A SURVEY OF THE PRACTICE OF FAMILY ASSESSMENT BY NURSES WHO WORK WITH CHILDREN

by

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CHAPTER I

INTRODUCTION

The family is the most important social organization and emotional environment that individuals encounter in the process of growth and development (Sedgwick, 1981). Research has indicated that the quality of family life is closely related to the health of family members, and therefore the family is a major concern in clinical practice (Friedman, 1980). It is believed by many family theorists that any dysfunction affecting one family member will in some way affect other members and the family unit as a whole (Friedman, 1980; Sedgwick, 1981). However, little attention has been given to the systematic study of family assessment in nursing curriculums, and most nursing assessments and plans of intervention are focused only upon the individual patient, with the family remaining in the periphery (Eichel, 1978; Sciarillo, 1980). In my own clinical experience, and in that of other nurses (Eichel, 1978; Friedman, 1980; Porter, 1979; Sciarillo, 1980), the assessment of the family in an organized and systematic manner, is not a prevailing practice. In order to find ways of improving the quality of nursing care to children and their families, the focus of nursing must be expanded to include the entire family.

In the past decade, an assortment of family assessment

tools have been published (Friedman, 1980; Hymovich, 1980; Janosik, 1980b; Morgan & Macey, 1978; Sciarillo, 1980), yet the extent to which nurses are practicing family assessment and utilizing such assessment guides is unclear. Information about nurses' use of family assessment and factors which might influence this practice is needed to guide the expansion of family nursing practice and the education of future nurses.

Review of the Literature

There are many theoretical approaches useful in viewing families. The systems approach frequently noted in the nursing literature (Fawcett, 1975; MacVicar & Archbold, 1976; Miller, 1980) regards the family as an open system in which there is a constant exchange of energy between members and with the environment. The developmental approach (Duvall, 1977) views the family as an entity evolving over time, with tasks to be accomplished in each stage. Another framework used in nursing, the interactional approach, focuses upon the family members' verbal and nonverbal communication patterns, problem solving, and decision making with one another (Schraneveldt, 1973).

Viewing the family as a system helps the nurse to regard the family functions as an interrelated whole. Thus, a systems framework guides the nurse in deciding what sort of data should be obtained about the family in assessing family functions in order to carry out an effective plan of care

(Miller, 1980).

Because systems theory encourages nurses to work with the family as a whole and is applicable in all nursing settings (Fawcett, 1975), the systems framework is used to describe the family for the purposes of this study. The nature and functions of the family, and the interacting effects of illness in the family unit is discussed first. Next, the nurses's involvement with the family is considered. Thirdly, the concept of family nursing, which is the therapeutic involvement of the nurse with the family, is reviewed. Lastly, the nursing assessment of the family, as a necessary prerequisite to providing effective family nursing, is discussed.

The Family as a System

The family defined. To define family nursing or family assessment, one must first define family. Who comprises the family? The composition and structure of the family has changed considerably in recent years. The single-parent, nuclear, extended, childless couple, and communal living groups can all be considered as family types, having the common quality of biological and/or social bonding and emotional interdependence inherent within it (Atkinson, 1976; O'Brien, 1979).

For the purpose of this study, Terkelson's (1980) definition of the family will be used:

The family is a small social system made up of

> individuals related to each other by reason of strong reciprocal affections and loyalties, and comprising a household (or cluster of households) that persists over years and decades. . .Family also refers to any subdivision of this kind of social unit, which itself possesses these same attributes of affection, loyalty, and durability of membership.

The variety of family structures seen today can be represented by this definition.

The nature of the family. Systems theory views the family as a distinct entity in itself, just as the individual person is such. It is not just an aggregate of individuals, but rather a system of relationships which is different from the persons who comprise it. The components within the system may be described by their attributes, but it is the relationship among the components and their attributes that tie the system together. Because of these relationships, the family's characteristics cannot be predicted from the individual members, as the system behaves as an inseparable whole (O'Brien, 1979). A change in one part of the system inevitably results in a change in the entire system due to the interacting pattern of their relationships (Friedman, 1980).

The family's responsibility in relation to health is the need attainment of all its members. These needs include

the survival, the physical security, and the development of all members (Terkelson, 1980). The family provides the opportunity for learning roles, for developing belief and value systems, and for developing personal identity (Barnard, 1978). O'Brien (1979) states that the family is the primary basis of security of the adult as well as of the socialization and development of the child. One's health attitudes and practices are primarily determined by one's family, because of the interdependence of family members who have common genetic backgrounds and psychophysiological experiences (U.O.H.S.C., 1980). The family also acts as a buffer between the society and the individual in time of stress, and mediates the needs and demands of family members with those of society (Fawcett, 1976; O'Brien, 1979).

Family functions. Family functions are those operations which are undertaken by the family in order to accomplish goals of survival and development of its members. The functions that the family performs for its members include giving affection, security, companionship, a sense of purpose, identity, self esteem, a pattern of morals, and meeting the physical needs of its members. The functions that the family performs for society are to procreate and to socialize its members (Friedman, 1980; Hymovich, 1980).

The interacting effects of illness on the family. It is generally agreed that families influence the health of members in various ways: the family's definition of illness,

the recognition of the symptoms of illness, decision making concerning when an ill member should seek professional help, and support or lack of support of the ill member (Framo, 1979; Griffin, 1980; Johnson, 1979; O'Brien, 1979). At times the impact of families can be detrimental to individuals as in cases of family maladjustment (Friedman, 1980).

Evidence is increasing that family functioning is integrally related to individual well-being and health behavior. Stress in human relationships has been found to precipitate somatic illness (Arbogast, Scratton, & Krick, 1978). In some individuals, symptoms are learned in an attempt to satisfy a need or resolve a problem. Many of the symptoms are directly related to a dysfunction in the whole family system and to family patterns of response to stress. One member might unconsciously substitute a physical ailment, caused by an unmet need (Arbogast et al., 1978; Framo, 1970; Richter, 1979). However, once the family can learn to recognize some of the problems in their interaction patterns and can try more effective ways of coping, the symptoms will no longer be needed in the system (Richter, 1979).

It is also widely accepted that illness in a family member brings about changes in the family unit, both subtle and drastic in nature (Johnson, 1979; Kaplan, 1976; MacVicar & Archbold, 1976). Certain stresses can result in poor family functioning or even in the dissolution of the family unit. Other common familial responses to illness in

one of its members are anxiety, guilt, and fear. Some parents overindulge their ill child, which often leads to resentfulness in the siblings (Hymovich, 1980). Illness usually results in more stress in today's smaller nuclear families than in large extended families, due to fewer social supports available to nuclear families (Craven & Sharp, 1972).

Disruptions in family functioning and in role obligations are of major importance at the time of illness. Illness forces role reciprocation and reorganization in order to achieve a new equilibrium in the system. Reorganization and role reciprocation requires a measure of flexibility and adaptability in the family unit and in family members. The family's vulnerability to illness is related to its flexibility and its ability to redefine goals and to modify roles (Griffin, 1980; Hymovich, 1980; MacVicar & Archbold, 1976).

Other factors which appear to influence the family's ability and manner of coping adequately with illness are their socioeconomic status, the family's available external resources, the perceived threat to family relationships and goals, the character of the event, the life stages of the ill member and other family members, the family's past experiences with crises, and the attitudes towards one another in the home which existed prior to the illness (deGive, 1980; Griffin, 1980; MacVicar & Archbold, 1976). An understanding of how illness disrupts the network of family relationships

and a knowledge of the factors which influence the family's coping abilities, are fundamental in the nurse's assessment of the family.

The Nurse's Involvement with the Family

The nurse's function has traditionally included the assessment, planning, implementation, and evaluation of nursing care given to the individual patient. The nursing literature has recently emphasized the need for nurses to expand their practice to being family oriented. Although the need for nurses to become involved with families is emphasized, there is a sparsity of literature about the nurse's function within the family, and about the family unit-nurse relationship.

Johnson (1979) asserts that nurses are best qualified to coordinate the health care of the whole family because of having relatively frequent contact with families in the hospital, home, and clinic. They are often better able than other health care workers to be in tune with family needs through their opportunities for listening to, observing, and teaching the family (Barnard, 1978).

In addition to alleviating the disruptive effects of illness in the individual, the nurse can also reduce unnecessary stress in the family. The nursing literature has emphasized the preventative value of family nursing. In the family approach, the nurse's goal is the well-being of the family as a unit, even when promoting or restoring

the individual's health (Barnard, 1978; Luciano, 1972a; U.O.H.S.C., 1980). The nurse helps the family to work together to identify its problems, weaknesses, and strengths. Together, the nurse and family plan for family change so that the family can grow in the ability to meet its own needs in more healthful ways (O'Brien, 1979). By supporting and reinforcing family strengths, rather than by competing with the family for the function of caring for its members, the nurse is promoting family health and preventing family distress (Barnard, 1978).

To offer family care, Sobol and Robischon (1975), Eyres (1972), and Sedgwick (1981) state the need for the nurse to develop skills in relating to the family. This relationship requires much time, effort, and commitment on the part of the nurse. It is necessary to have the family's confidence before planning interventions with them, thus the nurse sets the climate for a positive experience for the family. The nurse is available and flexible in the time spent with the family and seeks to act as an advocate for them.

Since the family's influence on the individual patient far outlasts the nurse's contact with the patient, the nurse must evaluate how his or her nursing practice is helping the family to improve in its ability to care for itself (Barnard, 1978).

Family Nursing

Family nursing defined.

The terms "family-centered

care" and "family nursing" often appear to be used synonomously in the literature, and their differences seem to be subtle or even undefined. Some authors have written about the term "family-centered care" while providing a definition which is synonymous with what is termed "family nursing" by other authors. This researcher regards the difference to be in the focus of nursing care. When family-centered care is given, the family is included in the process of giving care to the ill family member, in order to better understand and meet the needs of that individual. In family nursing, the nurse presupposes the existence of interractional forces of the members upon one another and the inseparability of the family, its members, and the environment. Consequently, the family system needs to be considered when assessing, planning, implementing and evaluating the care given to the individual. The family as a whole becomes the unit of care.

Family nursing involves a planned approach in effectively using the family's and the nurse's complementary skills and potentials in identifying and resolving family health problems. The nurse's actions encourage the family's own problem solving by helping them to see new realities and alternative solutions, leading to a positive growth experience for the family (Eyres, 1972; Johnson, 1979; O'Brien, 1979). Each member is recognized and considered important in making objectives to meet health needs. In addition, the nurse's actions are individualized to suit

each family, in recognition of its uniqueness. Finally, family nursing involves the commitment of being available at the time of the family's need, and it demands an environment which is conducive to developing a therapeutic relationship with all of the family members (Johnson, 1979; Luciano, 1972a).

The development of the practice of family nursing. Ford (1973) suggests that the quality of "becoming" rather than "being" characterizes the state of the art and science of family nursing. The concept of family nursing has always been with us, most notably in community health nursing, as community health nurses have claimed more opportunities and responsibilities for family care than others in nursing practice (Ford, 1973). However, over time, other areas of nursing, including nurses working in the in-patient setting, have also demonstrated an interest in family care.

In the late 1950's, hospitals began to recognize the need for more flexible hours for parents to visit their sick children, as a result of evidence that the forced separation between a child and his parents during his hospitalization could cause serious detrimental effects in the child. Many nurses have written about the positive impact of the parent's presence during the child's hospitalization, and have recognized the valuable opportunities it affords for more comprehensive patient care (Beatty, 1972; Issner, 1972; Kunzman, 1972; Lore, 1969; McElnea, 1971;

Nissan, 1969).

Nurses have written about the value of the family's presence in order to provide the ill member with extra care and attention and to play a supportive role (Nicklin, 1979; Rasie, 1980). For example, fathers have become more involved in the maternity setting in order to support new mothers, as well as to receive attention to their needs for support and education (Candy, 1979). It has also been recognized that the observation of patterns and states of a mother's and/or father's behavior toward their infant is necessary in order to provide preventative care that can improve the health of the whole family (Chapman, Harrington, & Loewenkie, 1977; Funke & Irby, 1978).

There is evidence that school nurses also have recognized the need for a family focus in their practices. Snyder, Mennick, and Anderson (1980) designed a study to determine if there was a difference between the number of school nurse visits from children of intact homes and the number of visits from children of divorced homes. They found that children from divorced homes visited the nurse more frequently. The authors believed that the drastic changes in the family affected the child's ability to cope with health related problems and developmental tasks.

Recently, there has been a trend towards holistic and preventative care. However, the prevention of illness and the improvement of health in the individual demands an

improved life style of the family (Friedman, 1980; Mowrey, 1980). The complexity of family interactions, the reciprocal nature of family relationships, and the repetitive patterns in family behavior are influential factors in physical as well as psychological health (O'Brien, 1979; Richter, 1979). The increasing evidence that family functioning is integrally related to individual well being indicates the need for the family to be the unit of service in nursing practice.

Within the past decade the need for further developments in family nursing has clearly been recognized. However, to be able to understand the family, within a fast changing society, and to meet the family's needs and demands, requires professional nurses to be more theoretically and clinically competent (Ford, 1973).

Factors affecting nurse's practice of family nursing. No studies were found in the literature which examined the practice of family nursing, as defined in the present study. One study, by Porter (1979), investigated health care workers' orientations to family-centered care. Porter defines family-centered care as "an open, multidimensional system of health management which acknowledges the inseparability of the individual from his family and environment, and which effectively and efficiently utilizes the complementary skills of all members of the health team, including the client and his family." The health care workers

included professional nurses, nursing students, nonprofessional nursing personnel, and physicians. Study sites included in-patient facilities, private and public ambulatory clinics, and community health departments. The sites were chosen in both rural and urban areas of the United States and the Philippines. Porter investigated the differences among health care workers who had a family-centered care orientation and those who did not, on the premise that the workers' values have an impact upon the health care that is given. Porter found that the worker's belief system, in particular the way the employee viewed his or her health care role, affected the worker's orientation to giving family-centered care.

In Porter's study, the health care worker's orientation to family-centered care was measured by the Family-Centered Child Care Scale (FCCS) which examined the worker's therapeutic use of self, the practice of setting a therapeutic climate, and acting as an ombudsman. Porter found that health care workers who valued their positions and the regulations of the system in which they worked, were lower on the FCCS than workers who were oriented more towards valuing their creativity and independence in their professional roles. Other factors which correlated positively with a high score on the FCCS were work experience of 10-13 years, an age of 34-37 years, higher education (in nurses), and the absence of children at home, which Porter believed

could be an indication of having more available time to devote to the professional practice. The study revealed that subjects who worked in pediatric in-patient wards were most strongly oriented to family-centered care, and workers in the public health departments were consistently found to be least oriented to family-centered care.

Luciano (1972b) also studied the family-centered approach in nursing. She described family-centered care as "a multidimensional, global concept of nursing care that embraces the family in their entirety during the total experience of illness and hospitalization,. . .is carried out through a many faceted approach and. . .is goal directed toward the family's well-being" (Luciano, 1972a). Luciano found that the work setting influences the practice of family-centered care in nursing. She and other staff in a large medical center tried to implement family-centered nursing care on various in-patient units at a large children's hospital. The hospital's in-service department created a staff development program whereby all nurses on their staff could be given in-service education in family-centered nursing. There were twelve workshops held over a two year period. The evaluation after the first year showed that the nurses who had been successful in changing their nursing focus had experienced success because of team cooperation, supervisory support, and perseverance in the removal of barriers to their performance. Others, who were not

successful in applying the knowledge learned in the classroom, had experienced a lack of encouragement and support from administrative personnel, the lack of participation and collaboration of all staff working with the patients, and poor management in the use of personnel on their units. Luciano maintains that the values and the philosphy of both the nurse and the facility's nursing administration have an influence on the perspective of the care giver.

Several authors have stated that the nurse's need for more skill and knowledge in family assessment, and the lack of family theory and its clinical application in nursing programs, have resulted in a reluctance to go beyond the family-centered approach, to adopt the family approach to nursing practice (Craven & Sharp, 1972; Friedman, 1980). Miller (1978) found in her personal teaching experience that until the family theory became an integral part of students' thinking, they perceived and responded to families from a personally biased viewpoint.

The nurse's definitions of "family", of "family nursing", as well as the nurse's perspective of what is necessarily involved in assessing the family and providing family nursing care, influence how and to what extent the nurse practices with a family focus. In the past, many nurses who care for children have defined families' needs by what the mother of the child reports as she is usually the most accessible person with whom to verify these needs. However, Larson

(1974) found that there were significant differences in the perceptions of individuals from the same family concerning their family's structures and processes. For example, the mother's, father's, and children's responses to questions regarding measures of power in the family, the family's problem solving processes, and family division of labor reflected perceptions that differed systematically by both age and sex. Therefore, an accurate assessment of the family cannot be made from just one member's perspective of the family unit. The interaction of the perceptions of each member influences the family as a whole (O'Brien, 1979).

Brown (1980) has noted that research in the area of family health care is less defined than it is for individual care. The lack of systematic comprehensive assessment tools, developed for working with the family as a unit in the clinical setting, has impeded the practice of family nursing (Friedman, 1980; Miller & Janosik, 1980; O'Brien, 1979). Finally, the complexity of the family in its effect upon the individual and the charged, emotional aspects of family life may be reason for some hesitation in applying a family focus in nursing (Brown, 1980; Framo, 1970).

In summary, several factors which affect the nurse's practice of family assessment have been suggested by nurse researchers and educators. These factors include (a) the nurse's personal philosophy and view of the health care role, (b) work experience, (c) age, (d) educational background,

(e) the presence of children in the nurse's home, (f) the nursing setting, such as in-patient, out-patient, or community health locations, (g) the nurse's own perceptions of what is involved in family nursing, (h) the nurse's work situation, particularly the values and expectations which are communicated to the nurse by the administration under whom he or she works, and the administration's use of nursing personnel, and (i) the availability of tools for working with families as a unit.

Nursing Assessment of the Family

Pertinant information. Research has shown a wide variety of factors to be of importance when assessing the family's values and behaviors, the family's impact upon the development of its members, and the family's ability to adapt to crisis. Some of these factors are social class (Miller & Janosik, 1980), religion, ethnicity (Janosik, 1980a), and the ages of family members (deGive, 1980; Griffin, 1980). Other factors reported to be significant are child-rearing practices, family resources and supports, financial needs, social supports, health habits, the health history of each member, critical incidences and major stresses which the family has experienced, the level of physical and emotional energy of each member, and the living conditions of the home and neighborhood (deGive, 1980; Friedman, 1980; Sedgwick, 1981; Sobol & Robischon, 1975).

Certain functions and family attributes are also

important to assess. All families develop patterned and organized ways of functioning which provide for self-regulation of the system. Thus, in assessing family function, the nurse needs to identify those patterns which are detrimental to health (O'Brien, 1979). Family cohesiveness, shared goals and values, and the willingness to share in group tasks have been found to make families less vulnerable to the disruption of illness (McVicar & Archbold, 1976). Such qualities depend to a large extent upon the integrity and strength of the parental coalition and the parent's promotion of family values, goals, and interests (Arbogast et al., 1978). Also important to note in the assessment are: patterns of communication, intrafamilial alliances, the quality of the intrafamilial relationships, the nature of the parent's influence in the home, parental stability, role flexibility, prioritizing of time, the family's ability to make and to follow through with decisions, and the family's involvement in the community and in the lives of others outside the family (Gregory, 1975; Holt, 1979; Hymovich, 1980; Melicher, 1980; Morrison, 1980; Rasie, 1980; Sedgwick, 1981; Sobol & Robischon, 1975; Swaffield, 1980; Talabore & Graves, 1976). With this information, the nurse and family together can evaluate family needs, problems, weaknesses, and strengths, and consider how the family can resolve its conflicts.

Methods used in gathering data. There are several sources from which family data can be obtained, such as

referrals, medical records, and the communication with other health care workers. Information about the family can also be collected from nurses' observations and interviewing of the family, and by physical measurements of the family members (Friedman, 1980; Luciano, 1972a). The assessment of family health cannot be obtained by merely summing the measurements of health status of each family member, for these are attributes of the individuals. An appraisal of family health necessitates an assessment of family functions and family interactions, which are interrelated to the individual members' attributes of health (O'Brien, 1979).

The assessment of the family necessitates a systematic appraisal on three levels: the family's environment, the family unit, and the individual family member (Friedman, 1980). Important in the assessment of the family's environment are the home, neighborhood, school, and community, as well as the family's interactions with persons outside the family unit. The history, functions, and characteristics of the family unit, their effects upon the individuals within the family, and upon the surrounding society, are added to the data. By assessing the family's style of interaction and communication patterns, the nurse can also appraise many important aspects of family functioning. The assessment of the individual members includes each member's health history, problematic issues, and the members' unique perspectives about their family (Friedman, 1980; Johnson,

1979; Sobol & Robischon, 1975).

Bishop (1976) stated that sometimes nursing interventions are based upon a gut level feeling. Although such interventions might be appropriate, they are hard to explain or defend (Bishop, 1976). The use of theory as a basis for nursing actions results in a more cohesive and systematic approach to the family. Theoretical frameworks are useful in collecting data and in determining a nursing diagnosis when the goals are flexible and are set within the context of the family's unique needs (Friedman, 1980; Miller, 1980; Sobol & Robischon, 1975). The assessment tools which are derived from theoretical frameworks must also be flexible and allow for and identify family growth and change (Morgan & Macey, 1978).

The Value of the Family Assessment

The data provided by the family assessment is essential for planning and delivering family nursing care. The dynamic state of each member and of the family unit, necessitates a continual process of assessment throughout the period of the nurse's involvement. The data about the environment, the family unit, and the individual members are synthesized in order to plan interventions with the family which would increase the solidarity of the family unit, improve the health of its members, and help them to achieve their desired goals (Johnson, 1979; Sobol & Robischon, 1975).

Summary

There are many theoretical frameworks by which the family can be appraised. For the purpose of this study, the systems framework was chosen as the basis from which to view the family. The systems framework helps the nurse to regard the family as an interrelated whole. From the systems perspective, a disturbance in one family member will have an effect upon all the other members and upon the family as a unit. In addition, the family has a significant influence upon the health of the individual members. Thus, the family is a primary concern in the promotion of health and in the prevention and treatment of illness.

Recently the health care system has recognized the need for a family approach to care, however, most health care workers, for a variety of reasons, have retained an individual rather than a family focus. In order to initiate effective intervention for families, the nurse must first make a family assessment. This involves the systematic and comprehensive collection of significant data about the individual members, as well as the family as a whole.

Conceptual Framework

Systems theory is a major framework used in analyzing the family. It allows for viewing the family holistically and in interaction with smaller and larger units. From this perspective, the family cannot be considered merely as the sum of parts, but must be viewed as greater and different

than the sum of its parts. Therefore, the assessment of the family unit cannot be based upon the sum of the analysis of each family member or sets of relationships within the family, but must be based upon the unit as a whole.

By definition, a system is a whole entity composed of interdependent, mutually interacting parts. The interrelationships of the parts are so intricately tied together that a change in one part inevitably results in a change in the entire system. Thus, an illness in one member necessarily affects the entire family, creating the need for the family to adapt in order to meet the demands of illness. Conversely, a change in the system will affect each of its parts.

The nurse's goal is to help the patient to achieve an optimum level of health. Because of the reciprocal nature of family relationships, individual family members who are ill are both affected by the family, and in turn, create an effect in the family system (O'Brien, 1979). Family nursing intervention affords benefits for both the family as a unit, as well as for the individuals within the family. The nurse functions within the family by working together with them to effect a plan which will help the family to grow in the ability to meet needs of family members in more healthful ways (Johnson, 1979; Luciano, 1972a). This concept has implications for health maintenance, preventative, and restorative care.

The nursing literature has addressed the need for the

assessment and intervention of the family as a unit, in order to adequately care for the individual family member, and tools for assessing the family unit have been published (Friedman, 1980; Morgan & Macey, 1978; Sciarillo, 1980). Because little research has been done regarding nurses' actual practice of family assessment and factors which affect it, an investigation of the use of family assessment was believed to be useful in expanding the practice of family nursing.

Research Questions

The primary research questions of this study are:

1. To what extent are nurses, who work with children and their families, obtaining the assessment of the family?

2. What factors affect nurses' practice of family assessment?

These questions are explored through the following subquestions:

a. What methods are used by nurses in assessing families?

b. What kinds of information do nurses try to find out in assessing families?

c. Does the extent of the nurses' education influence the practice of family assessment?

d. Does the content of the nurses' education influence the practice of family assessment?

e. Does the nurses' work experience correlate with the

practice of family assessment?

f. Does demographic data, such as age and the presence of children in the home, correlate with the practice of family assessment?

g. Do job related factors, such as working conditions and administrative policies, correlate with the practice of family assessment?

h. Do nurses who work with children in a variety of settings, i.e. community health, school, in-patient, and out-patient settings, practice family assessment to the same extent?

Operational Definitions

Family:

> A small social system, or subdivision of this social system, which is made up of individuals related to each other by. . .strong reciprocal affections and loyalties, and comprising a household (or cluster of households) that persists over years and decades. (Terkelson, 1980).

For purposes of this study, the family must include at least one child.

Family-Centered Care: A system of health management which acknowledges the influence of the family and the environment upon the individual, as well as the individual's effect upon the family. Family-centered care effectively utilizes the complementary skills of the nurse, the individual patient, and the patient's

family, in order to better understand and meet the needs of the individual.

Family Nursing: A system of health management in which the family unit is the client. It assumes the interactional forces of family members, and the inseparability of the family, its members, and the environment. The family's and the nurse's complementary skills are utilized in order to help the family to grow in its ability to meet family needs in more healthful ways.

Family Assessment: The purposeful, systematic, and on-going gathering of data about the primary patient's family by way of observing and communicating with the family members. Family assessment includes the appraisal of the family's environment, the family unit, and the individual family members. The data includes a wide base of information which influences the health status and functioning of the family, and which is obtained for the purpose of planning appropriate intervention with the family.

CHAPTER II

METHODOLOGY

Description of the Study

The purpose of the study was to broaden the understanding of what nurses who work with children are practicing with regard to the assessment of the family and to isolate factors which appear to be related to family assessment. The study was an investigative survey, utilizing a questionnaire. Because the type of nursing setting was to be investigated as a factor related to the practice of family assessment, the questionnaire was given in four different areas of nursing: community health, the public elementary and high schools, the in-patient hospital setting, and the out-patient clinic setting. In the following paragraphs, a description of the sample, the settings, the instrument and procedure of administering it, and the data analysis are given.

Subjects

A total of 99 nurses were selected to complete the questionnaire. Sample selection criteria consisted of nurses who possessed an Oregon registered nursing license and who were currently working with children and their families. The criteria did not require that they be paid employees or working full time. The subjects were chosen in their respective locations on the basis of availability to the researcher. Therefore, one of the study's limitations

is that the data are not representative of all nurses who work with children.

Setting

The study took place in 10 different locations, also chosen on the basis of availability, in order to obtain a sufficient number of nurses working in the four areas of nursing. Included were three teams from a county health department, a county office of elementary and middle school nurses, an organization of volunteer public high school nurses, four out-patient facilities, and a large, private in-patient facility. A description of these settings and the nurses working within them is given.

A county health department was chosen for the community health setting. The health department employed community health nurses for home visiting, health teaching and supervision of families, and to service adult and well-child clinics. The sample included 18 nurses from three teams, located in different areas of the city, which all had the same nursing functions. Six nurses were obtained from each team.

School nurses were obtained from two different locations. The first location was a county office of elementary and middle school nurses. The office employed 10 nurses to provide primary health care, health teaching and counseling to children at school, and to visit the homes of the children when necessary. All 10 nurses were included in the sample.

The second source of school nurses was an organization of volunteer public high school nurses which was contacted through the coordinator of the volunteer school nurse organization. Most of the volunteers did not work out of a central office, however, they periodically met as a group. The volunteer school nurses were also engaged in health teaching, counseling, and giving primary health care to children at school. Twenty-seven nurses were acquired from this group.

Four ambulatory care facilities were chosen to obtain the group of 24 out-patient nurse respondents. The first ambulatory setting was a state and federally funded facility which employed nurses to evaluate, test, and participate in the treatment of mentally and/or physically handicapped children. The second ambulatory setting was a pediatric clinic in a large, state supported medical center. The medical center employed nurses in the pediatric out-patient clinic to provide well-child care and to assist the physicians in treating ill children. The third ambulatory setting was a pediatric department at a private out-patient facility. The nurses who worked in this clinic were engaged in well-child care, treating ill children, and assisting the physicians. The fourth ambulatory setting was a facility which evaluated and treated children with orthopedic diseases. Nurses who were employed here did physical examinations, assisted the physicians with various treatments, and counseled

parents regarding the care of their child at home. From the above facilities the numbers of respondents were 7, 6, 8, and 3, respectively.

A sample of 20 nurses was obtained from a large, private, 500 bed in-patient facility. These nurses provided in-patient care for acute and chronic health problems of children.

Instrument

The review of the literature revealed no available standardized instruments for surveying nurses' practice of family assessment. Therefore, the investigator developed a tool, the Family Assessment Questionnaire (Appendix B).

When the literature was reviewed, pertinent information about family assessment in nursing was noted which provided the support for the questions that were formulated (Appendix C). In addition, content validity for the questionnaire was obtained by the review of five faculty who have expertise in either family nursing or in research. After these faculty individually reviewed the questionnaire, revisions were made by the researcher based upon their critiques.

The questionnaire included 30 questions in multiple choice and short answer form. The questions asked for information concerning the extent to which nurses assessed families, methods used in family assessment, and information about a variety of factors that could influence this practice. These factors included educational background, characteristics

of the work situation, attitudes towards family assessment, past experience in nursing, and demographic data. Approximately twenty minutes was required to complete the questionnaire.

In order to calculate a score for family assessment for each respondent, a scale was devised using six questions on the questionnaire. The six questions included 25 items dealing with the extent to which family assessment was done by the nurse (Appendix D). In scoring the scale, the more information about the family which the nurse elicited, the more complete the assessment was considered to be. It was also considered that assessing each family member, assessing family units, interviewing families together, and recording the family assessments, all contribute to a more comprehensive and useful family assessment. Thus, the above factors were regarded in determining each nurse's score.

The family assessment scores were determined in the following way. The questions concerned with the extent to which the nurse assessed the whole family unit and what was done with that information (Appendix A, questions 12, 13, 14, 17, and 28), yielded ordinal data that was recorded as either "usually", "sometimes", and "rarely", or "most", "some", and "few". A value of one point was given for the answers "usually" and "most", a value of 0.5 point was given for the answers "sometimes" and "some", and a value of zero was given for the answers "rarely" and "few". The nurses checked

all information which they usually elicited when assessing families (Appendix A, question 19). For each piece of information that was checked, a value of one point was given. A zero was given for the information left unchecked. The total number of points represented the extent to which the nurse assessed the families of their patients.

The 25 items which were considered in the respondents' family assessment scores have been compiled into the Family Assessment Scale (Appendix D). In the remainder of the thesis, the 25 assessment items will be referred to as the Family Assessment Scale.

Data Collection Procedure

Permission to do the study was obtained from the directors or supervisors of the nursing staff in each of the 10 locations. In order to improve the response rate, the questionnaires were presented by the investigator rather than mailed to each individual nurse. In six of the facilities, the questionnaires were presented and distributed at staff meetings. In the other four facilities where staff meetings were not being held, the researcher contacted either the nurses or the supervisors at the facilities individually. In three of the latter four facilities the questionnaires were distributed by the researcher. In the remaining facility, the questionnaires were mailed to the supervisor of the facility who had previously agreed to distribute and to collect the questionnaires from the nurses who wished to

participate in the study. In all cases, the researcher provided both written and verbal instructions with the questionnaire and was available to answer all questions, either in person or by telephone.

Each respondent was given the option to decline participation in the study. After instructions were given, the questionnaires were left for the nurses, in order to allow for privacy while completing the tool. In three of the facilities, one questionnaire was left unfilled.

A cover letter with the instrument explained the purpose of the study and provided directions for completing the questionnaire. Written consent to participate in the study was obtained from each of the nurses. It was requested that names not be put on the questionnaires in order to protect the confidentiality of the information obtained. After the questionnaires were collected, they were coded for the type of setting in which the nurse worked.

The researcher answered all questions directed to her concerning the meaning of the questions. However, the possibility that some nurses misunderstood certain questions but did not inquire about them, contributed to the limitations in the methodology. Another limitation was the possibility that some responses, regarding the nurses' actual behavior, were not accurate.

Data Analysis

Information about the respondents and their use of family assessment was analyzed using percentages, means, and ranges. Relationships between the scores from the Family Assessment Scale and various characteristics about the nurses and the health care settings were calculated by using Pearson's r.

To analyze differences in family assessment scores among nurses in the four different settings, analysis of variance was used because the mean scores of more than two groups were compared. After the analysis of variance was completed, Tukey's HSD statistic was used in a second test in order to discover where the differences occured among the four groups. Comparisons were made between all possible pairs of settings regarding each groups' mean family assessment score. Tukey's HSD was recommended (Kirk, 1968) as one of several post hoc tests which can be used when the analysis of variance reveals a significant F ratio, and when predictions have not been made regarding the outcome of the test. Because type I errors are committed more frequently as more comparisons are made, Tukey's HSD test is valuable because it controls the error rate, holding it at a fixed level for a set of comparisons (Keppel, 1973). Tukey's HSD test was also found to be valuable in this study because the formula could easily be calculated without the use of a computer.

Analysis of variance, followed by the Newman-Keul's

procedure was used to analyze differences in the characteristics of the subjects and in the characteristics of the health care settings among the four groups of nurses. Like Tukey's test, the Newman-Keuls procedure was used to find where the differences occured among the four groups. The Newman-Keuls procedure was recommended (Kirk, 1968) as another post hoc test which can be used when the analysis of variance reveals a significant F ratio and when predictions have not been made regarding the outcome of the test. The Newman-Keuls test is valuable because it also provides protection for all possible pairwise comparisons against type I errors. Although it is less conservative toward type I errors than Tukey's HSD statistic, it has the advantage of being more sensitive to the differences among the groups (Keppel, 1973). In order to extract the most information about the groups' differences in regard to the characteristics of the nurses and of their settings the Newman-Keuls test was preferred.

The t-test was used to analyze differences in family assessment scores between nurses with baccalaureate degrees and nurses without baccalaureate degrees. The t-test was used because the comparisons involved only two independent groups.

CHAPTER III

RESULTS AND DISCUSSION

Results

The results and implications of this survey are discussed in this chapter. In order to address each research question the results are presented in the following way. The characteristics of the subjects, the characteristics of the health care settings, methods nurses used in obtaining family data, and the extent that family assessment was done are discussed in terms of descriptive statistics. The family assessment scale and its level of reliability are summarized. Individual items on the family assessment scale are discussed descriptively. The family assessment scores are subsequently discussed in relationship to the characteristics of the nurses and their positions. Finally, the nurses' opinions regarding the usefullness of family assessment are presented.

Characteristics of the Subjects

Characteristics of the subjects are presented in terms of the proportion of nurses in each of the four settings, their position titles, demographic data, work experience, and educational background. Of the four work settings represented in the sample, school nurses comprised the greatest percentage. The other settings were represented more uniformly, as can be seen in Table 1.

Table 1

Percentage of the Sample Represented in Each Work Setting

Work Setting	Percentage
Community health	18%
In-patient	20%
Out-patient	24%
Schools	37%

The respondents' employee positions were not included in any of the analyses because the categories of position were divided similarly to the categories of work setting. For example, the nurses who were employed in the community health setting all had an employee position of "community health nurse". Those who formed the out-patient nurse population exhibited some variation in position titles. Out-patient nurse employee positions included staff nurses, supervisors, pediatric nurse practitioners, clinical nurse specialists, and a telephone advice nurse.

Only one nurse out of the 99 respondents was a male, thus sex was also not considered in any of the analyses. Forty-nine percent of the sample stated that they had children under age 16 living at home.

The ages of the sample ranged from 22 to 70 years with a mean of 38.94 years. Differences in the ages of the

respondents were seen according to their settings. By using the Newman-Keuls procedure it was found that in-patient nurses were significantly younger than the other three groups of nurses. There were no meaningful differences in age among the other three groups. Table 2 includes the mean age of each group of nurses and the level of significance at which differences were found between the in-patient nurses and the other three groups.

Table 2

Comparison of Respondents Ages in Years

Group mean ages and standard deviations (in parenthesis)				Overall F from ANOVA	Significant pairwise comparisons[a]
C.H.	In-pt.	Out-pt.	School		
42.22 (11.85)	29.45 (7.71)	38.63 (9.65)	42.78 (10.44)	F(3,94)= 8.36**	Out-pt> In-pt.* C.H. > In-pt.* School> In-pt.*

[a]Pairwise comparisons of means were carried out using the Newman-Keuls procedure.

*$p < .05$

**$p < .001$

The nurses' job experience, in terms of the length of time they had been registered nurses, ranged from less than one year to 39 years, and 25% of them had been registered nurses for less than five years. By using the Newman-Keuls procedure, it was found that in-patient nurses had less

experience as registered nurses than the rest of the sample. There were no significant differences in experience as registered nurses in out-patient, community health, and school nurses. Table 3 includes information on the mean years of experience as registered nurses of the four groups of respondents and the level of significance at which differences were found between the in-patient nurses and the other three groups.

Table 3

Comparison of Respondents' Experience as Registered Nurses

Group mean years of R.N. experience and standard deviations (in parenthesis)				Overall F from ANOVA	Significant pairwise comparisons[a]
C. H.	In-pt.	Out-pt.	School		
16.17	6.23	16.67	20.59	F(3,95)=	Out-pt. > In-pt.*
					C. H. > In-pt.*
(12.86)	(7.89)	(11.12)	(10.78)	7.77**	School > In-pt.*

[a]Pairwise comparisons of means were carried out using the Newman-Keuls procedure.

*$p < .05$

**$p < .001$

The number of years of experience in working with children ranged from less than one year to 35 years. Forty-six percent had less than five years of experience working with children. As shown in Table 4, the Newman-Keuls procedure revealed no significant differences among the four groups

in regard to the length of time they had worked with children.

Table 4

Comparison of Nurses' Experience in Working with Children

Group mean years of experience with children and standard deviations (in parenthesis)				Overall F from ANOVA	Significant pairwise comparisons[a]
C. H.	In-pt.	Out-pt.	School		
9.67	7.33	9.00	8.36	F(3,95)=	No statistical differences
(8.07)	(7.12)	(5.82)	(9.01)	.321*	among groups

[a]Pairwise comparisons of means were carried out using the Newman-Keuls procedure.

*$p > .05$

The number of years of experience in the current employee position ranged from less than one year to 22 years. Thirty percent had just one year or less in the position.

Community health nurses had a significantly greater number of years of experience in their present positions than did the other three groups. Table 5 shows that in-patient, out-patient, and school nurses did not differ significantly in the number of years they had held their postitions.

Table 5

Comparison of Nurses' Experience in Their Employee Positions

Group mean years of experience in the employee position and standard deviations (in parenthesis)				Overall F from ANOVA	Significant pairwise comparisons[a]
C. H.	In-pt.	Out-pt.	School		
7.61	2.93	3.67	3.07	F(3,95)=	C.H. > In-pt.*
					C.H. > Out-pt.*
(6.98)	(2.76)	(3.33)	(2.16)	6.66**	C.H. > School *

[a]Pairwise comparisons of means were carried out using the Newman-Keuls procedure.

*$p < .05$

**$p < .001$

The sample's educational background can be seen in Table 6. Again, comparisons can be noted among the four groups. The sample as a whole consisted of mainly baccalaureate graduates, however, diploma graduates were just as prevalent as baccalaureate graduates in the out-patient setting. The sample included no nurses with doctoral degrees.

Table 6

Groups' Level of Education by Percentage

Group	A.D.	Diploma	Baccalaureate	Masters
Total sample	2%	28%	64%	6%
Community health	0%	6%	94%	0%
Out-patient	0%	42%	42%	16%
In-patient	5%	20%	75%	0%
School	3%	30%	62%	5%

Five percent of the sample were certified pediatric nurse practitioners, one among the community health nurses, and four among the out-patient clinic nurses. Four of the nurses had masters degrees in nursing. A fifth nurse had a masters degree in health education. The sixth nurse with a masters degree did not state the discipline in which the degree was earned.

Eighty-seven percent of the nurses who had received information about family assessment, 75% of the nurses who had received information about family theory, and 78% of the nurses who had received information about the application of family theory, did so in baccalaureate programs. All of the nurses with masters degrees in nursing reported having had content in both family assessment and family theory. There was a significant relationship between having been taught family assessment and having been taught family

theory ($r = .5865$; $p = .001$). There were also significant relationships between having been taught family assessment and the application of family theory ($r = .6505$; $p = .001$) and between having been taught family theory and the application of family theory ($r = .8165$; $p = .001$). Thus, if a nurse had been taught one of the three aspects of family content he or she probably also had been taught the other two aspects.

As shown in Table 7, the Newman-Keuls procedure revealed that school nurses had been taught family assessment to a significantly lesser extent than both community health and in-patient nurses, but not less than out-patient nurses. School nurses were taught family theory to a significantly lesser extent than out-patient nurses only. There were no other meaningful differences among the four groups in the extent to which they had been taught family assessment and family theory. There were no significant differences among the four groups in the extent to which the application of family theory had been taught.

Table 7

Comparison of the Extent to Which Nurses Received Instruction in Various Aspects of Family Nursing

Aspects of family nursing education	% of nurses who were instructed in aspects of family nursing				Overall F from ANOVA	Significant pairwise comparisons [a]
	C. H.	In-pt.	Out-pt.	School		
Family assessment	66%	63%	48%	31%	F(3,92)= 3.69**	C. H.> School* In-pt.>School*
Family theory	77%	70%	78%	47%	F(3,95)= 2.95**	Out-pt.>School*
Application of family assessment	66%	70%	58%	50%	F(3,93)= 1.78*	No significant differences among groups

[a]Pairwise comparisons were carried out using the Newman-Keuls procedure.

*p > .05

**p < .05

Characteristics of the Health Care Setting

Although 98% of the nurses thought that the assessment of the family was a nursing responsibility, only 39% of the sample claimed that assessing the families of their patients was required of them in their work situations. About two-thirds stated that their administrators encouraged it. Fifty-two percent of the sample stated that they had frequent contact with their patients' families, but less than one-third stated that their jobs usually gave them the flexibility or the needed amount of time to assess families. About half of the sample stated that the physical layout in the work areas allowed for family assessment.

By using the Newman-Keuls procedure, significant differences were again found between the four groups of nurses in regard to characteristics of the work setting, as shown in Table 8. It was found that family assessment was required in the nurses' postitions more often in the community health setting than in the other three groups. The encouragement of the nursing administrators to do family assessments was greatest in the community health setting and differed significantly with the out-patient nurses only. There were no differences among the four groups in respect to whether or not the physical layout of the work area allowed for family assessment. School nurses had significantly less contact with the families of children

than any of the other three groups. In-patient, out-patient and community health nurses did not differ significantly in the frequency of their contact with families. Community health nurses had significantly more time available to them to assess families than any of the other three groups. The degree of flexibility experienced in the work situations differed widely among the groups. Community health nurses had more flexibility than any of the other three groups. School and in-patient nurses had more flexibility than out-patient nurses, but did not differ significantly in flexibility from one another.

Table 8

Comparisons of Groups' Perceptions of Their Work Settings Regarding Features Supportive of Family Assessment

Features of health care setting supportive of family assessment	Group means of nurses' perceptions of their work settings regarding features supportive of family assessment and standard deviations (in parenthesis) [a]				Overall F from ANOVA	Significant pairwise comparisons[b]
	C. H.	In-pt.	Out-pt.	School		
Family assessment is required in the job.	1.11 (.32)	1.58 (.51)	1.70 (.47)	1.81 (.40)	F(3,93)= 11.26****	C.H.> In-pt.** C.H.> Out-pt.** C.H. > School
Nsg. administration encourages family assessment	1.06 (.24)	1.29 (.47)	1.54 (.51)	1.36 (.49)	F(3,91)= 4.02***	C.H.> Out-pt.**
Physical layout of work area allows for family assessment	1.29 (.47)	1.41 (.57)	1.55 (.51)	1.63 (.49)	F(3,87)= 2.01*	No significant differences among groups
Frequent contact with patients' families	1.18 (.39)	1.45 (.60)	1.38 (.65)	2.22 (.79)	F(3,94)= 13.82****	C.H.> School** In-pt. > School** Out-pt. > School**
Usually enough time to assess families	1.22 (.43)	1.95 (.60)	2.33 (.70)	2.32 (.71)	F(3,95)= 13.82****	C.H.> In-pt.** C.H. > Out-pt.** C.H. > School**
Flexibility in the job which allows for spending enough time with families	1.17 (.38)	2.00 (.65)	2.50 (.59)	2.30 (.81)	F(3,95)= 15.84****	C.H.> In-pt.** C.H.> Out-pt.** C.H. > School** In-pt. > Out-pt.**

[a]The smaller the mean value, the more nurses perceived that their work settings had features supportive of family assessment.

[b]Pairwise comparisons were carried out by using the Newman-Keuls procedure.

*p ≥ .05
**p < .05
***p < .01
****p < .001

Methods Used in Gathering Family Data

The research subquestion A asks how nurses gather information about the family. Communication with the parents was the most often used method, followed by communication with the child, communication with other staff, observations of the family, and use of the health record, respectively. Twenty-nine percent of the sample communicated with the entire family, which was the least used method of gathering family data. Table 9 provides the frequency count of how family data was usually obtained by each of the four groups.

Table 9

Percentage of Respondents Who Utilized Various Methods of Data Collection

Method of Data Collection	C.H.	In-pt.	Out-pt.	School
Communication with parents	89%	75%	100%	70%
Communication with child	83%	58%	75%	89%
Communication with staff	67%	67%	65%	65%
Observation of the family	94%	67%	85%	27%
Health record	78%	42%	30%	78%
Communication with entire family	55%	38%	20%	14%

When asked upon whom they usually relied for information about family needs if the entire family was not accessible, 43% designated the mother or parent to be the informant.

This function was also assigned to others in the following order of frequency: the child, whomever happened to be present, the parent and the child together, the physician attending the child, and the child's responsible social agent, such as a caseworker.

The majority of nurses did not use standardized tools to assess families. The 12% who did, used tools which were printed forms from their places of employment. Fourteen percent stated that they utilized one or more theoretical models as a basis for their assessments. These models included stage theories, such as Piaget's and Erikson's theories; family development theory; crisis intervention theory; and systems theory.

Extent to Which Nurses Practice Family Assessment

The first major research question of the present study concerns the extent to which nurses practice family assessment. More specific questions which relate to this are the extent to which the total family is assessed and the kind of family data which is usually gathered in the assessment.

The majority of the nurses indicated that they gathered some information about family members most of the time. About one-third indicated that they assessed family units most of the time. Fewer yet stated that each family member was routinely assessed or that family members were interviewed together. Community health nurses assessed the total family, in regard to the above four aspects of assessment, to a greater extent than the other groups of nurses (see Table 10).

Table 10

Percentage of Respondents Who Assessed the Total Family

Extent Variable	C. H.	In-pt.	Out-pt.	School
Some information is usually gathered about family members	94%	25%	50%	43%
Family units are routinely assessed	78%	15%	25%	14%
Each family member is routinely assessed	61%	0%	13%	3%
Family members are interviewed together	28%	15%	21%	3%

Question 15 on the questionnaire sought information regarding the types of families the nurses assessed. This question was omitted from the data analysis because about half of the respondents did not answer it. Due to the way in which question 15 was worded, most respondents, though not all, who had answered "most" or "few" on question 14 omitted question 15. Thus, question 15 failed to obtain the entire sample's family assessment practices.

Table 11 presents the kind of family data that the respondents usually gathered in family assessments. Items most often elicited were names and relationships of family members and the quality of the child-parent relationship, indicating that both family functions and demographic data were considered to be important information in their family assessments.

Table 11

Percentage of Respondents Who Elicited Items of Family Data

Data	% of Total Sample
Names and relationships of members	73%
Quality of parent-child relationships	72%
Health history and health status of members	64%
Family's style of child care and discipline	56%
Occupations	56%
Socio-economic status	54%
Conflicts within the family	53%
Social support system	47%
Quality of mother-father or husband-wife relationship	47%
Communication patterns within family	45%
Closeness of family relationships	45%
Quality of sibling relationships	40%
Ethnicity	40%
Stressors experienced by each member	39%
Existence or importance of extended family	38%
Family decision making patterns	32%
Division of responsibility	27%
Religion	20%
Family coalitions	13%
Community involvement	13%
Family geneology	11%

Family Assessment Scale

The Family Assessment Scale (Appendix D) is composed of 25 items from the questionnaire that deal with the extent to which family assessment is done. For scoring purposes, one point was allotted for each item, making a maximum of 25 points possible. The scores of the respondents ranged from 0 to 23.5 with a mean of 11.82 and a standard deviation of 6.7.

Two approaches in scale construction, an exploratory factor analysis and a reliability analysis, were used to determine how best to create the Family Assessment Scale. The factor analysis was done in order to determine if the original 26 items comprising the scale should be broken down into categories of subscales. The factor analysis revealed that the 26 items on the scale comprised 25 small subscales and one large subscale that accounted for 35.7% of the variance. Thus, the scale items were not broken down into categories of subscales.

It was found in the reliability analysis that the correlation of each of the items to the total scale was .33 or greater, with the exception of religion. Religion did not correlate well with the other individual scale items and its correlation with the total scale was the lowest at .179. Thus, religion was omitted from the scale, decreasing the number of assessment items on the scale to 25. The omission of religion from the scale increased the Cronbach's alph level from .922 with religion to .924.

Correlations Between Family Assessment Scores and Sample Characteristics

In order to investigate the second major research question, which asked what factors affect nurses' practice of family assessment, correlations were made between the scores from the family assessment scale and the characteristics of the nurses and of the health care settings in which the nurses practiced. The factors included were the nurse's age, the presence of children in the nurse's home, the extent and content of the nurse's educational background, the nurse's work experience, the nurse's opinion of whether or not family assessment is a nursing function, the methods which the nurse used in collecting family data, the factors supportive of family assessment in the nurse's work setting, and the type of nursing with which the nurse was involved. The correlations in which $p \leq .05$ were considered to be statistically significant.

Subquestion F asked whether or not the nurse's age and the presence of children in the home correlate with the practice of family assessment. Increasing ages of the respondents correlated with increasing family assessment scores ($r = .266$; $p = .015$). The presence of children in the home was not found to relate significantly to the scores.

Subquestion E asked whether or not the nurse's work experience is related to the extent that family assessment is done. Table 12 describes the relationship between the nurse's work experience and family assessment scores. The

family assessment scores positively correlated with experience in the present employee positions and in working with children. Community health nurses as a group had the most experience in working with children. No significant relationship was found between longevity as registered nurses and the family assessment scores.

Table 12

Correlations Between Work Experience and Family Assessment Scores

Work Experience	r	p
Years as registered nurse	.1489	.078
Years experience with children	.3310	.001
Years experience in present position	.3619	.001

Research subquestion C asked if the extent of the nurses' education impacts on the use of family assessment. Due to the small numbers of A.D. and Masters graduates, the sample was divided into two groups rather than four: those with baccalaureate degrees or higher, and those without baccalaureate degrees. The t-test which was done between the family assessment score means of these two groups revealed that they were significantly different ($p < .05$), as is shown in Table 13.

Table 13

Differences in Family Assessment Scores Between Two Educational Groups

Group	N	Score $\bar{x}$	Minimum Score	Maximum Score
A.D. and Diploma	27	9.44	1.0	21.5
Baccalaureate and Masters	65	12.79	0.0	23.5

$t(90) = 2.22$; $p < .05$

The study revealed that the content of the nurses' education also related to their practice of family assessment (subquestion D). Nurses who had had instruction in family theory in their nursing programs had significantly higher family assessment scores than nurses who did not have this educational content ($r = .1958$; $p = .029$). Nurses who had been taught how to do a family assessment in their nursing programs also had higher scores than nurses who were not taught how to do a family assessment ($r = .3265$; $p = .001$). Education in the application of family theory did not relate significantly to the extent of family assessment.

An analysis of variance revealed that the extent to which the nurses practiced family assessment differs significantly among the four settings studied (subquestion H). The analysis of variance among the four settings and the descriptive statistics of each is shown in Table 14.

Table 14

(A) Analysis of Variance Among the Four Settings

Source	df	ss	$\bar{x}^2$	f ratio	f prob.
Between groups	3	1398.096	466.032	15.273	.0000
Within groups	88	2685.263	30.514		

(B) Statistical Summary of Respondents' Scores According to Setting

Group	N	$\bar{x}$	sd	S.E.	Minimum Score	Maximum Score
Community health	18	19.000	3.757	.886	12.00	23.00
In-patient	20	7.325	4.165	.931	1.00	15.00
Out-patient	18	12.250	7.612	1.794	0	23.50
School	36	10.500	5.683	.947	1.50	22.50

Tukey's HSD test (Kirk, 1968) was used to compare family assessment means for all possible pairs of settings. Each setting was compared with the other three to determine significant differences. Community health nurses had significantly higher family assessment scores than did the other three groups of nurses. Out-patient nurses had significantly higher scores than did in-patient nurses. There were no significant differences between the scores of

in-patient nurses and school nurses, and between school nurses and out-patient nurses.

Table 15 shows the differences in the mean scores between all possible pairs of settings using Tukey's HSD test. The difference between the mean scores of two given pairs of settings is significant if the table value is less than the q value. The differences between the mean score of in-patient nurses and school nurses and between out-patient and school nurses were not found to be significant. Significant differences were found between all other pairs of settings.

Table 15

Family Assessment Score Differences
Between All Pairs of Settings

Groups Compared	q[a]	Table Value	p
In-pt. - C. H.	9.72	4.59	$<.01$
C. H. - School	7.08	4.59	$<.01$
Out-pt.- C. H.	5.62	4.59	$<.01$
In-pt. - Out-pt.	4.10	3.74	$<.05$
In-pt. - School	2.64	3.74	$>.05$
Out-pt.- School	1.45	3.74	$>.05$

[a]The q value is significant if it exceeds the table value.

The use of tools and models also correlated positively with the family assessment scores ($r = .257$; $p = .017$ and $r = .249$; $p = .010$ respectively). Other methods of gathering family data that related positively to the scores were communicating with the entire family ($r = .4214$; $p = .001$), observing the family ($r = .384$; $p = .001$), and communicating with other staff ($r = .313$; $p = .002$).

The family assessment scores also related positively to characteristics of the nurse's work setting. Factors which correlated most strongly were the nursing administration's requirement of the nurse to do family assessments on the job, having enough time and flexibility in the position to allow for family assessment, and working with a nursing administration who encourages it. Having frequent contact with family members correlated to a lesser degree to the scores, yet it was still significant. The physical layout of the work area did not relate significantly to the assessment scores. The correlations among characteristics of the health care setting and family assessment scores are shown in Table 16.

Table 16

Correlations of Characteristics of the Health Care Settings to the Family Assessment Scores

Characteristics of the Setting	r	p
Family assessment is required	.4698	.001
Nurse has flexibility in the job	.4556	.001
Nurse has time available for family assessment	.4310	.001
Administration encourages family assessment	.4205	.001
Nurse has frequent contact with family members	.2205	.018
Physical layout of work area is supportive of family assessment	.1455	.093

Nurses' Opinions of the Value of Family Assessment

The majority (64%) of the sample believed that their assessments of families helped them in planning nursing care for the child. Thirty-five percent believed that their family assessments usually helped them to prevent or alleviate some family problems. There was a positive correlation between nurses who scored higher on the assessment scale and those who believed that assessing families was helpful to them in planning nursing care for the child ($r = .5432$; $p = .001$).

Discussion

The implications of this survey are examined and compared to the findings of other studies. The methods of data gathering used by the respondents, the extent to which family assessment was done, and the correlations of the family assessment scores to characteristics of the nurses and their health care settings are topics included in this discussion.

Methods Used in Gathering Data

In general, nurses used a variety of methods for gathering family data. However, few nurses assessed the entire family together. Communication with the entire family was the least used method of gathering family data. Most nurses used more accessible methods, such as talking with the child, the parents, and the staff, reading the health record, and observing the family when they were in view. Such methods require less time and organization from the nurses than does talking with each family member. A complete family assessment would seem to necessitate communicating with all family members in order to obtain a more accurate and complete assessment (Larson, 1974).

The present study showed that the mother was used as the informant concerning family needs 43% of the time when the entire family was not available. However, Larson (1974) provided evidence that family members often differ in their perceptions of their families' needs, structures and

processes. The mother is often the only other member available to give such information, expecially if the child is too young to provide it, thus the mother continues to speak for the family. The nurse's setting could influence how many family members with whom the nurse has direct contact. For example, the community health nurse who visits homes usually has more opportunity to talk with siblings and fathers than does the nurse in the out-patient clinic.

There was a positive correlation between the Family Assessment Scale scores and communication with the entire family. However, the fact that out-patient clinic nurses, in-patient nurses, and school nurses generally have less opportunity to see entire families has practical implications. Perhaps administrative changes could be made in settings where nurses see entire families less often in order to give nurses more opportunities for interaction with families. For example, nurses could be given time to make a home visit for the assessment of each family. Because mothers are often the only family member available to be an informant for the family, there is indication of the need for the development of more tools that could be used with mothers which would provide accurate family data for the nurse's use.

Few of the respondents used tools and models in their assessments of families. However, there was a positive correlation between nurses who did use tools and models

and nurses who scored higher on the family assessment scale. Most of the nurses who did use tools reported that the tools were questionnaires and forms originating from their places of employment. Argobast et al. (1978) and Janosik (1980b) observed a scarcity of suitable tools in the literature which are based upon family theory, suited for the whole family, designed and tested by health professionals, and which can be used in the clinical setting. However, nurses who do not have a family orientation in their work and nurses who are not encouraged to use published tools and models by their nursing administrators would likely be less motivated to investigate and use the tools and models which are found in the literature.

Extent to Which Family Assessment is Practiced

Wide differences in the sample are shown by the range of scores on the Family Assessment Scale. Some possible reasons for this will be discussed.

As mentioned in the preceding section, the respondents seldom interviewed families together or assessed every family member. The results showed that, although community health nurses had the highest family assessment scores, 72% of the community health nurses also indicated that they usually had enough time to assess families. Only 20% or less of the school, in-patient, and out-patient nurses indicated that they had enough time to do family assessments. Community health nurses also had the most frequent contact with

patients' families of all four groups. Therefore, the time available to the nurse in the health care setting and the amount of contact the nurse has with all family members might in part determine how much the nurse talks with and focuses upon the entire family, as suggested by Porter (1979).

More than half of the information which nurses usually obtained about family members was demographic data and other objective information, such as the names and relationships of family members, members' health history and status, occupations, and socioeconomic status. Demographic data are more easily obtained because astute observations are not required and it is sometimes less threatening for the family to provide. Seventy-two percent of the nurses assessed the quality of the parent-child relationship, 56% assessed the style of child care and discipline, and 53% assessed family conflicts, items which strongly influence the child's development (Hymovich, 1980). However, the inadequacy of family assessment done by this sample, as a whole, is shown by the fact that other variables that also have a strong influence on the child's development were assessed by less than half of the nurses. Such variables which were often overlooked were the closeness of the family, the quality of the mother-father or husband-wife relationship, the quality of the sibling relationships, and communication patterns within the family.

Less than half of the sample usually elicited data

about the family's social support system, extended family, and the stressors experienced by each family member. Such data provide information about potential resources available to the family and are often related to the family's vulnerability to crises (MacVicar & Archbold, 1976). Therefore, the results, which showed that the above three variables were often overlooked, indicates an additional lack in the comprehensiveness of this samples' family assessments.

Only 40% of the nurses usually considered ethnicity in their family assessments, although ethnicity is believed to be important information in the nursing assessment. The needs, behaviors, and beliefs of clients are often better understood when considered in the light of their ethnic backgrounds (Janosik, 1980).

Additional deficiencies in the family assessments were shown in areas of family functioning. Only 27% of the nurses assessed the family's division of responsibility and 32% assessed family decision making patterns. These factors often relate to the family's ability to cope with illness and other family disruptions (MacVicar & Archbold, 1976).

The family's community involvement, family coalitions, family geneology, and religion, were lowest in the extent to which they were assessed and were apparently not as important to this particular sample. The employee position, the setting in which the nurse works, and the nurse's own values would probably make a difference in what kind of

data the nurse considers valuable.

It is important to note that only 54% of the nurses usually recorded their assessments for their own and other staff's reference. In many cases, information which could be valuable to other staff was not documented. Inefficiency in recording could also jeapordize the objectivity of the nurse's approach in family intervention. For example, if the nurse does not record the family assessment, selective recall and distortions in the nurse's impressions of the family might take place. The nurse's family intervention would probably reflect an incomplete or inaccurate family assessment.

Correlations of the Family Assessment Scores to Characteristics of the Sample and Their Health Care Settings

In this section, the implications of the relationship between family assessment scores and characteristics of the respondents and their health care settings are considered. Sample characteristics include demographic data, work experience, work setting, and educational background.

In the present study, the children in the homes of the subjects did not make any difference in the extent to which family assessment was done. In Porter's (1979) study, there was a significant difference in the family-centered care orientation between health care workers who did not have children in the home and those who did. Porter suggests that health care workers who do not have domestic pressures

can invest more time and attention to the quality of professional practice. However, the family-centered care orientation of Porter's study was partly measured by the health care workers' attitudes towards their positions and towards the administration, rather than by the nurses' practice of family-centered care, exclusively.

The positive correlation between age and family assessment scores in the present study suggests that experience contributes to having a family orientation. The present study did show that nurses' experience in working with children and working in their present positions related positively to the extent that family assessment was done. In Porter's sample the family-centered care orientation was greatest between the ages of 34 to 37 years. Porter also found that health care workers with 10-13 years of clinical experience were most inclined towards participating in decision making and having autonomy in their work situations, qualities which she believed encouraged the family-centered care orientation. However, workers with more than 13 years of experience and those between the ages of 46 to 49 years were lowest in qualities associated with a family-centered focus. The backgrounds of these older and more experienced workers were not reported and Porter gave no explanation for these findings. Perhaps the older and more experienced workers received educations which were less family-centered than the younger and less experienced workers.

One might conclude that persons working in in-patient settings would be patient oriented rather than family oriented, due to the immediacy of patient needs and the many time demands of in-patient workers. In the present study, which involved only nurses, the setting made a significant difference in the extent to which family assessment was practiced but the findings were contrary to Porter's. Porter's study, which involved several types of health care workers, including nurses, revealed that in-patient workers had the highest family-centered care orientation. Health care workers in out-patient clinics had an orientation almost as high as in-patient workers. Community health workers, who are traditionally thought to be family focused due to the nature of their work, had the lowest orientation in Porter's study.

The present findings showed that community health nurses scored highest on the family assessment scale and in-patient nurses scored lowest. The differences in scores could be attributed partly to educational differences as the community health nurse group had more baccalaureate graduates proportionately than the other groups. It could also be related to conditions in the work setting. The community health nurses claimed to have working conditions (e.g. enough time, flexibility, encouragement from nursing administrators) that are favorable to doing family assessments, to a greater extent than the other three groups. Community health nurses

were also older than in-patient and out-patient nurses. Community health nurses were more experienced in their current work positions and in working with children. More community health nurses had been taught family assessment than any other group of nurses. The variables of age, experience, and educational curricula all related significantly to the family assessment scores. Thus, the aspect of the study regarding how nurses' work settings influence the practice of family assessment was confounded, making it impossible to draw definite conclusions concerning the variable of setting.

Out-patient nurses also possessed certain qualities which correlated positively with high family assessment scores. Out-patient nurses had worked in their present positions longer, had more years of experience working with children, and had more contact with the families of their patients, than all except community health nurses. In addition, out-patient nurses had been taught family theory to a wider extent than any other group. However, the out-patient group had the widest variation in their scores of any of the four groups. Both the highest and the lowest family assessment score was made by the out-patient group. Perhaps the wide variation in scores can be explained in part by the fact that the out-patient nurses had more master's graduates, as well as non-baccalaureate graduates, than the other three settings.

It was expected that the group of school nurses would

have rated higher on the scale than they did because 73% of them were volunteers. It was assumed that they would have more flexibility and perhaps more initiative than some of the paid employed nurses. Results showed that in general they did not perceive their work situations to be as supportive of family assessment as did the community health and in-patient nurses. For example, 19% of the school nurses stated that assessing the family was expected of them in their work, whereas 83% of the community health nurses believed family assessment to be a requirement of them. Because public schools are oriented to individual students rather than to entire families, perhaps it is more difficult for school nurses to maintain a family focus than it is for nurses in some other settings. It is also possible that some school nurses were working voluntarily only to keep their nursing licenses updated and were not willing to assume the added challenge of family intervention in their work.

In regard to educational background, the findings of the present study showed that nurses who had baccalaureate degrees and above made significantly higher family assessment scores than nurses with associate degrees or diplomas. Porter (1979) likewise found that nurses who had advanced higher educationally in a professional career were more oriented to family-centered care. She suggested that a nurse with a baccalaureate degree might have been influenced

by the family/community nursing concepts sometimes found in baccalaureate curriculums. In addition, the foci of the A.D. and diploma programs are technically based rather than professionally based. Therefore, the educational content of A.D. and diploma programs differs from that of baccalaureate programs. Baccalaureate programs prepare nurses more extensively in the use of the nursing process, interpersonal relationship skill, and leadership skills (Hover, 1975; Michelmore, 1979). Perhaps such an emphasis in baccalaureate programs helps to equip nurses in becoming skilled in family nursing.

Miller (1978) found through her experience as a nursing instructor, that having the course objective be the actual use of theories in a variety of situations, rather than mere knowledge about the theories, encouraged the application of theoretical ideas. Her conclusions were not researched based, but were based upon the performance of her students. In the present study, having had the application of family theory in one's nursing curriculum had no significant relationship to the extent that family assessment was done. This finding is difficult to explain, unless having had content about how to apply theory does not guarantee that knowledge will be gained in how to use theory to obtain family data. Nurses who were taught how to do a family assessment in school had significantly higher family assessment scores. If the curriculum content of how to do a family assessment was based upon a theoretical framework of family, then this content could also

be viewed as the application of theory.

The fact that family assessments helped 64% of the nurses in planning nursing care for children indicates that in general, family information was being utilized in caring for the individual. The utilization of family information in giving care to individuals suggests that family-centered care was being offered by the majority of the respondents. Only 35% of the respondents believed that their family assessments were translated into intervention that prevented or alleviated family problems, which is a goal of family nursing. This finding could reflect deficits in nursing education with regard to the application of family theory, which would contribute to nurses' lack of skills for intervening effectively with families.

According to the researcher's definition of family nursing, it appears that the community health nursing group approached the model of family nursing more closely than the other three groups studied. In family nursing, the family unit is the client. When community health nurses assessed families, they communicated with the entire family and observed the family more frequently than any of the other three groups of nurses. Community health nurses also assessed family units and each family member more often than the other three groups (see Tables 9 and 10). Thus, the community health nurses seemed to view the family, rather than the individual, as the client to a greater extent than the other

respondents.

Luciano (1972) observed that having an environment which is conducive to developing a therapeutic relationship, having adequate personnel, and having the encouragement and support from the nursing administration are all necessary in order to develop a family focus in nursing care. The present study could not show that the physical layout of the place of employment was related to doing a more extensive family assessment. However, the nurse's available time and the encouragement of the nursing administration were found to be factors that significantly related to the extent to which family assessment was done. Although most nurses' work settings did not require family assessments nor did most nurses have the flexibility to spend the needed amount of time in family assessment, the requirement of family assessment in the work setting and nurses' flexibility in the work situation also related positively to the family assessment scores. Nurses' flexibility in their work can provide autonomy in scheduling time and in guiding their actions by internal standards, rather than by the policies of the agency or the institution (Porter, 1979).

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS FOR FURTHER STUDY

Summary

The major research questions that were addressed in this study were: (a) to what extent are nurses who work with children and their families obtaining an assessment of the family? (b) what factors affect nurses' practice of family assessment?

A review of the literature supported that, although the quality of family life is closely related to the health of family members, nursing assessments and care plans are generally still focused upon the individual patient rather than upon the family system. Research on the extent that nurses assess families, and the relationship of this practice to characteristics of the nurse, is needed to provide information about how nurses can be helped to expand the practice of family nursing.

A sample of 99 nurses was obtained from in-patient, out-patient, community health, and school nurse settings, on the basis of availability to the researcher. They were given a 30 item questionnaire dealing with their own practice of family assessment, and information about themselves, their work experience, work conditions, and educational background. The outcome of each question was analyzed with descriptive statistics.

The Family Assessment Scale (Appendix D) was devised from six questions on the questionnaire, which included 25 assessment items, dealing with the extent to which family assessment is done. A reliability analysis on the scale showed the Cronbach's alpha level to be .924. A score was given to each respondent, according to each one's answers to the six questions comprising the Family Assessment Scale. The scores from the scale were then correlated with demographic data of the nurses, the settings in which they worked, their work experiences, work conditions, and educational backgrounds, using Pearson's r. Analysis of variance and Tukey's HSD test were used to determine differences in the scores of the four groups of nurses working in different settings. Analysis of variance and the Newman-Keuls procedure were used to analyze differences in the characteristics of the subjects and in the characteristics of the health care settings among the four groups of nurses. Analysis of variance and t-tests were used to determine differences in the scores of nurses who differed in the extent of their education.

It was found that most nurses do some family assessment, but few assess the family unit as a whole. The sample's mean family assessment score was 43% of the maximum possible points. As a group, the community health nurses scored the highest on the Family Assessment

Scale, followed by out-patient, school, and in-patient nurses in that order. Differences in family assessment scores among the four groups were significant between community health nurses and the other three groups, and between the in-patient and out-patient groups.

Variables which positively correlated with family assessment were (a) age, (b) experience in working with children, (c) experience in one's current nursing position, (d) having been taught family theory and how to do family assessments in nursing school, (e) having at least a baccalaureate degree in nursing, (f) having the encouragement to do family assessments by the nursing administration in one's work position, (g) being expected to assess families as part of one's nursing responsibilities, and having enough (h) time, (i) flexibility, and (j) contact with patients' families in one's position to allow for family assessment. Because the community health nurses were characterized by some of these variables to a significantly greater degree than the other three groups, it is difficult to determine the influence of health care setting alone on the practice of family assessment.

It was found that nurses generally observe families and communicate with the parent, child, and/or other staff when assessing families, rather than communicate with the entire family. Tools and models for family assessment

were seldom used. More than half of the sample usually gathered demographic data and information relating to family functioning when assessing families, such as the quality of parent-child relationships, the family's style of child care and discipline, and conflicts within the family. In general, however, the sample's family assessment practices appeared to be lacking in comprehensiveness.

Conclusions

In general, nurses identified family assessment as being a nursing responsibility. There was a positive correlation between nurses with high scores on the Family Assessment Scale and nurses who believed that the assessment of the family helped them to plan nursing care for the child, as well as to prevent or to alleviate family problems.

It was apparent that nursing curriculum content and educational level make a difference in the extent to which nurses later practice family assessment. The knowledge of and access to practical tools for family assessment might also be influential in this practice.

Because nurses in different settings did not practice family assessment to the same extent, efforts should be made to teach nurses how to make family theory applicable in a variety of settings. Since those who have been registered nurses longer and educated earlier did not assess families as extensively as more recent graduates, in service education in the area of family nursing should be offered for

their benefit.

Implications for nurse administrators include giving encouragement to nursing personnel regarding the assessment of families, and providing nurses as much time and flexibility as possible to implement family nursing care. A nursing administration which supports the family focus, employs adequate personnel, and gives nurses the autonomy to apply their skills in a self-directed way in providing individualized care, could help to create conditions that would promote comprehensive family care.

As professional nurses in all nursing settings are helped to develop their skills in family assessment and intervention through available educational means, the movement toward family nursing will progress. As nursing administrators develop ways of allowing nursing personnel the time and opportunities to widen the focus of intervention to include the family, the benefits of family nursing will be realized by nurses as well as families.

Limitations

Inherent weaknesses of a self-administered questionnaire include the possibility that the meaning of some questions could have been misunderstood and not brought to the attention of the investigator for further clarification. Due to circumstances at the clinical locations, the questionnaires were not distributed to the sample uniformly. The manner in which the questionnaires were distributed might have

influenced the amount of time which the nurses took to answer the questionnaires, as well as whether or not the nurses took time to ask the researcher about questions which they did not understand.

The sample was small and was not randomly selected. Therefore, the generalizability of the findings are limited.

Due to the large numbers of variables cited in the questionnaire concerning the nurse and the practice of family assessment, analyzing the nature of all of the related variables was beyond the scope of this study. For example, the nursing setting was correlated with the sum scores of the Family Assessment Scale rather than with all of the individual items which made up the scale, each of which would have a different level of significance in its relationship to work setting.

Recommendations for Further Study

The findings of the present study suggest several recommendations for further research. First, the questionnaire should be further tested and revised in order to improve its reliability and validity. Questions which have a doubtful interpretation should be eliminated, such as question 15. If the Family Assessment Scale is used separately from the questionnaire, then the reliability should be reexamined for the scale exclusive of the questionnaire.

Secondly, the study should be replicated using a random sample of nurses rather than those from selected agencies.

Nurses who do not necessarily work with children could be included. To investigate nurses' reports of their practice of family assessment, neutral raters could be used in order to obtain more objective information about the nurses.

Thirdly, further investigation should be done of the relationship between the teaching of family theory application in nursing curriculums with the students' application of family theory later as professional nurses. The present study indicated that there was no significant relationship between the nurses' scores on the family assessment scale and having been taught family theory application in nursing school. Perhaps by gaining more knowledge about factors affecting the nurses' clinical application of family theory, improvements can be made in family nursing education.

Fourthly, further studies in the use of family assessment tools which could be used in the clinical setting are also needed. The capacities of various tools to elicit accurate information about the family, particularly when only one family informant is available, could be compared.

In final summary, the findings of this study have provided a data base from which to design further research in family assessment. Such research will provide direction for increasing nurses' effectiveness in family intervention.

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APPENDIX A

CONSENT FORM FOR HUMAN RESEARCH

OREGON HEALTH SCIENCES UNIVERSITY

SCHOOL OF NURSING

CONSENT FORM FOR HUMAN RESEARCH

I,_____, agree
(First Name) (Middle Initial) (Last Name)
to serve as a subject in the study entitled "A Descriptive Survey of the Practice of Family Assessment in Nurses Who Work with Children", conducted by Patricia R. Temple, R.N., B.S.N., graduate student of nursing at the Oregon Health Sciences University, under the supervision of Sherry Boyd, R.N., Ph.D.

The aim of the study is to collect information about what nurses who work with children are doing in the assessment of their patient's families. In addition, background data about the nurses will be collected to see how it relates to assessment of families. The study requires me to complete a 20 minute questionnaire on my use of family assessment in nursing.

I understand that it involves no known risk to me. My name will not be requested on the questionnaire. All information I give will be handled confidentially. I may not obtain any direct benefit from participating, but understand that my contribution will help to expand the knowledge about what nurses are now doing in the assessment of the family.

I understand that I am free to withdraw from participation in this investigation at any time without affecting my relationship with, or treatment at, the Oregon Health Sciences University. Patricia Temple, (760-5143), has offered to answer any questions I might have about this study.

I have read the preceding explanation and agree to participate in this study, as described above.

Date_____ Signature_____

Witness_____

APPENDIX B

COVER LETTER AND QUESTIONNAIRE

Dear Participant,

In partial fulfillment of the requirements for a master's degree in nursing from the Oregon Health Sciences University, I am conducting a research study which is a survey on what nurses who work with children are doing in regard to the assessment of their patients' families. It is believed that this information could be helpful in the development of assessment tools, for educational planning in nursing, and as a basis for further nursing research.

You are invited to participate. This will involve filling out the attached questionnaire, which will take approximately 15-20 minutes of your time. It is requested that your name not be put on the questionnaire. Please answer each question in the way you believe to be most accurate. All information you give will be handled confidentially. If you have any questions about the questionnaire, please feel free to ask me.

Thank you very much for your participation.

Sincerely,

Patricia R. Temple
10050 S.E. Pardee St.
Portland, Oregon 97206

Family Assessment Questionnaire

Age_____ Sex_____ Employee Position_____

1. Do you have children at home between the ages of birth to 16 years? (Check one): yes no

2. How many months or years have you been an R.N.? _____

3. What is your highest level of nursing education preparation? (Check one): A.D. Masters Diploma Ph.D B.S.N.

4. If you checked Masters or Ph.D., in what discipline is your graduate education? _____

5. Are you a Nurse Practitioner? yes no

   If yes, how long was your program? _____

6. Did you learn how to do a family assessment in nursing school? yes no

   If yes, which nursing programs included this content? (Check one or more): A.D. Masters Diploma Ph.D. B.S.N.

7. Did your nursing program include content about family theory? yes no

   If yes, which nursing programs included this content? (Check one or more): A.D. Masters Diploma Ph.D. B.S.N.

8. Did your program include content about how to apply family theory in the clinical areas? yes no

   If yes, which nursing programs included this content? (Check one or more): A.D. Masters Diploma Ph.D. B.S.N.

9. How many months or years have you worked with children and their families?* _____

10. How many months or years have you had your current job? _____

11. Do you think that the assessment of the pediatric patient's family is part of the nurse's role and responsibility?
yes
no

12. Do you gather information about the family members of your patients?
usually
sometimes
rarely

13. Do you routinely assess each of the family members of the primary patient?
usually
sometimes
rarely

14. Do you make an assessment of the family units of most of your patients, some of them, or few of them?
most
some
few

15. If you answered "some" to question 14, which types of families do you assess? (Check one or more):

Families of severely ill children
Families of chronically ill children
Families of handicapped children
Families who visit often
Families who volunteer information
Other_____

16. How do you usually gather information about the family? (Check one or more):

Health record
Communication with child
Communication with parents
Communication with entire family
Communication with other staff
Observation of the family
Other_____

17. Do you interview the family members together?
usually
sometimes
rarely

* For the purpose of this questionnaire, the "family" is composed of two or more individuals, organized into a single unit, in order to perform certain family functions and attain certain goals.

18. When the entire family is not accessible, upon whom do you rely for information regarding family needs? _____

19. Which of the following information do you routinely find out about the patient's family? (Check all applicable):

Names and relationships of family members
Health history and health status of members
Socio-economic status
Closeness of family relationships
Quality of mother-father or husband-wife relationship
Quality of child-parent relationship
Quality of sibling relationships
Family coalitions
Family's style of child care and discipline
Occupations
Division of responsibilities
Ethnicity
Religion
Family geneology
Existence and/or importance of extended family
Conflicts within the family
Communication patterns within the family
Decision making patterns within the family
Stressors experienced by each member
Family's community involvement
Social support system
Other_____

20. Do you use a standardized tool to assess the family? yes no

If yes, what is it? _____

21. Do you use one or more theoretical models as the basis for your assessment? yes no

If yes, what is it? _____

22. Is the assessment of the patient's family required in your job?	yes no
23. Does the administration in your place of employment encourage the assessment of the child's family?	yes no
24. Does the physical layout in your place of employment allow for the assessment of the child's family?	yes no
25. How much contact do you have with the families of your patients?	frequent occasional infrequent
26. Does your job allow time for the assessment of family members?	usually sometimes rarely
27. Do you have the freedom or the flexibility in your job to spend the needed amount of time with your patient's families?	usually sometimes rarely
28. Do you record your assessment of the patient's family for your own and other staff's reference?	usually sometimes rarely
29. Does your assessment of the child's family help you in planning nursing care for the child?	usually sometimes rarely
30. In your estimation, does your assessment of the child's family help you in preventing and/or alleviating some family problems?	usually sometimes rarely

APPENDIX C

RATIONALE FOR QUESTIONNAIRE ITEMS

Rationale for Questionnaire Items

Questionnaire Items	Rationale	Sources
1. Demographic data: Children in the home Age Sex	Porter's study revealed that health care workers' ages and the presence of children in their homes affected their orientation to family-centered care.	Porter, 1979
2. Job experience: As an R.N. Working with children In the present position	Porter found that clinical experience of 10-13 years correlated positively to an attitude towards one's job which was conducive to maintaining a family-centered care orientation.	Porter, 1979
3. Extent of education	Porter found that the further the nurse had advanced in nursing education, the more the nurse was oriented to giving family-centered care.	Porter, 1979
4. Content of education	Little attention has been given to the systematic study of family in nursing curriculums, especially in the utilization of theories.	Eichel, 1978 Miller, 1978
5. Factors related to the nursing setting: Encouragement of assess families by nursing administration Physical layout of the job locale Family assessment is a requirement of the nursing position	Prerequisites for effectively working with families include being available and flexible in the time spent with them, having an environment conducive to the development of a therapeutic relationship with all family members, adequate personnel, and encouragement and support from a nursing administration who also has a family focus.	Eyres, 1972 Luciano, 1972a Luciano, 1972b Sedgwick, 1981

Questionnaire Items	Rationale	Sources
5. (continued) Frequent contact with the family Enough time allowed for family assessment Freedom and/or flexibility in the work setting		
6. Attitude about family assessment as a nursing function	(a) The worker's belief system, in particular the way that the health care role is viewed, affects the worker's orientation to family-centered care. (b) There is often resistence to the family approach due to the charged, emotional aspects of family life.	Porter, 1979 Framo, 1970
7. How family data is gathered: The use of tools and models Assessing each family member Assessing family units Interviewing the family together Communicating with the entire family Observation of the family Health record Communication with the child, parents, other staff	(a) Family assessment tools have recently been published in the nursing literature. (b) Each member contributes a unique perspective of his family and should therefore be recognized in making family goals to meet health needs.	Hymovich, 1979 Morgan and Macey, 1978 Friedman, 1980 Johnson, 1979 Luciano, 1972 Sedgwick, 1981

Questionnaire Items	Rationale	Sources
8. The kind of information which usually is gathered about the family	The literature shows certain information to be of importance in family assessment, including values, communication, roles, abilities to cope with crisis, families' impact upon the development of its members, and the influence of illness upon family functioning.	deGive, 1980 Framo, 1970 Friedman, 1980 Melicher, 1980 Sedgwick, 1981 Sobol and Robischon, 1975 Talabore and Graves, 1976
9. Results and benefits of the family assessment: Recorded for other staff Aids in planning nursing care for the child Prevents or alleviates family problems	(a) Small system changes can make great differences in total family functioning. (b) The data provided by the family assessment is essential for planning comprehensive care.	Framo, 1970 Johnson, 1979 Sobol and Robischon, 1975

APPENDIX D

FAMILY ASSESSMENT SCALE

Family Assessment Scale

(Q. 12) 1. Information is gathered about the family members of your patients: usually = 1; sometimes = 0.5; rarely = 0.

(Q. 13) 2. Each of the family members of the primary patient is routinely assessed: usually = 1; sometimes = 0.5; rarely = 0.

(Q. 14) 3. Assessment is made of family units of most, some, or few of your patients: most = 1; some = 0.5; few = 0.

(Q. 17) 4. Family members are interviewed together: unually = 1; sometimes = 0.5; rarely = 0.

(Q. 28) 5. The assessment of the patient's family is recorded for your own and other staff's reference: usually = 1; sometimes = 0.5; rarely 0.

(Q. 19) The following information is routinely gathered when you assess a family: yes = 1; no = 0.

6. names and relationships of family members
7. health history and health status of members
8. socio-economic status
9. closeness of family relationships
10. quality of mother-father or husband-wife relationships
11. quality of child-parent relationships
12. quality of sibling relationships
13. family coalitions
14. family's style of child care and discipline
15. occupations
16. division of responsibilities
17. ethnicity
18. family geneology
19. existence and/or importance of extended family
20. conflicts within the family
21. communication pattern within the family
22. decision making patterns within the family
23. stressors experienced by each member
24. family's community involvement
25. social support system

APPENDIX E

FAMILY ASSESSMENT SCORES

Family Assessment Scores

Score	Frenquency
0	1
.50	1
1.00	1
1.50	1
2.00	3
2.50	4
3.50	2
4.00	4
5.00	1
5.50	3
6.00	3
6.50	1
8.00	3
8.50	3
9.00	4
9.50	4
10.00	3
10.50	1
11.00	3
11.50	1
12.00	2
12.50	2
13.00	4
13.50	4
15.00	4
15.50	3
16.00	1
16.50	2
17.00	1
17.50	1
18.00	2
19.00	1
19.50	1
20.00	2
20.50	2
21.00	3
21.50	2
22.50	2
23.00	4
23.50	2
Incomplete	7
Total	99

ABSTRACT

AN ABSTRACT OF THE THESIS OF

Patricia R. Temple

For the MASTER OF NURSING

Date of receiving the degree: June 11, 1982

Title: A SURVEY OF THE PRACTICE OF FAMILY ASSESSMENT IN NURSES WHO WORK WITH CHILDREN

Approved: _____
Sherry Boyd, Ph.D., Thesis Advisor

This study is a survey of 99 nurses from four different settings for the purpose of determining the methods and degree of utilization of family assessment and the variables that correlate with its use. The nurses were employed in out-patient, in-patient, school, and community health settings, and all of them worked with children and their families. The subjects were selected on the basis of availability to the researcher.

Subjects were given a questionnaire dealing with their own background and the extent to which they assessed the families of their patients. The Family Assessment Scale was derived from items on the questionnaire dealing with the degree to which subjects assessed families. Intercorrelations between the subjects' scores on this scale and various factors about the subjects were made using Pearson's r. Comparisons were made among the four groups concerning the extent to which family assessment was

practiced and the factors which were found to correlate with this practice, using analysis of variance, t-tests, Tukey's HSD test, and the Newman-Keuls procedure.

Findings indicated that most nurses do some family assessment but few assess family units as a whole. As a group, community health nurses scored the highest on the family assessment scale, however the community health nurses also possessed certain characteristics which correlated with the practice of family assessment. The factors which related significantly to the practice of family assessment were identified and discussed. The implications of these findings include educational strategies and administrative practices which would encourage the practice of family assessment among nurses.