PERCEIVED RESPECT IN OHIO NURSING HOMES AND THE FACTORS ASSOCIATED WITH IT

by Anju Paudel

Respect to residents and their choices has been established as a fundamental right of nursing home residents. Despite the importance of this basic right, little is known about perceived respect in nursing homes and the factors associated with it. The purpose of this cross-sectional study was to examine perceived respect and its possible correlates across Ohio nursing homes. On average, nursing homes in Ohio had relatively high respect scores. After adjusting for a range of facility factors, I found facility size, facility location, resident participation in care planning and Center for Medicare and Medicaid star ratings in the staffing domain to be associated with perceived respect. Our understanding of how these factors affect respect among the resident population in Ohio nursing homes would benefit from a more nuanced examination of each subdomain of respect. Although additional research is needed, this study identified several potential next steps for policymakers seeking to ensure that residents are treated with respect.
PERCEIVED RESPECT IN OHIO NURSING HOMES AND THE FACTORS ASSOCIATED WITH IT

A Thesis

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# Table of Contents

Chapter 1: Introduction .................................................................................................................. 1
  Perceived Respect ......................................................................................................................... 2
  Determinants of Perceived Respect .............................................................................................. 3

Chapter 2: Methodology .................................................................................................................. 8
  Data Sources ................................................................................................................................. 8
    2013 Ohio Long-Term Care Resident Satisfaction Survey ......................................................... 8
    2013 Biennial Survey of Long-Term care Facilities- Nursing Facilities ................................. 8
    Nursing Home Compare (NHC) .................................................................................................. 9
    Certification And Survey Provider Enhanced Reports (CASPER) ......................................... 9
  Measures ..................................................................................................................................... 9
    Dependent Variables .................................................................................................................. 9
    Independent Variables ............................................................................................................. 10
  Analytic Sample .......................................................................................................................... 12
  Analysis ...................................................................................................................................... 12

Chapter 3: Results ............................................................................................................................ 13
  Sample Characteristics ............................................................................................................... 13
  Perceptions of Respect ............................................................................................................... 15
  Correlates of Respect to Person ................................................................................................. 15
  Correlates of Respect for Choice ............................................................................................... 17

Chapter 4: Discussion ...................................................................................................................... 20
  Limitations ................................................................................................................................. 23
  Potential implications for future research and practice .............................................................. 24
  Conclusion ................................................................................................................................. 25

References ..................................................................................................................................... 26
List of Tables

Table 1. Descriptive statistics of the nursing facilities .................................................................14
Table 2. Average respect scores in nursing facilities for both subdomains of respect .................................................................15
Table 3. Correlates of respect for person: Results of simple and multiple regression .................................................................16
Table 4. Correlates of respect for choice: Results of simple and multiple regression .................................................................18
List of Figures

Figure 1. Quality of life—the domain of respect and its subdomains
......................................................................................................................1
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Chapter 1: Introduction

Approximately 1.5 million older adults reside in nursing facilities in the United States (U.S. Department of Health and Human Services, Administration for Community Living & Administration on Aging, n.d.). For these millions of residents, the nursing home is their home. As noted by Xu, Kane and Shamliyan (2013), a considerable amount of research has focused on the quality of care that these residents receive, with much less attention given to the quality of their lives. While, as mentioned by Shippee, Henning-Smith, Kane, & Lewis (2013), quality of care is related to quality of life, they are different aspects of the lived experience of nursing home residents.

Quality of life has been defined and measured in many ways; however, it is generally agreed that it is a multidimensional construct (CDC, 2011; Shippee et al., 2013). In the nursing home setting, commonly examined domains include: autonomy (i.e., choice and control over day to day life), dignity (i.e., respectful treatment that enhances feelings of worth), comfort (i.e., absence of physical pain and material discomfort), food enjoyment, individuality (i.e., self-identity as a distinct individual), meaningful activity, privacy, social relationships, and security (i.e., feelings of safety in the current living environment; Burack, Weiner, Reinhardt & Annunziato, 2012; Kane et al., 2004; Xu et al., 2013).

While an overall assessment of quality of life is important and valuable, researchers have emphasized the need to study the individual domains of quality of life. As Shippee and colleagues (2013) discussed, solely focusing on overall quality of life scores lessens our understanding of the phenomenon. More specifically, it does not allow us to determine if there are particular subdomains of quality of life that are especially consequential for nursing home residents. Further, as emphasized by Kane and colleagues (2004), nursing homes are responsible for ensuring that they perform well across the individual domains. Thus, it is important to examine each domain separately.

Figure 1: Quality of life – the domain of respect and its subdomains
Perceived Respect

Among the domains of quality of life examined in the nursing home context, respect—sometimes referred to as dignity—is an especially important and understudied domain of quality of life. Broadly speaking, to treat a person with respect means to show sincere regard for the worth of the person, including being polite, listening to what the person has to say and being considerate of his or her feelings as well as the choices he or she makes (Medicare.gov, n.d.; Dignified Revolution, 2009; Family Care America, 2015; American Health Care Association, n.d.). Thus, as illustrated in Figure 1, the larger domain of respect encompasses two subdomains—respect to person and respect for choices.

Existing research reveals the importance of respectful treatment in the nursing home context. In several qualitative studies, perceived respect has been observed to be a key dimension of quality care as reported by older adults. Chao & Roth (2005) explored important dimensions of quality care among residents of long-term care facilities in Taiwan. A caring attitude and respect for individual choices in daily care activities were amongst the important dimensions of care as perceived by older adults. Among responses to an open-ended survey item administered to older adults in North Wales (i.e., what one change today could make a difference to you tomorrow?), Morgan (2012) found independence and individual respect in care to be key themes. Likewise, Bolmsjo, Sandman & Anderson (2006) studied everyday ethics in a nursing home in Sweden. Results revealed the existence of an unfulfilled desire among the residents to be autonomous and respected. In a US-based study of residents of two retirement facilities in Minnesota, Shippee (2012) explored how residents work to maintain their sense of self, identity and a socially active life in the context of functional transitions and status decline. Residents expressed the importance of politeness and particularly maintaining autonomy as they experienced these changes (Shippee, 2012). In addition to research suggesting that older adults in long-term care facilities believe respect to be a key dimension of quality care that is important for their quality of life, the Center for Medicare and Medicaid Services (CMS) highlights these domains of quality of life in their list of resident rights. More specifically, CMS states that nursing home residents “have the right to be treated with dignity and respect, as well as make [their] own schedule and participate in the activities [they] choose”. They also “have the right to decide when [they] go to bed, rise in the morning and eat [their] meals” (Medicare.gov, n.d.).
Importantly, existing literature suggests that perceptions of respect have positive effects on older adults. Burack and colleagues (2012) studied the association of quality of life domains with elder satisfaction in 3 nursing homes in New York State to see what had the most impact on older adults. Along with other domains, *dignity* (e.g., Do staff here respect your modesty?) and *autonomy* (e.g., Can you decide what clothes to wear?) were positively associated with overall nursing home satisfaction. Dignity was also found to be a significant predictor of resident satisfaction with staff. Similarly, in a cross-sectional study of 6,722 US adult patients aged 18 years and over participating in the Commonwealth Fund 2001 Health Care Quality Survey, Beach and colleagues (2005) investigated the relationship between perceived respect (i.e., being treated with dignity and involved in decisions) and a variety of health-related outcomes, including satisfaction with care. They found both being treated with dignity and being involved in care decisions to be associated with high levels of satisfaction with care.

**Determinants of Perceived Respect**

Prior research suggests that a number of resident-level factors is associated with the quality of life of nursing home residents and, in particular, the subdomain of perceived respect. Degenholtz, Kane, Bershadsky, & Kling (2006) examined factors associated with quality of life among 2,829 residents of 101 nursing homes in 6 US states. Although not the primary focus of the research, they found gender and length of stay to be significantly associated with quality of life domains, with female gender and length of stay associated with higher quality of life scores. Shippee and colleagues (2013) also examined predictors of quality of life among nursing home residents. They found age and length of stay to be associated with several domains of quality of life, including domains capturing elements of respect to person and choice. Specifically, older age was negatively associated with personal attention (e.g., “Are you treated with respect here?”, “Do the people who work here listen to what you say?”), environment (e.g. Can you take care of your own things as much as you want to?), and engagement (“Do the people who work here know you as a person?”, “Do the people who work here ever stop by just to talk?”). Longer length of stay, on the other hand, was positively associated with environment and engagement but not overall quality of life. In other words, individuals who had been in the nursing home longer were more likely to report being respected and listened to in terms of their choices, likes and dislikes.
The quality of life of nursing home residents also appears to be associated with structural characteristics of nursing homes (i.e., characteristics related to facility infrastructure and resources such as facility size, ownership, location and percentage of Medicaid residents; Shippee et al., 2013; Xu et al., 2013). In Shippee and colleagues (2013) aforementioned study, for profit status and larger facility size were associated with lower quality of life in two domains—engagement and personal attention. For the same domains—personal attention and engagement—lower quality of life was observed for facilities with a higher percentage of Medicaid-only residents. As mentioned above, both of these domains capture elements of respect to person and choice. In another study examining the effects of facility characteristics (e.g., number of beds, rural/urban location, and ownership type) on quality of life domains, Kane and colleagues (2004) found only ownership type (i.e., private nonprofit, public, and for profit) to be significantly associated with dignity (i.e., respectful treatment that enhances feelings of worth), with private nonprofit facilities having better dignity scores than public and for profit facilities. No facility-level characteristics were significantly associated with autonomy in their study. In a review of research examining the effect of facility-level characteristics on quality of life among nursing home residents, Xu and colleagues (2013) reported that nonprofit and government facilities had fewer quality of life deficiencies and resident right deficiencies compared to for profit/independent facilities, including in the areas of patient dignity and choice. Although the precise reason is not known, it may be that nonprofit facilities place less weight on financial gain and, therefore, are less likely to make organizational decisions that undermine the quality of life of the residents. Xu and colleagues also reported that some research suggests that rural facilities have better self-reported quality of life than urban facilities. Facilities in rural and small towns may have a more home-like atmosphere that facilitates close resident-staff relationships, encouraging greater expressions of respect for residents and their choices (Lucas et al., 2007).

Besides structural facility characteristics, another set of facility factors that might be associated with perceived respect are the functional characteristics of a nursing home (i.e., characteristics related to facility operation such as consistent assignment of nursing assistants, the tenure of the director of nursing, and staff retention). In 15 nursing homes in Massachusetts, Bishop et al. (2008) examined organizational factors influencing the retention of nursing assistants and how retention affects resident well-being. They found higher levels of quality of life among residents in units where nursing assistants intended to remain in their jobs. Similarly,
Castle (2011) found more resident quality of life deficiency citations—including citations in the areas of respect to person and choices—in facilities with greater turnover. In facilities with high turnover of nursing staff, nurses might be more stressed, less satisfied and have a greater workload which negatively affects their interactions with residents and, ultimately, perceptions of respect among residents.

Another facility characteristic that might affect perceived respect is the tenure of the director of nursing (i.e., how long the director of nursing has held the position). In an exploratory study of the care delivery process in 486 facilities in Missouri, Rantz et al. (2003) found longer tenure of the director of nursing to be associated with better clinical outcomes (i.e., pain management, lower pressure ulcer rates, less use of restraints) among residents. Similarly, Anderson, Issel and McDaniel (2003) examined the effect of nursing home management practices on resident outcomes in 164 nursing facilities in Texas and reported that longer tenure of the director of nursing resulted in better clinical outcomes (e.g., less use of restraints). Although these studies focus on clinical outcomes, they suggest that tenure of nursing leadership has the potential to affect the quality of life of nursing home residents. Better clinical outcomes suggest that residents are receiving good quality care. Since quality care is related to quality of life, better quality care may translate to greater perceptions of respect among residents.

Consistent assignment of nursing staff (i.e., residents are cared for by the same nursing assistant most of the time; Advancing Excellence in America’s Nursing Homes, n.d.) and resident involvement in care planning are key components of the culture change movement in nursing homes (Office of the State Long-term Care Ombudsman, n.d.; Koren, 2010; Rahman, Straker, & Manning, 2009) that also have the potential to influence perceived respect. In a review of studies on consistent assignment in nursing homes, Rahman, Straker, & Manning (2009) concluded that consistent assignment of nursing staff is promoted as a best practice for improving resident quality of life. Consistent with this assertion, Castle (2011) reported that facilities with consistent assignment of nursing assistants had lower quality of life deficiency citations, including citations related to respect and choice. When cared for by the same nursing assistant most of the time, residents may feel more comfortable expressing their needs/preferences and they might not need to continue repeating their preferences. This, in turn, may make residents feel that they are being listened to and that their choices are being respected.
Like consistent assignment, resident participation in care planning also appears to influence resident quality of life, including perceived respect. Kane et al. (2007) compared resident quality of life in a green-house modeled nursing home with two traditional nursing homes in Mississippi. Findings show higher resident quality of life—including in domains related to respect and choice—in green-house modeled nursing home compared to traditional nursing homes. Green-house modeled nursing homes, a person-centered care initiative, promote resident involvement in daily care planning (Rabig et al., 2006). Similarly, Jones (2010) assessed the effect of a culture change intervention on resident quality of life in two units of a nursing home in Florida. The intervention focused on staff acknowledgement of residents and their choices as well as training staff to involve residents in planning care. Findings suggest improved quality of life among residents, including in the area of respect. Although these studies do not directly assess resident involvement in care planning, they suggest improved quality of life (and maybe greater perceptions of respect) in settings in which staff are encouraged to listen to resident wishes.

Another functional facility characteristic that may be associated with perceived respect is the staffing star rating of a nursing home. Briefly, Nursing Home Compare offers consumers an online indicator of the quality of nursing homes using a five-star rating system (CMS, 2014). Facilities receive a star rating, ranging from one through five, in each of three domains: annual onsite health inspections (a mandated annual state inspection of facilities participating in Medicare and Medicaid to determine if standards and regulations are being met/followed), performance on quality measures (includes a range of measures such as percentage of residents with pressure ulcers, fall rates, and use of physical restraints), and staffing ratio (a measure based on total RN hours and total nursing staffing hours per resident day adjusted for resident care need levels; CMS, 2015). Based on these domain ratings, an overall star rating for a facility is computed. While existing research suggests that a higher overall star rating does not necessarily translate to better overall quality of life among nursing home residents (Kim et al. 2014) and does not sufficiently reflect satisfaction among nursing home residents (Williams, Straker and Applebaum, 2014), it is possible that a higher star rating in the staffing domain is associated with greater perceived respect among nursing home residents. A higher star rating in the staffing domain is indicative of greater nurse hours. This may mean that nurses in facilities with a higher staffing star rating have more time to foster close relationships with the residents and develop a
better understanding of their wishes. This understanding, in turn, might promote greater feelings of perceived respect among the residents.

Despite the wide recognition of the importance of perceived respect among nursing home residents, there is a limited body of research on perceptions of respect and choice in nursing homes. Much of the existing research is qualitative and done outside of the US. While informative, qualitative studies involve small samples and, hence, limit our ability to generalize study findings. Moreover, existing quantitative studies generally lack a nuanced examination of perceived respect and the factors that might be associated with this specific aspect of resident quality of life. In this investigation, I will build on the existing body of research by examining facility level correlates of perceived respect in a large sample of nursing homes in the state of Ohio. In particular, I will attempt to answer the following questions:

1. How do resident perceptions of respect vary among nursing homes?

2. How do resident perceptions of choice vary among nursing homes?

3. To what extent do facility characteristics explain variation in resident perceptions of choice and respect among nursing homes?
Chapter 2: Methodology

Data Sources

This study involves the use of data from four sources: 1) the 2013 Ohio Long-Term Care Resident Satisfaction Survey, 2) the 2013 Biennial Survey of Long-Term Care Facilities - Nursing Facilities, 3) Nursing Home Compare and 4) Certification and Survey Provider Enhanced Reports (CASPER).

2013 Ohio Long-Term Care Resident Satisfaction Survey

The Ohio Long-Term Care Resident Satisfaction Survey is a biennial survey of Ohio nursing home residents. The study sample was selected using census lists provided by each nursing home (Vital Research, n.d.a). To ensure that the proportion of long stay and short stay residents matched the proportion in each nursing home, proportional random sampling was used (Vital Research, n.d.a). In the case of small facilities (i.e., facilities where the number of eligible residents was lower than 30), all residents were included (Vital Research, n.d.a). A total of 27,085 residents at 953 nursing facilities were approached for interview (Vital Research, n.d.b). Of those, 22,964 residents participated in the study.

Via face-to-face interview, residents were administered a 46-item questionnaire assessing satisfaction in 9 domains: activities, choice, direct care & nurse assistants, administration, therapy, meals & dining, laundry, environment and overall satisfaction with services they receive. In the current study, all 8 items under the “choice” domain and 5 items from the “direct care & nurse assistants” domain were used to calculate “respect for choice” scores and “respect to person” scores, respectively. For detailed information on the Ohio Long-Term Care Resident Satisfaction Survey and the development of the survey, see Wheatley et al. (2007) and Straker, Ejaz, McCarthy & Peters (2007).

2013 Biennial Survey of Long-Term Care Facilities - Nursing Facilities

The Biennial Survey of Long-Term Care Facilities—Nursing Facilities is a longitudinal survey of nursing facilities in Ohio that has been conducted by Scripps Gerontology Center at Miami University since 1994 (Nelson, Applebaum, Mehdizadeh, & Straker, in press). The survey is designed to collect information on nursing homes in Ohio that is of relevance to consumers, providers and policy makers (Nelson et al., in press). Nursing home administrators complete a self-administered questionnaire about their facility, including questions on admissions rates,
ownership type, number of beds, and occupancy rates by payor source. Data are primarily collected online; however, as mentioned in the guidelines in the survey, administrators can complete a pen and paper version of the survey and return it via mail. The response rate for the 2013 survey was relatively high, with 96% of nursing homes completing the survey (Nelson et al., in press).

**Nursing Home Compare (NHC)**

All Medicare and Medicaid certified nursing facilities in Ohio receive star ratings from Centers for Medicare and Medicaid services (CMS). As noted previously, an overall star rating is computed for each facility based on star ratings in three domains: annual onsite health inspection, staffing, and performance on quality measures. These ratings are publicly available on *Nursing Home Compare*, a website designed to help consumers compare and contrast nursing homes. For this investigation, only star ratings for the staffing domain were utilized. At the time of analysis, *Nursing Home Compare* had staffing star ratings for 963 nursing homes in Ohio (Medicare.gov, n.d.a). Staffing star rating range from 1 to 5, with higher ratings suggesting greater staffing hours (CMS, 2015).

**Certification And Survey Provider Enhanced Reports (CASPER)**

Medicare and Medicaid certified facilities are surveyed by state officials every 9 to 15 months (Ohio Department of Health, 2014). CASPER is an administrative database that includes data from these on-site visits along with information on resident and facility characteristics (Center for Medicare and Medicaid Services, n.d.; Cowles Research Group, n.d.). Data on the percentage of Medicaid residents in Ohio nursing homes were obtained from this database.

**Measures**

**Dependent Variables**

Perceived respect includes respect to person and respect for a person’s choices. To capture respect to person, five items included in the 2013 Ohio Long-Term Care Resident Satisfaction Survey were used: 1) “Does a staff person check on you to see if you are comfortable?,” 2) “Do the people who work here know what you like and don’t like?,” 3) “Are the nurse aides gentle when they take care of you?,” 4) “Do the nurse aides treat you with respect?,” and 5) “Do the nurse aides spend enough time with you?.”

Eight items from the same survey were used to capture respect for choices: 1) “Can you go to bed when you like?,” 2) “Can you decide when to get up in the morning?,” 3) “Can you
Responses to each of these above items included two levels of response. First, residents were asked to provide a simple yes or no response to each item. Depending on the response given, they were then asked if it was “Yes, always” or “Yes, sometimes” or “No, hardly ever” or “No, never.” For example, a person who replied “Yes” to the question “Can you decide when to get up in the morning?” was then asked if it was “Yes, always” or “Yes, sometimes.” Likewise, a person who replied “No” was then asked if it was “No, hardly ever” or “No, never.”

Following Vital Research (n.d.), responses were scored from 0 to 100 as follows: Yes, always = 100; Yes, sometimes = 67; No, hardly ever = 33 and No, never = 0. For both subdomains of respect (i.e., respect to person and respect for choices), scores for each item were summed and the average score across items was calculated for each resident. As was done by Vital Research, the score for a subdomain was calculated only if a respondent answered at least three respect to person items and six choice items. Individual scores were aggregated at the nursing home level to obtain facility level scores. Higher scores reflect greater perceptions of respect among the residents.

Independent Variables: Structural and functional characteristics

To help understand variation in perceived respect across nursing homes, several structural and functional facility level characteristics were examined. Structural characteristics include facility size, facility ownership, facility location and percentage of residents covered by Medicaid. Functional characteristics include State Tested Nursing Assistants (STNAs) retention rate, Registered Nurse/Licensed Practical Nurse (RN/LPN) retention rate, tenure of the Director of Nursing (DON), resident participation in care plans, consistent assignment of nursing assistants, and the staffing domain star rating.

Structural Characteristics. Facility size was categorized as small (0 to 50 beds), medium (51 to 100 beds) and large (100 or more beds). Facility ownership included for-profit facilities, not-for-profit facilities and government-run facilities. Due to the small number of government run facilities (n=19), government-run facilities were combined with not-for-profit facilities,
creating a dichotomous variable (1= for-profit facilities, 0= not-for-profit and government-run facilities). Depending on the county in which a facility was located, facilities were categorized as urban or rural. Lastly, the percentage of residents covered by Medicaid was computed by dividing the number of residents in a facility covered by Medicaid by the total number of residents in the facility.

**Functional Characteristics.** Nursing assistants’ retention rate was calculated by dividing the total number of nursing assistants retained until the last payroll period of 2013 by the number of nursing assistants employed during the first payroll period of 2013. The RN/LPN retention rate was calculated in the same fashion. The tenure of the Director of Nursing (DON) was calculated by subtracting the DON’s start date from the survey deadline (May 27, 2015). Since data were available only for the start year and start month for the DON, it was assumed that all DON’s started on the 15th day of the month. Response options for ‘resident participation in care plans’ and ‘consistent assignment of nursing assistants’ included: a) Yes, this describes our facility, b) This partially describes our facility; we have this in progress and c) No, this does not describe our facility. Due to the small number of facilities selecting option “c” (n= 7 for resident participation; n= 45 for consistent assignment), category ‘c’ was combined with category ‘b’ creating dichotomous variables for resident participation and consistent assignment (1= Yes, this describes our facility, 0= partially/no, does not describe our facility). Staffing domain star ratings represent star ratings for the fourth quarter of 2013. Eleven facilities did not have data for the fourth quarter. For those facilities I used the most recent data available. Staffing star ratings range from 1 to 5. Given the small number of facilities with a star rating of 5 (n=27), facilities with a star rating of 5 were combined with facilities receiving a rating of 4 stars.

**Independent Variables: Resident Characteristics**

Several resident characteristics that have the potential to affect perceptions of respect were also included in the analysis. These include age, gender, and length of stay. Age in years was derived by subtracting each resident’s birth date from their interview date and then dividing by 365.25 days. The percentage of males and females and the percentage of long-term and short-term residents were calculated using data from the Resident Satisfaction Survey. All resident characteristics derived from the Resident Satisfaction Survey were aggregated at the facility level.
Analytic Sample

A total of 955 nursing homes were surveyed as part of the Biennial Survey of Long-Term Care Facilities. Data on 41 of those facilities were unavailable due to closure of the facility or a change in the name or ownership of the facility over the course of the year that prohibited merging of all relevant data. Of the remaining 914 facilities, 750 facilities had complete data for all the variables examined in this study.

Analysis

The analysis unfolded in a series of steps. First, means and percentages were calculated for all independent and dependent variables. In the case of variables that came from the Resident Satisfaction Survey (i.e., age, gender, long-term residency status, respect to person scores and respect for choices), individual resident values were aggregated at the facility level.

Following the calculation of descriptive statistics, simple linear regression was used to examine the unadjusted association between each independent variable and each subdomain of respect. Multiple linear regression was then used to examine these same associations, after adjusting for all other variables in the analysis. To enhance the meaning of findings from the regression analysis, age was divided by five and the percentage of Medicaid residents was divided by 10, meaning that every unit increase in age represents five years and every unit increase in the percentage of Medicaid residents represents 10 percentage points.
Chapter 3: Results

Sample Characteristics

Table 1 shows the characteristics of the facilities examined in this investigation. On average, the nursing facilities had a largely female resident population (71.1% female) with a mean age of 82.03 years. Across nursing facilities, the average length of stay was 2.4 years, with an average of 88% of the resident population classified as long-term residents.

As shown in Table 1, 86% of the sampled facilities were medium (48.4%) or large (37.9%) facilities. Most of the sampled facilities were for-profit (81%) and located in an urban area (73.7%). An average of 63% of residents in the facilities was covered by Medicaid.

At year end, an average of 66.4% of nursing assistant (CNAs) and 73.2% of RNs and LPNs had been retained. The average tenure of the Director of Nursing was 4.5 years. Most of the sampled facilities (87%) included residents in care planning and more than half (61%) had consistent assignment of nursing assistants meaning that no resident was cared for by more than 8 different nursing assistants within a 30-day period. Lastly, more than half of the facilities received a staffing star rating of 3, 4, or 5.
Table 1. Descriptive statistics of the nursing facilities

<table>
<thead>
<tr>
<th>Resident characteristics</th>
<th>Mean (SD) or % (n)</th>
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</thead>
<tbody>
<tr>
<td>Age (years; range: 69-91)</td>
<td>82.03 (3.7)</td>
</tr>
<tr>
<td>Male (%)</td>
<td>28.9 (0.1)</td>
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<tr>
<td>Long-term (%)</td>
<td>87.8 (0.1)</td>
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</tbody>
</table>

<table>
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<tr>
<th>Structural characteristics</th>
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</thead>
<tbody>
<tr>
<td>Facility size (%)</td>
<td></td>
</tr>
<tr>
<td>Small (0-50 beds)</td>
<td>13.7(103)</td>
</tr>
<tr>
<td>Medium (51-100 beds)</td>
<td>48.4(363)</td>
</tr>
<tr>
<td>Large (100+ beds)</td>
<td>37.9(284)</td>
</tr>
<tr>
<td>Facility ownership (%)</td>
<td></td>
</tr>
<tr>
<td>For-profit</td>
<td>81.2(609)</td>
</tr>
<tr>
<td>Not-for profit/Government</td>
<td>18.8(141)</td>
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<tr>
<td>Facility location (%)</td>
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<tr>
<td>Urban</td>
<td>73.7(553)</td>
</tr>
<tr>
<td>Rural</td>
<td>26.3(197)</td>
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<tr>
<td>% of Medicaid residents</td>
<td>62.7(15.7)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Functional characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>STNAs retention rate (%)</td>
<td>66.4 (16.9)</td>
</tr>
<tr>
<td>RN/LPN retention rate (%)</td>
<td>73.2 (17.3)</td>
</tr>
<tr>
<td>DON tenure (years)</td>
<td>4.5 (6.08)</td>
</tr>
<tr>
<td>Resident participation in care plan (%)</td>
<td></td>
</tr>
<tr>
<td>Describes facility</td>
<td>87.3(655)</td>
</tr>
<tr>
<td>Partially/does not describe facility</td>
<td>12.7(95)</td>
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<tr>
<td>STNAs consistent assignment (%)</td>
<td></td>
</tr>
<tr>
<td>Describes facility</td>
<td>60.7(455)</td>
</tr>
<tr>
<td>Partially/does not describe facility</td>
<td>39.3(295)</td>
</tr>
<tr>
<td>Staffing domain star ratings (%)</td>
<td></td>
</tr>
<tr>
<td>1 star</td>
<td>24.1(181)</td>
</tr>
<tr>
<td>2 stars</td>
<td>21.3(160)</td>
</tr>
<tr>
<td>3 stars</td>
<td>22.9(172)</td>
</tr>
<tr>
<td>4/5 stars</td>
<td>31.6(237)</td>
</tr>
</tbody>
</table>

Note: STNA—State Tested Nursing Assistant; RN—Registered Nurse; LPN—Licensed Practical Nurse; DON—Director of Nursing; n= sample numbers
Perceptions of Respect

On average, facilities had relatively high scores for both subdomains of respect. Across facilities, the mean respect to person score was 86.4 (SD=5.7) and the mean respect for choices core was 87.8 (SD=5.1).

Table 2. Average respect scores in nursing facilities for both subdomains of respect

<table>
<thead>
<tr>
<th></th>
<th>Mean (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect to person</td>
<td>86.4 (5.7)</td>
<td>57.4 - 99.5</td>
</tr>
<tr>
<td>Respect for choices</td>
<td>87.8 (5.1)</td>
<td>66.1 - 100.0</td>
</tr>
</tbody>
</table>

Correlates of Respect to Person

As shown in Table 3, the results of the unadjusted analyses indicate that respect to person scores were significantly associated with all three resident characteristics (i.e., age, gender and long-term residency status). Specifically, every 5 year increase in the average age of residents was associated with a 1.6 point increase in average respect to person scores. In contrast, every one point increase in the percentage of male residents lowered the average respect to person score by 6.1 points. A similar pattern was evident for the percentage of long-term residents; every one unit increase in the percentage of long-term residents decreased the average respect to person score by 7 points.

With the exception of facility location, all structural characteristics were significantly associated with respect to person scores in the unadjusted analysis. Relative to small facilities, average respect to person scores were 1.3 points lower for medium-sized facilities and nearly two points lower for large facilities. Facility ownership was also associated with respect to person scores. Relative to not-for-profit/government facilities, the average respect to person score was 1.4 points lower among for-profit facilities. Moreover, every 10 point increase in the percentage of residents covered by Medicaid was associated with a 0.8 point drop in respect to person score.

With the exception of staffing star rating and a borderline significant association for consistent assignment (p=.055), no significant associations were observed for the functional characteristics examined and average respect to person scores. Compared to facilities with a
staffing star rating of 1 star, average respect to person scores were 1.7 points higher for facilities with a rating of 3 stars and 2.6 points higher for facilities with a rating of 4/5 stars.

Table 3. Correlates of respect for person: Results of simple and multiple regression

<table>
<thead>
<tr>
<th>Variables</th>
<th>Simple Regression, $\beta$ (SE)</th>
<th>Multiple Regression, $\beta$ (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resident characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>1.6 (0.3)**</td>
<td>0.7 (0.4)</td>
</tr>
<tr>
<td>% Male</td>
<td>-6.1 (1.4)**</td>
<td>-2.1 (1.7)</td>
</tr>
<tr>
<td>% Long-term residents</td>
<td>-7.0 (1.7)**</td>
<td>-5.5 (2.1)*</td>
</tr>
<tr>
<td><strong>Structural characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility size (Ref= Small)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>-1.3 (0.6)*</td>
<td>-1.4 (0.6)*</td>
</tr>
<tr>
<td>Large</td>
<td>-1.9 (0.6)**</td>
<td>-1.9 (0.7)**</td>
</tr>
<tr>
<td>Facility ownership (For-profit)</td>
<td>-1.4 (0.5)**</td>
<td>0.2 (0.6)</td>
</tr>
<tr>
<td>Facility location (Urban)</td>
<td>-0.9 (0.5)</td>
<td>-0.9 (0.5)</td>
</tr>
<tr>
<td>% of Medicaid residents</td>
<td>-0.8 (0.1)**</td>
<td>-0.2 (0.2)</td>
</tr>
<tr>
<td><strong>Functional characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STNAs retention rate</td>
<td>0.01 (0.01)</td>
<td>0.02 (0.01)</td>
</tr>
<tr>
<td>RN/LPN retention rate</td>
<td>0.00 (0.01)</td>
<td>-0.01 (0.01)</td>
</tr>
<tr>
<td>DON tenure (years)</td>
<td>0.05 (0.03)</td>
<td>0.03 (0.03)</td>
</tr>
<tr>
<td>Resident participation in care plan (yes)</td>
<td>0.9 (0.6)</td>
<td>0.7 (0.6)</td>
</tr>
<tr>
<td>STNAs consistent assignment (yes)</td>
<td>0.8 (0.4)</td>
<td>0.6 (0.4)</td>
</tr>
<tr>
<td>Staffing star ratings (Ref= 1 star)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 stars</td>
<td>1.0 (0.6)</td>
<td>0.4 (0.6)</td>
</tr>
<tr>
<td>3 stars</td>
<td>1.7 (0.6)**</td>
<td>0.9 (0.6)</td>
</tr>
<tr>
<td>4/5 stars</td>
<td>2.6 (0.6)**</td>
<td>1.2 (0.6)*</td>
</tr>
</tbody>
</table>

Note: STNA—State Tested Nursing Assistant; RN—Registered Nurse; LPN—Licensed Practical Nurse; DON—Director of Nursing; SE—Standard Error; *p<.05, **p<.01, ***p<.001
After adjusting for all other factors, age, percentage of males, facility ownership, percentage of residents covered by Medicaid and consistent assignment were no longer significantly associated with respect to person scores. Although the effect was reduced, long-term residency status remained statistically significant, with every one unit increase in the percentage of long-term residents associated with a 5.5 point decrease in the average respect to person score. Facility size also remained significant, with average respect to person scores 1.4 points lower for medium-sized facilities and nearly two points lower for large facilities. A borderline significant association (p=.051) was evident for facility location, with average respect to person score 0.9 points lower for urban facilities. Lastly, with the exception of staffing star rating, no significant association was observed for any of the functional characteristics and average respect to person scores. As compared to facilities with a rating of 1 star, average respect to person scores were 1.2 points higher for facilities with a rating of 4 or 5 stars. No significant association was evident for those with a star rating of 2 or 3 in the adjusted analysis.

**Correlates of Respect for Choice**

As shown in Table 4, the results of the unadjusted analyses indicate that respect for choice scores were significantly associated with all three resident characteristics (i.e., age, gender and type of resident). Specifically, every 5 unit increase in the average age of residents was associated with a 0.7 point increase in average respect for choice score. In contrast, every one point increase in the percentage of male residents lowered the average respect for choice score by 5.1 points. A similar pattern was evident for the percentage of long-term residents; every one unit increase in the percentage of long-term residents decreased the average respect for choice score by 5.2 points.

With the exception of percentage of Medicaid residents, none of the structural characteristics were associated with respect for choice scores in the unadjusted analysis. However, two of the functional characteristics—resident participation in care plans and staffing star rating—were associated with average respect for choice scores. Compared to facilities with partial/no resident involvement in care planning, average respect for choice scores were 1.2 points higher for facilities that involved residents in care planning. Likewise, facilities with a staffing star rating of 4 or 5 had an average respect for choice score that was 1.6 points higher than facilities with a star rating of one.
Table 4. Correlates of respect for choice: Results of simple and multiple regression

<table>
<thead>
<tr>
<th>Variables</th>
<th>Simple Regression, $\beta$ (SE)</th>
<th>Multiple Regression, $\beta$ (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resident characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.7 (0.2)**</td>
<td>0.1 (0.3)</td>
</tr>
<tr>
<td>% Male</td>
<td>-5.1 (1.3)**</td>
<td>-4.0 (1.5)**</td>
</tr>
<tr>
<td>% Long-term</td>
<td>-5.2 (1.5)**</td>
<td>-5.3 (1.9)**</td>
</tr>
<tr>
<td><strong>Structural characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility size (Ref= Small)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>-0.3 (0.6)</td>
<td>-0.7 (0.6)</td>
</tr>
<tr>
<td>Large</td>
<td>-0.6 (0.6)</td>
<td>-0.9 (0.6)</td>
</tr>
<tr>
<td>Facility ownership (For-profit)</td>
<td>-0.6 (0.5)</td>
<td>0.2 (0.5)</td>
</tr>
<tr>
<td>Facility location (Urban)</td>
<td>0.04 (0.4)</td>
<td>-0.1 (0.4)</td>
</tr>
<tr>
<td>% of Medicaid residents</td>
<td>-0.3 (0.1)**</td>
<td>0.1 (0.2)</td>
</tr>
<tr>
<td><strong>Functional characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STNAs retention rate</td>
<td>0.00 (0.01)</td>
<td>0.01 (0.01)</td>
</tr>
<tr>
<td>RN/LPN retention rate</td>
<td>-0.01 (0.01)</td>
<td>-0.02 (0.01)</td>
</tr>
<tr>
<td>DON tenure (years)</td>
<td>0.01 (0.03)</td>
<td>0.01 (0.03)</td>
</tr>
<tr>
<td>Resident participation in care plan (yes)</td>
<td>1.2 (0.6)*</td>
<td>1.3 (0.6)*</td>
</tr>
<tr>
<td>STNAs consistent assignment (yes)</td>
<td>-0.1 (0.4)</td>
<td>-0.3 (0.4)</td>
</tr>
<tr>
<td>Staffing star ratings (Ref= 1 star)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 stars</td>
<td>0.7 (0.5)</td>
<td>0.4 (0.5)</td>
</tr>
<tr>
<td>3 stars</td>
<td>1.0 (0.5)</td>
<td>0.8 (0.5)</td>
</tr>
<tr>
<td>4/5 stars</td>
<td>1.6 (0.5)**</td>
<td>1.3 (0.5)*</td>
</tr>
</tbody>
</table>

**Note:** STNA—State Tested Nursing Assistant; RN—Registered Nurse; LPN—Licensed Practical Nurse; DON—Director of Nursing; SE—Standard Error; *p<.05, **p<.01, ***p<.001
Adjusting for all other factors, age and percentage of residents covered under Medicaid were no longer associated with respect for choice. Gender, however, remained significant. Specifically, every one point increase in the percentage of male residents lowered the average respect for choice score by 4 points. Long-term residency status also remained significant; the average respect for choice score was 5.3 points lower with every one point increase in the percentage of long-term residents. Resident involvement in care planning likewise remained significant, with average respect for choice scores 1.3 points higher for facilities with resident involvement in care plans compared to those with partial/no resident involvement in care planning. Although the effect was reduced after adjusting for other factors, staffing star rating remained significant with average respect for choice scores 1.3 points higher for facilities with a rating of 4 or 5 stars relative to those with a rating of one.
Chapter 4: Discussion

The purpose of this study was to examine perceived respect in Ohio nursing homes and the factors associated with it. On average, nursing homes in Ohio had relatively high respect scores, however, there was variability across nursing homes. Several facility characteristics were found to be associated with respect scores. Specifically, a significant and borderline significant association was evident for facility size and location (i.e., urban vs rural facilities) and respect to person; resident involvement in care planning was associated with respect for choices. In addition, Nursing Home Compare staffing star ratings were associated with both subdomains of respect. In contrast with existing research, no association was evident for perceived respect and either facility ownership type or percentage of Medicaid residents in adjusted analyses. For resident characteristics, the percentage of men was associated with respect for choice scores and the percentage of long-term residents was associated with both subdomains of respect.

My finding that medium/large sized facilities have lower respect to person scores compared to small facilities is consistent with recent studies (Shippee et al., 2013; Xu et al., 2013) of resident quality of life in which lower quality of life was observed for large facilities, especially in regard to perceived respect. It is possible that residents and staff in small facilities have a closer relationship with their caregivers. The familiarity and comfort that are a part of a close relationship might, in turn, promote feelings of respect among the residents. Likewise, although the association only reached borderline significance, my finding that urban facilities have lower respect to person scores compared to rural facilities is consistent with a recent review of studies (Xu et al., 2013) on resident quality of life in which lower quality of life was observed for urban facilities. As mentioned by Lucas and colleagues (2007), facilities in rural and small towns tend to have homier environments than those in urban areas where the environment tends to be more formal and institutional. A homier environment might reflect a nursing home culture that encourages more personal resident-staff interactions. Staff might be more caring and gentle towards the resident which could translate to greater feelings of respect among the residents in rural facilities.

Corresponding with Kane et al. (2007) and Jones (2010), I found that nursing homes that included residents in care planning had higher perceived respect scores for the choice domain. When nursing facilities involve residents in the planning of care, residents wishes are likely to be acknowledged and implemented to a greater degree than in facilities where this is not a part of
the culture. As with Kane and colleagues (2004) in their examination of resident autonomy, I observed no significant association between respect for choices and facility size, facility ownership type or facility location. Based on the results of this investigation, resident perceptions of respect for choices appear to be more influenced by operational factors that directly relate to resident’s daily routine (e.g., a culture of involving residents in care planning) than these formal structural factors.

In this investigation, I found that perceived respect was associated with staffing star ratings with facilities with higher staffing ratings having higher respect scores in both domains. There is no prior research examining perceived respect and staffing star rating. However, two recent studies (Kim et al., 2014; Williams, Straker & Applebaum, 2014) examining overall star ratings and quality of life and satisfaction among nursing home residents found that overall star rating did not translate to better quality of life and satisfaction among the residents. Part of the reason for this discrepancy may be that the current study used the star rating for the staffing domain rather than the overall star rating. The staffing star rating is a measure of resident-staff ratios (adjusted for need levels) and may, therefore, more directly relate to perceived respect. As mentioned earlier, higher staffing star ratings suggest higher staffing hours which could mean more time for resident-staff interaction. To the degree that this is true, this could enhance staff understanding of residents and their wishes and lead to greater perceptions of respect among residents.

In contrast with work by Kane et al. (2004), I found no significant association between facility ownership type and respect to person, after adjusting for all other factors. One possible reason for this variation is that I was able to account for a broader range of potential confounding factors. While Kane and colleagues (2004) controlled for facility location, facility size and percentage of private rooms in examining the effect of facility ownership type on quality of life domains, I controlled for many other facility characteristics (e.g., percentage of long-term residents, Nursing Home Compare staffing star ratings). As with facility ownership type, no significant association between percentage of Medicaid residents and perceived respect was evident in adjusted analyses. Other researchers (Shippee et al., 2013), however, have reported lower quality of life among residents—particularly in the domains capturing perceived respect—in facilities with a higher percentage of Medicaid residents. This discrepancy in findings might
be due to differences in the measures used to assess perceived respect. Different measurement instruments were used in the two studies and, therefore, may capture different aspects of perceived respect.

As noted previously, resident characteristics (i.e., percentage of men and percentage of long-term residents) were also significantly associated with perceived respect. Respect for choice scores were inversely related to the percentage of men in a facility. While the reason for this is unclear, some evidence suggests that men have less satisfaction with nursing home care and life compared to women (Lucas et al., 2007). Although future research is needed, there might be two possible reasons for this. First, long-term care facilities may have fewer activities geared towards men which could make male residents feel that nursing facilities put less value on their choices. Second, perhaps men feel that they are treated differently in nursing facilities in an industry where the majority of caregivers and residents are female. Third, there might be something different about nursing facilities that serve a higher percentage of men. For example, some facilities with a high percentage of males may serve a unique population with characteristics that affect perceptions of respect.

The percentage of long-term residents in a facility was associated with both respect to person and respect for choices. While existing research (Degenholtz et al., 2006; Shippee and colleagues, 2013) suggests that quality of life is higher for long-term residents, I found that respect scores declined as the percentage of long-term residents increased. One possible reason for this disparity in results might be variation in the measure used to capture long-term residency status. In the current study, long-term residency was defined as an intended length of stay of more than 30 days. In contrast, Degenholtz and colleagues (2006) used a cut point of 90 days and Shippee and colleagues (2013) measured length of stay in years. Hence, residents with the same length of stay (e.g., 85 days) would be classified differently in the studies. Because this study used a cut point of 30 days, residents classified as short-term in other studies were classified as long-term in this study. Despite this difference, there might be things about long-term residents that contribute to lower perceived respect scores. For example, long-term residents usually have significant difficulty performing activities of daily living. Staff might offer assistance to residents for their protection and safety while residents might prefer to be more independent and not be so appreciative of staff assistance.
There is one particularly important observation in this study. In some instances, the two subdomains of respect were not related to the same facility characteristics. Facility location and size, for example, were associated with respect to person scores but not respect for choice scores. And while resident participation in care planning was associated with respect for choice scores, it was not related to respect to person scores. This is, however, not unexpected. As explained previously, respect to person and respect for choices are two distinct subdomains of the larger construct of respect. Similar to what has been discussed by other researchers in the broader context of quality of life (Kane et al., 2004; Shippee et al., 2013), there are likely to be unique correlates of each subdomain of perceived respect. Because they are both subdomains of the same construct, however, there should also be shared correlates among these subdomains as was observed in this study. For example, as the percentage of long-term residents increased, respect scores for both the subdomains decreased.

Limitations

This study has several limitations that should be acknowledged. First, this is a cross-sectional study, which limits my ability to draw causal conclusions about the independent variables examined and perceived respect. Second, data were missing for 22% of Ohio facilities. To the extent that facilities with missing data are systematically different from facilities with complete data, findings may be biased. A comparison of the characteristics of the sample used in this study with other statewide data reported by Nelson et al. (in press) suggests, however, that the sample closely matches statewide data with respect to the percentage of for-profit facilities, the percentage of facilities in urban areas and the percentage of residents supported by Medicaid. Third, the present study is confined to the state of Ohio. Given that nursing home regulations vary from state-to-state, it is unclear if the findings observed in this investigation hold true for other states. Fourth, perceived respect is a subjective feeling that might not always represent reality. Nevertheless, resident self-report captures the experience of residents from their perspective. Fifth, some of the independent variables lack nuance. In this investigation, for example, I examined the relationship between consistent assignment and perceived respect. It is possible that a resident is consistently assigned to a nurse that puts more emphasis on his/her assignments than the residents and their choices. Hence, additional measures that capture the quality of resident-staff interaction should also be assessed. Similarly, it is possible that the Director of Nursing has been in the position for a long time but does not foster respectful
treatment of residents among his or her staff. Hence, it is also important to assess the beliefs of the Director of Nursing regarding how residents should be treated. Sixth, the present study included both long-term and short-term residents in the analysis. The long-term care industry has changed in recent decades with an increasing number of residents utilizing nursing homes for acute care and rehabilitation (Decker, 2005 & Nelson, 2015). Since short term residents may have different goals and needs, future researchers might consider limiting the analysis to the long-term resident population. Seventh, the present study is a facility level analysis. Therefore, our understanding of how perceived respect varies by individual resident characteristics (e.g., presence of cognitive impairment, functional limitations, and depression) is limited. Lastly, there may be some additional factors (e.g., percentage of private rooms) that might contribute to variation in perceived respect which the current study did not account for.

Potential implications for future research and practice

The findings from this study have several implications for ongoing research and practice in gerontology. An important next step for researchers will be to gain a better understanding of why factors such as facility size, facility location (i.e., urban vs rural), and staffing star rating are related to perceived respect. How is it, for example, that facility location and size influence levels of perceived respect among a facility’s resident population? Likewise, precisely why is the staffing star ratings associated with perceptions of respect? Additionally, there were some facility factors that were associated with one subdomain of respect but not the other. A more nuanced examination of each subdomain of respect and its correlates would provide a deeper understanding of the particular associations observed in this study. Finally, resident level studies are also needed. In particular, resident level qualitative research aimed at exploring why resident perceptions of respect vary by facility characteristics would help us understand why resident perceptions of respect vary across nursing facilities. Likewise, resident level quantitative assessment of variation in perceived respect by resident level factors (e.g., health and functional status of residents) would add to our understanding of how the characteristics of the resident population in nursing homes influences perceived respect.

Although additional research is needed, the findings from this study are also relevant to the practice of long-term care. They tentatively suggest that facilities that involve residents in care planning have a resident population that feels that their choices are more respected. While more research is needed, nursing facilities might consider implementing and maintaining resident
participation in care planning. The findings of this study also suggest that facilities with low staffing star ratings have a resident population that feels less respected. While findings are preliminary, policymakers seeking to ensure that residents are treated with respect might consider targeting facilities with low staffing star ratings for effective policy and programmatic interventions. Frequent assessment and evaluation of the performance of these nursing homes by state authorities particularly in the areas of resident respect could be one possible intervention. Finally, this study suggests that facilities with a higher percentage of long-term residents have lower perceived respect scores. While further research is required, policymakers seeking to enhance facility performance regarding respectful treatment of residents might consider focusing on facilities with a high percentage of long-term residents.

**Conclusion**

Respecting residents and their choices is a critically important part of long-term care. Results of this investigation indicate that the percentage of men, percentage of long-term residents, facility size and location (i.e., urban vs rural), resident participation in care planning and staffing star ratings are associated with perceived respect in Ohio nursing homes. Future research is needed to investigate why these factors are related to perceived respect. Although additional research is needed, results suggest the need to consider: 1) implementing and maintaining resident participation in care planning and 2) targeting facilities with low perceived respect for policy and programmatic interventions. This may help increase perceptions of respect in Ohio nursing homes and protect residents’ right to be treated with respect.
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