern Illinois University and Concordia University Wisconsin). Results are summarized in Table 1.
Table 1

*PubMed Search Results*

<table>
<thead>
<tr>
<th>Search terms</th>
<th>Initial results</th>
<th>Title screen</th>
<th>Abstract/full text</th>
<th>New results</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI x EHR x nurses</td>
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<td>--</td>
<td>13</td>
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</tr>
<tr>
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<td>308</td>
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</tr>
<tr>
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<td>1*</td>
<td>10</td>
</tr>
<tr>
<td>EHR x nurses</td>
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<td>3*</td>
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<td>6*</td>
<td>27</td>
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<td>4</td>
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<tr>
<td>Nurses x OC</td>
<td>459</td>
<td>56</td>
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<tr>
<td>QI x EHR</td>
<td>2,611</td>
<td>81</td>
<td>1*</td>
<td>50</td>
</tr>
</tbody>
</table>

Notes: (1) Abbreviations of MeSH terms: QI, quality improvement; EHR, electronic health record; OC, organizational culture; NH, nursing home. (2) Filters applied to all searches were articles written within the past 10 years (2010-2020), abstract available, and English language. (3) A * denotes additional filters of systematic review/complementary and alternative methods to increase likelihood of relevant results. (4) New results were supplemental articles available between May and December 2021. (5) “Initial results” refers to the total number of citations obtained with the combination of search terms (x referring to the Boolean operator AND) and time frame filter of the last 10 years. “Title screen” is the number of results after a manual search of titles for relevance. “Abstract/full text” is a subsequently obtained number after adding filters to require either abstract or full text to be available. “New results” is the number of additional relevant articles with abstract/full text available on the final search in December 2021.

Theoretical/Conceptual Framework

Schein’s Organizational Behavior and Cultural Analysis Lens

Edgar Schein’s three-level model of cultural analysis forms the core of the study’s theoretical framework (2017). This allows holistic examination of OC with insight as to whether the culture needs to be changed at all in order to address QI issues. Schein’s levels of culture, defined as shared experiences that influence what things and how staff learn in an organization, are (a) visible artifacts, (b) espoused values, and (c) unstated underlying assumptions.

Literature-based examples of visible artifacts (a) can include virtual and in-person meetings,
routine or unusual tasks performed by staff, and the arrangement of technology within a workplace (Sawan, Jeon, Fois, & Chen, 2016). Examples of values (b) include honesty, integrity, and commitment to innovation – which staff repeat orally and in writing (Schein, 2017). Finally, examples of assumptions (c) include an internal need for one’s work to be effective, and to be in control of the outcome (Sawan, Jeon, & Chen, 2018).

In the context of the proposed research, artifacts (a) include QI implementation, verbal and nonverbal staff interactions, and setup of computers for documentation. Values (b) include what is advertised on NH websites, told to employees at orientation through employee handbooks and other written/oral sources from administrative staff completing the orientation, and shared between employees and supervisors as rationales for decisions. Underlying assumptions (c) include the beliefs that are invisibly enmeshed in an organization’s workings until unearthed by root cause analysis and organizational history.

To learn about culture at all three levels, the selection of culture carriers and longer-tenured members of organizations is instrumental. Culture carriers are often leaders and founders. While culture change efforts are generally more successful when led by ground-level staff in cooperation, leaders can try to change culture by several mechanisms during an organization’s lifespan. Analysis can be qualitative or quantitative, depending on the purpose.

Quality Improvement Implementation Survey (QIIS)

The QIIS, a secondary framework for the interview guide in this study, is a survey instrument to examine NH culture at a surface level as it relates to QI. Originally developed for use in hospitals, which are the most common sites for QI initiatives, the QIIS can apply to any
health care setting (Shortell et al., 1995). Respondents distribute points across 4 facility culture categories: (a) warm and group-friendly (group), (b) innovative and risk-embracing (developmental), (c) rule-oriented and structured (hierarchical), or (d) product- and goal-oriented (rational) (Quinn & Kimberly, 1984). Cultures that are more risk-embracing (b) or group-friendly (a) have been shown to be more likely to implement QI initiatives successfully, in NHs as well (Sud et al., 2011).

While there is little research-based overlap between Schein’s model and the QIIS, the four categories of culture framed by the QIIS are a practical way to think about a facility’s culture, particularly when the focus of the investigation is related to QI issues such as documentation. NH personnel can determine what category of the QIIS the facility’s culture is most like, based on visible behaviors (Schein’s 1st level of analysis) and stated values (2nd level). The study’s qualitative interviews were framed by QIIS cultural descriptions and Schein’s cultural analysis model as shown in Figure 1. Note that this study targeted levels 1 and 2 of Schein’s model due to the methodology (individual interviews) and participants (NH administrators and ground-level nursing staff, who hold a more bird’s-eye and a more localized view of the NH culture, respectively).

**Review of Research**

**Conceptual Summary**

In the literature reviewed, a framework of sub-concepts occurred as a layer beneath the broader ideas explored in the dissertation study itself. Under the OC heading, sub-concepts were
IPE/teams, leadership, turnover, and context. Under QI were care transition, telehealth, theory of constraints/project management, outcomes/outcome measures, deficiency, and champion. Under documentation were communication, IT/Agile, and workflow. No subheadings were found under literature searched for attitudes, lending credence to the established literature gap.

Organizational culture included all of the following sub-concepts in at least two studies each. Concerning interprofessional education and teams, the Institute for Healthcare Improvement recommends a team-based culture to achieve the Triple Aim. Leadership, frequently referenced, often drives OC change from the top down. Culture change has been successful even in high-turnover scenarios if some consistent staff or consultants are present. Finally, context was vaguely defined but useful to describe culture.

Quality improvement was a larger umbrella concept. QI targets included care transitions (due to high occurrence of related medical and communication errors) and telehealth, an emerging focus with a few practice standards. Approaches to controlling health care costs include project management and the theory of constraints. In any care setting, deficiencies (penalized by financial charges and requirements for plans of correction on state-level facility surveys) are typically addressed by formal or informal, qualitative or quantitative outcomes and outcome measures. Finally, a QI champion is a leader of QI efforts at any level of staff.
Documentation as a concept was shown to be a critical component of care in NHs and other health care settings. Its primary purpose is communication, whether for a legal record or care continuity purpose. Information technology, sometimes with an Agile mindset, provides process and structure for effective EHRs as a basis for documentation (Kitzmiller, Hunt, & Sproat, 2006). (Agile, per this same reference, is a method of software development that emphasizes iterative back-and-forth communication between developers and users, resulting in versatile and adaptable software.) As such, poor information technology can make or break the workflow of a care provider or team. Workflow includes all the aspects of one’s job besides point-of-service or delayed documentation.

Documentation-related attitudes did not appear to have sub-themes in the literature. However, through the reviewed studies there were a few allusions to its unexplored importance. In particular, it was suggested that RNs and other levels of care staff may not see the true value of their documentation as a tool for communicating knowledge as well as care (e.g., Lu & Lin, 2016).
**Quality Improvement in Nursing Homes**

QI is at the core of Quality Assurance/Performance Improvement (QAPI), a CMS mandate for all NHs (CMS, n.d. QAPI). QMs are a part of the 5-Star NH Quality Rating System; other parts are staffing levels and health inspection data (CMS, n.d.). Annual surveys by health department inspectors in each state, plus NH voluntary reporting into the Online Survey, Certification and Reporting (OSCAR) dataset, inform a facility’s rating. The most common issues seen in state surveys across the United States, as of 2015, were indwelling catheter use, physical restraint, and inappropriate antipsychotic or antidepressant medication use (Hansen, Hyer, Holup, Smith, & Small, 2019).

NHs approach QI in various ways. Some use formal methods adapted from non-healthcare fields – such as Plan-Do-Study-Act (PDSA), Total Quality Management (TQM), and Six Sigma (Boyle, O’Neil, Berry, Stowell, & Miller, 2013; Yanamadala, Heflin, White, & Buhr, 2012; Blumberg, Feldman, Murray, Burnes, & Murawski, 2018; Johnson, 2021). Others are less formal and can be either multicomponent or freestanding. Multicomponent interventions recognize the importance of interprofessional team (IPT) function and so integrate provider communication, leadership support, all-staff buy-in, and training and education (Arling et al., 2014; Abrahamson, DeCrane, Mueller, Davila, & Arling, 2015; Boyle, O’Neil, Berry, Stowell, & Miller, 2013; Matwiejtczyk et al., 2018).

An IPT is any grouping of at least two types of health care providers, whose goal is to improve patient care and outcomes by communication and mutual respect for each other’s roles. Outside of this aspect, researchers have examined other QI methods such as the use of vignettes to assess resident fall risk, as compared to inspection of nurses’ documentation (Colón-Emeric et
Involvement of the recipients of care, the residents themselves, in selection and implementation of QI projects is also a desired practice and is accomplished by resident council meetings and other mechanisms (Boelsma, Baur, Woelders, & Abma, 2014; Nakrem, 2015). Many facilities measure the satisfaction of residents and their families to inform QI and care philosophy; this is only one part of successful QI (Zuidegeest et al., 2012).

Regardless of intervention, the time commitment needed for sustained QI, especially in NHs designated by CMS as needing improvement to survive, is anywhere from 6 months to more than 2 years (Chodosh et al., 2015; Rantz, Zwygart-Stauffacher, Flesner, Hicks, Mehr, Russell, & Minner, 2012). Therefore, feasibility studies of QI interventions should ideally include lengthy follow-up and support to organizations so that sustained change is more likely. On the practice side, this fact illustrates the difficulty of sustaining positive change.

Challenges exist in the research and facility-level implementation of QI. For NHs that try to pursue continuous QI, common barriers include documentation burden on all staff, difficulty in measuring outcomes objectively, and staff resistance to change (Abrahamson et al., 2015). These obstacles may relate to poor IPT function and overly complex processes within the NH. From the researcher standpoint, NHs are difficult settings in which to conduct randomized controlled trials due to inflexible RCT recruitment strategies and NH leadership turnover (Daddato et al., 2017). Thus, effective research in NHs requires creativity and flexibility while maintaining scholarly rigor.

QI target issues, frequently matching quality measures (QMs), are as diverse as the methods used to address them. Fall risk is a common target because more injurious falls occur in older adults than in younger adults (Colón-Emeric et al. 2018; Arling et al., 2014). Other targeted QMs include pain (Abrahamson et al., 2015), depression (Chodosh et al., 2015), and nutritional
status. Nutrition and metabolism can influence resident quality of life, so general nutritional status (Blumberg, Feldman, Murray, Burnes, & Murawski, 2018; Matwiejtczyk et al., 2018), vitamin D treatment (Yanamadala, Heflin, White, & Buhr, 2012), and complex diabetes care (Boyle et al., 2013) fall under this umbrella. Some QI projects can also reduce undesired behaviors, such as aggression, in persons with dementia (Fitzler, Raia, Buckley, & Wang, 2016). Curiously, few studies specifically address the improvement of IPT function, instead assuming that the function will improve by itself (Desveaux, Halko, Marani, Feldman, & Ivers, 2019).

Organizational Culture and Quality Improvement

Organizational culture (OC) and QI have a documented relationship in multiple settings, as OC is the context in which QI must take place. Two popular OC theories are Schein’s 3-level model of cultural analysis and Cameron & Quinn’s paradox metaphor. The paradox metaphor is based on the Competing Values Framework (CVF) from which the Organizational Culture Assessment Instrument was developed (Yu & Wu, 2009). The CVF takes a high-level view of an organization and assumes the need for change based on organizational effectiveness. Conversely, Schein’s model assesses an organization in a more neutral way and can be used to complete various levels of analysis; it acknowledges that OC does not necessarily need to change just because it is assessed.

Schein’s model (2017) is the preferred theoretical framework for the dissertation. Its more neutral stance allows the researcher and participants to look at individual NH OC without feeling the need to change it for the sake of change. Three levels of analysis Schein proposes are visible artifacts/behavior, espoused values, and unstated underlying assumptions. In the context
of the completed project, behaviors include QI implementation, verbal and nonverbal staff interactions, and setup of computer systems/hardware. Values include what a NH website advertises, what orientation leaders tell new employees, and what employees and supervisors tell each other as rationales for decisions. Underlying assumptions include integrated beliefs of the founders. However, no one is consistently aware of them in day-to-day organizational activities. Often, cultural analysis or review of organizational history conducted by an internal or external party is effective to clarify what an organization’s underlying assumptions are (Schein, 2017).

**Culture classification.**

The literature does not indicate a clear gold standard for QI-related OC classifications. In a partnership culture, specific leadership context and strong support are needed for effective patient-provider collaboration and open communication (O’Connor, di Carlo, & Rouleau, 2018; Vogelsmeier & Scott-Cawiezel, 2011). More generally, health care OC can be change-driven (Eid & Quinn, 2017) or safety-focused (Giménez-Marín et al., 2015; Hallman, O’Connor, Hasenau, & Brady, 2017) to drive the transfer of QI from older to newer employees. A generic “safety culture” is extremely common in the literature.

Of note, a biomedical culture – i.e., one focused on the systematic diagnosis and treatment of disease without respect to the psychological and social makeup of providers and patients – can hamper collaboration and providers’ ability to be flexible (Dobscha, Cromer, Crain, & Denneson, 2016). In some health fields, there has been a shift toward a biopsychosocial focus, which allows more holistic prevention and treatment of disease while making patients and providers feel better cared for (Sikka, Morath, & Leape, 2015). Such professions may use IPTs
more often. However, other professions such as genetics and biology sub-fields are still biomedically based (Mabry, Olster, Morgan, & Abrams, 2008).

Despite lack of a standard OC classification system, ample research has explored the intersection of OC and QI. Hospitals are a widely studied setting because they are the places where the majority of all medical care is provided (Quatman-Yates et al., 2019; Stone, Lee, & Sharek, 2016; Cumbler et al., 2013; Giménez-Marín et al., 2015; Hallman, O’Connor, Hasenau, & Brady, 2017). Outpatient and other primary care settings have also been studied (Olin et al., 2014; Dobscha, Cromer, Crain, & Denneson, 2016; Patel et al., 2018). In the NH environment, a few studies have examined processes, rationale, and underlying assumptions of OC for QI. Ginsburg et al. (2018) found 5 themes relating to how QI was implemented: structural support, specificity to the facility, interpersonal relationships, visible results, and team member training. Research tools have been adapted for frontline QI use (Hartmann et al., 2017). Consistent with work on OC and QI (e.g., Shortell et al., 1995), NHs with a change-oriented culture are likelier to see better care quality from culture change efforts, translating to fewer citations on annual surveys (Miller, Lepore, Lima, Shield, & Tyler, 2014).

Diverse issues come to light in the joint study of OC and QI. These issues fall into two main categories: team roles/functions and QI mechanisms. Several studies show how vital IPT function is, perhaps because sustained change cannot happen without team coordination and member buy-in (Stone, Lee, & Sharek, 2016; de Vos Maartje et al., 2013; Dobscha, Cromer, Crain, & Denneson, 2016). One study focused on the underappreciated roles of physical and occupational therapists in hospital IPTs (Quatman-Yates et al., 2019). Concerning how QI happens, research shows that individuals’ habit changes occur in an OC context (Cumbler et al.,
2013) and that knowledge dissemination alone is insufficient for sustained change (Lemire, Demers-Payette, & Jefferson-Falardeau, 2013).

**Culture change.**

This movement has been prominent in NHs, with a goal of resident-centered holistic care (Jones, 2011). Industries have applied similar principles; one text took a high-level view of the intersection of culture change and organizational complicatedness (Morieux & Tollman, 2014). The premise was that a method of simplification could produce positive changes in culture, individual behavior, and outcomes. At first glance, this conflicts with the tenet of the Health Belief Model that attitudes influence behavior (Hayden, 2014).

However, the method’s features and the HBM are reconcilable; this helps undergird the present study and is consistent with NH-focused literature. Morieux & Tollman posit that people behave according to strategy, and the interpersonal cooperation needed to simplify hyper-complexity and increase the value of one’s work is often hindered by rules, excessive structure, and conflict-averse work relationships. Their thesis is that contextual changes that increase personal autonomy and facilitate cooperation (i.e., behaviors) will improve efficiency, accuracy, and satisfaction (i.e., attitudes) with work. These ideas are compatible in that leaders’ attitudes and emotions that enable contextual changes are the same ones needed for personal improvement – willingness to take risks, compassion, and commitment (Schein, 2017). Additionally, the cultural (or contextual) actions facilitated by Morieux & Tollman’s process – listening to individual employees, committing to value-added activities, using feedback loops, tolerating a measure of error, and rewarding cooperation and transparency – mesh well with the cultural
descriptions of the Quality Improvement Implementation Survey best shown to be conducive to successful quality improvement efforts: risk-embracing and group-friendly (Sud et al., 2011).

Studies show that employee empowerment and incentivized cooperation also fit in with institutional culture-change efforts, which center on staff-resident relationships that honor both parties (Jones, 2011). Encouragement and support of all staff is associated with blending QI and OC change efforts and reducing staff-level resistance to OC change (Wild & Kydd, 2016; Tyler et al., 2018). Empowerment of CNAs is common in culture change and increases retention (Berridge, Tyler, & Miller, 2014). OC remains a complex and useful concept, and research continues to explore its influencers and effects.

**Quality Improvement in Nurse Documentation**

For many NH administrators, it makes the most sense to address issues that directly impact budget and resident safety. Documentation of nurse-provided care is one of these issues. Because many NHs have documentation deficiencies and associated financial penalties (CMS, 2015), it is worthwhile to examine the intersection of QI and nurses’ documentation of care. Almost all NHs use electronic health records (EHRs) for residents’ information, so some aspects are specific to electronic versus paper documentation. Four documentation-related QI targets are quality, time spent, the use of EHR-suggested “smart” phrases, and information exchange during residents’ transitions between care settings (Karp, Freeman, Simpson, & Simpson, 2019; Esper & Walker, 2015; Sarzynski et al., 2019).

Investment in user-friendly, capable, comprehensive technology is an important way to improve nurses’ documentation (Lu & Lin, 2016). Other ways are user education (Esper &
Walker, 2015), workshops with individual coaching (Jefferies, Johnson, Nicholls, & Lad, 2012),
and simple EHR-embedded trackers for time and efficiency of use (Karp, Freeman, Simpson, &
Simpson, 2019). Any interventions need factors of team leadership and supportive EHR supplier-
user partnership to succeed (Shea, Reiter, Weaver, & Albritton, 2016; Dennehy et al., 2011).

One can describe nurses’ documentation in terms of its importance, complexity, and
related attitudes. Legal entities, other care providers, and auditors must be able to discern what
care did and did not take place based on written documentation alone (Cheevakasemsook et al.,
2006; Embi, Weir, Efthimiadis, Thielke, Hedeen, & Hammond, 2013). In fulfilling these vital
purposes, nurses must make their documentation individualized and patient-centered, reflective
of education provided and clinical judgment, logical and sequential, done at or near the point of
service, and meeting all applicable legal standards (Jefferies, Johnson, & Griffiths, 2010).
Complexity involves “disruption, incompleteness and inappropriate charting”
(Cheevakasemsook et al., 2006, p. 366). Disruption can occur due to poorly organized work
environment and daily schedules; documentation is one of many non-patient-care activities that
add up to almost two-thirds of a typical nurse’s day (Furâker, 2009).

However, comparatively little research exists on relationships between nurses’ attitudes,
the quality of their documentation, and the culture of their workplaces. While many studies
connect organizational culture and QI, or QI and nurses’ documentation, there is a gap in the
literature on possible direct connections between organizational culture and nurses’
documentation. Based on Schein’s model (2017), entries in a NH resident’s EHR are artifacts at
level 1 of the model, and the attitudes and thought processes that nursing staff use while
choosing when, where and how to document are stated beliefs and values at level 2 of the model.
Features of organizational culture, such as stated leadership priorities and commitment to
ongoing staff training and quality checks, could affect the quality of documentation as well as staff attitudes toward it (Cornelison, Hermer, Syme, & Doll, 2019; Patel et al., 2018; Tyler, Lepore, Shield, Looze, & Miller, 2018).

A few studies do describe documentation-related attitudes. Positive attitudes include that an EHR is useful for efficiency and communication (Lu & Lin, 2016). Negative attitudes include dislike of the conflict between speed and constraints of documenting in EHRs that may be based on how hard-copy charts are structured, rather than designed with all users in mind (Embi et al., 2013). Therefore, the proposed study can significantly contribute to the literature at the intersection of attitudes, quality, and organizational culture related to nurses’ documentation in NHs. Subsequent quantitative work can address NH culture, QI implementation and survey development (for documentation-related attitudes).

**Conclusion**

Much research and analysis exist pertaining to organizational culture, quality improvement, and nurses’ documentation in health care and specifically nursing home contexts. OC and QI, and QI and documentation, are strongly linked conceptually. However, little work has been done directly linking OC to documentation, nor with possible roles of documentation-related attitudes. Thus, a research gap exists which the current study can begin to fill.
CHAPTER III
METHODOLOGY

Introduction

Qualitative interview methods are appropriate for investigating previously unexplored aspects of people’s views and behaviors. The present study focused on health care providers’ attitudes about documentation in the context of their individual nursing homes’ quality improvement efforts and workplace/organizational culture. Because no measurement tools exist to assess attitudes and beliefs in this context, and because a written open-ended questionnaire or focus group would not have been practical to gain the amount and type of data desired, individual interviews via videoconference technology were the best method (MacDougall & Fudge, 2001). Constraints on determining what was practical for this study were the limitations on the PI’s network of contacts, the depth of commentary desired within participant responses, and COVID-19 restrictions on meeting in groups outside of one’s primary workplace. To extract the most useful material from the data, the PI used thematic analysis and associated coding techniques. This chapter discusses the design and methods used in the dissertation, focusing on qualitative data collection and analysis techniques.
Research Design/Methodology

Study Design/Procedures

Because relationships between study variables are exploratory, qualitative in-depth interviews were the focus of the design. Due to restrictions on non-health-care-provider activity within NHs that continued throughout the data collection period, the study was conducted via videoconference, with informed consent emailed through the primary investigator’s university account following IRB approval through Northern Illinois University. Some NHs in Wisconsin did open to visitors during the study period, but the researcher remained classified as “non-essential” so videoconference remained the preferred medium.

To facilitate maximal participation while reducing the risk of transmitting infection, the PI reached out to the facility via phone. The main phone number, physical address, and administrator name are publicly available on the Wisconsin Department of Health Services (DHS) website and updated every 1-2 months. After initial contact, the PI asked for the administrator’s email address, to which a blank informed consent PDF file with further study information was sent.

In-depth individual interviews.

Because no existing surveys address nurses’ documentation-related attitudes, individual interviews (approximately 30 minutes) were chosen as an important first step toward instrument development (Olivia Lemberger, personal text communication, August 3, 2020). Post-dissertation steps (see Appendix 1 for timeline) may include focus group or Delphi consensus for
initial questions, quantitative pilot testing and principal component analysis for refinement, and larger-scale testing for psychometrics and further validation. For this first study, however, individual interviews with NH administrators and their nursing staff were appropriate to gain a multifaceted view of attitudes in the context of organizational culture, QI, and COVID-19 complications (Mazur et al., 2012). In order to refine the interview guide, the PI conducted pilot interviews with 1 NH administrator and 1 nurse already known personally through work history. No substantive changes to the interview guide were deemed necessary, so these pilot interviews remained in the main data set.

Given a choice of qualitative sampling strategies, purposive seemed the most appropriate because it is underpinned by theory, ensuring a focused framework that can yield useful survey questions (MacDougall & Fudge, 2001). As the study did not formally draw on grounded theory approach, the thematic analysis of data only partially overlapped with data collection. Networking was the recommended strategy to gain a purposive sample of NH administrators, who might otherwise have been too busy to consider joining a focus group or organization that meets regularly. Self-selection was an appropriate sampling strategy for participating NH administrators’ nursing staff in order to avoid bias by potential coercion. After interviews were transcribed, the PI and co-coder began thematic analysis per the procedure in Table 2 with attention to saturation anticipated by 12-15 participants (Vaismoradi, Jones, Turunem, & Snelgrove, 2016). More guidance for analysis came from Guest, MacQueen, & Namey (2012).
Table 2

Procedure for Theme Development

<table>
<thead>
<tr>
<th>Step</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection</td>
<td>Develop and pilot interview guide with team input; participant feedback via oral summary during interview; verbatim transcription protocol</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>• Initialize: Read and highlight transcript, code in a team (deductively), write notes</td>
</tr>
<tr>
<td></td>
<td>• Construct: Classify, compare, label, translate, define, describe</td>
</tr>
<tr>
<td></td>
<td>• Rectify: Immerse, then distance, relate to what is known, stabilize theme descriptions</td>
</tr>
<tr>
<td></td>
<td>• Finalize: Develop story line</td>
</tr>
<tr>
<td>Ensure Rigor</td>
<td>Member checks; audit trail; negative/deviant case analysis; support claims with quotes</td>
</tr>
</tbody>
</table>

Note: Sources were Vaismoradi, Jones, Turunem, & Snelgrove (2016) and Guest, MacQueen, & Namey (2012).

Research Objectives

Research Questions

The central questions addressed by this exploratory study were: (1) What are NH administrator/nurse perspectives on possible connections between OC and nurses’ documentation in their NHs? (2) What are NH administrator/staff attitudes toward nursing documentation in their NHs? (3) What do NH administrators and staff perceive as influences on documentation-related attitudes in their NHs? (4) What themes connect the concepts of OC and QI to documentation-related attitudes?
**Specific Aims**

Two aims undergirded the research project in order to more fully answer the questions under consideration.

**Aim 1:** Explore NH administrator and ground-level nursing staff perspectives on documentation and related attitudes with respect to QI, OC, as well as the current influences of COVID-19 (research questions 1-3). Policies and procedures in NHs stem from the top down, so a NH administrator may be a change agent regarding documentation practices and other processes. However, culture change efforts can just as often start at a grassroots level, so staff at multiple levels can have valuable perspectives (Mazur et al., 2012). In-depth individual interviews (Table 4) were appropriate to ascertain these views in a purposive sample.

**Aim 2:** Explore perceived relationships between the key variables of OC types, documentation-related attitudes, and documentation quality/QI efforts while considering changes in influences associated with COVID-19. There is a clear relationship between OC and QI in the literature, and some work on QI efforts that target documentation. However, OC/QI’s role of and influences upon documentation-related attitudes remain unclear. Personal work experience suggested that NH quality may be closely related to attitudes; exploring themes and potential influences could yield rich insight into ways to improve documentation quality in a variety of NHs. Some culture change is deliberate, and some is determined by influences beyond an organization’s control. The coding team analyzed themes from the same interviews as in Aim 1 to suggest relationships among these variables that may be explored by later quantitative study.
Setting

The study took place in NHs in Wisconsin, where the researcher was located. By sampling one state, the PI ensured geographic and demographic diversity across more than 50 counties as well as similar practices by virtue of one state DHS. Facilities in WI were for the most part for-profit, and size ranged from 25 to more than 400 beds across the entire Medicare 5-Star Quality Rating scale (1 to 5 stars), maximizing diversity if NH administrator response and staff interview completion proceeded as planned. The researcher had over 7 years of work experience as a physical therapist and assistant rehab director in various state NHs, developing rapport and gaining experience in QAPI team involvement, which was hoped would allow for improved access to the NHs for research purposes including pilot interviews.

Participants

Inclusion/Exclusion Criteria

Inclusion criteria for a facility were Wisconsin location and dual Medicare/Medicaid certification for a more homogenous population. The PI screened interested NH administrators at initial contact to ensure that they had been in their current position for at least 1 month, were able to set aside up to 45 minutes for the interview, and interact verbally with their frontline staff at least once per week to gain their perspectives on issues and facility culture (Arling et al., 2014; Zuidegeest et al., 2012). For ground-level nursing staff, the investigator encouraged the NH administrator to distribute the information/consent document and interact directly with staff to
encourage participation. A longer tenure increased the likelihood that a participant would have enough familiarity with the facility culture to give thorough answers on the interviews. Exclusion criteria were non-Wisconsin, non-certified facilities, and NH administrators/nursing staff not meeting the above criteria.

**Sample Size, Budget, and Timeline**

An adequate sample size would help solidify significance of results by increasing the likelihood of representation of the population under study. As of the writing of the research proposal, there were 338 NHs (Medicare and Medicaid certified) across 68 counties in Wisconsin (Department of Health Services, 2020). In order to establish data saturation, at least 10 to 15 participants were recommended (Guest, Bunce, & Johnson, 2006). For this study, a purposive sample of administrators and nursing staff was sought at NHs at multiple quality ratings across the 5-Star Quality Rating System, resulting in 10 participants – 6 NH administrators, 3 RNs (two of which were directors of nursing or DONs) and 1 LPN at a total of 8 facilities. Five participants were assigned to each phase (1 or 2). From the procedure outlined in Guest, Namey, & Chen (2020), the PI determined retrospectively that thematic saturation had indeed happened by 8 interviews (see Table 7).

Caveats to this sample size reflected the complexity of research in NHs. Diversity in the number of beds, NH tenure, for-profit status, and number of NHs per county was wide. Due to this and other variation between facilities, even a saturated sample may not be applicable to other NHs. Additionally, due to the ongoing ramifications of the COVID-19 public health concern, participant tenure was more difficult to achieve at times due to furloughs, turnover, and illness.
Compensatory strategies included recruitment across WI NHs and participant screening at initial phone contact, to determine whether the NH administrator and most nursing staff had been present at the facility for over a month.

For this study, the budget is outlined in Table 3. Potential funding sources included the Fellowship for Geriatric Research and Adopt-a-Doc Award through the Academy of Geriatric Physical Therapy, Northern Illinois University’s Research Support, and NIU’s Dissertation Completion Fellowship. Only the Dissertation Completion Fellowship was obtained.

A detailed timeline for the dissertation process and subsequent studies is outlined in Appendix 1. Staff turnover and COVID-19-related restrictions extended the data collection time well into 2021. Possible areas for post-dissertation study include quantitative comparison with organizational culture and QI instruments such as the QIIS, and instrument development, as no existing surveys exist for attitudes toward documentation (Olivia Lemberger, personal text communication, August 3, 2020). Larger future studies may also examine relationships between attitudes, documentation quality, and OC or culture change efforts.

**Recruitment**

A purposive sampling strategy for NH administrators was used, originally based on the star ratings of Wisconsin NHs but in actuality based on NH distribution across counties. Because QI efforts and resources may differ by the star rating of a NH (Mike Gulock, personal oral communication, January 7, 2019), the original plan was to recruit 1-3 NH administrators from each star rating (1 through 5). Due to recruitment issues, however, the PI changed the sampling plan to reach out to at least one NH per county, and network with additional NHs if one
administrator successfully put the researcher in direct contact with another administrator. Since most NHs were concentrated within a few counties – approximately 50% of NHs were in 14 of 68 total counties – attention focused on less-dense counties for sample breadth, but participants tended to be more concentrated in the denser counties. Beginning with administrators known to the PI, recruitment proceeded until 10 participants completed interviews.

Sampling proceeded in three iterations to maximize saturation. First, the PI interviewed one NH administrator known to her and obtained direct referral to another administrator (snowball). About 2 months passed before the second interview due to participant availability. Second, after IRB amendment approval, the PI called one NH per county in the middle of each sub-list, resulting in 66 NHs called with 7 more interviews completed over the next 3 months. Third, the PI called the first NH in each sub-list where the county had at least 5 NHs, resulting in 30 additional NHs contacted with 9 total interviews. One interview was joint with both NH administrator and DON present per participant availability.

Obtaining Consent

A PDF informed consent form was included in recruitment materials. The form described study purposes, use of the data, risk/benefit analysis, and the voluntary and confidential nature of participation. Anonymity of participants was ensured to avoid potential repercussions, and the PI emphasized the need to avoid overt or covert coercion of nursing staff to NH administrators.
Incentives

Twofold incentives were offered to participants. Entry into a drawing for four $25 Amazon e-gift cards was part of recruitment and completion of an interview without withdrawal from the study. A gift card link was emailed or texted depending on participant preference for mode of contact. Also, NH administrators were emailed a preliminary 2-3 paragraph summary of the completed research before all coding was completed, to inform future QI efforts and serve as a member check for the PI. Only one participant responded, with no substantive feedback to guide changes.

During the initial phone contact with each NH based on the number given in the Wisconsin DHS list, the researcher asked for administrator email address where she sent informed consent, study information, and Microsoft Teams interview scheduling details. Based on work experience, it was anticipated that turnover at some NHs would be high during the first and second waves of the pandemic; it started to stabilize during the third wave but remained an ongoing issue. By the time data gathering began (anticipated in October 2020 but did not start until February 2021), all NHs had protocols in place for staff and resident safety with visitors - e.g., an outside researcher could access the front lobby and speak with staff there. Non-family and non-staff were still considered “non-essential,” however, so all data collection took place entirely via telecommunication. Lower performing NHs tended to have moderate administrator turnover at baseline, which was screened by asking the length of tenure in the NH.
Table 3  
**Dissertation Budget**

<table>
<thead>
<tr>
<th>Item</th>
<th>Base price</th>
<th>Quantity</th>
<th>Proposed</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recording device</td>
<td>$35</td>
<td>2</td>
<td>$70</td>
<td>$35</td>
</tr>
<tr>
<td>Secure flash drive for data</td>
<td>Already owned</td>
<td>1</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Transcription time</td>
<td>PTO</td>
<td>24-30 hours (est.)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Qualitative analysis software</td>
<td>$99 for Atlas.ti student license (2 years)</td>
<td>1</td>
<td>$99</td>
<td>$0 – Word Online</td>
</tr>
<tr>
<td>Gift cards for drawing</td>
<td>$25</td>
<td>4</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Site visits to NHs for interviews</td>
<td>54.5 cents/mile x 20-50 miles/trip</td>
<td>10 visits</td>
<td>Up to $272.50</td>
<td>$0 - COVID</td>
</tr>
<tr>
<td>Research dissemination</td>
<td>$1000/conference</td>
<td>2</td>
<td>Up to $2,000</td>
<td>Pending defense</td>
</tr>
<tr>
<td>Tuition with assist from fellowship (2020 rate)</td>
<td>$882.18/credit; $357/credit assist for 5 cr.</td>
<td>7 credits</td>
<td>$6,175.26</td>
<td>$4,590.26</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$8,716.76</strong></td>
<td><strong>$4,725.26</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Notes:* (1) Actual transcription performed by Word Online with cleaning taking approximately 3 hours per interview. (2) Conference cost assumes $500 for lodging and $500 for transportation if in-person.

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**Data Collection**

Each interview began with demographic questions about facility and total tenure in the participant role (e.g., NH administrator), age to the nearest 10 years, identified sex, and perceived nursing staff turnover rate at the facility (at, above, or below industry average). Since the vast majority of NHs have documentation deficiencies on state surveys, the PI did not ask specifically about deficiencies, though most participants spontaneously mentioned whether their NH had “clean” or “rough” surveys. Similarly, the PI did not ask about the specific EHR used at
the facility because no statewide data were available for comparison. The questions allowed
demographic description in light of Wisconsin’s overall NH administrator corpus. Work scope is
standard across NHs for administrators; thus, detailed questions about that area were
unnecessary.

After demographic data collection, the individual interviews proceeded according to the
guide, outlined in Table 4 and graphically summarized in Figure 2 (see Chapter 2,
Theoretical/Conceptual Framework, for explanation of Phase 1 and Phase 2). Flexibility in
phrasing and follow-ups depended on the participant’s level of understanding and direction taken
with the questions; the PI recorded and verbatim transcribed each interview for data analysis.
Due to participants’ frequent time limitations, the ability to ask follow-up probes was limited, at
times restricting richness of data gathered. Main areas of the interviews included general
thoughts on QI, facility culture, procedures and issues with nurses’ documentation or auditing
thereof, and the impact of COVID-19. The original plan was for the PI to summarize the entire
interview at the end in order to check understanding, but the interviews proceeded more
smoothly with briefer summaries/restatements after each question or small group of questions.
<table>
<thead>
<tr>
<th>Theoretical Connection</th>
<th>Interview Questions (Planned)</th>
<th>Interview Questions (Post-Pilot)</th>
</tr>
</thead>
</table>
| Literature-based connection between OC and QI. Use framework of Schein’s levels 1-2 and QIIS categories. Documentation as QI target due to survey penalties. | **General/Opening**  
- Interest in connecting NH quality and other factors. Rate NH as above, at, or below average.  
- Describe NH culture by what it most values: friendly groups of people, innovation and risk, rules and structures, or products and goals. (Probe for level 1 and 2 indicators per Schein’s model.)  
- OC and QI are related. Describe QI projects in this NH.  
- Transition to questions focused on charting. | **General/Opening**  
- Participant demographics and perceived NH turnover  
*Organizational Culture*  
- Phase 1: words/phrases to describe NH culture.  
- OR Phase 2: describe NH culture by what it most values: friendly groups of people, innovation and risk, rules and structures, or products and goals. (Probe for level 1 and 2 indicators per Schein’s model, and for if OC has changed.)  
- Transition: describe QI or performance improvement (PI) projects at NH. |
| Explores connections between variables and sets the stage for investigation of attitudes | **QI-Documentation Relationship**  
- Most NHs penalized for documentation deficiencies. Ask about QI-documentation relationships in NH.  
- Compare/contrast ideal and actual process of daily documentation. (Summarize differences.) | **QI-Culture Relationship**  
- Ask if NH OC might relate to QAPI approach. (Probe for why/not and how.)  
*QI-Documentation Relationship*  
- Transition: ask how QI and documentation might be related in this NH.  
- Compare/contrast ideal and actual process of daily documentation. (Summarize differences.) |

(Continued on next page)
(Continued from previous page)

Table 4 (continued)

<table>
<thead>
<tr>
<th>Attitudes (at Schein’s 2nd level of stated values) influence actions which can influence quality of finished work</th>
<th>Documentation-Related Attitudes</th>
<th>Documentation-Related Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ask for thoughts, feelings, attitudes, and reasons for differences between ideal/actual documentation processes.</td>
<td>• Ask about feelings about documentation. (Probe for examples.)</td>
<td></td>
</tr>
<tr>
<td>• Ask if those feelings might impact personal charting and coworker dynamics. (Describe.)</td>
<td>• Hypothesize causes (and if QI/OC are referenced) of those emotions or attitudes for self/others.</td>
<td></td>
</tr>
<tr>
<td>• Ask if COVID-19 affected any of those feelings, processes, or OC at this NH. (Probe.)</td>
<td>• Hypothesize how those emotions or attitudes impact own or others’ work. (Same probes as previous question.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Wrap-up: further thoughts about content.</td>
<td></td>
</tr>
</tbody>
</table>

Data Analysis

Analysis Plan

Data were analyzed via qualitative methods: deductive coding and thematic analysis (Table 2). Deductive coding started with a preexisting basic set of code (concept) areas based on interview guide areas (i.e. QI, organizational culture, documentation/charting, attitudes), but also allowed flexibility depending on what participants said. Originally, the PI wanted to combine deductive and inductive coding to see whether results would agree. The co-coder did not have access to the interview guide or prior theoretical model, thus approximating an inductive coding procedure before she and the PI met virtually to discuss preliminary coding and thematizing.
results. Thematic analysis sought to organize data into overarching ideas that could bring further insight while not losing the reader in the details (Bradley, Curry, & Devers, 2007). Demographic data noted to describe respondents included participant tenure at the facility, nursing and administration turnover rates (subjectively high, average, or low), and NH size (number of beds, obtained from DHS website). Features of the analysis process were aimed at meeting the core qualitative criteria, as described by Guba & Lincoln (1989), of credibility, transferability, dependability, and confirmability.

Coding was the initial step in analysis following cleaning transcripts. The procedure recommended by Guest, MacQueen, and Namey (2012) was followed for production of a precise codebook using a small team of researchers. The team consisted of the PI and an external faculty member with experience in health-related qualitative data analysis (Meredith Kneavel of LaSalle University). The team coded asynchronously due to geographic separation after an initial synchronous video conference to establish mutual procedures. Once refined, each code in the book was planned to have the following components: (1) code 4-12 characters long in all capital letters, (2) brief 20-80-character definition, (3) 2-10 sentence full definition, (4) inclusion criteria, (5) exclusion criteria including links to other codes that might be better to use, and (6) an example using a brief interview quote. Table 5 shows examples of the analytic process, similar to the procedure used in Danielsson, Kihlbom, & Rosberg (2016).

In detail, the initial round of coding that enabled production of a summary codebook proceeded as follows. Once transcripts were completed and cleaned, the coding team met to establish the initial coding procedure. Each completed this process separately: (1) reading through all transcripts 2-3 times, (2) extracting meaning statements (very brief verbatim phrases), and (3) sorting those meaning statements into broad categories. After a second meeting where
the team discussed similarities and differences in categories ("themes") and sub-categories ("codes"), the PI formulated a codebook with codes, descriptions, and sample supporting quotes.

Following this step, the PI immersed herself in the transcripts using the codes to test and solidify the impressions obtained by the team. This step (rectifying) yielded stabilized descriptions of themes and codes that reflected more closely what participants had said. From there, a storyline or overall linkage between themes was developed (finalizing) prior to sending a list of theme and code descriptions to participants for member checking. As noted above, the co-coder’s lack of access to the interview guide and initial theoretical model provided a counterbalance to the PI’s deductive-coding bias.
<table>
<thead>
<tr>
<th>Example of meaning statement</th>
<th>Codes</th>
<th>Analytic restatement</th>
<th>Category</th>
<th>Analytic restatement</th>
<th>Umbrella theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat the person with the mind, body, spirit, the whole wellness of the person</td>
<td>Family-type culture</td>
<td>Traits of family include equal treatment of residents and staff</td>
<td>Family-based</td>
<td>NH culture can be like extended family. Implications for staff relationships and resident care.</td>
<td></td>
</tr>
<tr>
<td>Loving, more Christian approach</td>
<td>伞形主题</td>
<td>Overall culture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very challenging and manual documentation outside influences</td>
<td>Some EMRs not user friendly essential characteristics</td>
<td>Most charting is done by EMR. Permanent record of care and decisions. Legal and other uses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If it’s not documented, it didn’t happen</td>
<td>Documentation accuracy and objectivity</td>
<td>Common phrase on legal nature of charting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation outside influences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>So much of our energy was in audits, completing audits, education</td>
<td>Varied focus of QAPI</td>
<td>Quality improvement of basic care and documentation</td>
<td>Variability</td>
<td>QAPI is a flexible tool for improving any process or product in a NH. Facilities choose what to focus on. Attitudes might affect success.</td>
<td></td>
</tr>
<tr>
<td>QAPI process can be a really positive thing if done right</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varied success of QAPI</td>
<td>QAPI must be done so make it good</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The unit manager said that she witnessed how the staff was afraid of those, that mother-daughter team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost a couple of people, either from part-time or full-time status to like a lower status like casual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stability versus turnover</td>
<td>Pathological staff dynamics</td>
<td>Turnover in culture</td>
<td>Turnover can be good or bad. Many influences including other staff and external factors to facility, industry. People create the culture of a building.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect of COVID on staffing</td>
<td>Staff documentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 2
*Interview Guide Mapped to Theoretical Model*

Data Handling/Storage

Privacy and confidentiality of data were ensured in compliance with federal and university regulations. All data were stored on a secure personal computer, in a password-protected OneDrive folder through NIU. A copy of the data was stored on a password-protected *.zip file on a flash drive in a locked cabinet in a secure location. After the bulk of analysis, the researcher performed member checks to verify credibility of findings with participants (via a report sent to NH administrators) before the final report was done.
Risk/Benefit Assessment

The proposed study had moderate risks and benefits by the PI’s assessment, but low risk with likely benefits per the NIU IRB. Risks included misinterpretation of results by facilities, and psychological distress caused by fear of reprisal (mitigated by confidentiality procedures), especially if negative answers were given. Benefits included a feeling of contributing to the body of knowledge, increased knowledge on how and whether to address facility culture, and potential improvement of RN/LPN documentation efforts by thought processes triggered by interview completion. Anticipated benefits outweighed the risks, making the study safe and worthwhile.

Human Subjects Protection

Protection of human subjects, in agreement with the principles of the Belmont Report (Department of Health, Education, and Welfare, 1979), was accomplished by the following strategies. First, clear informed consent ensured voluntary participation and awareness of potential risks and benefits. Second, NH administrators were educated on confidentiality and privacy aspects of their interviews. Third, all participants were able to withdraw at any time. Fourth, all data were de-identified during transcription, before analysis (names of participating facilities were changed to numeric codes in order of interview, and any names of persons, locations, or facilities referenced were redacted to first initials).
Conclusion

Thematic analysis of individual qualitative semi-structured interviews was the main technique used to investigate research questions in the present study. Due to the relatively unexplored nature of the content – specifically, novel intersections of previously researched concepts – codes and themes resulting from these interviews formed a useful framework that could be used in later studies to support potential instrument development. The results, described in Chapter 4, are a small piece in the ongoing urgent task of long-term care reform.
CHAPTER IV
FINDINGS

Introduction

Based on results of 10 interviews from participants at various levels of responsibility in 8 Wisconsin NHs, findings contributed to a richer understanding of relationships among workplace culture, QAPI efforts, documentation quality, and documentation-related attitudes. Based on demographic characteristics discussed below, findings may be applicable to NHs with relatively long NHA/DON tenure, relatively experienced management, and a smaller number of beds. Applicability is supported by participant statements about other facilities they had worked in, a sense of unity-in-diversity of results, and the diversity of participant demographics. This chapter discusses dissertation participant characteristics, major and minor study findings organized by theme, and relationships to the originally proposed theoretical model. Figure 3 shows the original theoretical model in which themes are fitted.
Findings

Demographically, the sample was intentionally diverse, but some patterns emerged in tenure and NH characteristics. Consistent with state and national prevalence, 6 of the 8 NHs (75%) were for-profit, similar to 72% in Wisconsin and 69% nationally (Department of Health Services, 2020; Centers for Disease Control, 2021). Overall nursing staff turnover was roughly equally rated as average or below perceived industry average, with two NHs reporting above-average nursing turnover. NHA tenure of 4-5 years at their current facility (9-10-year average as a NHA in total) was much longer in participating facilities than the industry average of 1-3 years (Angelelli, Gifford, Shah, & Mor, 2001). Most participating NHs had 50-60 beds, which may have related to the prevalence of reported family-type culture which in the PI’s experience is hard to maintain as the number of beds increases.

Additional notable features of this sample included a trend toward mid-career as shown by participant tenure (previous paragraph) and mean age 40-50 years. The youngest and least experienced NHA, aged 24 with 11 months’ experience at interview, left for a different position at an unknown time following the interview; one of the oldest participants retired. Nurses of any license type typically had extensive experience (6 months-21 years at the NH, 6-21 years total in the role). A slightly greater proportion of nurses than NHAs was interviewed using Phase 2 cultural descriptors, due to unforeseen recruitment difficulties.
Figure 3
*Theoretical Model with Themes from Analysis*

Thematic analysis revealed many aspects consistent with the PI’s experience working in NHs, with some additional notable findings. Overall, participant responses, and member check feedback gathered from the preliminary summary sent to participants, seemed to fit the originally hypothesized theoretical model (Figure 1) with some exceptions discussed below (see Figure 3 for a model incorporating the themes discovered). One original interview was a deviant case; however, that participant withdrew, which prevented data from being included in the bulk of analysis. Full definitions of themes and codes are in Appendix 3, and a discussion of pertinent findings occurs under each research question. Table 6 summarizes the prevalence of each umbrella and sub-theme and should be interpreted in light of the fact that approximately 90%
saturation was achieved in the first 4 interviews, and >95% saturation by 8 interviews with 22 available themes for the corpus of transcripts (please reference Table 7 for calculation).

**Umbrella Theme: Facility Culture**

The larger theme of facility culture spanned smaller themes of family-oriented, care-oriented, team-oriented cultures, and turnover aspects within each. Taken together, the three OC orientations were a continuum representing varied degrees of resident centrality in staff members’ minds. In both phases of interviews, participants classified their facilities into one or more of these three main categories. QIIS categories of developmental, group, and hierarchical corresponded to these three OC types, respectively (Table 8). Most participants also commented on the turnover within their facilities, and some hypothesized whether or not turnover was related to the organizational culture. The predominant culture type for a given NH was estimated by the relative number of quotes per code.

Traits for each OC type were partially unique but mostly overlapping or undifferentiated. Family-oriented NH cultures had a high priority on written documentation and a higher priority on oral communication, as well as strong interpersonal relationships among staff and residents. Care-type cultures also highly valued communication and relationships, though these relationships centered more on staff than on residents. Finally, team-oriented cultures valued relationships among staff, but were inconsistent in their reported quality of documentation. Characteristics common to all OC types included perceived linkages to documentation and QAPI, greater completeness of oral than written communication, positive and negative feedback loops for staff work quality based on interpersonal and inter-shift relationships, and a dual
administrative priority on objective documentation and resident care. Specific quotes related to each characteristic are included in the sections on other umbrella themes.

Family-type cultures were richly described. At one facility, adjectives used were “very friendly . . . empathetic . . . immature at times, nonconfrontational, um, and clique-ish at times” (NH administrator, facility 1). At another, similar terms of “compassion, respect, stewardship . . . [and] a level of not-perfect harmony” described the culture (NH administrator, facility 7). Most staff fit in to such a building’s culture, and the few who did not were easily identified. At another building, the participant expressed thankfulness for a new coworker but indicated that “there’s a lot of jealousy” among other staff about that same worker (LPN, facility 3). Longevity was a mark of some family-type cultures, including “a CNA that was in her 80s . . . maybe a year after she quit, she ended up coming in as a resident” (LPN, facility 3). Finally, family-like relationships often engendered respect: “These [residents] rely on you; you know, they are your family. So, you want to be respectful because of that” (RN, facility 6).

Care-oriented facilities were similar to, yet subtly distinct from, family-oriented ones. Descriptors included “willingness, dedicated and also resistant [to change] (NH administrator, facility 2), community orientation, “caring, [and] compassion” (DON, facility 4). Residents were seen not as family members but as deserving community members: “We’re all out to meet our goal, which is to provide the best care possible to our residents” (RN, facility 6).

Team-oriented facilities were more like care-oriented than family-oriented NHs. Lip service was given to the existence of friendly groups of people, but the stronger emphasis was on “a whole new team” or “interdisciplinary team” (LPN, facility 3). Even in one NH with an interim administrator, “there’s good teamwork with people working together” on needed tasks (NH administrator, facility 5). Distinct teams of nursing and management worked together – one
facility’s workaround for staffing challenges was for the “management team” to “work on the floor frequently” (NH administrator, facility 6).

The final sub-theme of staffing stability versus turnover in relationship to OC had two main aspects. First, regardless of participant rating of overall nursing staff turnover (as below, at, or above average for the industry), negative emotions about staffing or documentation were uniform and unrelated to level of turnover. Second, staff at lower levels (e.g., CNAs) cycled through NHs at a higher rate than those at higher levels (e.g., RNs), although there was also “not a lot of stability in the [NHA] position” depending on facility (NH administrator, facility 1). Therefore, many NH administrators cited the need for annual and as-needed education to CNAs in particular, to ensure that their documentation was based on an accurate understanding of definitions of levels of assistance they provided to individual residents.
Table 6
*Theme and Code Organization with Prevalence*

<table>
<thead>
<tr>
<th>Umbrella Theme</th>
<th>Category</th>
<th>Sub-Theme (Code)</th>
<th>Interviews</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility culture (CULTURE)</td>
<td>Family-based</td>
<td>Family-type (FAMILY)</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>Care-based</td>
<td>Care-centered (CARE)</td>
<td>3</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Team-based</td>
<td>Teams-centered (TEAMS)</td>
<td>4</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Turnover in each type</td>
<td>Stability versus turnover (TURNOVER)</td>
<td>8</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Staff documentation (CHARTING)</td>
<td>Attitudes and emotions</td>
<td>Frustration-type emotions (FRUSTRATE)</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preference for resident care (PREFERENCE)</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Essential characteristics</td>
<td>Accuracy and objectivity (ACCURATE)</td>
<td>10</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promptness or point of service (PROMPT)</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documentation by exception (EXCEPTION)</td>
<td>6</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse-CNA differences (DIFFERENCE)</td>
<td>7</td>
<td>10</td>
<td></td>
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<tr>
<td>Connections to culture</td>
<td>May (not) know path to improvement (KNOWPATH)</td>
<td>8</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outside influences (INFLUENCES)</td>
<td>8</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documentation related to culture (DOCCULTURE)</td>
<td>3</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>QAPI process (QAPI)</td>
<td>Variability</td>
<td>Varied success of QAPI (SUCCESSRATE)</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Varied focus of QAPI (FOCUSSHIFT)</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Influences</td>
<td>Staff understanding of QAPI goals (KNOWHOW)</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Keys of teamwork and communication (QAPIKEYS)</td>
<td>8</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inherent staffing variability (STAFFINGVAR)</td>
<td>7</td>
<td>19</td>
<td></td>
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<tr>
<td>Conceptual relationships</td>
<td>QAPI related to culture (QAPICULTURE)</td>
<td>7</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>QAPI related to documentation (QAPIDOC)</td>
<td>3</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Range of prevalence</strong></td>
<td>2-10</td>
<td>4-31</td>
<td></td>
</tr>
</tbody>
</table>
### Table 7
**Retrospective Calculation of Thematic Saturation**

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculation</th>
<th>Sample Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculate base size (smallest number of interviews to gain initial theme count)</td>
<td>4 (approx.)</td>
<td>4 (interviews 1-4)</td>
</tr>
<tr>
<td>Calculate run length (small number of additional interviews to examine at a time for added theme count)</td>
<td>2 (approx.)</td>
<td>2</td>
</tr>
<tr>
<td>Set new information threshold (analogous to p-value in quantitative studies)</td>
<td>5% or less</td>
<td>5% or less (0.05)</td>
</tr>
<tr>
<td>Set denominator as number of themes in base</td>
<td>Count base themes</td>
<td>20</td>
</tr>
<tr>
<td>Set numerator as number of themes within first run</td>
<td>Count run #1 new themes</td>
<td>1 (interviews 5-6)</td>
</tr>
<tr>
<td>Calculate new information ratio</td>
<td>Numerator / denominator</td>
<td>1/20 = 0.05</td>
</tr>
<tr>
<td>If new information ratio is at/above new information threshold, repeat with the next run</td>
<td>n/a</td>
<td>Repeat prior 2 steps</td>
</tr>
<tr>
<td>Run #2 themes</td>
<td>1 (interviews 7-8)</td>
<td></td>
</tr>
<tr>
<td>Run #2 ratio</td>
<td>1/21 &lt; 0.05</td>
<td></td>
</tr>
<tr>
<td>Saturation</td>
<td>8 interviews</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Guidance is per Guest, Namey, & Chen (2020).*

### Umbrella Theme: Staff Documentation

The large theme of staff documentation spanned smaller themes of frustration-type emotions, emphases on accuracy and objectivity, importance of promptness or point-of-service writing, differences between nurses’ and CNAs’ documentation, widespread preference for resident care, varying degrees of knowledge about how to improve poor documentation, and how documentation was related to OC of the facility. Broader categories of these smaller themes were (1) attitudes and emotions, (2) connections to OC, and (3) essential characteristics. Overall, the
Attitudes and emotions.

Smaller themes in this category were frustration-type emotions and preference for resident care. Frustration or other negative emotions were by far the most common mentioned when the PI asked how each participant felt about the NH’s overall documentation. Preference for resident care rather than extensive time spent to maximize documentation quality was frequently mentioned, though not specifically asked for in the interview questions. Common reasons for frustration-type or otherwise negative emotions included staff interactions at multiple levels, perceived inadequacy of staff on other shifts, and lack of behavior change despite education. Preference for resident care was a given due to the function of NHs and the caring attitudes of staff who sought and kept jobs at such facilities.
Table 8
Cultural Self-Classification by Facility Number

<table>
<thead>
<tr>
<th>NH Number</th>
<th>Family-type (QIIS: developmental)</th>
<th>Care-type (QIIS: group)</th>
<th>Team-type (QIIS: hierarchical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>X*</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>X</td>
<td>X*</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: (1) * indicates the most quotes if a NH seemed to be a mix of cultural types. (2) **Bold** indicates the predominant culture type for each NH.

**Negative emotions.** The predominant emotional temperature of participants toward coworkers’ documentation was negative, though a few facilities reported overall good-quality notes from floor staff. Specific emotions included bewilderment at others’ apparent carelessness, frustration, embarrassment for the facility’s image, stress from day-to-day crises and difficulties improving overall note quality, fear of future state surveyors not being able to find needed written information, and being burdened by extensive Medicare requirements for reporting.

Specific reasons for these emotions related mainly to handicapping impacts on facility operations and lack of behavior change from amply educated staff. Inconsistent daily charting left an incomplete legal and clinical record of care and events – often, the catchphrase “if it wasn’t documented, it didn’t happen” was cited as an unfortunate truism. One participant overtly questioned the phrase as “bogus” (NHA, facility 8), while a few others agreed that excellent care did happen but was not necessarily documented. In a similar vein, some NHAs found it difficult to perform QAPI tasks such as root cause analysis from poor charting, causing further inefficiency and possible financial difficulties: “We’re underfunded as it is,” and inadequate
documentation meant that reimbursement would not be optimized, so “we can’t provide the care that we’re supposed to” (NHA, facility 7). Staff who audited documentation (such as MDS coordinators) complained of pressure from upper management and corporate, which they felt powerless to react effectively to: “I’m sending in updates and then there’s no documentation . . . and then [floor staff are] pressured . . . they have too much” (LPN, facility 3). Pressure was complicated by a lack of assistance from above: “Why are they waiting for years? . . . Now you’re seeing this stuff?” (LPN, facility 3). Other causes of negative emotions included lack of follow-up or behavior change from staff or corporate, lack of staff-resident relationships (such as with temporary CNAs to fill staffing shortages), and too little time to document well.

Differences in the completeness of oral and written communication were uniform across all culture types. Oral communication was an essential part of quality care: “We’re a very ‘err on the side of caution’ type facility . . . we want to make sure that we follow up [with the doctor] on everything,” usually via phone (DON, facility 4). However, what was said did not necessarily make it into the written record, even if it was judged necessary to document. Sometimes, the lack of writing impaired the follow-up on a resident being treated for a problem such as a facility-acquired wound: “Why did it take two weeks for somebody to say [that a treatment isn’t working]?” (RN, facility 6). This disconnect caused NHAs and one MDS (Minimum Data Set) administrator, an LPN, who by job description must audit all staff documentation, to express widespread frustration.

Reasons for frustration about documentation were diverse, in light of the given facility’s culture and associated emphasis on documentation quality for effective communication. Some nursing staff members followed hearsay or personal preference rather than established guidelines: “People say, ‘I have heard that you want it to be a little bit vague’ . . . why would you
ever write that?” (NHA, facility 2). A director of nursing pointed out that nurses “bring in their own experience and their own bias of what they feel is important, what they feel they should chart” (DON, facility 4). Some participants also saw upper management as not helping the situation: “But why are they waiting for years [to notice problems]? . . . Now you’re seeing this stuff?” (LPN, facility 3). Finally, even though documentation was a frequent topic of discussion in staff meetings and other communiques, staff did not necessarily internalize recommendations: “It seems very self-explanatory . . . especially when we talk about it a lot” (NHA, facility 2).

This seemed to be a problem on evening or night shift especially; one NH’s infection control nurse worked evening shift and said, “I got all my stuff done at 8 . . . so now I’m upset because I’m wondering what they do from 8 to 10 when all of our care plans and charting isn’t as good as we had hoped” (NHA, facility 6).

Resident care preference. Staff and participants at all facilities much preferred resident care to documenting that care; however, there were negative effects from not prioritizing documentation more highly. For CNAs, poor-quality notes were common: “Our CNAs are very, very focused on care, and don’t always maybe understand or see the value of what they document” (DON, facility 4). Despite this, they usually had a good work ethic: “I think they care about the residents, they care about each other . . . to, you know, pick up when we’re short” (NHA, facility 7). Floor nurses, similarly, “would rather be spending more time doing direct patient care . . . [they] are documenting just ‘cause it’s something that has to be done . . . I haven’t seen any really good notes” (NHA, facility 5). From an administrative perspective, the expectation communicated to staff was that their “primary job is to take care of residents” (NHA, facility 7). However, in NH settings it was exceedingly difficult to balance good care and good charting: “Documentation kind of always sadly takes a backseat” (NHA, facility 7). Causes of
this included staff blindness to “the value of what they document” (DON, facility 4), putting off documentation, and feelings of being rushed and overwhelmed. Leaders acknowledged the cumulative burden of documentation requirements “doesn’t prioritize the person as much as it prioritizes the proof that something happened” (NHA, facility 8). The NHA at facility 7 expressed the conflict well:

Nobody likes to document and it’s at the end of the day; if they have to care for residents and, you know, if they’re short and something’s going to give, the documentation is going to give ‘cause you know they’re going to care for residents.

**Connections to OC.**

Two themes in this category were an explicit and implicit OC-documentation connection and knowledge of how to improve QI based on OC and other factors. Aspects of the connection between OC and staff documentation included feedback loops from interpersonal relationships, high value placed on both objectivity and resident care, and various negative influences on individuals’ documentation quality. Possible paths toward improvement of documentation included education, auditing, emotional self-control, and optimally supportive technology.

*Documentation-culture connection.* For communication in general, family- and care-type cultures seemed positively related. One family-type participant stated, “We know each other . . . it’s easier to communicate when you know each other well” (NHA, facility 7). Similar statements came from a care-type participant: “The CNAs are . . . basically our ears, they’re our eyes . . . the great communication that we have, and just cooperation” (RN, facility 6). In both of these culture types, the resident is explicitly and implicitly at the center of care; participants
generally conveyed a more relationship-based, organic “feel” to the daily tasks. By contrast, in a
team-type facility, the perceived relationship was weaker, possibly due to a lower priority placed on subjective, facility-wide interpersonal relationships:

Nurses . . . are documenting just ‘cause it’s something that has to be done . . . The
director of nursing has to be the one that drives that [careful documentation] (NHA, facility 5).

Two closely related aspects of the documentation-culture relationship were the high priority on accuracy and objectivity, and the conflict displayed in a strong preference for resident care (expressed across all staff levels), linked by one proposed path to improvement. Uniformly, the need for objectivity was summarized as the need to write the happenings, “even bad things” (DON, facility 4) despite one’s personal bias or preference. In a NH culture with a focus on quality, nurses took “pride in being very specific, very objective” (NHA, facility 5). In other places where quality was not as closely tied to resident-staff relationships, documentation was seen as a necessity and not as strongly valued – but rather saved toward the end of the day when the focus was exclusively on providing care. A common path to improving the quality of documentation without compromising resident care was periodic education based on turnover levels: “You can almost predict about every nine months to a year, you, we have to come back and do some significant re-education, education of CNAs about ADL charting” (NHA, facility 7).

Participants summarized the culture-documentation relationship from several angles. In particular, the concept of a positive feedback loop (or avoiding of a negative feedback loop) showed up as a metaphor. Specifically, the loop concept occurred in an auditing context: “We
review it as IDT [interdisciplinary team] and we determine, ‘Yup, that was a good intervention’. . . a self-fulfilling, um, positive feeling” (NH administrator, facility 1).

Cultures that emphasized personal accountability and pride in one’s work could, in participants’ minds, feed into staff taking more time to document care thoroughly, furthering one’s education or knowledge, and exerting peer pressure on team members to do their personal best: “You don’t want to let that other person down” (NH administrator, facility 1). A few participants verbalized the possible detrimental effects of a negative feedback loop, but none stated that this loop existed at their facilities. Negative peer pressure, or disappointing coworkers, “creates a negative culture of maybe retribution” (NHA, facility 1). If staff attitudes toward documentation were just to “get through this shift,” that could incentivize them to document poorly, with downstream impacts on QAPI, awareness of possible medical instability in a resident, and emergency situations (NHA, facility 5).

From another angle, participants cited several categories of influence on staff charting, and the effects of those influences on documentation and care. Influence was never positive; categories included increased workload or caseload, EMR issues, day-to-day distractions, and staffing issues requiring temporary agency CNAs or RNs. Even pre-COVID, participants noted that “the workload has gone up significantly” (NHA, facility 1) and that meeting care and documentation requirements in a NH is “hard work and time does get away from us” (NHA, facility 6). Staffing issues were widespread, due to different government requirements for caregiver-resident ratios compared with better-staffed hospitals, as well as the chronic difficulty of finding enough permanent staff to even meet those minimum ratios.

Technology-related issues included poor-quality computers that “should never be” allowed to exist according to corporate (LPN, facility 3), national EMR outages, and existing
EMRs that “[slow] you down” (LPN, facility 3) by being “very cumbersome, very challenging and very manual” (NHA, facility 8). Facilities using paper-based systems were not exempt from problems: “This facility . . . is not online, so trying to read people’s handwriting sometimes, it’s, you know, it’s impossible. It feels like, so it just turns into scribble” (NHA, facility 2). A few participants noted that while EMRs solved legibility problems that had occurred with paper-based charts, the benefits paled at times in light of the inefficiency and inflexibility of many software systems. The NHA at facility 8 noted that “We’re using a system that is completely, like, nonexistent in other skilled nursing facilities. They all use some that are built specifically for long term care. Ours is not.” At facility 3, the LPN said that the EMR did not effectively protect against error by a nurse who did not know a patient’s medications beforehand: “I mean, even that it would be so easy for, um, a mistake, a med error.”

People-related issues, besides caseload, included daily disruptions to workflow and inadequate staffing, which related back to caseload and workload issues cited. Workflow was rarely smooth because of the baseline NH environment of “day to day crisis management” (NHA, facility 5), involving demanding residents or other “crazy stuff . . . the phone rings or a family comes up to you and, you know, you lose your train of thought” (DON, facility 4). Individual facility or department heads were sympathetic to this: “It’s easier to sit back in an office and read through notes when maybe you don’t have all those other things going on” - which made “the reality of life” to mean that “we all get interrupted and we all lose our train of thought” (DON, facility 4). Staffing issues related to shifts worked and the degree to which temporary workers were needed. Participants were puzzled by the worse charting on non-morning shifts: “Our QA/infection control nurse . . . had worked PM shift Tuesday night and she
said, ‘I got all my stuff done at 8 . . . so now I’m upset because I’m wondering what they do from 8 to 10 when all of our care plans and charting isn't as good as we had hoped’” (NHA, facility 6).

If no temporary staff were available, CNA charting in particular suffered. If agency staff were available, that did not fully solve the problem: “There’s only so much you can do with temporary staff, um, in terms of motivation and expectation,” presumably because these staff were not as invested as permanent staff in the NH’s individual culture (NHA, facility 5).

Together, these multiple negative influences had detrimental impacts on both charting and patient care. Charting frequently ended up incomplete because “it’s easier to miss things in that [chaotic] environment” (DON, facility 4), or because of lack of staying on top of things: “What tends to happen is if it’s not being monitored, you know, by a director of nursing . . . maybe it doesn’t get charted on every shift, so there’s not like a real detailed record” (NHA, facility 1). Downstream effects on patient care included medical decline or even an “emergency situation” because lack of documentation meant that there was no record of monitoring of patients’ vital signs or other clinical issues, resulting in lack of awareness of small, preventable changes in a patient’s condition (NHA, facility 1).

**Perceived improvement paths.** Most participants had the consistent attitude that documentation needed improvement; mechanisms with variable perceived success included education to groups and individuals, auditing, and optimization of their own emotions as well as technology available for charting. The umbrella idea of education encompassed as-needed and annual training, use of a dedicated clinical nurse educator to “really look at all of our onboarding processes” (NH administrator, facility 8), and individual follow-up for skill development and “to make sure that the documentation is thorough and complete, and it’s a skill” (NH administrator,
facility 4). Specific areas included accuracy, promptness, and understanding the relative weight of one’s own documentation. One colorful example came from the RN at facility 4:

If the nurse doesn’t chart an assessment, that’s probably a little different than if somebody didn’t chart that the resident went to BINGO . . . What’s more critical? Is the world gonna end ‘cause I didn’t chart BINGO on somebody, [laughs] or is it going to end ‘cause I didn’t try to chart change of condition and nobody knew about it, you know?

Besides education, participants mentioned the audit process, examination of the current EMR, and observance of one’s emotions when presenting information to supervisees. NHAs, DONs, and MDS coordinators were the primary auditors of daily charting, as a major part of their days: “I read a lot of chart info” (DON, facility 4). This process, if prompt, ensured minimal gaps and maximal follow-up.

Regarding specific EMR software, leaders sought to either maximize staff efficiency in use of the current system or “making this switch” to a less awkward software (NHA, facility 8). The NHA was aware that most NH-specific EMRs were poorly designed for workflow and clinical decision support (NHA, facility 8), despite progress in this area in the hospital setting (G. Chen, personal oral communication, March 24, 2022). Regarding the emotional tone in which education and feedback were presented to staff about charting deficiencies, one NHA (facility 8) was keenly perceptive: “I think if we're coming from kind of a frustrated point of view, you know I certainly try to be careful about it and explain . . . the reason . . . How it's presented is how it's going to be perceived and how it's going to be put into place.”
**Essential characteristics of documentation.**

Smaller themes (codes) in this category were accuracy/objectivity, promptness, pertinent brevity, and differences among staff. Each characteristic was portrayed as either typical of most staff, expected from all staff, or both. Accurate records were supported by promptness (point-of-service), at least in theory, but staff rarely had the time or incentive to complete notes after each patient’s care, every time. Brevity, or “documentation by exception,” was a common phrase that ironically connoted thorough records. Staff differences were due to the types of care provided, licensure levels, and relative turnover rates of nurses versus CNAs.

**Accuracy and objectivity.** Accuracy was the most deeply talked-about desired characteristic of written care records. Reasons for accuracy included providing a clear picture or understanding of resident status, facilitating follow-up and communication with other providers about resident status, readying for annual state surveys, maintaining transparency for integrity and the possibility of the family reading the EMR, and facilitating QAPI or root cause analysis. Aspects of accuracy included objectivity (versus subjective or “emotional” word choice), clarity, completeness, and a combination of individualization and protocol-following as indicated by the situation: “If somebody were to fall, you’re going to chart witnessed fall or unwitnessed fall. What’s the protocol . . . [for] vital signs and neuro checks? . . . I would like to put a little [daily] note in” regardless (RN, facility 6).

Responses were mixed as to whether nurses’ and CNAs’ documentation was on the whole accurate in a given facility. Prerequisites for high accuracy related to process, culture, and adequate staffing levels; perceived causes of poor accuracy related to personal bias, inadequate technology, and low staffing levels. Processes included legal protocols, condition- or event-
specific flowsheets - “protocols for charting persons” (RN, facility 6), and a designated person for auditing - “I’m actually the third nurse, so we’re actually doing the triple checks” (DON, facility 8). Culture displayed itself in an emphasis on “err[ing] on the side of caution” and “being very transparent” (DON, facility 4). In facilities where documentation was reportedly inaccurate, some nurses simply were “not charting. They’re not passing meds the way they’re supposed to legally do it” (LPN, facility 3). In NHs with paper charting – admittedly the rarity – records “just [turned] into scribble” (NHA, facility 2). Inadequate staffing levels led to not enough time to individualize: “If you’re staffing close to where you should be, you have more time to document and probably get a more accurate picture” (NHA, facility 7). Regardless of staffing, “Nurses . . . bring in their own experience and their own bias” causing inconsistency in clinical records (DON, facility 4). Due to generally higher turnover in CNAs than in RNs, “annual education [of] what those definitions actually mean [for charting ADLs]” was needed to increase poor quality (NHA, facility 8).

**Promptness.** Surprisingly few comments related to the timeliness of required documentation, but participants’ insights were rich. On the whole, prompt documentation – that is, immediately after caring for one resident – seemed an unattainable ideal: nurses would “give the meds and, and sit down and chart later” (LPN, facility 3). CNAs were also “supposed to document as they go” (LPN, facility 3), but time and staffing shortages prevented that. The effect of a lack of timeliness was inaccuracy due to memory decay: instead of material being “fresh in their mind” (LPN, facility 3), the information was “quite different when [nurses] finally [sat] down” to document (RN, facility 6) because in many cases staff would care for many residents in a row before taking time to chart for the batch at a workstation. From the PI’s experience as a physical therapist, point-of-service is possible, but requires somewhat firm boundaries with
residents as well as aggressive time management. Either of these features may be more difficult for those working in non-therapy disciplines, due to differences in the care or therapy types and parameters provided.

**Pertinent brevity.** The criterion of documenting exceptions to the norm was frequently cited, but how that was interpreted was usually in more detail than the phrase would imply. Clinical care involves a large number of routine tasks (e.g., vital signs assessment) as well as recording and communication of abnormal events (e.g., a fall with major injury). In order to avoid excessive length of clinical records, staff are educated to summarize routine care and elaborate on unusual information “by exception.” Participants’ comments related to types of content, and whether the criterion was actually followed. Types of content included “changes in condition, any follow-up calls” (NHA, facility 1), “any conversation . . . any type of education . . . any transaction” (NHA, facility 2), “everything . . . that you do” (DON, facility 4), major events like “a fall” (RN, facility 6), and “things out of the norm” (RN, facility 6). Given this breadth of possible documentation content, a few participants acknowledged that “if everything is fine, you know, we don’t chart every day on, you know, every person” (RN, facility 6). Protocols for recording details of events like falls were completed to standardize charting as well. So, while the phrase “by exception” may give a deceptively brief image of documentation, it typically did happen in participants’ NHs, but “not necessarily” (NHA, facility 2).

**Nurse-CNA differences.** Participants at all levels indicated that key expected aspects of documentation were consistent across the staff member’s level of responsibility, but that differences existed mainly in the EMR interface based on the level of care provided; problems were similar regardless of staff license or certification – with an admittedly miniscule sample of one LPN (lowest licensing level), several RNs (including DONs), and administrators (separate
license with qualifying exam). DONs and NHAs, who audited staff documentation, universally endorsed blanket expectations for accuracy of each staff member’s records, acknowledging that across the board the act of documenting would occur at the end of the workday. Because RNs and LPNs typically documented higher-level care such as medication administration and body systems assessment for each resident, they were expected to be “a little more thorough” (DON, facility 4) and individualized with both free text and “smart phrases” (NHA, facility 7). Conversely, because CNAs performed lower-level tasks such as more non-medical assistance with activities of daily living (ADLs), their EMR interface used mostly smart phrases and “yes/no type” options on touch screens (DON, facility 4). Common issues resulted from lack of periodic training, inadequate time, and not using established processes that would otherwise streamline the workflow while maximizing accuracy: “Where the process breaks down is when they’re not using the process” (NHA, facility 8).

**Umbrella Theme: QAPI Process**

The large theme of QAPI processes within NHs encompassed smaller themes of varied focus, varied success, level of staff understanding of QAPI goals, critical aspects of teamwork and communication, inherent staffing variability affecting QAPI, and QAPI’s relationships to culture and documentation. These can fit into categories of (1) variability, (2) influences, and (3) conceptual relationships. Overall, the QAPI process theme paints a picture of QAPI being integral to NH culture and function, and driven by people and processes.
Variability.

Two ways in which QAPI varied between NHs included focus areas and success rates and factors. Major focus areas were employee attrition and orientation, QMs related to safety and quality (flags on reports, ADLs, mobility, infections, weight loss, and rehospitalizations), staff documentation, critical events, finances, satisfaction, and miscellaneous projects. Broad success factors included who was driving the process, whether efforts were more proactive or more reactive, and impacts of COVID on the trajectory of success.

QAPI foci spanned the entire daily workings of each NH – employees, residents, and the records of care provided. One facility that treated QAPI more like a series of projects than an overarching initiative worked on COVID-related measures: “One of our goals was to get through the vaccine clinic” (NH administrator, facility 2). Maintaining or improving a safety-focused culture encompassed “infection control, dietary, falls, and all those things” even if the administration did not explicitly communicate specific QAPI goals to ground-level staff (RN, facility 6). Employee-focused initiatives were comprehensive: “developing an orientation program . . . increasing recruitment efforts and then retention” (NH administrator, facility 1). Documentation either supported initiatives or was the target of them: “Documentation is, is the major issue . . . so there’s a lot of reviews . . . trying to get those done within the week” (NH administrator, facility 6).

Overall, participants saw QAPI trajectories as positive but challenging, regardless of whether a DON or IDT drove initiatives, and regardless of the proactive-reactive balance. Even in more challenging NHs, most QMs did improve with concerted QAPI efforts, at least until
COVID-related factors interfered: “COVID just kind of threw a wrench in everything” (NH administrator, facility 6).

Some administrators thought that a team was better than a single person to drive QAPI: “It’s really only been driven by the [strong] DON . . . that’s also bred complacency amongst other department heads” forming the IDT (facility 1). A DON from another facility sought a balanced approach while involving the IDT: “We also tried to do assessments that lead us to getting ahead of things as well . . . before things happen and then after things happen” (facility 4). Based on QAPI focus areas, though, most facilities were more on the reactive side because of the great challenge caused by “putting out the fires the rest of the day” (NH administrator, facility 8).

**Influences.**

Three main areas of influence on the degree of QAPI success were key common aspects, level of staff understanding of goals, and consistency of staffing itself. Key aspects included written and oral communication, teamwork, and all-staff buy-in that enabled regular follow-up. Contributors to staff understanding ranged from regular meetings and formal educator roles to unexpected insights and an impression that quality of care was the broad goal. Finally, staffing variables that influenced QAPI included COVID, heavily rural or heavily urban worker pools, and the perpetual revolving door of CNA turnover and supply.

Communication and investment of the whole IDT working together were essential to good QAPI. Staff generally knew they “need[ed] to participate” and use “a shared language” (NH administrator, facility 1), though follow-up was inconsistent after monthly or quarterly
meetings. Communication happened in informal conversations, written records, and calls to supervising physicians when small issues came up to prevent them from spiraling out of control. To maintain chart quality, some administrators reviewed charts themselves, while others had serial audits at 2-3 levels of supervisory staff. One facility’s DON saw herself as infamous for emphasizing proactivity and solid documentation to support root cause analysis and the total QAPI effort (facility 4).

And again, we are a facility that is trying to be proactive with things, so we’ve definitely worked really hard to instill that in our staff. Um, and I have had people from other facilities come here. And they’re like, “wow, you guys, like, call the doctor at 10.” Yup we do! You know, and, and even the providers complain and I just say I don’t care.

Working together required buy-in from and training of staff at all levels in “a group mindset” (RN, facility 6) and enabled sharing of tasks to spread out the cognitive load. Training at one NH involved a particularly vivid anecdote: “I like to tell the story to all new employees . . . there’s a little diagram that has little stick figures. They’re all pulling out on a rope . . . And if we’re all pulling together . . . it’s going to bend the graph up or down” (NH administrator, facility 7).

Participants expressed their knowledge of QAPI philosophy and goals in various ways depending on their level of responsibility. Administrators and DONs focused on “tracking metrics” (facility 1), regular meetings including NH medical directors (facility 2), and dedicated educators and processes for orienting new staff (facility 8). Floor nurses said that while their supervisors used multiple modes of communication of meeting decisions, a “common sense” mentality for “basically quality of care” prevailed rather than specific goals (facility 6). Some improvements happened outside of the normal QAPI process as well, whether by “providers working and talking to families” or not-quite-unexpected “learnings” (NH administrator, facility
Overall, knowledge translation processes for committee-to-staff communication were either set in place or in development.

Staffing challenges influenced QAPI success, especially if leadership turnover was high—though the sampling strategy for this study was biased toward leadership of higher tenure. (Granted, one administrator cited a study about a 12-18-month average administrator length of stay [facility 5].) Issues specific to rural settings (e.g., facility 1) included a low baseline of full-time employment, high numbers of staff related by blood or marriage to coworkers or residents, and a very small market for recruiting new employees. In urban settings (e.g., facility 3), more “minute [management]” and cutting of staff hours and incentives by corporate influenced morale and QMs at times. Across the board, the pandemic caused widespread fatigue, decreased hours scheduled, lack of “in-person visitation from leadership” (NH administrator, facility 1), and variability in resident care due to staff quarantines. To meet minimum care requirements, NHs had to supplement “a very skeleton crew of CNAs” with agency staff (LPN, facility 3; NH administrator, facility 5). Finally, although some facilities had staff who dedicated their careers to being CNAs at one NH for 10-20 years, the majority were short staffed: “CNAs have always had trouble with turnover period . . . the nurses are more stable and consistent” (NH administrator, facility 7). Higher turnover meant more frequent need for education in QAPI processes and goals.

**Conceptual relationships.**

Based on existing literature (see Chapter 2, specifically sections Organizational Culture and Quality Improvement, and Quality Improvement in Nurse Documentation), the PI
anticipated that participants would relate QAPI to both their facility’s culture and documentation; this was indeed the case. QAPI-culture links were generally positive, especially if there was more buy-in from all levels of staff and corporate. QAPI-documentation links, while not as prevalent in interview statements, mainly related to staff critical thinking and the need for accurate records in order to complete process improvements.

Most participants expressed a direct, positive relationship between QAPI and the building’s culture, though two alluded to negative work ethic tarnishing the positive. These administrators referenced “excuses” and an attitude of “Well, we have to do it, so let’s do it” among their staff (facilities 2 and 6). Besides these remarks, however, aspects of a strong positive relationship were personal investment in the NH’s success, improvement focus of the larger organization, and culture change efforts including Six Sigma Green Belts or daily integration of QMs into the mindset of all staff. The DON at facility 4 said, “I do think they’re related because I do think if people are invested in your facility, invested in your residents, and they truly care about the job they do, they want to do a good job.” At facility 7, the NHA indicated that “[Ours] was the first healthcare organization that won the Malcolm Baldridge Award, just like this. So, the organization is always adding focus on improvement.” To support this culture, “we have the [Six Sigma] Green Belt here on, on our ministry . . . the organization has CI [continuous improvement] people who support groups of facilities.” The NHA at facility 8 reported “trying to come up with ways and mechanisms of getting [QAPI-related] conversations that we have behind closed doors and in those QAPI meetings into an active part of daily life [laughs] for, for everybody on the team.”

Besides allusions in previous themes relating to the need for accurate, auditable written records, few participants explored the QAPI-documentation relationship further. This is not
surprising because accuracy of charts provided a solid foundation for multiple aspects of NH function and financial viability: “We want an accurate picture of what’s going on” (LPN, facility 3). Auditing documentation as part of QAPI could help ensure this accuracy (NH administrator, facility 2). One interesting remark, perhaps reflecting deeper issues that future research can explore, referenced the sporadic use of “[critical] thinking from a floor nurse” that made her documentation more than merely a tally of care provided (NH administrator, facility 1):

There was an example of a nurse on the day shift who had a change of condition. I heard her say . . . ‘hey did so and so have – didn’t they have COVID already?’ . . . I [checked my computer and] went back out and I’m like, yup, they definitely had it at this time. She said OK. And then she starts going through the process . . . ‘So this is what I think is happening in what I can say about that’ [versus saying] ‘hey, DON [director of nursing], tell me what to do.’

Extrapolating from these pairwise relationships among QAPI, OC, and documentation, several things are worth noting. First, according to these experienced participants, there are definite or probable relationships among QAPI, culture, and documentation. Second, based on near-unanimous opinion, the different types of OC (especially family and care types) seemed to relate similarly to QAPI and documentation, so that it may not matter as much as previously thought (e.g., by authors involved in developing the QIIS) what culture type a NH has in terms of its attitude toward QAPI and documentation. This is supported by comparable statements (sections above) discussing relationships between QAPI and nurses’ documentation in interviews where participants described their facilities’ OC in different ways. Third, based on the second implication, the link between QAPI and documentation may be much stronger than the link between culture and either QAPI or documentation.
Conclusion

Synthesis of individual themes in relation to the original research questions (RQs) yielded the following which will be discussed further in Chapter 5. RQ 1 asked about perspectives on OC-documentation connections. Culture types were mostly parallel to the QIIS categories. Nurse documentation was generally seen as written communication, while both written and oral were part of daily manifestations of NH culture. More specifically, their written communication related to quality aspects (accuracy and objectivity) while conflicting with the high priority placed on resident care, via positive or negative feedback loops between staff. Frustration about documentation had many causes. RQ2 went deeper into attitudes toward documentation, finding not only a variety of negative emotions (bewilderment, embarrassment, frustration, stress, fear, and burden) but also simultaneous expectations of objectivity, promptness, and brevity that were negatively influenced by varied factors, including differences among staff. RQ 3 synthesized answers to questions 1 and 2. Finally RQ 4 investigated connections among OC, QI, and documentation-related attitudes, finding pairwise relationships OC and documentation were connected by feedback loops and whether the DON or IDT drove the process. OC and QAPI were connected via inspiration, core values, initiatives, and the larger organization at times. Last, QAPI and documentation were connected via accurate writing, critical thinking, and occasional focus on documentation as a QAPI project.

Thematic analysis of the interviews revealed not only thematic saturation but also a rich yet consistent variety of themes and meaning statements about the data. Participants discussed three types of facility culture, several key features of staff documentation, their (usually negative) emotions about documentation and associated requirements, and the QAPI process.
with its relationships to culture and documentation. Based on the finding that documentation may be related to QAPI strongly regardless of culture type, NHs may be able to focus their efforts in this connection area even if culture change efforts are less successful than hoped.
CHAPTER V
DISCUSSION

Introduction

The present qualitative interview study, with analysis completed in October 2021, provided rich insight into facility culture, staff attitudes, and administrator perspectives on QAPI and documentation in the context of Wisconsin NHs in times affected by COVID-19 on top of other factors currently affecting the long-term care industry. Many findings were consistent with the originally proposed theoretical model, which in turn was based on relevant literature and PI experience. Several novel findings, as well as a bulk of confirmatory data, led to conclusions that both further and can spur multiple new lines of research in long-term care reform.
Summary of Findings

A thematically saturated sample of NH administrators and nurses provided study data via interview transcripts. Compared with demographics of NHs in WI and the United States overall, the study sample trended toward smaller numbers of beds and longer-tenured management and nursing staff, regardless of overall staffing levels in the NH. This may represent a self-selection bias – an inherent risk of qualitative interview work – and limit applicability of the findings to smaller, more stable NHs. Findings were overall consistent with prior literature and the PI’s past work experience, with the original theoretical model (chapter 2) supported. Exceptions to this model, as well as unexpected findings, are highlighted in the Conclusions section, below.

A total of 10 participants at 8 NHs spoke to questions on facility culture, documentation quality, and QAPI efforts, yielding 3 umbrella themes and 19 smaller themes. The first umbrella theme, facility culture, covered a continuum of family-type (4 NHs), care-oriented (3 NHs), and team-focused (1 NH) types, mostly with an average or below-average staff turnover reported. The second umbrella theme, staff documentation quality, was a much richer concept that encompassed key features of documentation, influences and (negative) related emotions, details on how different types of nursing staff approached their documentation of care, relationships seen to NH culture, and ways to improve overall quality. The final umbrella theme, QAPI, bore some similarities to the documentation-quality theme: related to both NH culture and documentation, influenced mainly by staffing variability inherent in NHs, and with varied focus areas and success rates. Unique sub-themes here were a broad and implicit floor-level staff understanding of QAPI goals, and widely expressed key success features of teamwork and good communication.
Synthesis of Findings

Based on the summary of findings above, most results were consistent with anticipated findings, with interesting, unexpected insights generated as well. In chapter 4, they were explored by theme, but here, they are organized by research question (RQ), with **bold** indicating unanticipated or novel findings. Overall, the study contributes to published literature on the three interrelated concepts of NH culture, staff documentation, and QAPI efforts. Brief member checks – i.e., periodic oral summaries/rephrasing by the interviewer to make sure she understood the participant’s expressed thoughts correctly – at points during and after each interview confirmed the findings, though only one participant responded to the email requesting feedback on the preliminary summary after all interviews had been completed.

RQ 1 asked about the perspectives of NH administrators and nurses on any possible connections between NH culture and the documentation done by nursing staff in those facilities. A prominent concept here was that **communication is a strong link**. Oral communication and culture feedback loops were present in family- and care-type cultures, while team-type cultures gravitated more toward written communication as a link. In any NH, the content that was said about a patient’s behaviors or condition was always more than what was written in the chart; this was a frequent cause for frustration when administrators or directors of nursing went back to audit or retrieve documentation for state surveys. Another major cause for frustration-type emotions was the conflict and dual emphasis between high-quality documentation and resident care. Many participants suggested **staff education to decrease the conflict**, despite a lack of positive examples of education producing the desired outcome. The impression was that the dual emphasis was a permanent difficulty, but that its severity could possibly be reduced.
RQ 2 asked about participant attitudes toward nursing staff documentation within the NH, asking participants to hypothesize what attitudes non-participant staff might have. Most expressed attitudes were negative, with frustration being a common thread. Reasons related mainly to often-unmet key expectations, such as accuracy (with different “weight” of content depending on whether an RN or a CNA was charting), promptness, and pertinent brevity; resources were seen as inadequate to meet the demands without realistic solutions in sight, making this a “wicked” problem. Why were expectations not met? Participants cited outside influences that were never positive despite organizational and management desires (which apparently did not influence staff attitudes), and the “necessary evil” attitude because all staff wanted to care for residents but disliked documenting the care they provided. Interestingly, the concept of “documentation by exception” was not truly by exception, but rather with variable length and detail depending on the participant and NH. Paths to improvement ranged from education, to audits and quality control, to moderating one’s own emotions before writing or speaking to someone about writing down an aspect of care.

RQ 3 asked about perceived influences on documentation-related attitudes. Responses spanned 3 broad attitudes, and 3 categories of influences on those attitudes. Attitudes encompassed pride (or lack thereof) in one’s own documentation, feeling too rushed to remember what to write once time was available, and recognition (or lack thereof) of the importance of good-quality documentation. Influences on these attitudes were either positive or negative – intrapersonal influences were positive, such as a hard-working mindset, higher level of investment in the NH’s culture, and a sense of justice as far as the time needed to write good documentation. (Personal pride in one’s documentation may have been over-represented in the sample due to a self-selection bias toward more motivated participants.) Internal to the NH itself,
positivity was mixed: variable interpersonal harmony, infrequent administrative support, sub-optimal staffing levels, and challenging resident behaviors influenced respondents’ attitudes. Turnover levels did not influence attitudes, at least in direct and indirect statements. This may be due to different causes of turnover which were not specified in interviews – for example, voluntary versus involuntary. External to the NH, primary (negative) influences were upper management requirements and general lack of support for meeting those requirements. Because turnover did not influence attitudes, but staffing did, participants grudgingly accepted this aspect of the NH landscape.

Finally, RQ 4 asked about themes connecting all three concepts of OC, QAPI, and documentation-related attitudes. The Summary of Findings section noted that there was no single relationship expressed in the interviews, but that each pair of concepts was seen as related in various ways. In the realm of two-concept relationships, the one surprising finding was that the NHA and an RN at one facility disagreed on whether QAPI and culture were related; this is likely due to perceptual differences and unfortunately was not explored further. The main relationship between QAPI and documentation was indirectly stated – that written communication can ease the QAPI process if done well and could be a focus or project of the QAPI committee if not done well. The overall conclusion was that every type of culture seemed to relate; because culture-QAPI links were not specific, the QAPI-documentation link may be the strongest. Notably, Schein’s fourth type (rational) was not represented in the sample. Based on his cultural classification model, group and developmental cultures (“care” and “family” type cultures in the present study’s interviews) would have the greatest success in integrating QAPI efforts. Given a lack of quantitative data, one cannot conclude whether this hypothesis was supported by the present study.
Discussion

Success, Applicability, and Range of Research

This qualitative interview study achieved its goals of thematic saturation and novel findings (specifically previously unexplored thematic intersections). While recruitment took much longer than anticipated, this was due to a combination of COVID-induced heightened NH staff workloads and other major life events cited by several interested staff who ended up not responding to follow-up emails. All anticipated limitations (see section below) encompassed the challenges experienced during the research process.

Applicability, addressed in Chapter 4, relates to limitations in sampling. Because the study was qualitative and interview-based, the potential to apply findings to other participants and settings is not statistically based, but rather based on Guba & Lincoln’s (1989) features of credibility, transferability, dependability, and confirmability. Member checks (albeit with a low response rate) and team-based coding helped to increase rigor, and verbatim transcription with consistent interview guide reference enhanced dependability. Confirmability was increased by transparent description of methods and an audit trail. Therefore, NHs with smaller numbers of beds and longer-tenured administrators (compared to industry average) can expect similar findings in terms of facility culture, staff attitudes about documentation, documentation quality, QAPI, and relationships among these phenomena. This range of findings matched the theoretical model well, with additional novel findings that fit the model with few highlighted exceptions.
Limitations

There were four anticipated limitations to the present study related to the sample and participants. First, because the responses of NHs were voluntary, the resulting sample was not reflective of the state of Wisconsin. Second, in applying the results, state data did not reflect the nation’s situation. Third, turnover endemic to many NHs was anticipated to severely restrict sample size and cause higher-turnover facilities to be under-represented in the data. Fourth, NH administrators were thought to possibly have a different view of their facilities’ culture than would floor-level staff. These limitations were addressed by thoughtful sampling, a comprehensive and balanced interview guide, adequate demographic data collection, clear explanation of potential benefits when recruiting, and use of member checks and procedure audits to increase the credibility, transferability, dependability, and confirmability required for effective qualitative research (Guba & Lincoln, 1989).

Additional limitations were biases of skepticism based on work experience, literature review, and methodological reading (Chapter 1). These were (1) doubtful potential for NH reform, (2) difficulty of changing attitudes of staff, (3) unknown role of attitudes in NH culture and quality issues, and (4) the potential inevitability of burnout. Within the study, these PI biases were mitigated by an outside coder (which also facilitated a combination of deductive and inductive coding) and standardized interview guide (Chapter 3). However, they will still be considered in future work based on the present study.

After data analysis, some sample-related limitations turned out to be true while others were not as bad as anticipated. Based on existing quantitative data about NH features of for-profit status and number of beds per facility, the Wisconsin-based sample was similar to state
and national levels. From interview data, the combination of thematic saturation and instances of NHA agreement with their RN or DON supported the potential to apply results to other samples. However, the atypical sample characteristics of longer-than-average participant tenure and average/below-average NH staff turnover should caution the reader against blanket application of results.

**Implications and Research Directions**

There are three immediate research implications of the present study. First, further investigation of the NH culture-QAPI link may not be as well supported due to nonspecific associations between culture type and QAPI success. (Admittedly, this small qualitative study was not intended to lend statistical confirmation or non-confirmation to Schein’s hypothesis.) Second, the complex construct of staffing variability may be worth investigating in more depth because it was cited as an influence on multiple aspects of QAPI and documentation, which are both important areas of focus in NHs. Third, because only *negative* influences on documentation and related attitudes were cited, it may be worthwhile to investigate what aspects may positively improve attitudes and/or quality, in the complex NH environment. (Education and auditing, the two most cited solutions for quality issues, do not have a clear positive impact on attitudes of those educated or audited.)

Future research, then, may go in several directions (see Conclusion section of chapter 5 for more detailed road maps of possible future research questions). First, by exploring areas of under-representation (Schein’s fourth culture type and higher-turnover NHs), further links among the concepts of QAPI, culture, and documentation/attitudes may be elicited. Second, the
inherent variability in staffing, across geographic areas and the NH industry, may be important to address in LTC reform, due to its perceived effects on care, documentation, and QAPI success. Third, quantitative studies could examine impacts of education and auditing on related attitudes. Finally, further qualitative and quantitative work on ways to improve attitudes may have the downstream effect on improving documentation quality in NHs without adversely impacting staff stress levels.

Additional implications for practice and NH administration include the following. For daily clinical practice of NH nursing staff, interpersonal relationships and adequate time are important to facilitate quality charting for residents under their care. Because adequate staffing levels are difficult to maintain consistently, enough time may be particularly difficult to carve out. For NH administrators, the quantity and quality of staff are important variables for ensuring good documentation quality and ability to audit. Administrators may need to reevaluate the role and effectiveness of education they provide to staff at various levels.

Through the dissertation process, this recently completed qualitative interview study met its objectives of enriching insight into the intersection of NH culture, QAPI, documentation, and staff and administrator attitudes and emotions. Despite the relatively narrow scope of the sample (8 Wisconsin NHs during the COVID-19 pandemic), most findings agreed with the theoretical model, itself based on the larger scope of literature. Novel findings included the perceived importance of communication in relating concepts of culture and QAPI, the negative influence of outside factors and perceived irrelevance of turnover in documentation quality, and lack of representation of a rational-type NH culture. Taken together, anticipated and unanticipated findings contribute to the literature and practice in the long-term care field.
Conclusion

To summarize, certain interview data answered each research question. The remainder of data can be further examined to suggest future research questions and methods.

RQ 1: what were participant views on OC related to documentation? This answer required three components: culture descriptions, documentation descriptions, and exploration of the consistent relationship between the two. NH cultures were family-type, care-centered, or team-centered, corresponding to Shortell’s categories of developmental, group, and hierarchical, respectively. Documentation was described in terms of (negative) attitudes and emotions, and essential characteristics to support timeliness and accuracy. Culture and documentation were seen as related by staff attention to quality in their tasks of care and charting, as well as use of oral communication within a building’s culture to expand upon written charting.

RQ 2: what were participant attitudes and emotions toward documentation? Data categories answering this question were encompassed by two codes (themes) in the CHARTING umbrella theme: frustration-type or negative emotions and preference for resident care. Emotions included bewilderment, frustration, embarrassment on the facility’s behalf, stress about daily crises, fear about state surveys, and feeling burdened by regulatory requirements. Staff preferred to care for residents and spend less time documenting their care, because they were caring individuals and because administration told them to prioritize this way – despite also telling them to document accurately, thoroughly, and at the time of care. Thus, the conflicting preference for resident care served as an additional attitude about documentation, that it took a close second place.
RQ 3: what were participant views on what influences documentation? The answer came from influences on documentation and influences on QAPI, likely because documentation was seen as either a tool for or a target of QAPI processes. Three levels of direct influence on documentation emerged: individual peer-peer relationships, nursing home-level policies and practices, and external aspects like geographic setting and federal or state regulations. QAPI-specific influences included staff knowledge of what was required, the level of teamwork and oral communication present, and variability of staffing levels.

RQ 4: how did participants think OC, QI, and documentation-related attitudes might be connected? Relevant data came from the QAPI and documentation umbrella themes, specifically the codes of documentation relating to culture, QAPI relating to culture, and QAPI relating to documentation. QAPI and charting were related by charting being a target of or tool for QAPI, regardless of culture type. In most facilities, QAPI was seen as a natural extension of the culture but also a requirement from an external regulator (CMS).

Future RQ 1: What is the effect over time of NH staff education on documentation quality and related attitudes? Participants in this study thought that education was an effective strategy to improve or maintain quality but had not cited specific examples of success. This question would be addressed with quantitative methods using a longitudinal data-gathering approach. Key variables to consider would be the type, mode, periodic duration, and frequency of education; prior staff knowledge and experience; and real-world situations of each participating NH (such as the COVID-19 pandemic in the present study). Ideally, a pragmatic trial design would maximize both statistical controls and real-world applicability of findings.

Future RQ 2: What are the effects of staffing variability on QI, documentation, and related attitudes? As noted above, staffing variability is a complex concept and thus requires
careful operational definition to differentiate it from turnover. Participants had mentioned but not elaborated upon it as a potential influence on the three variables in the question, which would be addressed using quantitative or mixed methods using a survey approach. Qualitative components of a mixed-method study would allow for participant description of effects and factors not evident in a literature review. Ideally, the sample would include all or most levels of NH staff to differentiate various opinions that might be due to position or education/skill level.

**Future RQ 3**: In a different population of low-quality NHs, what are the perceived relationships among OC, QI, and documentation? This study would seek to replicate the presently completed work, with a distinctly different sample. Thus, either qualitative or mixed methods could be used, depending on the presence or absence of updates to the body of literature regarding establishing measurable relationships between variables. A more focused interview guide and a sample including individuals and/or focus groups representing higher-turnover and lower-quality NHs would support thorough qualitative data collection.
REFERENCES


MacDougal, C., & Fudge, E. (2001). Planning and recruiting the sample for focus groups and in-depth interviews. *Qualitative Health Research, 11*(1), 117-126.


APPENDIX A

STUDY ACTIVITY TIMELINE
Note: Activities began in 2020 (August) and concluded in 2022 (May).

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APPENDIX B

THEME AND CODE DEFINITIONS
Umbrella theme: CULTURE. Definition: Participants' self-selected words or phrases that described the overall workplace culture of their facility. Some participants were assigned to select from a list of four options based on the Quality Improvement Implementation Survey classification of health care facility culture. Sub-themes (codes) are:

- FAMILY. Definition: Facility culture was centered around viewing residents and staff as a single large family unit. This was stated to have mostly helped life and relationships for both residents and staff, but also some dysfunction, similar to a “typical” nuclear or extended family.
- CARE. Definition: Facility culture was centered around viewing the main duty and privilege of staff as caring for the residents. This represents an intermediary cultural classification between family-oriented and interdisciplinary.
- TEAMS. Definition: Facility culture was centered around the concept of all departments and staff working closely together, communicating orally and in writing, to provide optimal resident care. This represents a “bookend” of the family-care-interdisciplinary cultural continuum in terms of staff view of residents.
- TURNOVER. Definition: Facility culture was referenced as having varying degrees of turnover. Stability and high turnover levels were cited as each related to a family-oriented cultural type, depending on the level of function or dysfunction in the family-type unit of the facility.

Umbrella theme: CHARTING. Definition: Documentation generally referred to the clinical legal record of resident care written down by staff. Topics included MARs (medication administration records), TARs (treatment administration records), and Medicare charting (with specific time and content requirements for residents whose primary payor source at the time was Medicare part A). Sub-themes (codes) are:

- FRUSTRATE. Definition: Participants expressed frustration and similar negative emotions with various aspects of the documentation of self or fellow staff. Specific areas of frustration included software used, access issues, quality of others' documentation, and the time of documenting and/or auditing one's own work.
- ACCURATE. Definition: Objectivity - encompassing clinical completeness of documentation of one's assessment or interaction - was cited as a core criterion for "good" documentation. Reasons included external auditors, the possibility of family members requesting access to a resident's chart, and ease of follow-up over subsequent shifts and days.
- PROMPT. Definition: Promptness was cited as a core criterion for "good" documentation. Reasons included the limitations of the caregiver's memory, the desire to include as much relevant detail as possible, and a longstanding industry expectation. Participants noted infrequent point of service, instead noting that staff would care for a group of residents before sitting down to document for all of them en masse.
- EXCEPTION. Definition: Pertinent brevity was cited as a core criterion for "good" documentation. This entailed more thoroughly describing variations in a resident's health or behavioral status, and less thoroughly describing or summarizing what was a resident's medically appropriate baseline.
- INFLUENCES. Definition: Participants cited specific forces external to the documenter that adversely affected documentation and/or the time available for resident care and
personal life. These forces included regulatory criteria, agency/temporary staff (related to turnover), administrative changes/oversight, and needy or "demanding" residents.

- **DIFFERENCE.** Definition: Participants at all levels of clinical care and administration noted similarities and differences to how RNs and CNAs tended to document. Similarities included "by exception" and not always "point of service." Differences included free-text versus check-box, and different appreciation of the import of the content of one's documentation for a particular resident.

- **PREFERENCE.** Definition: A strong preference for direct resident care was cited as a frequent reason for documentation deviating from expectations. Administrators and floor staff acknowledged this, in varying degrees of positivity. The preference was expressed as a personal characteristic, administrative or corporate expectation, and industry standard, depending on the interviewee.

- **KNOWPATH.** Definition: Inconsistency occurred in whether staff and administrators had a clear mental image of how to remediate subpar documentation so that it met expectations. Facilities with designated documentation-related QAPI projects and a continuous improvement mindset seemed to have a clearer mental image among participants.

- **DOCCULTURE.** Definition: When prompted, staff at all levels predominantly agreed that the facility's culture and its documentation process seemed to be related, less strongly than the QAPI-culture relationship. Specifically, a culture attentive to quality of care tended to have staff attentive to point-of-service, objective documentation; and a culture more entrenched in positive or negative family-type dynamics tended to have less consistent written documentation quantity and quality.

_**Umbrella theme: QAPI.** Definition: QAPI is a standardized process requirement promulgated by Centers for Medicare and Medicaid Services. The specific implementation and targets are flexible, but must include five components listed on the CMS website. Sub-themes (codes) are:

- **FOCUSSHIFT.** Definition: QAPI focus varied widely by facility, including micro to more macro levels. Some facilities referred to Performance Improvement Projects as "tasks" that had less structure. Frequently mentioned areas for QAPI focus were infection control, falls, and mobility loss.

- **SUCCESSRATE.** Definition: QAPI success varied by facility, and was impacted by internal and external variables including staffing/turnover, administrative continuity, and a negative facility culture. Carryover by floor-level staff seemed to be a factor, but it was unclear whether the mode and frequency of communication from administration about QAPI priorities was related to this.

- **KNOWHOW.** Definition: Ground-level and administrative staff seemed to have a consistently strong understanding of what specific QAPI requirements, expectations, and facility projects. Communication of specific focus items, interdisciplinary participation in QAPI meetings, and degree of floor-level staff participation in efforts varied across facilities.

- **QAPIKEYS.** Definition: Staff at all levels expressed an understanding that communication (both oral and written) and teamwork were foundational to essential QAPI. Administrators frequently noted that staff tended to communicate resident status
changes with each other orally at change of shift, but not necessarily put them in writing. Documentation was seen as generally relating to the success rate of QAPI efforts.

- **QAPICULTURE.** Definition: When prompted, staff at all levels predominantly agreed that the facility's culture and its QAPI process seemed to be related, strongly or plausibly. Generally, they were able to elaborate on whether culture seemed to drive QAPI, or culture change attempts interacted or interfered with QAPI.

- **STAFFINGVAR.** Definition: Several phrases described the inherent variability and unpredictability of staffing in a NH. These included biologically and maritally related nursing staff, seasonal employment, small-town locales offering a limited employment pool, phased retirement due to plans or chronic disease, and interpersonal conflicts whether real or perceived.