SCOPE OF NURSING PRACTICE IN HOME HEALTH: A DESCRIPTION

by

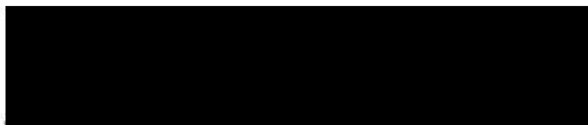
Jennifer L. Green, R.N., B.S.N.
Bonnie Driggers, R.N., B.S.N.

A Descriptive Study

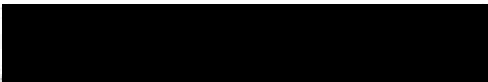
Presented to
The Oregon Health Sciences University
School of Nursing
in partial fulfillment
of the Requirements for the Degree of
Master of Science in Nursing

May 22, 1986

APPROVED:

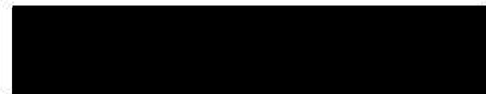


Joyce Semradek, R.N., M.S.N., Masters, Research Project Advisor



Barbara Stewart, Ph.D., First Reader

Linda Fahr, R.N., M.N., Second Reader



Carol A. Lindeman, R.N., Ph.D., Dean, OHSU School of Nursing

TABLE OF CONTENTS

Page

Introduction 5

Literature and Conceptual Framework 7

Design 10

Setting 11

Data Collection 16

Data Analysis 20

Results and Discussion 21

References 49

Appendices

A. History of the Problem and Review of the Community Health Nursing Literature 52

B. Questionnaire 74

C. Case Studies and Interview Format 82

Abstract 93

LIST OF TABLES

Table		Page
I	Distribution of Study Subjects Across Agencies	13
II	Educational Preparation of Home Health Nurses Completing the Questionnaire	14
III	Nursing Experience of Home Health Nurses Completing the Questionnaire	15
IV	Roles Identified by the Home Health Nurse as Part of Nursing Practice in Home Health Care	23
V	Practice Changes Experienced in the Last Two Years by Nurses Completing the Questionnaire	36
VI	Roles Identified as Problematic by Nurses Making a Transition from Inpatient Acute Care to Home Health Care	37
VII	Roles Identified as Problematic by Experienced Home Health Nurses Identifying an Increase in the Acuity of Home Health Nursing Clients	38

As a result of complex interrelationships between economics, policy, social trends, and technological advances, health care is moving out of the hospital and into the community. This shift in the site of nursing care affects the practice of nursing widely and profoundly; an area which has felt the effects of the changing health care delivery system is community health nursing. As clients are discharged earlier from hospitals, the acuity of the nursing care delivered in the community approaches that of inpatient nursing care. As a result, increasing numbers of community-based nurses are delivering illness-generated health care in the client's home.

The shift in the site of nursing care is reflected in the rapid expansion of the home health care segment of the health care delivery system. Home health care agencies numbered 250 in 1963, prior to Medicare. The number of agencies increased dramatically in 1966 after the enactment of Medicare and further increased by 1984 to a high of 4445. Additionally, Alford and Stanhope (1985) note that the Department of Health and Human Services projects a continuing increase in home care agencies at the rate of 30% a year. Concomitantly, a shift in the site of nursing employment from the hospital to the community is predicted. According to the National Sample Survey of Registered Nurses, conducted most recently in November of 1980, 6.6% of nurses were employed in community settings. However, Alford and Stanhope (1985) report that the Department of Health and

Human Services projects that by 1990 the number of nurses employed in the community will increase by 225%.

Home health nursing has been in existence in the United States since the late nineteenth century. However, the relationship of home health nursing to community health nursing has not been clear. What is the scope of nursing practice in home health nursing? How does the current practice of home health nursing vary from conceptions about community health nursing? The increasingly acute nature of the nursing care delivered in a home health context and the expanding home health market provide a new impetus for the examination of this segment of the health care delivery system. Without a clear conception of how home health nursing relates to other nursing specialities, many practice and education decisions cannot be made in a logical manner. Such decisions are important for both nursing practice and education and relate to:

- the design of community health nursing curricula
- the design of inservice programs to address the changing nature of home health nursing
- the design of new employee orientation
- criteria for selection of employees
- what constitutes an appropriate referral to the home health setting
- what services and scope of practice are appropriate for the home health setting

In order to address the pressing questions noted, a survey was conducted to describe the scope of nursing practice in home health care, as indicated by the roles taken on by the nurse in the course of providing such care.

Literature and Conceptual Framework

While the practical impetus for an examination of the scope of nursing practice in home health is clear, there are also conceptual issues central to a consideration of home health nursing. Within the literature, there is little agreement about the nature of community health nursing itself. The lack of agreement is a result of the changing nature of community health nursing, the differing opinions of educators writing about community health nursing, and the relative distance of those writing about community health nursing from the realities of clinical practice.

Conceptions of community health nursing range from the narrow, as characterized by a dependence on practice setting as a defining characteristic, to the broad, focusing on the community health nurse as caregiver to the aggregate. Aggregate-focused nursing care is care directed at meeting the needs of the community, through either interventions at the aggregate level, such as health policy and planning, epidemiology, and community diagnosis, or interventions at the individual level which are planned in accordance with community needs.

Helvie (1981) offers a limited conception of community health nursing as defined by the extrahospital setting in

which it occurs. Archer and Fleshman (1979) incorporate practice concepts relevant to aggregate-focused nursing care such as community organization, health planning, and epidemiology; they do not discuss community health nursing as either defined by or transcending the practice setting. Freeman and Heinrich (1981) acknowledge that some community health nurses function in the hospital, but they again emphasize that the practice setting is a significant characteristic of community health nursing. Tools for the practice of aggregate-focused nursing are limited to epidemiology and community assessment and diagnosis.

In contrast, Jarvis (1985) contends that community health nursing transcends traditional extrahospital settings and is characterized by a paramount reponsibility to the health of the entire community through aggregate-focused care delivered to individuals, families, groups, and communities. Tools for the practice of aggregate-focused nursing include epidemiology, health policy action, and the creation and management of change in the community. (A fuller discussion of the literature and history relevant to a consideration of this conceptual confusion can be found in Appendix A).

In addition to the confusion about the nature of community health nursing, a second conceptual issue is that the relationships between home health nursing, community health nursing, and acute care nursing have not been explored. Home health nursing incorporates knowledge from

both community health nursing and acute care nursing, and neither community health nor acute care nursing conceptions alone are adequate to guide the practice of home health nursing. It is important to understand the relevant conceptualizations from both acute care and community health nursing. To that end, the current study was conducted to describe the scope of nursing practice in home health, as indicated by the roles taken on by the nurse in the course of providing home health care.

The community health nursing literature was also reviewed for the purpose of developing a preliminary list of potential roles of the home health nurse. There are several descriptions of the roles of the community health nurse. Elkins (1984) describes the roles of promoter or health advocate, teacher, adjunct, and provider. Spradley (1981) identifies community health nursing as comprising the roles of care provider, educator, advocate, manager, collaborator, leader, and researcher. Burgess (1983) selects the following roles as ones that are commonly practiced by the community health nurse: advocate, consultant, coordinator, counselor, educator, evaluator, planner, provider, researcher, and specialist.

Current information on home health is only now beginning to appear in the literature and is limited. There are no detailed descriptions in the literature of the roles taken on by the home health nurse. Cherryholmes (1986) informally enumerates the roles of the home health nurse as "...part

social worker, financial counselor, dietician, consumer or client advocate, teacher, case manager, and coordinator... a friend, a spiritual comforter, a psychologist,...a physical therapist, an occupational therapist, and a translator of medical information...(and a) facilitator." The following roles were extracted from the literature and from the experience of the researchers and were used as an initial guide to tool development and data analysis: advocate, educator, case manager, primary care provider, case finder, community health facilitator, coordinator, evaluator, referrer, promoter, preventer, and resource allocator.

Design

Nurses practicing home health at three Portland metropolitan, non-public home health agencies were surveyed -- 32 nurses by questionnaire and 14 of these by interview-- about the practice roles taken on in the course of providing such care. The three agencies were selected as collectively representing the range of nursing practice in home health care. As a group, these agencies provide care for clients of all ages with both acute and chronic illness, utilizing intermittent or continuous care. The agencies were not selected nor was the study designed with the intent of making comparisons between agencies; rather, the design was intended to maximize variation between participants so that the current scope of nursing practice could be captured and explored.

Qualitative analysis of interview data revealed nineteen

roles comprising the current practice of home health care. Qualitative analysis of questionnaire data yielded information about the practice modifications a nurse might have undertaken in making one of two transitions: the change from acute care nursing to nursing in the home or, for the experienced home health nurse, the transition to taking care of more acutely ill clients in the home. Quantitative analysis of questionnaire data allowed the depiction of the study participants in terms of nursing education, experience, and current employment.

Setting

Visiting Nurse Association Home Healthcare, Inc. is Oregon's largest home care agency. It is a nonprofit, Medicare certified, licensed home health agency offering an interdisciplinary approach to home care through a broad range of intermittent services from skilled specialty nursing programs to personal care services. Some of the specialty programs offered by the VNA include hospice, home intravenous therapy, and respiratory care. The services which are offered are designed to help keep people out of hospitals and nursing homes, thereby saving the community's financial resources.

Kaiser Permanente Home Health Agency/Hospice is an agency of Kaiser Foundation Hospitals, Northwest Region. It is a nonprofit, Medicare certified, licensed home health agency affiliated with a health maintenance organization. An interdisciplinary approach characterizes the broad range

of intermittent services offered, from skilled nursing to homemaker services. The services are available to any members within the service area who are homebound or essentially unable to travel to a medical office for care. Additionally, the agency has a specialty hospice program. All of the services are designed to allow clients to remain in their homes for health treatments as an alternative to costly hospital or nursing home care.

New Nursing Concepts, Inc. is a for profit, privately held, licensed private duty nursing agency. It offers specialized pediatric nursing care for clients 0 to 20 years of age, primarily utilizing shift care in the home. The agency designs care to provide a transition from the hospital to the home.

Thirty-two subjects from the three agencies volunteered for unpaid participation; the distribution of the subjects across agencies is a result of the relative size of the agencies and the willingness of nurses from each to participate (Table I). From the initial pool of subjects, fourteen were randomly selected for interview.

All subjects met the minimum criteria for participation of completion of orientation to the employing agency and at least one year of experience in home health nursing. The characteristics of the subjects are summarized in Table II and Table III. There was a wide variation beween subjects in terms of years since completion of nursing education, duration of experience in community-based nursing, and

Table I.

Distribution of Study Subjects Across Agencies

Agency	RNs receiving questionnaire	Subjects completing questionnaire	Subjects participating in interview
#1 VNA	21	20	5
#2 KHH	12	5	4
#3 NNC	10	7	5
Total	43	32	14

Table II.

Educational Preparation of Home Health Nurses Completing the Questionnaire.

	N	%
Highest nursing degree completed		
diploma	3	9.4
associate degree	4	12.5
baccalaureate degree	21	65.6
master's degree	4	12.5
	N = 32	

Table III.

Nursing Experience of Home Health Nurses Completing the Questionnaire.

	Range	Mean	Median
Years since completion of basic nursing education	3 - 32	12.2	11.0
Duration in years of employment with current agency	0.5 - 13	3.5	2.5
Duration in years of nursing experience in home health or community health	0.5 - 13	4.3	2.75
Duration in years of nursing experience in inpatient setting	0 - 16	5.7	4.25

duration of experience in acute care nursing.

There were two general characteristics of the study participants. First, the nurses surveyed indicated that their nursing experience was predominantly in acute care nursing. Nineteen (59%) of the 32 subjects had more acute care nursing experience than community-based nursing experience. There were only two nurses who had had no acute care nursing experience. This is consistent with the observation that, as the home health care market has expanded, nurses have moved from inpatient, acute care settings to the home health setting; this movement may be a result of the desire of the nurse to pursue community-based employment or of the necessity for the nurse to seek other options as the number of available acute care positions decreases.

Secondly, the recentness of the changes in the health care delivery system is reflected in the relatively short duration of the nurses' experience in community-based nursing. For 27 of the 32 subjects (84%), the current home health role comprised the entirety of experience in community-based nursing. The duration of current employment was also short, with a mean length of 3.5 years. More striking is the observation that 19 (59%) of the nurses had been employed in their current position less than three years.

Data Collection

A questionnaire and structured interview schedule were

developed by the researchers, reviewed by an expert panel, and pilot tested in a home health agency not included in the sample. The questionnaire (Appendix B) which was distributed included items soliciting subject characteristics and questions pertaining to the current scope of practice in home health nursing. Through the questionnaire, the researchers also probed two transitions potentially experienced by the home health nurse in the last two years: the transition from acute care nursing in an inpatient setting to home health nursing and, for the experienced home health nurse, the transition to taking care of more acutely ill clients in the home. The purpose of exploring the noted transitions was to identify nursing roles which might be problematic for the nurse experiencing a change in practice.

The interview format was based on three written cases developed by the researchers and reviewed by three nurses experienced in home health. The three cases represent a range of characteristics of potential home health nursing situations including client age, payor source, client outcome, level of acuity, required procedures, prevention needs, and the presence of other potential clients requiring care. All of the cases can be found in Appendix C; an example follows:

> Robert Jones is a 75 year old male who has recently been discharged from the hospital. He has been diagnosed as having chronic renal failure and is on

> hemodialysis. In addition to his renal failure, Mr. Jones has COPD and uses oxygen consistently with exertion. Yesterday, he had a Hickman catheter placed for dialysis access.
>
> His wife is his primary caretaker and his health care is funded by Medicare. He and his wife have recently moved into a new home. The previous owner is delinquent in making promised repairs to the leaking roof; Mrs. Jones has not been successful in trying to get the repairs completed.
>
> You have been asked to provided intermittent visits three times a week for one hour to monitor his COPD and renal failure and to teach him and his wife Hickman care.

The purpose of using the cases was twofold. First, they provided a framework from which the respondents could describe their practice without relying on their current caseload. Secondly, through the cases, nurses were exposed to a variety of cognitive stimuli which offered them an opportunity to describe a scope of nursing practice of varying breadth; the nurses were given the opportunity to identify a variety of roles as part of their nursing practice.

The interviews also included direct questions about roles such as community health facilitator and health promoter which were less likely to be incorporated into responses to the cases (Appendix C).

The researchers attended regularly scheduled staff meetings at the three agencies. After an explanation by the researchers of the purpose and requirements of the study, 42 questionnaires with metered, self-addressed envelopes were distributed to the nurses. It was also explained that the return of the questionnaire by mail within two weeks after distribution would be considered as consituting informed consent to be randomized for interview selection.

Initial return rates were very discouraging. One week after questionnaire distribution, those who had not yet responded received a personalized written reminder, and a poster reminding participants to return questionnaires was displayed in each agency. After another week, a note of thanks or a reminder, accompanied by an enticement in the form of a chocolate truffle, was distributed to all who had received questionnaires. Due to time constraints, one set of subjects received an enticement of fresh croissants and coffee at the time of questionnaire distribution. One week after their introduction to gastronomy, nonrespondents received a phone call requesting their participation. As noted, after written reminders, truffles, croissants, and phone calls, thirty-two questionnaires were eventually received, yielding a respectable return rate of 74%.

Five subjects from each of two agencies were randomly selected for interview; all four subjects at the third agency who met the employment criterion for participation were interviewed. Each subject was contacted by phone to

establish both willingness to continue with the study and an appointment for the interview. After the transcription of one of the fourteen interviews was lost due to a mechanical malfunction, a total of thirteen interviews were available for analysis.

Two of the agencies agreed to allow the interviews to be conducted on work time. All of the interviews were conducted at a time and place chosen by the subject, ranging from the subject's home to the workplace to a local restaurant. Subjects were randomly assigned to be questioned about two of the three developed cases, and the order in which the cases were presented was systematically rotated. After having read the case, each subject was asked to describe the interventions she would undertake. The interviews lasted an average of 45 to 60 minutes, although the longest was nearly two hours. Each interview was tape recorded, with the subject's permission, and later transcribed.

Data Analysis

Using the preliminary list of potential roles developed from the literature, the content of the interviews was analyzed to extract the roles taken on by the nurses in the course of providing care. As transcriptions of initial interviews became available for review, subsequent interviews were modified to incorporate the exploration of unanticipated roles.

All data analysis was conducted jointly by the

researchers to ensure that the emerging roles were conceived of similarly by both, and to ensure that both were optimally familiar with all of the data. Coding sessions lasted from one to four hours and occurred almost daily for four weeks.

Each transcription was initially reviewed and coded, then set aside to be reviewed at the next coding session. Each code was discussed until agreement was reached by the researchers. After the second review of the transcription, each comment coded as relevant to a role was cut out and pasted on to an index card. Each card also contained a code for agency, subject, and whether the comment was solicited or unsolicited. The approximately 600 cards were then filed according to the role addressed by the subject's comment.

The statements in each role category were then reviewed again for fit within the category as operational definitions of the roles began to emerge. When the researchers were satisfied that each comment was in the appropriate category, final definitions of the roles were developed, based on the dimensions of the roles which emerged during the interviews.

Results and Discussion

In responding to the cases, the home health nurses described a total of nineteen roles. Roles which, to the best of our knowledge, either have not appeared elsewhere in the literature or have a previously undescribed dimension are marked with a double asterisk. Listed in

order of the aggregate frequency with which a role was mentioned, the descriptions below are based on the comments of the interviewed nurses; the position of a role on this list was compared to the pattern of responses about that role on the questionnaire to uncover any discrepancies. The roles are also listed, in order of the number of interview subjects identifying each, in Table IV.

1. Educator--facilitates learning for clients and/or whoever else is responsible for the provision of care, including the nurse herself and her peers, related to treatment, knowledge of disease process, prevention of complications, health promotion, and avenues of access to the health care delivery system.

"...I would teach his wound care...and signs and symptoms... and some diet teaching...and then ostomy care...and how to get supplies and where to get them and who will pay for them ."

" We might be able to go in there and teach her (wife of the client) for a week how to care for the Hickman, how to change the dressing..."

" I'd teach him signs that he should be tested again (for recurring cancer)..."

" ...(I'd) give her some guidelines (about when to) call the doctor."

" I'm always feeling like I need to go research a disease or go to the library..."

Table IV.

Roles Identified by the Home Health Nurse as Part of Nursing Practice in Home Health Care.

Role	Number of nurses identifying role (N=13)
* Educator	13
Direct Care Provider	13
Preventer	13
Relationship Structurer	12
Assesser	12
Coordinator	10
* Evaluator	10
Referrer	9
Counselor	9

Note. The relative importance or value of a role is not implied by the number of nurses identifying it as part of their nursing practice.

* denotes roles about which more than 50% of comments were solicited, as opposed to volunteered, during interview.

Table IV. (continued)

Roles Identified by the Home Health Nurse as Part of Nursing Practice in Home Health Care.

Role	Number of nurses identifying role (N = 13)
Case Finder	8
Resource Utilization Regulator	7
Adapter	7
Personal Resource Allocator	6
Collaborator	5
Case Manager	4
Advocate	3
* Health Promoter	3
* Primary Care Provider	2
* Community Health Facilitator	1

Note. The relative importance or value of a role is not implied by the number of nurses identifying it as part of their nursing practice.

* denotes roles about which more than 50% of comments were solicited, as opposed to volunteered, during interview.

2. Direct Care Provider--delivers necessary treatments and procedures to clients in the home.

3. Preventer--delivers nursing care, often through education, which emphasizes safety and is directed at limiting disability due to illness through the early recognition of complications such as infection and exacerbation of disease; the nurse may also deliver nursing care, such as education about home safety, which averts illness or injury or facilitates rehabilitation.

> (after being asked aboutprevention for a client)"...I think of him as knowing a little bit about his disease process and what the medical treatments are for and what the initial signs and symptoms are of something that's not going right..."
>
> "Safety, the immediate teaching is the safe use of oxygen, how to use, when to use, what you do and do not do with it."
>
> "...There goes the oxygen tube from her into the other room, and she's going to trip over it, and FuFu the dog is going to get tangled up in it..."

**4. Relationship Structurer--systematically structures the interactions between the nurse and client and/or family to meet the goals of entry into the home, role and responsibility clarification leading to client independence, delineation of professional activities, and facilitation of open communications.

"A lot of contracting goes on because if you walk into

someone's home, it's not like in the hospital where they're walking into your home. They call the shots..."

"...as soon as you start admitting, you discharge...and you tell the patient exactly what you're going to do and who's going to see them so that they don't depend on you being the nurse every day because you can't always be there and you just set those guidelines when you start."

"...if you get a chance to spend some time with them and find out who they are as a person...they've built some kind of a bond and you can get a lot further and dig a little bit deeper."

**5. Assesser--systematically gathers data related to the client and/or family physical and psychosocial response to illness, client and/or care provider ability to perform necessary treatments and procedures, support systems, and client financial status as it relates to the provision of care.

"...we have to kind of watch the parent interact with the child, see if they're feeling comfortable, see if they're withdrawing, maybe they don't want to bond."

"...you have to assess how strong is the wife,...what type of a woman is she? Is she going to be able to carry on, she might need a lot of support from the community..."

"Sometimes you can get an idea of a person's financial situation just by looking around their home, looking at what they do or don't have in the refrigerator..."

6. <u>Referrer</u>--takes responsibility for linking the client with the resource most appropriate to the client's current need based on a working knowledge of available community resources.

"I would refer to social work, again, for the financial part of it..."

"I would make a referral to the social worker for some help ... with these other things with the house"

"I might refer them to PACT."

"I might do a referral to legal aid..."

"I will call Meals on Wheels directly."

"I would want to get some physical therapy..."

"We also have our enterostomal therapists that can go out..."

"I'd probably do a referral to the respiratory team..."

7. <u>Coordinator</u>--ensures that the client's care is consistent across providers and agencies by facilitating communication which reduces or explains inconsistencies of care.

"...there's constantly involvement ...back and forth involvement between the physicians and the nurse involved together (so that) everybody knows what's going on."

8. <u>Case Finder</u>--looks beyond the specific reason for referral to the home to address care needs of others in the environment through assessment, education, counseling, referral, and/or direct care.

"I might kind of try to explore with her (client's mother) in a tactful way why she's not taking her medication..."

"We'll be real specific about helping them set up plans (for managing medications) and talk to them about the importance of follow-through with those plans...and if something negative happens as a result of their not complying, we can bring that to their attention...If it's still a problem, then we refer it back to the physician and the physician counsels with the parent."

"I would probably work with her husband in helping him ...he really needs some assistance..."

9. Evaluator--assesses, through informal or formal processes, the extent to which the nursing care provided results in the desired outcomes.

"...we write a pretty structured thing...when we send in the care plan that's sort of written in stone...but on a day to day basis I change mine depending on what I find."

"Really only formally do I look at the care plan and make sure that it is appropriate every two months when I have to do a (Medicare) recertification."

**10. Resource Utilization Regulator--brings the use of nursing resources into conformance with payor regulations through planning of care which is in accordance with regulations and careful documentation in support of

continued service.

"...he is Medicare, therefore, with careful planning you could probably do a pretty good job with him for medical coverage and payment."

"...it does require alot of paperwork because, as far as the regulatory agencies are concerned, if you don't document it then it wasn't done and if you miss charting a visit, you can't expect to get paid for it."

11. Counselor- structures interpersonal communications designed to improve a problematic response to illness on the part of the client or family.

"...you have to help him see how he can reconstruct his life... so that he can be a functioning man sexually, whatever he sees a man as.. .it does take alot of counseling and it does take alot of readjustment ...because your body image is totally changed."

**12. Adaptor--adjusts the nursing care delivered in the home setting through the modification of equipment and procedures and/or the incorporation of family and client goals and desires, recognizing the distinction between what is safe and effective in the home versus what is optimal.

"...we have the hospital policies for procedures and you can't use those for home."

"In a hospital, everyone has their own little set of supplies and you don't touch any body else's but (in the home)...you beg, borrow, and steal just to do the work and then...the scissors and stuff you put in the oven

and clean..."

"So what we try to do is to come up with something that will suit the child and will be something that the parents can work with."

13. Case Manager--directly influences decision-making about a client's plan of care including frequency of visits, utilization of other providers through collaboration and referral, educational approach, and the point of termination from home health care.

"I make this care plan out so that each time someone or myself goes into the home the care plan is followed. It gives people an idea of what I am looking for."

" (I'd) see him for probably a couple weeks and reevaluate and then probably dismiss him."

**14. Personal Resource Allocator--determines the efficient and effective use of the nurse's personal resources, including time, ability, and motivation.

"Nobody tells me how long I have to be there or how short I have to be there. If a person requires ten minutes, that is what they get and if they require an hour or two hours, then that is what they get."

"I would make a referral, just selfishly, because I couldn't deal with (the ostomy)."

15. Health Promoter--provides nursing care, often through education, which is not directly related to the client's current illness but which facilitates the client's attainment of optimal well-being.

"(I do) diet teaching and I do it alot to get people to exercise and vitamins and try to get some social things happening in their lives."

16. Advocate--acts on the behalf of the client or community, representing concerns and needs to resource and power sources to which they do not have access or sufficient influence.

"I think that I spend alot of my time being patient advocate, calling the doctors, begging them."

"I might contact the (ostomy association) in respect to this guy (who) is trying to tell (the client) how to take care of his ostomy. I don't see that as a role that the person from the ostomy association should be having so they might want to know about that."

17. Collaborator--utilizes information resources of other providers to enhance nursing care without making an actual referral or delegating care to them.

" I love doing joint home visits with other agencies, you learn a whole lot of stuff...."

18. Primary Care Provider--is available to the client as a point of entry into the health care system or facilitates entry through others.

"Once in a while I'll find myself attached to a patient so that I will remember their name and tell them to call me and help them back into the system..."

19. Community Health Facilitator- identifies care needs of the community and/or enables the community to meet

those needs.

> "(I provide nursing care) within the retirement homes or different things if they need a blood pressure screening or they need a foot clinic or flu shot clinic..."

While the roles are listed in order of frequency with which they were mentioned by all of the subjects, no implication about the relative importance or value of any of the roles is intended.

There are two roles which may have been systematically underrepresented and thus may be placed lower on the above list than may be the actual case. The first is the role of evaluator. During the interview process, it became evident that the role of evaluator had an informal as well as a formal dimension as nurses described ongoing evaluatory activities related to the nursing care plan. As this aspect of the role was recognized, the researchers began soliciting information from subsequent subjects. There were three subjects from whom this information was not solicited.

The other role which may have been underrepresented is that of case manager because the case manager often carries out activities which are also part of other roles, such as coordinator, referrer, and educator. When nurses described the initiation of such activities, they were not asked whether they considered themselves to be acting in the role of a case manager as they did so. A response was only coded as case manager when it was clear that the nurse considered herself to be acting as one. Although the role of case

manager appears relatively low on the list of roles by aggregate frequency, at least 56 percent of the nurses responding to the questionnaire identified that they were functioning as a case manager when planning care or coordinating the care of different providers at the agency. The relative position of case manager would have been higher on the list if the interviewed subjects had been asked explicitly about the role.

The role of community health facilitator is relatively less developed than the others. While it was included in the initial list of roles developed from the literature, very little information was offered about this role despite direct soliciting. Because only one nurse identified this role as part of her nursing practice, it is still unclear how this role might be operationalized for the home health nurse.

No single nurse interviewed described all of the roles as part of her scope of practice. The number of roles identified by individual nurses varied from eight to fifteen. The three roles of educator, direct care provider, and preventer were described by all of the nurses interviewed; the roles of relationship structurer and assesser were described by twelve of the thirteen subjects. Among the least frequent roles, health promoter was described by three subjects, primary care provider was described by two subjects, and, as noted, community health facilitator by only one.

Thus, it is clear that the scope of nursing practice, as indicated by the roles undertaken in the delivery of home health care, varies between individual nurses, perhaps as a result of a combination of individual capacities, interests, style, and agency characteristics.

The mean number of roles described by the nurses at each agency varied as well. At two of the agencies, the mean number of roles described during the nurses' responses to the cases was 11. Additionally, at one of these agencies, two roles were absent from the descriptions of all of the nurses; at the other, six roles were absent from the aggregate description of nursing practice. At the third agency, the mean number of roles described by the nurses was 13.6 ; this was the only agency in which all of the roles were present in the aggregate agency description of the scope of nursing practice.

While the study was not designed to make comparisons between agencies, it is interesting to note that the scope of nursing practice varied between agencies. The agency which had the highest mean number of roles described by nurses and was the only agency at which all of the roles were identified in the aggregate response is one which, traditionally, has provided comprehensive home care and has the longest history of providing home health services to the community.

All of the roles described relatively frequently are those which are focused on the client and/or immediate

family and the present or very near future: direct care provider, educator, preventer, relationship structurer, and assesser. Farther down the list, one begins to see roles which require a more comprehensive knowledge of nursing and the health care system, and a willingness to perceive the needs of the client and/or family as extending beyond the obvious medical reason for referral: referrer, coordinator, case finder, resource utilization regulator, case manager, counselor, and adapter. Finally, the least frequently mentioned roles are those which, with the exceptions of personal resource allocator and collaborator, imply that the scope of practice of the home health nurse extends well beyond the individual client and the current illness: health promoter, advocate, primary care provider, and community health facilitator.

Data were solicited by questionnaire about whether the nurse had experienced either a change from inpatient to home health nursing or an increase in the acuity of clients being cared for in the home. The numbers of nurses identifying that they experienced either transition are presented in Table V. Additionally, the roles which were problematic for the nurses undergoing a practice change are summarized in Tables VI and VII. A role was designated as problematic if it was identified by the nurses as requiring either the addition or modification of nursing skills and knowledge. Twelve of the nineteen roles were described as requiring addition or modification of skills and knowledge by the ten

Table V.

Practice Changes Experienced in the Last Two Years by Nurses Completing the Questionnaire

	Nurses	
	N	%
Transition from acute care nursing to home health nursing	10	31
Increased acuity of home care clients	8	22
No practice change experienced	10	31
Unspecified practice change experienced	4	12.5
	N = 32	

Table VI.

Roles Identified as Problematic by Nurses Making a Transition from Inpatient Acute Care to Home Health Care

Role	Number of nurses identifying as problematic (N=10)
Assesser	6
Adapter	5
Resource Utilization Regulator	4
Referrer	3
Case Manager	3
Direct Care Provider	3
Relationship Structurer	3
Educator	2
Coordinator	2
Personal Resource Allocator	2
Counselor	1
Preventer	1

Note. The relative importance or value of a role is not implied by the number of nurses identifying it as problematic during the transition.

Table VII.

Roles Identified as Problematic by Experienced Home Health Nurses Identifying an Increase in the Acuity of Home Health Nursing Clients.

Role	Number of nurses identifying role as problematic (N=8)
Educator	5
Direct Care Provider	4
Assesser	3
Adapter	2
Counselor	2
Relationship Structurer	2
Case Manager	1
Coordinator	1
Personal Resource Allocator	1

Note. The relative importance or value of a role is not implied by the number of nurses identifying it as problematic during the transition.

nurses making a transition from acute care to home health care. Nine roles were identified as problematic by the eight nurses experienced in home health care who confirmed an increase in the acuity of clients being cared for in the home.

The roles reported as problematic by only the nurses making a transition from acute care to home health were resource utilization regulator, preventer, and referrer. These are roles which are not part of the scope of nursing practice in an acute care setting. With respect to resource utilization regulation, the acute care nurse is generally unaware of the client's payor source, and is largely exempt from concerns about payor resource utilization. In contrast, the comprehension of Medicare guidelines was identified as vital knowledge to be acquired by the nurse moving from acute care to the home health setting.

Similarly, the role of preventer is very different for the acute care nurse than it is for the home health nurse. Should preventive nursing practices in an inpatient setting fail to meet their goal, there will always be other providers present to address any complications which arise, and no individual nurse is accountable for the failure of preventive care. However, for the home health nurse, the tools of preventive practice must be honed for several reasons. First, the accountability of the nurse to the client is direct. Secondly, the astute practice of prevention is a way of protecting the home health nurse's

resources; any complication which arises will be the responsibility of the nurse and require time and personal resources which are scarce.

The third role identified as problematic by only nurses making a transition from acute care nursing to home health nursing is that of referrer. This role required the addition of knowledge regarding available community resources and support services. This is a role unfamiliar to the acute care nurse who has both direct access to many institutional resources and the luxury of overlooking the client's needs after hospitalization, as other providers assume responsibility for the care of the client after discharge. In contrast, the practice of referring clients to other resources in the home health setting serves the best interests of the client and the nurse. The client's need is met by the most appropriate provider, and the nurse is allowed to conserve her scarce time and personal resources.

Four other roles which were problematic for nurses making the transition from acute care nursing to home health care were roles which are largely unfamiliar for the acute care nurse. The role of adapter was a problem, as the nurse learned how care could be given effectively and safely in the home without the ready material resources of the hospital, such as disposable dressing supplies and equipment. The role of adapter also required the development of the ability to incorporate client and family

needs and desires into the plan of care: "...in the home, the patient is truly in charge. Sometimes the lesser goals must be let go to achieve greater ones." Another problematic role for this group of nurses was relationship structurer as they learned how to stay professional in the home environment. Taking on the role of case manager was a challenge, as nurses assumed responsibility for guiding and directing the care of their clients, which required "improved independent decision-making skills with acute patients". The role of personal resource allocator also required development as the nurse moved into the home health setting, with multiple conflicting demands on time and a relatively unstructured working day.

Finally, an additional five roles were familiar to the acute care nurse but required modification. The role of assesser necessitated the upgrading of assessment skills in order to base treatment decisions upon them without consulting peers.

> "I think home nurses' asessment skills are more used than hospital general floor nurses. We have to make decisions about care based on our assessment, whether to call (the) MD, or change treatments."

The roles of educator, counselor, coordinator, and direct care provider in the home health setting are essentially the same as in the acute care setting. However, in the home setting, the individual nurse must take responsibility for and is accountable for nursing care which effectively

addresses client needs in these four areas. Skills and knowledge must be adequate to allow the home health nurse to perform individually what is performed collectively in the hospital.

Experienced home health nurses confirming an increase in the acuity of home care clients also identified the last nine roles above as problematic, although in different ways. The roles of assesser, direct care provider, and adapter required the upgrading of clinical skills and knowledge to care for more acutely ill clients using unfamiliar equipment. Modification of the role of educator often referred to education of the nurse herself about new treatments, medications, and equipment, as well as developing skills to teach the client more complex treatments and procedures. The role of case manager required an "...increased ability to solve and acknowledge multiple problems related to patient and family needs." As clients become more acutely ill, the demands on the nurse in the role of counselor increase:

> "...providing emotional support for family and caregivers; frequently these patients are long-term, slow healing with complicated nursing demands...If we as nurses get tired of these patients within the hospital, the family feels it geometrically and they have no hope of relief."

The role of relationship structurer requires increased communication skills as the care situation becomes more

complex. More acutely ill clients also require more coordination between the more numerous providers involved; consequently, the role of coordinator was also identified as problematic. Finally, increasing demands on the nurse's time in the form of multiple problems of high priority also require a modification of the role of personal resource allocator. While the described transitions are problematic for nurses experiencing either, more roles are modified or added as the nurse moves from acute care to the home health setting. It is tempting to infer that it is easier for the experienced home health nurse to adapt taking care of more acutely ill clients than it is for the acute care nurse to adapt to the delivery of nursing care in the home. However, the difference in the number of roles reported as problematic by each group may be accounted for by the difference in numbers of nurses in each group. Nonetheless, there is little doubt that the nature of the necessary modifications in nursing skills and knowledge are different for nurses moving from acute care into home health than for experienced home health nurses confirming an increase in the acuity of their home care clients. The former added some roles not part of the scope of nursing practice in the hospital, while the latter adjusted existing roles to incorporate unfamiliar diagnoses and new equipment and procedures.

The information about the transitions experienced by the nurses and the roles identified as problematic are

potentially useful for an agency planning inservice and orientation programs for employees experiencing either type of change. For the educator, this information illuminates the differences in scope of practice between acute care nursing and home health nursing.

Referring back to the above review of the literature, if one chooses the perspective that community health nursing is characterized by the delivery of aggregate-focused nursing care, then the scope of home health nursing practice as described has a substantially different focus. Concern with the needs of the larger community is minimal, as evidenced by the extremely low frequency with which the role of community health facilitator was described. With the curtailment of public funding for aggregate-oriented community health nursing activities and the expansion of home health nursing, the difference in focus becomes more important as there may be community needs which are no longer identified or addressed.

Additionally, many definitions of community health nursing emphasize a health, as opposed to illness, orientation (Williams, 1977; Freeman and Heinrich, 1981; Archer and Fleshman, 1979; Spradley, 1981). In contrast, concern for the client's current illness is paramount in home health nursing for reasons which include the fact that illness care is the basis for reimbursement by Medicare and other payors. In fact, a theme which emerged from interviews with four nurses was that the payor often defines

what constitutes nursing care for a client.

"...you do hear Medicare might cut back on even what kind of visits we can make. You know, it's almost as though those kinds of things define nursing, instead of nurses defining nursing."

" Medicare and its rules and regulations regarding documentation have a profound effect on home health services. We need to schedule our visit frequency, type of supplementary services (homemaker, home health aides) and even what kind of medication are given to patients based on what type of Medicare coverage they have."

The role of health promoter appears near the bottom of the list; only three nurses described the incorporation of health promoting nursing practice into their care. The frequency with which preventive nursing care extends beyond the prevention of complications from the current illness is also low; of the 13 nurses identifying prevention as part of their practice, only four described primary or tertiary prevention practices. Driven by reimbursement policy, the replacement, in a sense, of the community health nurse's preventive and promotive health focus by the home health nurse's illness-oriented perspective is likely to result in a failure to diagnose and address health concerns of the individual and the community.

In summary, part or all of five roles were newly identified as part of the scope of home health nursing practice, and fourteen roles previously identified in the

literature were described more fully. These roles have a variety of potential uses. For the practicing nurse, the roles provide a framework within which to examine current practice for fit with the style and scope of practice desired. For the agency, the roles also provide a framework from which to examine the current scope of nursing practice within the agency for fit with agency mission, philosophy, and goals and, further, to assist in the systematic development of employee selection criteria and performance appraisal. For the educator and theorist, the roles provide a tool for the examination of conceptions about home health nursing and its relationships to both acute care nursing and community health nursing. It is evident that the scope of practice in home health nursing is distinct from acute care and community health nursing. The scope of practice of the acute care nurse is relatively narrow in comparison to that of the home health nurse which, in turn, is relatively narrow in comparison to that of the aggregate-focused, community health nurse.

There are, however, limitations to the applicability of the results of this study. The study was designed to maximize variation between participants, not facilitate comparisons; any comparisons between individuals and agencies based on the information herein are inappropriate. While the results may suggest that the scope of nursing practice may vary by the characteristics of the individual nurse or by the type of agency in which he or she practice,

conclusions of this nature would need to be based on a study of an entirely different design. Comparability of individuals and groups across several dimensions are essential to this type of conclusion; again, the aim of the present study was to maximize variation rather than ensure comparability.

Secondly, as briefly mentioned, the differing numbers of nurses responding to different portions of the survey limit the conclusions which can be drawn about the information yielded. This is particularly the case with respect to roles which were problematic during recent changes in nursing practice.

Thirdly, the roles developed reflect the ability of each case study to draw the nurse into a description of her role. It may be that, with the use of other case studies, a different description of the scope of nursing practice in home health would have been developed.

Finally, the case studies occasionally represented a situation with which the nurse had little or no familiarity. Such was the case when nurses accustomed to intermittent visits were asked to respond to a case study in which the nursing care delivered was continuous. The ensuing description of the scope of nursing practice was a result of an extrapolation from the familiar to the unfamiliar and the nurse's estimate of what she might do in an unfamiliar situation.

According to Dickhoff and James (1968), "...theory is

born in practice, is refined in research, and must...return to practice if research is to be other than a draining-off of energy from the main business of nursing, and theory (is to be) more than idle speculation." The second level of theory described by Dickhoff and James is situation-depicting or factor-relating, "...depictions at a given moment in time".

A vital part of the depiction of home health nursing at the present moment is the clarification of the current scope of nursing practice. This is not to say that a description of the scope of practice presents a comprehensive picture of home health nursing; many elements, such as the support and resource network within which such care is delivered, are not addressed herein. Ample opportunity for further exploration of this emerging segment of the health care delivery system remains.

References

Alford, R., & Stanhope, M. (1985). The changing scene in home health care: trends in South Carolina. Family and Community Health, 8, 66-76.

Archer, S.E. (1976). Community nurse practitioners: another assessment. Nursing Outlook, 24(8), 499-503.

Archer, S.E. & Fleshman, R.P. (1975). Community health nursing: a typology of practice. Nursing Outlook, 23(6), 358-364.

Archer, S., & Fleshman, R.P. (1979). Community Health Nursing: Patterns and practice (2nd ed.). North Scituate, Mass: Duxbury Press.

Burgess, W., & Ragland, E.C. (1983). Community health nursing: Philosophy, process, practice. Norwalk, Connecticut: Appleton-Century-Crofts.

Cherryholmes, L.G. (1986). The qualities of a home health care nurse. In S. Stuart-Siddall (Ed.), Home health care nursing: Administrative and clinical perspectives. Rockville, Maryland: Aspen Publications.

Curtin, L., & Zurlage, C. (1984). DRG's: The reorganization of health care. Chicago: S-N Publications.

Davis, C. (1983). The federal role in changing health care financing. Nursing Economics, 1(1), 10-17.

Dickhoff, J. & James, P. (1968). Theory in a practice discipline. Part one: practice oriented theory. Nursing Research, 17(5), 415-435.

Elkins, C.P. (1984). Community health nursing: Skills and strategies. Bowie, Maryland: Robert J. Brady Co.

Feldstein, P.J. (1983). Health Care Economics (2nd ed.). New York: John Wiley and Sons.

Freeman, R.B., & Heinrich, J. (1981). Community Health Nursing Practice (2nd ed.). Philadelphia: W.B. Saunders Company.

Grace, H.K., Breed, S., Dineen, M.A., Foster, L.B., & Ideta, B. (1984). Organizing framework for NLN long range planning. Nursing and Health Care, 5(4), 180.

Helvie, C.O. (1981). Community Health Nursing: Theory and practice. Philadelphia: Harper and Row.

Jarvis, L. (1985). Community Health Nursing: Keeping the public healthy . Philadelphia: F.A. Davis Company.

Koerner, B.L. (1981). Selected correlates of job performance in community health nurses. Nursing Research, 30(1), 43-48.

Mundinger, M. (1983). Home Care Controversy: Too little: too late: too costly. Rockwill: Aspen Publications.

Spradley, B.W. (1981). Community Health Nursing: Concepts and practice. Boston: Little, Brown, and Company.

Sullivan, J.A. (Ed.). (1984) . Directions in Community Health Nursing. Boston: Blackwell Scientific Publications.

Tanner, D. (1984). Assessing hospital entry into home care. Caring, 7, 105-107.

Tigar, N.L. (1980). Competencies for practice of community health nursing. (Publication No. 52-1834). New York: National League for Nursing.

Williams , C.A. (1977). Community health nursing - what is it? Nursing Outlook, 25(4), 250-254.

Appendices

Appendix A

History of the Problem and Review of the Community Health Nursing Literature

History of the Problem and Review of the Literature

One of the most potent causes of the conceptual confusion noted above is the obscure nature of the relationships between community health nursing and acute care nursing. At no point, and perhaps in keeping with the constantly changing nature of health care, have the boundaries of either specialty been clear. While this has long been a conceptual problem, the recent trends in health care have stoked the fires of concern and added a very practical impetus to consideration of what the relationships between the two specialties are and how each in turn relates to the practice of illness-generated, in-home nursing care. The history of the conceptual disarray contributes a valuable perspective.

In the 1880's, public health nursing began on an institutionalized basis in response to multiple epidemics which overwhelmed existing medical and nursing facilities. It was also deemed appropriate to treat, in the community, the spread of diseases which were exacerbated by environmental factors. Sullivan (1984) states that the concepts underlying public health nursing at its inception were (a) the unit of service could be the individual, family, and/or community, (b) cultural differences must be respected in the delivery of care, (c) preventive health practices are as important to community health nursing as are care and cure, and (d) the skills and role behaviors

necessary for effective community health nursing practice require more education than basic hospital training. From its beginnings, then, community health nursing has been identified as a nursing practice different from acute care nursing, requiring more and different skills and being practiced in settings other than the traditional hospital environment.

The practice distinctions between community health and acute care nursing have been reinforced over the past century. The reinforcement has been due, in part, to the continuing conceptualization of community health nursing as distinguished by setting. The establishment of public and voluntary health agencies by the 1920's provided an identifiable locus of practice for community health nurses. The expansion of the federal role in determining health services was manifested by the Shephard-Towner Act of 1921 in which matching funds were provided for maternal-child health promotion. The effect of this legislation during its eight years of existence was to expand in scope the maternal-child services provided by public health nurses, increasing the visiblity and vitality of the relatively young discipline, and to legitimize health promotion as an activity within the practice domain of the public health nurse.

The passage of the Social Security Act in 1935 marked the initiation of the prominence, until recently, of federal support for the work of public health nurses. For most of

the past century, community health nursing has been linked conceptually with public health agencies. This link has served to perpetuate the distinction between community health and acute care nursing, which has functioned in public, nonprofit, and proprietary settings. However, the distinctions between community health and acute care nursing are not as clear as a narrow definition of community health nursing based on setting would allow nor are they as clear as they have been in the past. Indeed, the changing health care delivery system is challenging, if not eroding, the distinctions between community health and acute care nursing.

In terms of nursing education, the recent past reflects the confusion over the nature of community health nursing and its relationship to acute care nursing. The past century has brought first a recognition of the uniqueness of community health and, more recently, integration of community health nursing content into acute care areas to such an extent that many community health educators fear for the continued existence of community health nursing as a specialty. Separate educational preparation for nurses practicing in public health was implemented early in the 20th century. Although the inclusion of community health content in generic baccalaureate programs was prompted by the Goldmark Report of 1923, it was included as a specialty distinct from acute care nursing and integration of community health and acute care content was minimal at best.

Community health clinical experiences were conducted in agencies outside the hospital and the defining characteristic of the specialty was, for many programs, the setting in which the care was delivered. A very narrow definition of community health was thus reflected and promulgated; definitions of community health nursing which emphasize an extrahospital locus of practice are prominent in the literature and will be discussed below. This continues to be the case in some baccalaureate nursing programs across the nation.

However, in the 1960's and 1970's, there was a drive toward the more complete integration of community health concepts and principles into acute care nursing at the undergraduate level. Community health nursing educators could be found in traditional acute care areas, teaching the delivery of family and health-oriented nursing care. What was lost in the integration of community health and acute care nursing as described were the aggregate-focused principles of health planning, policy, and intervention derived originally from public health practice. As Williams (1977) states,

> While the integration of community health concepts into basic nursing programs might have been expected to facilitate such (aggregate) thinking, the teaching has frequently emphasized individualistic approaches as opposed to methods of defining problems and assessing impact at the aggregate levels.

If, some would argue, community health nursing is a 'synthesis of nursing and public health practice', the elimination of public health principles from undergraduate curricula removed one of the distinguishing characteristics of the specialty. It seems justifiable, then, for Jarvis (1985) to speculate that "as community health principles are integrated increasingly into curricula, there is a real danger that the uniqueness of this specialty will be weakened and perhaps lost forever."

Another factor which blurs the distinction between community health nursing and other nursing specialties is the rightful adoption by other specialties of the community health principles of health promotion and education and the provision of family-oriented, holistic care which is sensitive to pertinent factors in the client's environment. Additionally, practitioners educated in other specialties are increasingly moving into settings outside of the hospital; if, as some would argue, a community health nurse is so labelled by the setting in which he or she practices, then the movement of a nurse from the hospital to a public health agency would constitute the creation of a community health nurse. Again, there is a clear need for exploration of the essential characteristics of the community health nurse.

The literature yields existing conceptualizations of community health nursing which can be examined for fit with the present and likely future changes in the health

care delivery system. The variation between perspectives on community health nursing is substantial and vividly depicts the confusion over the present state of affairs. This confusion is even more apparent when one realizes that even the conceptions and definitions of the terms involved, such as 'public health nursing', 'public health', and 'community health', are not static but shift with the particular author. Sullivan (1984) states that by 1967, the term 'public health nursing' had been replaced by 'community health nursing' in an attempt to more accurately describe the practice in this field. The new term was intended to show a commitment to high-level wellness for the entire community, not only for selected segments of the population. While some authors use the terms synonymously, there are others who differentiate between the roles of community and public health nurses. Where the conceptions involved have been made explicit by the author, they will be communicated in the following review of the literature.

A second problem in reviewing the literature is that some writers have chosen to emphasize the distinctions between community health nursing and other nursing disciplines. As noted above, the current state of affairs is undermining the distinctions between community health and acute care nursing. Conceptions which emphasize distinctions rather than acknowledging commonalities, relationships, and overlap between nursing specialties are somewhat misleading and anachronistic. Again, where a

perspective of this nature is taken by the particular author, it will be acknowledged in the following review.

A point of departure within the formidable amount of literature available on the nature of community health nursing is the narrow conception of community health nursing as defined by the setting in which it takes place. Helvie (1981) offers a restatement of the definition adopted by the American Nurse's Association in 1973:

> Community health nursing is the synthesis of public health science and nursing science.It promotes the preservation of health and motivates populations to seek and maintain a high level of wellness. It focuses upon the total population and activities directed toward individuals, and groups are valid only as they contribute to the health of the total community.

While several other authors use the ANA definition as a cornerstone for their conceptual frameworks, Helvie alone does not quote it in its entirety nor include all of its elements in his synopsis. Building upon his abridged version, he states the defining characteristics of community health nursing as well. The first characteristic of community health nursing is that the setting (community versus institution) influences the nurse's role and makes additional concepts, theories, and models imperative for effective practice. The other two characteristics offered are further features of the practice setting of the community health nurse: the different length and intensity

of nursing services rendered, and the scope of responsibility of the community agency as compared to the hospital. The role of the community health nurse is depicted by a lengthy contrast with the role of the hospital staff nurse. The definition by contrast is dated, having been originally published by the author in 1968, and is an excellent example of emphasizing the distinctions between community health nursing and acute care nursing to the detriment of consideration of the issues at hand herein. Helvie makes no distinctions between public health nursing and community health nursing, nor does he elaborate upon the nature of the practice of public health. It is assumed by the reader that the first two terms are synonymous, and it is left to the reader to speculate about what the science of public health contributes to the practice of community health nursing.

With regard to the aggregate focus of community health nursing, Helvie offers only the topic of epidemiology and that on a very superficial level with little reference to its uses in community diagnosis. The interrelatedness of the individual, family, and group are developed through the use of systems theory, and systems theory is applied to the individual, family, and community at some length. Health policy, health planning, community assessment and diagnosis, and health care delivery systems are not considered in the text.

In summary, then, Helvie's work offers a traditional and

limited conception of community health nursing as defined by the setting in which it occurs. Its use for the topic at hand is limited to a perspective against which to compare other, more comprehensive considerations of the nature of community health nursing.

Archer and Fleshman (1979) offer a definition of community health nursing that excludes consideration of the practice setting:

> Community nursing is a learned practice with the ultimate goal of contributing, as individuals and in collaboration with others, to the promotion of the client's optimal level of functioning through teaching and the delivery of care.

The characteristics of community health nursing include its ultimate goal of the attainment and maintenance of an optimal level of functioning by the client or community being served and its ability to adapt and change in response to environmental demands. The final characteristic of community health nursing enumerated by Archer and Fleshman is its organization through which the steps taken to achieve the ultimate goal are centered on quality of life, the prevention of dysfunction, and continuous, pertinent health care.

Archer and Fleshman offer a description of public health, quoting Winslow:

> Public health is the science and the art of preventing disease, prolonging life, and promoting physical and

> mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of a social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.

They discriminate between 'public health' and 'community health'; their discrimination is based on the premise that, for many, public health means the activities of those who work for governmental bodies, at all levels, in the delivery of health care to various populations. They use the term "'community health' as an umbrella under which we all, government workers and otherwise, pursue our professional goals." The text written by Archer and Fleshman also incorporates practice concepts relevant to aggregate-focused nursing care. Epidemiology and its relationship to primary prevention are discussed, in considerably more depth than in Helvie's text. They discuss, as well, the uses of community organization, health planning, and political intervention for the community health nurse. The characteristics of the health care delivery system are explored; politics, economics, and health insurance are all discussed in some depth.

There are several interesting characteristics of the

conception of community health nursing proposed by Archer and Fleshman. First, as written, the definition of community health nursing could easily apply to any other nursing specialty. They have refrained from defining community health nursing on the basis of its differences from other nursing specialties. Only when the accompanying characteristics are examined does the definition begin to belong solely to community health nursing. However, there is no recognition of the universality of the definition in the text, leaving the reader to speculate as to whether it was intentional or not. If the definition was intentionally universal, the reader must also speculate about the reasons for defining community health nursing in this manner. One cannot assume that it was done out of recognition of the current erosion of distinctions between community health nursing and other nursing disciplines, particularly because the text antedates the current state of the health care delivery system.

Secondly, Archer and Fleshman do not mention the practice setting as a characteristic of community health nursing. However, once again, there is no explicit rejection of the practice setting as a relevant characteristic of community health nursing. The reader must again speculate as to whether it was excluded by design or by oversight.

Finally, while the definition of community health nursing as proposed by Archer and Fleshman only briefly

mentions aggregate-focused nursing care, a significant portion of the text is devoted to describing tools for aggregate-focused practice. Other authors have made the importance of an aggregate focus to community health nursing more explicit in defining and characterizing the specialty and it is somewhat paradoxical that Archer and Fleshman do not, considering the attention that it merits elsewhere in the book.

In summary, then, Archer and Fleshman's text takes us a step closer to defining community health nursing on bases other than the practice setting. However, there are several implicit assumptions in the text which must be made explicit by the authors. Without the explication of the above-mentioned assumptions, there is considerable risk of adapting the material in support of premises other than those which were intended by the authors.

Freeman and Heinrich (1981) offer a descriptive definition of community health nursing. It is based upon the following assumptions:

1. Community health nursing is a recognizable, though not sharply defined, area of health practice.

2. Community health nursing operates as a subsystem of the health and human services systems.

3. Community health nursing is responsive to the expectations of society and the professions and shapes its roles accordingly.

4. Community health nursing accomplishes its purpose

through the application of a defined process. In light of these assumptions, the following description of community health nursing is offered:

> Community health nursing is an area of human services directed toward developing and enhancing the health capabilities of people - either singly, as individuals, or collectively, as groups and communities. The goal ...is to enable people to cope with discontinuities in and threats to health in such a way as to maximize their potential for high-level wellness....(It) has a responsibility for the total population within a defined area or environment as well as to the individuals and families whose well-being is essential for community health. It is concerned primarily with conditions that are continuing rather than episodic and with situations in which the results of care depend predominantly upon the decisions and responses of the people involved rather than upon the highly specialized personnel and hardware of the hospital....(It) represents a subsystem to the larger health and human services system of the community, and ... is committed to share responsibility for the health program as a whole, and to interdependent as well as independent action in the accomplishment of its own purposes. Community health nursing is also an area of professional nursing and public health practice characterized by the systematic application of selected nurturing,

> medicotechnical, educational, or social action skills for the analysis and amelioration of personal or community situations inimical to preserving health...

In addition, two broad characteristics of community health nursing are elaborated upon. First, community health nursing focuses on the community; 'the direction of the nursing program is shaped by the needs of the community as a whole and by the nature of the total community health effort.' Secondly, community health nursing activities are based in the community rather than the hospital. Freeman and Heinrich acknowledge that some community health nurses function in the hospital, but they again emphasize that the practice setting is a significant characteristic of community health nursing. Tools for the practice of aggregate-focused nursing are limited to epidemiology and community assessment and diagnosis. Neither health planning and policy nor health care delivery systems issues are discussed.

Freeman and Heinrich make no distinction between community health nursing and public health nursing, and the contributions of public health principles to the practice of community health nursing are not made clear. The shifting and elusive boundaries between community health nursing and other nursing disciplines are acknowledged, and the authors refrain from defining the role of the community health nurse in contrast to that of the acute care nurse. In summary, the work of Freeman and Heinrich contributes

little that is new to the discussion at hand. While they do not represent the traditional perspective at its extreme, they do not aggressively take on any of the issues which are pertinent to the current state of health care delivery.

Jarvis (1985) offers the unabridged ANA definition of community health nursing:

> ...a synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations. The nature of this practice is general and comprehensive. It is not limited to a particular age or diagnostic group. It is continuing, not episodic. The dominant responsibility is to the population as a whole. Therefore, nursing directed to individuals, families, or groups contributes to the health of the total population. Health promotion, health maintenance, health education, coordination and continuity of care are utilized in a holistic approach to the family, group and community.
>
> The nurse's actions acknowledge the need for comprehensive health planning, recognize the influences of social and ecological issues, give attention to populations at risk and utilize the dynamic forces which influence change.

Jarvis also includes the definition written by the Public Health Nursing Section of the American Public Health Association:

> Public health nursing synthesizes the body of knowledge

> from the public health sciences and professional nursing theories for the purpose of improving the health of the entire community....Public health nurses work with groups, families, and individuals as well as in multidisciplinary teams and programs....

Further, Jarvis elaborates on the characteristics of community health nursing. "Above all else, community health nursing is oriented to the well-being of the entire community at large ...they must never lose sight of their main focus - the health of the total population." Additionally, practice settings for the community health nurse include 'schools, occupational sites, official and nonofficial agencies, housing complexes, ambulatory units, hospitals, and theoretically any other setting where health needs can be a major area of focus'. The focus of community health is health-oriented; primary, secondary, and tertiary preventive measures are tools for practice. Clients are active participants in the care process. Finally, both help-seeking and non-help-seeking populations are the concern of community health nurses.

Jarvis offers additional information on the science and practice of public health and its contributions to the practice of community health nursing; the relationships between the two practice disciplines are made sufficiently clear. However, Jarvis has substituted the term 'community health nursing' as a synonym for 'public health nursing' without offering a historical or semantic justification for

doing so.

Despite her contention that community health is a distinct specialty with definite goals, philosophy, services, and boundaries, Jarvis does not overemphasize the distinctions between community health nursing and other nursing disciplines. While this is an attractive feature of her perspective, it would have been preferable if she had specifically explored the relationship of community health nursing to other specialties.

The stated importance of the aggregate focus of community health nursing is reinforced in Jarvis' text by the inclusion of substantial content on the subjects of epidemiology, the health care delivery system, policy relevant to health care, political involvement of the community health nursing practitioner, and the creation and management of change in the community. There is, as well, substantial content included on social issues affecting community health such as population issues, environmental pollution, substance abuse, and community nutrition.

To summarize Jarvis' perspective, then, community health transcends traditional extra hospital settings and has a paramount responsibility to the health of the entire community through aggregate-focused care delivered to individuals, families, groups, and communities.

Williams (1977) begins with the premise that many nurses are confused, conceptually and semantically, about community

health nursing. She suggests looking at concepts and principles which have traditionally been a part of public health practice and explicating their relevance to the contemporary practice of community health nursing. Williams suggests that there are three barriers to the integration of a preventive, aggregate focus into the provision of therapeutic community services and to the planning and delivery of nursing services that are sensitive to community needs. The first barrier is the traditional definition of public health nursing solely in terms of the practice setting and/or whether the provider functions in a family-oriented manner. The second barrier is a failure to understand the distinctions between the different foci of public health practice and clinical nursing and medicine. The third and final barrier is in part a result of the first two conceptual failings; there is a paucity of practice settings in which the individualistic approach of nursing and the basic public health, aggregate-focused strategies are merged.

Further, Williams states that the focus of community health nursing is on two of the components of public health: the provision of personal health services and health promotion. With regard to the provision of personal health services, she states that implementing an aggregate focus into community health nursing comes from systematically directing clinical care services to aggregates and subpopulations; several examples are given of the

application of this systematic process.

Williams points out that there are several knowledge bases necessary to the effective practice of aggregate-focused community health nursing: epidemiology and biostatistics, social policy and the history and philosophy of public health, and the principles of management and organization for public health. It is Williams' contention that effective aggregate-focused practitioners will be prepared at the master's or doctoral levels. It is through systems management that an emphasis on the aggregate can be filtered down to the nurse delivering individual care.

In the brief article by Williams, public health nursing and community health nursing are synonymous. The relationship of public health to the practice of community health is made abundantly clear and, more importantly, examples which describe the effective integration of public health principles into the practice of community health nursing are offered. The author does not define community health nursing in contrast to acute care nursing. Williams takes a perspective different from that of the other authors reviewed herein; she proposes that the truly effective community health practitioner will be prepared at a level above a baccalaureate degree. This may be due, in part, to the fact that the article reviewed was not an undergraduate text, as is the case with the other authors mentioned.

Sullivan (1984) offers a comprehensive review of nursing research conducted in community health. The vast majority

of studies annotated are evaluative in nature; they address the efficacy of a particular screening program or the relative merit of nurse and physician care providers. Few address the questions relevant herein about the nature of CHN and the roles and behaviors of those who practice it.

In a study not cited by Sullivan, Koerner (1981) explored the relationship between job performance and the independent variables of age, education, work experience, state board licensure exam scores, job satisfaction, and agency leadership behavior. The variables chosen were measured rather arbitrarily; work experience, a potentially useful concept, was defined only as years of work experience since graduation rather than encompassing the nature of the experience. Similarly, the dependent variable of job performance was measured only by supervisor rating of employees. Predictably, only 38% of the total variation among items was captured. While the question addressed in the study is potentially relevant, the particular study does not contribute any useful information to the topic at hand.

In two articles, Archer (1976, Archer and Fleshman, 1975) presents a typology of community nursing practice. She attempts to characterize the practices of responding 'community nurse practitioners' according to primary activity, functional category, clientele, care focus, type of decision-making, and site of practice. The various functional categories were also characterized in terms of the directness of the intervention with clients (direct,

semi-direct, and indirect). The typology presents a comprehensive framework within which to examine the role of the nurse providing acute care in the community and the potential variety of skills necessary. A drawback to the typology lies in the advanced preparation of the majority of the respondents; 71% had master's or doctoral degrees, a finding which may skew the typology away from the activities likely to be practiced by the nurse providing direct care in the client's home.

Tigar (1980) identifies the changing dimensions of community health nursing and explores competencies requisite for effective practice. Building on the work of an NLN task force and the California Conference of Local Health Department Nursing Directors, she presents a simplified list of basic competencies that should be expected of all staff involved with the delivery of public health nursing services.

- Basic nursing skills.
- Basic knowledge of wellness and disease.
- Clear understanding of the focus of public health.
- Ability to apply the nursing process: to assess, plan, implement, and evaluate care for the identified client or client groups.
- Documentation and communication skills: the ability to read, write, listen, and speak effectively; the ability to interpret public health/community health nursing to consumers, other health professionals and

the community-at-large.

- Ability to plan time and set priorities for work loads.
- Ability to teach and counsel.
- Ability to solve problems, make decisions, and understand and implement change.
- Knowledge of community resources and how to use them.
- Understanding of the relationship of finances to service delivery.
- Ability to work with others.

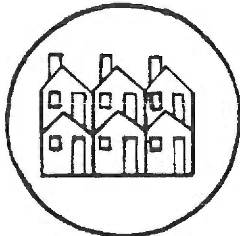
Tigar's work represents a timely treatise on the competencies relevant to community health practice.

It is apparent from the preceeding review of the literature that there is little or no research which contributes directly to a reconceptualization of community health nursing as it relates to the provision of illness-generated, in-home nursing care.

Appendix B

Questionnaire

NURSING IN THE HOME: A SURVEY
OF PRACTICING NURSES ABOUT THEIR ROLE



This survey has been designed to better understand nursing care provided in the home setting. Health care services are moving out of the hospital and into the community for economic, social and technological reasons. As a result, we recognize that nursing care in the home is different now than it was five years ago in that the acuity of clients has changed and the type of services offered in the home are different. This shift has resulted in new and different expectations of the nurse practicing in the community. Because so, ideas about community health nursing may need to be revised. We would like your help in generating a more accurate picture of what nursing in the home is like. This information could be used by administrators, educators, and practicing nurses in making decisions about appropriate education, hiring, orientation, and ongoing inservice programs.

You may be assured we have taken steps to maintain confidentiality. Each questionnaire will be coded with a number, your name will never be placed on it. In addition to the questionnaire, a few nurses will be selected for an in-depth interview. Again, to ensure confidentiality, we will contact interview subjects by phone to set up the interview rather than contact them through their workplace. We are not evaluating any one person's nursing practice. The information you give us will be combined with the responses of others before being analyzed.

We are not interested in learning about hospice care. If your nursing practice includes the care of hospice patients, please try to exclude it from your thoughts as you answer the questions.

Please do not discuss the questions or your responses with others because it may affect the way others answer the questions. We will share our results and conclusions with your agency after completing the study.

Please try to answer all the questions. However, we do expect that some of the questions we ask may not apply to your practice and that you may not be able to answer them. If you wish to make comments in the margin feel free to do so. Please mail the questionnaire in the envelope provided by ____________________ as we are anxious to report back to you.

Thank you for your help.

Bonnie Driggers, RN
Graduate Student - OHSU,SN

Jennifer Green, RN
Graduate Student - OHSU,SN

____
Code

1. How many years has it been since you completed your basic nursing education?

   ________ years

2. The highest nursing degree you have completed is: (circle one)

   a. diploma

   b. associate degree

   c. baccalaureate degree

   d. master's degree

3. In what areas of nursing have you practiced and for how long? Please list them in reverse order, beginning with your current position. An example is provided.

POSITION	AGENCY	LENGTH OF EMPLOYMENT
home health nurse	Kaiser	2 years

4. Has the nature of your nursing practice changed significantly in the past two years?

   Yes No

   If you answered "no", please skip to question 18 and continue.

5. If you answered "yes" to question 4, how has your nursing practice changed? Please choose only one answer.

   a. You made a transition from acute care nursing to nursing in the home.
      (IF YOU CHOOSE THIS RESPONSE OPTION, PLEASE ANSWER QUESTIONS 6, 7, 8, 9, 10, and 11; THEN SKIP TO QUESTION 18 AND CONTINUE.)

   b. Although you've practiced nursing in the home during the past two years, you've experienced an increase in the acuity of the clients you're caring for in the home.
      (IF YOU CHOOSE THIS RESPONSE OPTION, PLEASE SKIP TO QUESTION 12 AND CONTINUE.)

   c. Other. ____________________
      (IF YOU CHOOSE THIS RESPONSE OPTION, PLEASE SKIP TO QUESTION 18 AND CONTINUE.)

6. What new skills and knowledge were necessary to make the transition from acute care nursing to nursing in the home? (Question 7 is similar; please read it also before answering.)

7. In what ways did you modify existing skills and knowledge to make the transition from acute care nursing to nursing in the home?

8. Aside from needing to acquire and modify skills and knowledge, what hindered your transition to nursing in the home?

9. What eased or aided your transition to nursing in the home?

10. Since making the transition to nursing in the home, what activities are you doing less of compared to acute care nursing?

11. What inservices/orientation would you recommend for others making the transition to nursing in the home from acute care nursing?

---

12. What new skills and knowledge were necessary to make the transition to taking care of more acute clients in the home? (Question 13 is similar; please read it also before answering.)

13. In what ways did you modify existing skills and knowledge to make the transition to taking care of more acute clients in the home?

14. Aside from needing to acquire and modify skills and knowledge, what hindered your transition to taking care of more acute clients in the home?

15. What eased or aided your transition to taking care of more acute clients in the home?

16. Since you have experienced an increase in the acuity of clients you're caring for in the home, what activities are you doing less of than previously?

17. What inservices/orientation would you recommend for others making the transition to taking care of more acutely ill clients in the home?

18. How do you usually get referral information about new clients? (choose one)

    a. directly from the referral source

    b. indirectly from someone else at your agency

19. Before the first nursing visit, what person at your agency usually determines what nursing care is indicated for a given client? (circle one)

    a. physician responsible for care at the time of referral.

    b. discharge planner who contacts your agency

    c. your supervisor

    d. you, functioning as a case manager

    e. you, functioning as a staff nurse

    f. other ______________________________

20. Once the decisions about what nursing care is indicated are made, is there anyone, apart from the decision maker, who must give final approval?

    yes No

    If yes, who? ____________________

21. In general, how directly are you involved in the financial aspects of your clients' care? (circle one)

    a. you negotiate with payors directly

    b. you do not negotiate directly, but you plan nursing care according to the payment arrangements

    c. you are aware of the client's arrangements for payment, but it doesn't have much bearing on the nursing care provided

    d. you are not involved in or aware of the client's arrangements for payment

22. Who usually diagnoses nursing problems and keeps the nursing care plan current? (circle one)

    a. supervisor

    b. case manager

    c. staff nurse

    d. staff nurse as case manager

23. Who usually coordinates the care, for a given client, of all care providers at your agency?

    a. staff nurse

    b. client or family

    c. case manager

    d. staff nurse as case manager

    e. Supervisor

    f. other ____________________

24. As a general rule, is it part of your role to refer clients to other agencies from whose care they might benefit?

    yes no

25. If your answer to question 24 was "yes", do you usually refer clients:

    a. through someone else at your agency

    b. directly without consulting anyone else

    c. directly after consultation

26. When a client is being seen by providers at more than one agency, does someone at your agency coordinate the client's care?

    yes   no

27. If yes, who primarily coordinates the client's care? (choose one)

    a. supervisor

    b. case manager

    c. staff nurse

    d. staff nurse as case manager

    e. Client or family

    f. other ______________________________

28. Who is responsible for quality assurance activities in your agency? (choose one)

    a. staff nurse

    b. supervisor

    c. case manager

    d. staff nurse as case manager

    e. quality assurance coordinator

    f. other ______________________________

29. In general, can a client contact you after working hours? (choose one)

    a. a client can contact me anytime

    b. a client can contact me after working hours only if I'm on call

    c. a client cannot contact me after working hours

30. Who usually decides that nursing care is no longer necessary for a client? (choose one)

    a. staff nurse

    b. case manager

    c. staff nurse as case manager

    d. supervisor

    e. physician responsible for care

    f. other ____________________

31. In general, do you expect clients to call you if they have problems after their care has been terminated?

    yes no

Is there anything else about your practice you wish to share that may help us understand and describe it more fully?

Your contribution to this effort is greatly appreciated. Thank you again!

Appendix C

Case Studies and Interview Format

<u>Situation One</u>

Jim Wilson is a 45 year old male with cancer of the colon. He has had an AP resection and now has a new colostomy. His primary funding source for home care is Blue Cross insurance.

Postoperatively, he developed a wound infection on day eight. He has been referred from the hospital for daily two hour visits to do wound care and teach Jim to care for his ostomy.

Jim refuses to do his own ostomy care and a referral is made to the local ostomy association. The ostomy association tells Jim that everyone should irrigate their colostomy daily while his physician is adamant that he shouldn't. You find that the ostomy association representative is providing misinformation regarding irrigation.

Jim lives alone and his wound requires daily packing. He is supposed to take the packing out of the wound and take a sitz bath prior to your visits, which he refuses to do. He does not have a shower.

Two weeks after you begin seeing Jim, his infection is clearing, he is able to do his own wound and ostomy care, and the physician discontinues visits. However, Jim calls you a week later to tell you he has green drainage coming from his wound and that he is running a temperature of 101.

SITUATION ONE

1. What kind of nursing problems do you identify and what would you do about them?

2. Do you have the opportunity to evaluate the nursing care plan, either formally or informally?

3. What are your immediate teaching concerns?

4. What are your long-term teaching concerns?

IF PLAN OF ACTION INCLUDED CONTACT WITH THE OSTOMY ASSN., SKIP TO #7.

5. Would you contact the ostomy association? (IF NO, GO TO #7.)

6. What would be the purpose of the contact with the ostomy association?

7. What aspects of your care are preventive in nature? ELABORATE WITH: What problems are you trying to prevent in this situation?

8. What state and federal rules and regulations might apply to this situation or might you need to be aware of?

9. At the end of a visit with the client, you call your agency and find that your commitments for the next two hours have been cancelled. How would you spend the time?

   PROBING: If you decided to spend it with the client, what else might you do? What kinds of teaching might you cover with the extra time?

COMPLETE SITUATION HERE

10. What is your response to him?

Situation Two

Susie Nelson is a two month old girl with hypertension. She is also oxygen dependent because of bronchopulmonary dysplasia. She spent her first two months of life in a neonatal intensive care unit and has been referred for 24 hour nursing care as her blood pressure is marginally controlled on conventional therapy and pulmonary care is needed.

Susie's mother has severe rheumatoid arthritis and is noncompliant with her medication regimen; she is unable to provide care requiring manual dexterity to the infant. There are no other children in the home, and Susie's father works 9 to 5 and is very involved in his career. Since this is the couple's first child, they are curious about appropriate nutrition and have been asking about introducing solids into the baby's diet.

The family is insured by a very small carrier and has exhausted their benefits with the costs of Susie's hospitalization. They are utilizing their savings to pay for your nursing care. After three weeks, the infant has shown marked improvement related to BP control and respiratory status.

Situation Two - Adult Version

Susan Nelson is a twenty-five year old woman recently discharged from the hospital after a MVA. She sustained closed head trauma, fractured ribs, and a fractured pelvis. After being obtunded for 10 days, she is rapidly regaining neurological function and has an excellent prognosis. However, she is in a hip cast and developed pneumonia from restricted respiratory excursion and splinting. She has also been unable to void since the accident and requires intermittent catheterization. She has been referred for 24 hour nursing care for observation of her neurological progress, vigorous pulmonary hygiene, and intermittent caths.

Susan lives with her husband, who has severe rheumatoid arthritis. He is unable to provide care requiring manual dexterity; he is also noncompliant with his own medication regimen. There are no other family members in the area, and the Nelsons have no friends on whom they feel they could impose their problems.

The family is insured by a very small carrier and has exhausted their benefits with the costs of Susan's hospitalization. They requested to be discharged to home nursing care, feeling that it would be less expensive than hospital care, and are using their savings to pay for

nursing care. After three weeks, Susan continues to make excellent neurological progress and her pneumonia is resolved.

SITUATION TWO

1. What nursing problems do you identify and what would you do about them?

2. Do you have the opportunity to evaluate your nursing care plan either formally or informally?

3. What are your immediate teaching concerns?

4. What are your long-term teaching concerns?

5. Do you have any reponsibility for providing nursing care to this mother/husband regarding her/his arthritis?

6. IF YES: What would you do?

7. What aspects of your care are preventive in nature OR What problems are you trying to prevent?

8. What state and federal rules and regulations might apply to this situation or might you need to be aware of?

9. There is alot of 'down time' between nursing interventions with this child/woman. How might you spend that time?

   PROBING: What kinds of teaching might you cover with the extra time?

10. Are there types of care or teaching which you would like to be able to cover but which you might not have the time to?

Situation Three

Robert Jones is a 75 year old male who has recently been discharged from the hospital. He has been diagnosed as having chronic renal failure and is on hemodialysis. In addition to his renal failure, Mr. Jones has COPD and uses oxygen consistently with exertion. Yesterday, he had a Hickman catheter placed for dialysis access.

His wife is his primary caretaker and his health care is funded by Medicare. He and his wife have recently moved into a new home. The previous owner is delinquent in making promised repairs to the leaking roof; Mrs. Jones has not been successful in trying to get the repairs completed.

You have been asked to provide intermittent visits three times a week for one hour to monitor his COPD and renal failure and to teach him and his wife Hickman care.

Situation Three - Pediatric Version

Robert Jones is an eight year old male who has recently been discharged from the hospital. He has been diagnosed as having chronic renal failure and is on hemodialysis. In addition to his renal failure, Robert has chronic lung disease and requires oxygen intermittently. Yesterday, he had a Hickman catheter placed for dialysis access.

He lives with his mother and his health care is funded by Medicare because of his renal disease. He and his mother have recently moved into a new home. The previous owner is delinquent in making promised repairs to the leaking roof; Robert's mother has not been successful in trying to get the repairs completed.

You have been asked to provide intermittent visits three times a week for one hour to monitor his oxygen requirements and renal failure and to teach Hickman care.

SITUATION THREE

1. What nursing problems do you identify and what would you do about them?

2. Do you have the opportunity to evaluate your nursing care plan either formally or informally?

3. What are your immediate teaching concerns?

4. What are your long-term teaching concerns?

5. Who would you expect the client's wife/mother to call if he had problems at home?

6. Might you address this client's housing problem?

7. IF YES: What would you do?

8. What aspects of your care are preventive in nature OR what problems are you trying to prevent?

9. What state and federal rules and regulations might apply to this situation or might you need to be aware of?

10. At the end of a visit with the client, you call your agency and find that your commitments for the next two hours have been cancelled. How would you spend the time?

    PROBING: If you decided to spend it with the client, what else might you do?
    What kinds of teaching might you cover with the extra time?

11. What would you like to do for him that you might not have time or reimbursement for?

Final Questions

1. Do you have any responsibility for assessing the care needs of the community?

2. Is it part of your role to motivate or enable the community to meet those needs?

3. Are there state or federal policy issues relating to nursing in the home which concern you?

4. Are you engaged in health promotion activities?

5. If so, what?

6. Do you see a need for health promotion which isn't currently being met?

7. If so, how should it be met and by whom?

8. Is there anything else about your role that we haven't covered which you would like to share with us?

ABSTRACT

MASTERS RESEARCH PROJECT

Jennifer L. Green and Bonnie Driggers

Scope of Nursing Practice in Home Health Care:
A Description

Approved:
Joyce A. Semradek, R.N., M.S.N., Project Advisor

The purpose of the study was to describe the scope of nursing practice in home health nursing and to clarify the relationship of home health nursing to community health nursing and acute care nursing.

Thirty-two nurses practicing home health care at three Portland metropolitan, non-public home health agencies were surveyed by questionnaire; 14 of those nurses were randomly selected for interview. The interview was based on three case studies developed by the researchers; qualitative analysis of data yielded nineteen roles comprising the scope of nursing practice. Individual nurses identified eight to fifteen of those roles as part of their practice. Qualitative analysis of questionnaire data revealed that ten nurses recently making a transition from acute care to home health nursing found twelve roles problematic, and eight experienced home health nurses confirming an increase in the acuity of their clients found nine of the nineteen roles to be problematic. Quantitative analysis of questionnaire data revealed that the nurses were predominantly experienced in acute care nursing and new to community-based nursing, with a mean length of employment in home health of 3.5 years. The scope of nursing practice in home health was found to be distinct from that of both acute care and community health nursing.

The results provide a perspective from which the home health nurse may examine his or her current practice. For the administrator, the results may be used to compare the agency scope of practice for fit with mission, philosophy, and goals and to guide the systematic development of employee selection criteria and performance appraisal. For the educator and theorist, the roles provide a framework from which to examine conceptions about home health and its relationship to community health and acute care nursing.

Utilization of the findings is limited by the descriptive nature of the study; no comparison between individuals or agencies is appropriate. The case studies upon which the interview was based may have influenced the results; the use of other cases may yield different roles.