This study explored how direct care workers in nursing homes conceptualize good care and how their conceptualizations are influenced by external factors surrounding their work environment and the relational dynamics between them and residents. Study participants were drawn from a local service employees' union, and in-depth interviews were conducted. Data were analyzed using a grounded theory approach, and the results revealed that direct care workers equated good care, such as resident cleanliness, comfort, and happiness as a desirable outcome of care activities. Good care also meant affectionate, respectful, and patient attitudes of direct care workers toward residents in care delivery processes. Nursing home workers internalized the perspectives of residents and other professionals about what constitutes good care, and then drew their own conclusions about how to balance, combine, and compromise those diverse demands. It is important to communicate accurate and consistent messages about what comprises good nursing home care to nursing home workers and build a working environment where workers' conceptualizations about good care can be executed without organizational barriers.

Key Words: Quality of care, Nursing homes, Grounded theory, Nursing home workers

Background

Direct care workers in nursing homes provide most of the hands-on care that residents receive (Beck, Ortigara, Mercer, & Shue, 1999; Harmuth & Dyson, 2005). They not only provide instrumental care to residents in helping them perform activities of daily living and instrumental activities of daily living but also deal with emotional and psychological issues that residents might have during care interactions. For many residents, these workers are the only social outlet through which they can express their loneliness and needs (Grainger, Atkinson, & Coupland, 1990). Direct care workers in nursing homes are crucial in facilitating the adjustment process for new residents who are not accustomed to receiving prescribed care activities in an institutional setting (Hikoyeda & Wallace, 2001). Given the importance of direct care workers for the continuous provision of good nursing home care, many studies have examined the association between staffing level and quality of care in nursing homes, and more nursing assistant hours were associated with higher quality of care in general (Bostick, 2004; Bostick, Rantz, Flesner, & Riggs, 2006; Harrington, Zimmerman, Karon, Robison, & Beutel, 2000).

In those studies, quality of care was measured by various quality indicators, which tended to focus on resident outcomes. And the roles performed by these workers were translated into quantifiable measures, such as the number of nursing assistant hours per resident and the number of nursing assistants per 100 beds. Castle (2008) reviewed 59 studies that looked at the relationship between staffing and quality of care in nursing homes and found that 37% of the quality indicators had significant associations with the level of nursing assistant staffing. Thus, the ratio of nursing home workers...
to residents has been used more widely in previous studies to examine the quality of nursing home care, and there were limited efforts to understand nursing home workers’ own conceptualizations about good nursing home care. There are only a few studies directly addressing the role and views of these workers in the discussion of quality of nursing home care even though their care activities constitute the core of care delivery processes.

Pfefferle and Weinberg (2008) examined how nursing assistants attributed their own meanings to direct care in response to demeaning work environments. They were found to derive self-worth by considering their work “God’s work” and developing reciprocally caring relationships with residents. This, in turn, gave them motivation to work despite the organizational structure of nursing homes, which tended to devalue their work. Nursing assistants emphasized the importance of their own role in standing up for residents who could not take care of themselves or communicate their own needs. Bowers, Esmond, and Jacobson (2000) found that direct care providers considered personal relationships with residents key in providing more individual care while they explored the link between staffing and quality of nursing home care. Direct care providers in this study thought that their personal relationships with residents fostered familiarity, which enabled them to know and respect each individual resident’s personal preferences, thus ultimately enhancing quality of care. Short staffing was found to lower quality of care because insufficient time to care for residents made individualization and reciprocity difficult.

Although two previous studies addressed nursing assistants’ self-perceived roles and their perceptions about the link between staffing and quality of care, the following study explored nursing home workers’ care construct based on the assumption that the way they cognitively process what constitute nursing home care guides their actual care delivery processes (Anderson et al., 2005). The authors concluded that nursing assistants adopted two mental models and implemented them during care activities. Through “mental models,” nursing assistants interpreted care situations and chose the right actions based upon their reasoning. Specifically, the mental models were named “the golden rule” and “mother wit.” The golden rule implies that direct care workers put themselves in their residents’ shoes when making decisions on behalf of residents, and mother wit enables them to treat residents as if they were caring for their own children. If nursing assistants act upon their care construct during the care delivery processes, it could be inferred that their care construct would influence quality of care in the end because the contents of care activities and the way they are provided would determine the care quality. For example, Rantz and colleagues (1998, 1999) introduced a multidimensional model of nursing home care quality from the views of both residents and service providers. The staff was one of the key dimensions of care quality, and the model included several components directly related to the role of nursing assistants, such as caring, compassionate, responsive attitude towards residents, positive communication with residents, individualized care, treating residents as people, following through with care, and taking care of the basics.

**Purpose of the Study**

Even though nursing home workers’ conceptualizations or expectations about good care are seldom reflected in the official policy decisions dictating the quality of nursing home services, it is still important to integrate their voices and experiences into the current discussion about quality of care in nursing homes. By finding out how they conceptualize good care in nursing homes and exploring factors that might have influenced their view, it will be possible to contextualize the care delivery process and to broaden our understanding about interactive dynamics among nursing home workers and other professionals working in nursing homes. Thus, the purpose of this study is to determine what constitutes quality of care among those who provide direct care to nursing home residents and to identify any factors that might have affected the way in which these workers conceptualize quality of care. It will also be explored whether nursing home workers act upon their conceptualizations or there are any constraints on the execution of their conceptualizations during the actual care delivery processes.

**Design and Methods**

**Sampling**

The study employed a purposive and convenience sample of 21 direct care workers working in skilled nursing facilities in the greater Los Angeles area. Study participants were recruited through the SEIU Local 434B, a long-term care workers’ union. A letter to participants (including an information sheet about the study) and participant-release agreement (a postcard in which potential study
participants could indicate their willingness to be contacted along with their contact information) were approved by Institutional Review Board at UCLA. Two nursing home representatives from the union helped distribute these two forms among union members. Drawing study participants from the union allowed balanced representation among care workers in terms of their seniority and demographic characteristics.

To be eligible for this study, participants had to be working as full-time certified nursing assistants in state-licensed skilled nursing facilities where 24-h medical nursing care was provided for people with serious illnesses or disabilities. Second, participants had to have at least one year’s experience as a nursing assistant. This was to ensure that study participants knew the job well enough to have developed some ideas about their work and quality of care. All the interviews were conducted in English. Six of the participants were men and fifteen were women, and the average age of the participants was 42 years (ranging from 22 to 58). The average time working as nursing assistant was 11 years (ranging from 1 to 30 years), and all were employed full time. Thirteen of the participants were immigrants from countries in Central or South America, and the other eight were born in the United States.

Data Collection

Data were collected through 60- to 90-min face-to-face interviews with study participants using open-ended questions, and interviews were taped upon permission from study participants. An interview guide was developed and used to direct the interview without omitting pertinent questions and to focus on the primary topics of interest. Interviews were conducted at the study participants’ location of choice, but meeting in the union office was suggested first. Each interview began with broad and general questions about their work and care delivery processes. A field notebook was used to document the researcher’s initial thoughts and ideas while listening to study participants and to help the researcher recall the specifics of each interview, such as the date, time, location, and atmosphere. After each interview, the researcher also wrote down gut responses and feelings to elicit own biases and preconceived assumptions.

Data Analysis

Interview tapes were transcribed verbatim within a week after each interview. Field notes, face-sheets, and transcribed interviews were filed for each respondent with an identifiable number, not with a name. For data management purposes, ATLAS.ti, a qualitative research software, was used. Data collection and analysis occurred concurrently. And grounded theory approach was used to analyze interview data by conducting constant comparisons and identifying patterns and variations in the data (Corbin & Strauss, 1990).

Coding is a method of attributing labels to lines of transcribed interviews and is the first step of interpretation (Glaser & Strauss, 1967; Padgett, 1998). Open coding as the textual-level analysis was used to name each line of transcribed interviews and to reduce the temptation of interpretation. Then, axial coding was used to make conceptual links between the chunks of data that were grouped through open coding. Main categories were derived by assigning higher level, more abstract, overarching concepts to the chunks of data. Lastly, through focused coding, final decisions were made about which codes and categories were to be kept. Then, all the transcripts were recoded only with those selected codes and categories resulting in a fuller description of selected categories with their various attributes in more detail (Charmaz, 2006; Corbin & Straus, 1990).

While sorting out codes, memos were written about certain codes that mingled together naturally or were used many times. Memo writing was also used to make conceptual links among codes and to clarify why certain codes were grouped into one category and how each category was labeled. For example, “clean” was a main category that emerged from the data fairly early in analysis, and it turned out that to study participants, good care was reflected by a resident’s cleanliness. By using theoretical sampling, all of the quotations that were linked to the category named “clean” were examined. As a result, in subsequent interviews, new interview questions were added including why participants thought residents’ cleanliness was important. Thus, the properties of this category “clean” were elaborated upon by learning that direct care workers deeply cared about residents’ cleanliness because it was related to their reputation and evaluation. This began to reveal the importance of the visible outcomes of care activities in nursing homes when compared with the less visible process of providing care. Data collection continued until new properties emerged regarding all major categories including the category “clean.” According to grounded theory approach, data
collection can be suspended when the collection of new data no longer adds “theoretical insights” (Charmaz, 2006) and when a researcher does not find new properties of core theoretical categories or the same pattern (Glaser & Strauss, 1967; Morse, 1995). Therefore, once core categories with the greatest explanatory power were identified, it was considered appropriate to stop gathering new data.

One of the limitations of this study is that participants were recruited from a restricted geographical area. They were working in eight different for-profit nursing homes in Los Angeles County, California, and five of those facilities were managed by the same corporation. However, it is likely that the reality of traditional nursing facilities located in Los Angeles County, California was captured. Also, it turned out that the average length of employment as a nursing home worker was about 10 years among study participants. As a result, study findings might not reflect the wider spectrum of nursing home workers’ experiences working in nursing homes based on length of time in the profession. However, this could be a strength of this study because these study participants were more informed and knowledgeable about the intricacies of care delivery processes.

Results

When asked about quality of care, most study participants admitted that they had heard the phrase used by their administrator and nurses. However, they were not able to give a definition of their own. There were a couple of workers who said they had not heard of the phrase. Therefore, instead of what “quality of care” meant to nursing home workers, it was necessary to ask what they considered “good care” in order to indirectly capture their views on the properties of care quality. It is striking that almost all of the first reactions to the question on good care were oriented to visible outcomes of care activities. Then they talked about the importance of the care process and their attitudes toward residents as part of good care. Each quote is followed by the gender and length of time as a nursing home worker.

Good Care as Outcomes

Nursing assistants conceptualize good care by its desirable outcomes: resident cleanliness, happiness, and comfort. There is not much variation in their answers; these three desirable outcomes of care activities come up repeatedly. Instead of directly answering the question about what they consider good care, they report on what they consider to be desirable outcomes of their care. The following section describes these three desirable outcomes of care activities at the individual resident level.

Clean and comfortable.—To nursing assistants, it is crucial for their residents to look clean. They unanimously say that good care is reflected by the cleanliness of residents’ body parts including the mouth, nails, in between toes, and belly button. They consider themselves having delivered good care as long as their residents look nice and give good impressions to other people.

Good care is reflected by clean mouth, face, nail, hair. . .every part of the body needs to be clean. Also good clothes, good presentation, sitting up good. . .are examples of good care. (F, 17)

A good care means when the family can see the resident is nice. I mean, he gets a shower, he’s totally, totally clean, you can see one person is really clean. (M, 5)

Keeping residents clean is also perceived as what “other people” (including nurses, administrator, state surveyors, and family members) expect from nursing assistants. Nursing assistants think that the appearance and presentation of their residents are the primary evaluation criteria used to judge their job performance. Nursing assistants’ pursuit of cleanliness of residents, as a desirable outcome of good care, is acknowledged and complimented openly and easily. This implies that if residents do not look tidy and clean, it may cause unwanted troubles at work for nursing assistants.

Always keeping my patients clean, keeping my patients’ area picked up that is nice and when someone walks in, it give a good impression. (F, 10)

You always have your morning report with your LVN. . .basically they tell you. . .I want all my patients basically to look perfect, clean, neat, wonderful and not smelling. (F, 1)
Think about yourself. What do you want to see? Do you want to put on the same dress that you put on yesterday? Do you want to talk to somebody with your mouth smell? Think about it. (F, 5)

Good care is clean the patient beginning from his head to his foot, every part... You need to think. Maybe tomorrow or next time, that person can be you. It's gonna be you or it's gonna be your family... you expect the same for the person you take care of. (M, 5)

Also, nursing assistants make sure that residents have physical comfort in terms of their positioning or having their basic needs met. For the residents who spend most of their time either in bed or in a wheelchair, their positioning is very important to avoid unnecessary pain and pressure sores.

And make sure your patients are in comfortable position... sometimes they can be crooked in bed and that adds to the discomfort, too. So we have to position them right that they are not uncomfortable. (M, 29)

I always have my patients comfortable, if the patient is in wheelchair or in bed, make sure you reposition your patients for no bed sores. (F, 3)

Even though they cannot say ‘thank you’, seeing they are comfortable, not complaining about pain, that’s the most important. (F, 24)

Happy.—Nursing assistants also think that good care involves keeping residents happy and they strive to make residents feel happy out of sympathy toward residents who cannot live in their own homes. Nursing assistants believe that feelings of happiness will lead to better physical health among residents. These ideas seem to provide the justification that nursing assistants can and should do whatever is pleasing to residents.

For me the most important thing is to keep them happy. Happiness keeps you more health, better..... Happiness is everything. If you are depressed or disappointed, not happy, your health goes down. Happiness has no price. (F, 7)

I like to keep my patients happy because they are not in their house... so we have to try to keep them happy and please them anyway that we can. They are not with their family. (F, 3)

Keeping residents happy has another positive ramification for nursing assistants. Residents will not make any complaints against nursing assistants if they are pleased and happy. Complaints from residents might cause problems for nursing assistants resulting in a warning or write-up from their supervisors or the administrator, and they want to prevent that. Seeing residents who are happy also signifies that nursing assistants are doing a good job, and it makes them feel content. Nursing assistants are proud that their residents are in a good mood after they deliver care activities. Also, residents who are satisfied with nursing assistants are more cooperative with instructions, as if they want to return a favor received previously.

When they complain, there’s something wrong with the nurse. A lot of time when they are not happy, they complain. For example, ‘oh, she’s rough, she doesn’t answer my call lights.’ You know, sometimes that happens. (F, 7)

A lot of time when they are not happy, they complain.

Good care means to me is keeping your patient happy... as long as the patient doesn’t complain about anything. That means the patient is satisfied with you. (F, 30)

Nursing home workers want their residents to feel emotionally comfortable with them because in this way residents become more receptive to care activities and make nursing assistants’ work easier and faster. And after they deliver care activities they make sure residents are physically comfortable and have no complaints. Again, making residents comfortable is done not only for residents themselves but also for the benefit of nursing assistants. They comfort the residents who are emotionally distressed, afraid, depressed, or lonely. They notice and acknowledge such feelings among some residents and comfort them by hugging them or saying that things will get better. Once they recognize a resident as an individual, they find themselves trying harder to comfort the resident emotionally.

Once you get to know the resident and how, the first day might be rough because you are new person and they don’t know quite who are you and even if you communicate with them and put food in their mouth, they will try to resist... they have to be basically comfortable in order to feed them... the more comfortable they are with you, the more they will take it. (F, 1)

I try to comfort them as much as I can. I have compassion for sick people. I do my best making them comfortable. (M, 29)

Good Care as Processes

According to nursing home workers, good care includes not only the outcomes of care but also the attitude and mindset of caregivers. They
list affection, patience, and respect conveyed and exchanged during the care delivery process as good care. It is noteworthy that these views are expressed only after they mention the desirable outcomes of care activities as examples of good care. The fact that nursing assistants talk about affection, patience, and respect means they know the importance of the way they engage residents in the care delivery process.

**Affectionate.**—Most nursing assistants report that without affection, their care activities are never complete. It is difficult to measure and control the level of affection that nursing assistants have toward residents, as indicated by their description of care-giving as a natural talent or an instinct. They also feel pain and agony when residents to whom they have been emotionally attached pass away.

Nursing assistants try to empathize with residents by asking themselves how they would feel if they had limited physical ability and had to leave their own home and family. By putting themselves in the shoes of residents, nursing assistants can also win residents’ trust and acceptance into their lives. Nursing assistants get to understand why residents tend to feel depressed and sad and refuse to get attached to anyone in severe cases. Nursing assistants selectively share their own feelings with residents to open up a conversation and normalize residents’ venting of their own feelings.

Good care is just like you care for yourself, your kids, your family. Once you start care, your heart is just coming. I always think I want to treat them good. I'm at home but my heart is still with them, still at work. Like my kids are at school, I think about them. (F, 5)

Some people come to their job because they care about it. That’s what total care is, just show love, affection, like touching is affection. Cleaning them up is affection, that’s also love. (F, 1)

Because you can talk to them and sometimes they give you some advice, you become really attached to them. And to me, it really hurts when one of them passes away. It does hurt me so much. (F, 24)

**Respectful.**—Nursing assistants consider it important to talk to residents during the care delivery process. They first knock on the door and let residents know that they are entering the room. Then they start a conversation with residents, restating their name and what they are going to do step by step. Nursing assistants explain all the steps of care activities to residents and ask their permission before beginning a care activity no matter what their mental condition. It is a way of showing their respect and reducing unnecessary anxiety among residents by expressing verbally what will happen next. Conversation between nursing assistants and residents is not limited to specific care activities. Through conversation, nursing assistants build rapport, open up the long-term relationship, and smooth out their encounters with residents. Residents like to talk about their past, and workers try to get to know each resident as a whole person who had another life before coming to a nursing home. Their conversation can be a “talk therapy” through which nursing assistants may change residents’ moods and find out the cause of residents’ emotional downturns. Nursing assistants say they need to find time to talk to their residents in the midst of tight work schedules. They also put extra effort into engaging some of the residents who are not coherent or are depressed.

Some residents are not coherent but I would still talk to them. I didn’t know if they could hear me or understand me, but I would be considerate enough to say what I’m going to do and mention my name. When I come across with the patients who are coherent, I say ‘hello, my name is XXX and I’m gonna change you, I’m gonna turn you. What? Does it hurt you? I’m sorry’, things like that. I will talk to the patients. (F, 30)

You have to keep communicating with your residents. Because if I go up to you and take off your clothes, and you will be like oh my goodness, what are you doing? You feel uncomfortable, so you have to say hi, my name is xxx and I’m here doing such and such today and is this okay if I take your sweater off? (F, 1)

**Patient.**—Nursing home workers unanimously consider patience as one of the necessary attitudes to have when they interact with residents. There are two kinds of patience: one involves taking enough time with each resident and the other involves enduring any psychological and emotional stresses caused by interaction with residents. To give enough time to each resident, even when they are slow in responding and following instructions, is not easy due to the tight schedule workers must follow. The number of residents who are assigned to each worker is always predetermined. Therefore, nursing home workers sometimes have to make compromises and rush their residents in order not to fall behind schedule.

As care involves establishing a relationship with the resident, nursing home workers may
experience stress when dealing with residents who are not cooperative or are behaviorally acting out. A study participant states that residents are not machines and therefore they cannot be turned on or off. Nursing assistants understand that they need to be prepared to repress their own emotions that may result from clashes with residents and to keep doing what is required of them as their job.

It’s hard to understand patients’ feelings because you have to be patient with them. If you don’t, you’re gonna screw up and you’re gonna run away. (M, 3)

I have a lot of patience with them, but I don’t mind having more patience and more love for them. (F, 7)

You don’t rush them and just be patient. Take your time and deal with it. (M, 29)

Discussion

When nursing home workers conceptualize good care as involving desirable outcomes of care activities, the focus is on the residents. They describe properties of good care using adjectives like clean, comfortable, and happy. They expect their residents to look clean and comfortable after they provide care activities. One of the reasons these workers are more oriented to the immediate outcomes of care activities in their definition of good care might be current nursing home culture and the practice of being given instant feedback on their job performance. Nursing home workers are held responsible for the visible results of care activities and resident cleanliness and neat presentation are often used as the parameter of their job performance. Resident appearance and posture can be easily examined by other people, and it can be easily tracked whether nursing home workers have completed care activities related to residents’ hygiene (Bowers et al., 2000).

It is worthwhile to note that formal regulatory measures of quality of care also tend to focus on capturing outcomes of care activities (Mullan & Harrington, 2001). The Minimum Data Set (MDS), which is a part of the On-line Survey, Certification and Reporting system, is used to regularly monitor residents’ deterioration and/or progress in their functioning. The MDS contains information about each resident’s physical status, mental status, and other special conditions, such as contractures, pressure sores, incontinence, and the use of urinary catheters and physical restraints. These measures are considered to be outcome oriented in that they reflect both the positive and negative changes in a resident’s condition as a result of nursing services and care delivery processes. The focus of current nursing home regulations and annual state inspections, which mainly target the visible outcomes of care activities and the detectable changes in residents’ health status, may have been shared with nursing home workers. For example, workers report that that state surveyors check resident cleanliness and documentation in resident charts closely and use their observations to judge the quality of care during an inspection (Chung, 2012). As a result, even though nursing home workers are not aware that pressure ulcer rate and poor skin integrity are major quality indicators included in the MDS, they still rank resident hygiene and physical comfort as a top priority of their work.

Good nursing home care is also reflected by residents who are emotionally pleased and have no complaints after receiving care activities. The word “happy” and the phrase “keeping my residents happy” were repeatedly used by study participants. They provide emotional comfort to residents out of sympathy, knowing that residents tend to feel lonely and depressed. Keeping residents happy is also important because it means residents are satisfied and do not have complaints, which might cause a problem later. As a result, nursing home workers believe residents should feel happy and content if they delivered good care. When residents are emotionally comfortable, they tend to be more receptive of care activities and have less complaints, which is advantageous for nursing home workers as it will ease their workload and prevent a warning from their supervisors.

After study participants describe good care as involving desirable outcomes of care activities, they emphasize the importance of affection, respect, and patience toward residents. Their definitions of good care include what their mindsets and attitudes toward residents should be. Being affectionate implies nursing home workers treat residents as if they were their own family members allowing emotional attachment to residents. To be respectful toward residents during care delivery processes, nursing home workers address each resident as a distinct individual and accede to their requests. Nursing home workers hold back their own stresses and try to keep pace with residents who are slow in motion.
However, it is not always detectable whether workers are consistently respectful of their residents, because many care activities are delivered in resident rooms away from other people’s eyes. Also, there can be a discrepancy between what nursing home workers think they should do and what they actually can do, especially in a situation when good care as measured by outcomes takes a priority over good care as measured by processes. For example, nursing home workers might think that it is more important to make a resident eat to prevent weight loss than to respect and accommodate her preference not to eat at a particular time or to understand the psychological issues behind her refusal to eat. The prevalence of weight loss is one of the outcome-oriented measures of quality of care, but forcing a resident to eat for the sake of not triggering a quality indicator related to weight loss does not necessarily increase quality of care. Also, when nursing home workers are under severe time pressure, they might put more emphasis on the outcomes of care activities sacrificing care delivery processes. This is known as “corner cutting,” which tends to happen in the less visible and traceable area of care delivery processes (Bowers et al., 2000).

The comparison between how residents view quality of care and how nursing home workers perceive good care is crucial as it provides a more complete understanding of nursing home care quality. Bowers, Fibich, and Jacobson (2001) categorized residents into three types. The first group of residents considered care as service and thought workers’ efficiency and competence were most important. The second group of residents conceptualized care as relating and emphasized the importance of having a positive relationship with their caregivers. The third group of residents understood care as comfort and expressed their wish to be physically comfortable. It can be inferred that there could be mismatches of nursing home workers’ and resident’s conceptualizations about good care and priority. Residents who view care as good service expect professionalism among nursing home workers, which can be demonstrated by their punctuality and thoroughness in the provision of care. When these residents are assisted by nursing home workers who put the greatest value on relationship-building with residents, there might be disappointment and miscommunication between the two parties. Therefore, an environment under which residents and nursing home workers mutually understand that there can be multiple elements of good care and can adjust their expectations is desirable. Nursing home workers can be trained about how each resident may perceive good care differently so that they can provide more individualized care.

Implications

Anderson and colleagues (2005) cautioned that nursing home workers’ mental models could be shaped through the interaction between nursing home workers and others. The findings from this study suggest that nursing home workers’ conceptualizations about quality of care are not independent of other professionals’ expectations and organizational requests about their job performance. Their care actions based on such conceptualizations are influenced not only by the mental models of other professionals including administrators, nurses, and state surveyors but also by relational dynamics between them and residents. Thus, they tend to internalize the perspectives of residents and other professionals about what constitutes good care, and then draw their own conclusions about how to balance, combine, and compromise those diverse demands. Therefore, the feedback given to nursing home workers should not be just limited to pointing out what is lacking in resident appearance so as to prevent reinforcing a limited view of care-giving among workers. It is also important to communicate accurate and consistent messages about what comprises good nursing home care to nursing home workers and to build a working environment where workers’ conceptualizations about good care can be executed.

The results from this study reveal how the conceptualizations of nursing home workers are developed and maintained. It is necessary to approach their conceptual models from an organizational perspective to identify areas and strategies for modification if needed and to put more organizational efforts that are conducive to the accommodation of multiple conceptual models held by nursing home workers without causing unnecessary confusion. Positive attitudes toward residents and sound interpersonal care processes need to be rewarded in addition to desirable outcomes of care activities in nursing homes. Also, a nursing home as an organization may consider breaking down the definition of abstract but common phrases like individualized care and cultural sensitivity into specifics at the level of direct interaction with the input of nursing
home workers. By doing so, nursing home worker conceptualizations about good care can become more concrete and practice-oriented providing the foundation for improved quality of care and more therapeutic interactions between nursing home workers and residents.

Acknowledgments

I would like to thank Dr. A.E. (Ted) Benjamin and Dr. Ruth Matthias for their support and guidance in completing my dissertation.

References


