

## **Appendix E**

Resident-Level Protocol for Observation of Resident Affect

the (Each interviewer observed each residents in sample at 6 different specific times using protocols.)

# Resident Observation, Wave 1

## Face Sheet

## Resident Label

### Instructions

1. Each of the residents designated for observation will be observed 6 times.
2. The order of time periods does not matter.
3. Observations must be done at least an hour apart. That is, do not observe at 9:20 for period 1 and at 9:30 or 9:40 for Period 2.
4. Be sure that you complete the observation on the correct page: the one headed by the particular observation time period.
5. No more than 2 observations may be made on the same day.
6. Observations will NOT be made in the bathroom or at any time or when a care routine or medical or nursing procedure is occurring. If you have looked for a resident and he/she is in the bathroom or having a care procedure **either** wait till the resident has left the bathroom and no care procedure is taking place, or decide to seek out the resident later during this time period or during this time period on another day.
7. Observations will NOT be made during a meal.

## Observation at Time Period 1: 8:30 to 9:30 am

1. Observer Name and ID \_\_\_\_\_

2. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year

3. Circle Day of Week: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

<p>4. Place of Observation</p> <p><input type="checkbox"/> Resident=s bedroom</p> <p><input type="checkbox"/> Corridor on resident=s unit</p> <p><input type="checkbox"/> Group space on resident=s unit.</p> <p><input type="checkbox"/> In doors but off resident=s unit</p> <p><input type="checkbox"/> Outdoors anywhere Be.g. porches, patios, lawn, yard, etc.</p>	<p>5. What was resident doing during the observation?</p> <p><input type="checkbox"/> Asleep the whole time.</p> <p><input type="checkbox"/> Apparently doing nothing Bstaring, sitting</p> <p><input type="checkbox"/> In motion Bmoving in wheelchair or walking,</p> <p><input type="checkbox"/> Doing something alone Breading, watching T, on phone</p> <p><input type="checkbox"/> Present at an organized activity</p> <p><input type="checkbox"/> In interaction with a staff member</p> <p><input type="checkbox"/> In interaction with a resident(s)</p> <p><input type="checkbox"/> In interaction with someone else Bor someone observer cannot identify</p>	<p>6. Was resident in restraints during observation</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>7. Did resident speak to observer during observation</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>8. Did observer speak to resident</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
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Scoring of emotion:      1 = Never during 5 minute period.  
                                   2 = Seldom seen in 5 minute period (e.g. < 16 seconds)  
                                   3 = Occasionally seen (about 16 seconds to 59 seconds)  
                                   4 = More often seen (1 to 2 minutes)  
                                   5 = Most often seen (> 2 to 5 minutes)  
                                   6 = Unable to tell      DO NOT TIME LITERALLY BSUGGESTED TIMES GIVE GUIDELINES FOR SCALE

9. EMOTION OBSERVED: Circle for each emotion in the 5 minute period

PLEASURE: Smile, laugh, stroking, nodding, singing, arm or hand out-reach, open arm gesture.	1	2	3	4	5	6
ANXIETY/FEAR: Furrowed brow, motoric restlessness, repeated or agitated motion, facial expression of fear or worry, withdrawal from other, tremor, tight facial muscles, calls repetitively, hand wringing, leg jiggling, eyes wide.	1	2	3	4	5	6
DEPRESSION/SADNESS: Cry, tears, moan, sigh, mouth turned down at corners, eyes turned down and face expressionless, wiping eyes.	1	2	3	4	5	6
ANGER: Clenched teeth, grimaces, yell, curse, berate, push, physical aggression, fist shaking, pursed lips, eyes narrowed, brows knit.	1	2	3	4	5	6
INTEREST: Eyes following object, intent fixation on object or person, visual scanning, facial, motoric or verbal feedback to other, eye contact maintained, turn body toward person or object.	1	2	3	4	5	6

10. Note: Anything unusual about this observation \_\_\_\_\_

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## Observation at Time Period 2: 9:30 to 10:30 am

1. Observer Name and ID \_\_\_\_\_

2. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year

3. Circle Day of Week: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

<p>4. Place of Observation  <input type="checkbox"/> Resident=s bedroom  <input type="checkbox"/> Corridor on resident=s unit  <input type="checkbox"/> Group space on resident=s unit.  <input type="checkbox"/> Indoors but off resident=s unit  <input type="checkbox"/> Outdoors anywhere Be.g. porches, patios, lawn, yard, etc.</p>	<p>5. What was resident doing during the observation?  <input type="checkbox"/> Asleep the whole time.  <input type="checkbox"/> Apparently doing nothing Bstaring, sitting  <input type="checkbox"/> In motion Bmoving in wheelchair or walking,  <input type="checkbox"/> Doing something alone Breading, watching T, on phone  <input type="checkbox"/> Present at an organized activity  <input type="checkbox"/> In interaction with a staff member  <input type="checkbox"/> In interaction with a resident(s)  <input type="checkbox"/> In interaction with someone else Bor someone observer cannot identify</p>	<p>6. Was resident in restraints during observation  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p>7. Did resident speak to observer during observation  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p>8. Did observer greet resident  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p>
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 5 = Most often seen (> 2 to 5 minutes)  
 6 = Unable to tell      DO NOT TIME LITERALLY BSUGGESTED TIMES GIVE GUIDELINES FOR SCALE

9. EMOTION OBSERVED: Circle for each emotion in the 5 minute period

PLEASURE: Smile, laugh, stroking, nodding, singing, arm or hand out-reach, open arm gesture.	1	2	3	4	5	6
ANXIETY/FEAR: Furrowed brow, motoric restlessness, repeated or agitated motion, facial expression of fear or worry, withdrawal from other, tremor, tight facial muscles, calls repetitively, hand wringing, leg jiggling, eyes wide.	1	2	3	4	5	6
DEPRESSION/SADNESS: Cry, tears, moan, sigh, mouth turned down at corners, eyes turned down and face expressionless, wiping eyes.	1	2	3	4	5	6
ANGER: Clenched teeth, grimaces, yell, curse, berate, push, physical aggression, fist shaking, pursed lips, eyes narrowed, brows knit.	1	2	3	4	5	6
INTEREST: Eyes following object, intent fixation on object or person, visual scanning, facial, motoric or verbal feedback to other, eye contact maintained, turn body toward person or object.	1	2	3	4	5	6

10. Note: Anything unusual about this observation \_\_\_\_\_

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## Observation at Time Period 3: 10:30 to 11:30 am

1. Observer Name and ID \_\_\_\_\_

2. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year

3. Circle Day of Week: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

<p>4. Place of Observation  <input type="checkbox"/> Resident=s bedroom  <input type="checkbox"/> Corridor on resident=s unit  <input type="checkbox"/> Group space on resident=s unit.  <input type="checkbox"/> Indoors but off resident=s unit  <input type="checkbox"/> Outdoors anywhereBe.g. porches, patios, lawn, yard, etc</p>	<p>5. What was resident doing during the observation?  <input type="checkbox"/> Asleep the whole time.  <input type="checkbox"/> Apparently doing nothingBstaring, sitting  <input type="checkbox"/> In motionBmoving in wheelchair or walking,  <input type="checkbox"/> Doing something aloneBreading, watching T, on phone  <input type="checkbox"/> Present at an organized activity  <input type="checkbox"/> In interaction with a staff member  <input type="checkbox"/> In interaction with a resident(s)  <input type="checkbox"/> In interaction with someone elseBor someone observer cannot identify</p>	<p>6. Was resident in restraints during observation  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p>7. Did resident speak to observer during observation  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p>8. Did observer greet resident  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p>
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 4 = More often seen (1 to 2 minutes)  
 5 = Most often seen (> 2 to 5 minutes)  
 6 = Unable to tell      DO NOT TIME LITERALLYBSUGGESTED TIMES GIVE  
 GUIDELINES FOR SCALE

9. EMOTION OBSERVED: Circle for each emotion in the 5 minute period

PLEASURE: Smile, laugh, stroking, nodding, singing, arm or hand out-reach, open arm gesture.	1	2	3	4	5	6
ANXIETY/FEAR: Furrowed brow, motoric restlessness, repeated or agitated motion, facial expression of fear or worry, withdrawal from other, tremor, tight facial muscles, calls repetitively, hand wringing, leg jiggling, eyes wide.	1	2	3	4	5	6
DEPRESSION/SADNESS: Cry, tears, moan, sigh, mouth turned down at corners, eyes turned down and face expressionless, wiping eyes.	1	2	3	4	5	6
ANGER: Clenched teeth, grimaces, yell, curse, berate, push, physical aggression, fist shaking, pursed lips, eyes narrowed, brows knit.	1	2	3	4	5	6
INTEREST: Eyes following object, intent fixation on object or person, visual scanning, facial, motoric or verbal feedback to other, eye contact maintained, turn body toward person or object.	1	2	3	4	5	6

10. Note: Anything unusual about this observation \_\_\_\_\_

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## Observation at Time Period 5: 2:00 to 3:00 pm

1. Observer Name and ID \_\_\_\_\_

2. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year

3. Circle Day of Week: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

<p>4. Place of Observation  <input type="checkbox"/> Resident=s bedroom  <input type="checkbox"/> Corridor on resident=s unit  <input type="checkbox"/> Group space on resident=s unit.  <input type="checkbox"/> Indoors but off resident=s unit  <input type="checkbox"/> Outdoors anywhere Be.g. porches, patios, lawn, yard, etc.</p>	<p>5. What was resident doing during the observation?  <input type="checkbox"/> Asleep the whole time.  <input type="checkbox"/> Apparently doing nothing Bstaring, sitting  <input type="checkbox"/> In motion Bmoving in wheelchair or walking,  <input type="checkbox"/> Doing something alone Breading, watching T, on phone  <input type="checkbox"/> Present at an organized activity  <input type="checkbox"/> In interaction with a staff member  <input type="checkbox"/> In interaction with a resident(s)  <input type="checkbox"/> In interaction with someone else Bor someone observer cannot identify</p>	<p>6. Was resident in restraints during observation  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p>7. Did resident speak to observer during observation  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p>8. Did observer greet resident  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p>
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 5 = Most often seen (> 2 to 5 minutes)  
 6 = Unable to tell      DO NOT TIME LITERALLY BSUGGESTED TIMES GIVE GUIDELINES FOR SCALE

9. EMOTION OBSERVED: Circle for each emotion in the 5 minute period

PLEASURE: Smile, laugh, stroking, nodding, singing, arm or hand out-reach, open arm gesture.	1	2	3	4	5	6
ANXIETY/FEAR: Furrowed brow, motoric restlessness, repeated or agitated motion, facial expression of fear or worry, withdrawal from other, tremor, tight facial muscles, calls repetitively, hand wringing, leg jiggling, eyes wide.	1	2	3	4	5	6
DEPRESSION/SADNESS: Cry, tears, moan, sigh, mouth turned down at corners, eyes turned down and face expressionless, wiping eyes.	1	2	3	4	5	6
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INTEREST: Eyes following object, intent fixation on object or person, visual scanning, facial, motoric or verbal feedback to other, eye contact maintained, turn body toward person or object.	1	2	3	4	5	6

10. Note: Anything unusual about this observation \_\_\_\_\_

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## Observation at Time Period 6 3:00 to 4:00 pm

1. Observer Name and ID \_\_\_\_\_

2. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year

3. Circle Day of Week: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

<p>4. Place of Observation</p> <p><input type="checkbox"/> Resident=s bedroom</p> <p><input type="checkbox"/> Corridor on resident=s unit</p> <p><input type="checkbox"/> Group space on resident=s unit.</p> <p><input type="checkbox"/> Indoors but off resident=s unit</p> <p><input type="checkbox"/> Outdoors anywhereBe.g. porches, patios, lawn, yard, etc</p>	<p>5. What was resident doing during the observation?</p> <p><input type="checkbox"/> Asleep the whole time.</p> <p><input type="checkbox"/> Apparently doing nothingBstaring, sitting</p> <p><input type="checkbox"/> In motionBmoving in wheelchair or walking,</p> <p><input type="checkbox"/> Doing something aloneBreading, watching T, on phone</p> <p><input type="checkbox"/> Present at an organized activity</p> <p><input type="checkbox"/> In interaction with a staff member</p> <p><input type="checkbox"/> In interaction with a resident(s)</p> <p><input type="checkbox"/> In interaction with someone elseBor someone observer cannot identify</p>	<p>6. Was resident in restraints during observation</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>7. Did resident speak to observer during observation</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>8. Did observer greet resident</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
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9. EMOTION OBSERVED: Circle for each emotion in the 5 minute period

PLEASURE: Smile, laugh, stroking, nodding, singing, arm or hand out-reach, open arm gesture.	1	2	3	4	5	6
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DEPRESSION/SADNESS: Cry, tears, moan, sigh, mouth turned down at corners, eyes turned down and face expressionless, wiping eyes.	1	2	3	4	5	6
ANGER: Clenched teeth, grimaces, yell, curse, berate, push, physical aggression, fist shaking, pursed lips, eyes narrowed, brows knit.	1	2	3	4	5	6
INTEREST: Eyes following object, intent fixation on object or person, visual scanning, facial, motoric or verbal feedback to other, eye contact maintained, turn body toward person or object.	1	2	3	4	5	6

10. Note: Anything unusual about this observation \_\_\_\_\_

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