RELATIONSHIP OF COURSE OUTCOMES TO CONSUMER PERCEPTIONS OF SUPPORTIVE NURSE BEHAVIOR IN AN ASSOCIATE DEGREE PROGRAM

by

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CHAPTER I

INTRODUCTION

Since 1970, Mt. Hood Community College (MHCC) has been involved in constructing a competency based, career ladder nursing program leading to the Associate Degree in Nursing. In 1973, the faculty decided to more formally inquire into the felt needs of consumers and to use their ideas to evaluate course competency statements developed for the curriculum. Throughout this report, 'consumer' will refer to recipients of nursing services.

A grant proposal was submitted to the Department of Health, Education and Welfare titled "An Investigation of the Cost Benefits and Consumer Outcomes Related to Competency Based Education in a Nursing Program." The proposed project was designed to identify performance proficiencies at the aide, Practical (PN), and Associate Degree Nurse (ADN) levels; provide a description of the relationship between desired patient outcomes according to statements by selected consumers and student performance; and to provide comprehensive cost-benefit effectiveness analysis procedures.

Seven objectives for the proposed project were developed:

1. Define further the areas in which students will display competencies upon graduation from MHCC nursing program (program product behaviors).

2. Define competency and acceleration (program product area) for each nursing level within the MHCC program: aide, PN and ADN.

3. Set performance proficiency criteria for each behavior at the aide, PN, and ADN levels.

4. Define workable segments and sequences into which the curriculum could be divided.

5. Determine and strengthen the relationship between patient outcomes, program product behaviors and course behaviors.

6. Ascertain cost-benefit effectiveness for each course behavior and for each suggested curriculum alternative.

7. Suggest and later develop curriculum alternatives and extensions, each with proficiency level criteria (Dean, 1973, p. 3).

Appendix A provides a glossary of terms for the above list of objectives.

The current study was designed to provide data to meet objective number five: Determine and strengthen the relationship between patient outcomes, program product behaviors, and course behaviors.

Statement of the Problem

The goal of nursing care is that patient's needs are met. Nursing care is not limited to participation in medical treatments or to the expectations of the nurse. Most nursing curricula depend primarily upon faculty and administrative input for their structure and content. The consumer, though a valuable source of curricular information, is as yet unheard. There has been no mechanism established that will provide for effective collection of information from consumers and for its translation into surricular design. Consequently, this study was undertaken to elicit from consumers those behaviors they desired and expected from nurses (patient outcomes) and to use that data to determine the relationship between consumer specified behaviors and the course behaviors in the nursing program at MHCC.

Review of the Literature

The literature was searched for articles and research reports in which consumers participated directly in decision-making for health care services and education. No reference was found to show that advice by consumers has directly influenced curriculum development or

statements of performance criteria for program product. However, federal legislation passed in the decade from 1964 to 1974 has provided increased opportunity for consumer involvement. Experts from the health provider groups have spoken in support of consumer participation and have indicated methods by which this could be accomplished. A few reports were found describing consumer participation in the organization and evaluation of health care and health care facilities.

The Economic Opportunity Act of 1964 and the Civil Rights Act of 1967, set the stage for the consumer to become involved in decision-making for programs of vital concern to all. The Federal Community Action Programs called for "... maximum participation of local residents and members of groups served". They planned to "... mobilize and utilize resources within the community..." and to give preference to application for funds which were made by community action programs (United States Statutes at Large, Vol. 78, pp. 508, 509). A more recent act, the Health Maintenance Organization (HMO) Act of 1973, further emphasized the concept of consumer representation. The purpose of this act was to increase comprehensive health services to disadvantaged populations by providing funds to improve existing health facilities and to build new ones. It also provided for consumer representation as a means of ensuring that the services provided met the needs of the users of the HMO. Failure to adhere to the regulations or to provide quality care would lead to loss of funds (United States Statutes at Large, Vol. 87, p. 914). The Health Planning and Resources Development Act of 1974 has a provision which requires each Health Systems Agency to have a governing board of 10 to 30 members, the majority of whom must be consumers (DHEW publication No. 75-14015, p. 7). Barry (1969),

in agreement with the idea of consumer participation, wrote, "There is a principle in the concept of involvement: If a person becomes involved, contributes, learns, he develops the interest and commitment necessary to support findings and the community action (p. 229)".

A number of professional groups and individuals have made statements concerning the need for the consumer to participate in planning for health services. Brown (1948), an early investigator of nursing and nursing education, stated that we must "view nursing service and education in terms of what is best for society--not what is best for nursing (p. 11). She organized a Lay Advisory Committee to assist her during that study conducted immediately post World War II. Conway (1965), writing for the American Journal of Public Health, stated, "I cannot overstate the importance of involving the people we are trying to help in bringing about improvements for their benefit. Residents of target communities should be utilized at all levels of medical service" (p. 1786). Abdellah, speaking before the National League for Nursing Council of Baccalaureate and Higher Degree Programs (1972), noted that the professional schools were beginning to respond to society's need in their curriculum revisions. She stated that the consumer role in health care "will of necessity bring about changes in the way health care is delivered" (p. 4). The implication of the statements cited is that consumers must have opportunity to tell those in nursing education what is important in nursing care and that nursing education must respond to consumer concerns in ways which have a direct bearing upon the education and training of the nurse.

The Perloff Committee Report (1970) stated that a suitable mechanism should be developed to which the corporation (The American Hospital Association) could actively respond. The citizens of the community

would have a role in identifying how health services would be provided, to determining how care could be made more accessible, and the way in which delivery of care could best support the dignity of the individual and his family (p. 45).

The American Medical Association also expressed the need for the consumer to have a part in decisions regarding health care.

> Consumers have an obviously deep and primary interest in health services. The health professions alone cannot be the sufficient guardians of that interest. Consumers must have effective representation - whenever possible, a majority - in the policy making process of major health facilities and organizations. This representation must reflect all aspects of the community including cultural, racial, and linguistic diversities. Special emphasis should be placed upon meaningful representation of the poor (Report of the 37th General Assembly, 1970, p. 2193).

It was stated explicitly in the recommendations by the Oregon State Board of Education in 1973 that consumers should have direct access to decision-making in the nursing and allied health education programs at Mt. Hood Community College. This included the recommendation that the existing advisory committees to specific allied health programs be reorganized to include consumers. This recommendation was justified on the basis of the need for more diversified input into program development and evaluation.

Consumer Participation in Health Care Planning

An example of consumer participation in organizing health care centers was reported by Rabiner (1972), who detailed the purpose of a consumer advisory board organized to assist in the establishment of a satellite mental health center. The staff of Hillside Hospital, Glen Oaks, New York was asked by the city of New York to expand its mental health services. The community to be served was invited to participate

in decisions regarding the type of facility and programs which would be offered. The advisory board established would: 1) evaluate the center programs, 2) participate in planning priorities, and 3) implement community programs. Rabiner attributed the success of this project to two factors: the willingness of able groups and individuals in the community to contribute their time to obtain mental health programs for their community, and the willingness of the professional medical center staff to listen to concerns, to respect ideas, and to act on recommendations of the advisory board (p. 118).

Articles by Milio (1967), Hulka (1971) and Kane (1972), dealing with disadvantaged populations, indicate that while certain consumer groups may be insufficiently educated, they are able to verbalize their expectations from those who deliver health care. Milio involved the black ghetto neighborhood in organizing a maternal-child health center so that services offered would be "...consonant with the life of the people..." (p. 619). Kane's study of statements by Navajo consumers indicated that complaints were related to the manner in which they received care rather than to a lack of care. Their forceful replies to questionnaires indicated that the Navajo was eager to participate in making his health care facility more fully fit his needs. A low income population in South Carolina further emphasized the need for personal care. They perceived that doctors did not really care for them because the doctors rarely knew the patients' names (Hulka, 1971).

This impersonal quality of health care was exemplified by one of the largest health insurance organizations in the United States which did not accept representation from the community. According to Tyler

(1971), there was discontent expressed by members of the health insurance organization, largely relating to the impersonal quality of the health service. The board of directors was made up of four members from the health organization and others were businessmen, educators and doctors. The directors felt that efficient and economical functioning would be jeopardized by involving users in the decision-making.

A concern of professional nurses is that plans for care include the statement of goals of the individuals who are receiving nursing services. It is not possible to identify a plan which applies equally to all patients. Holmes (1967) states that it is not even realistic to expect patients to always get better as a result of being nursed (p. 329). What is important is that the goals identified by the client are determiners for the direction of the plan for care.

The goals identified by clients will, no doubt, include outcomes of health care, but also include aspects of what might be considered human rights--legal rights and rights which are felt to exist by the very nature of the relationship between patient and health care providers. These include: respect and concern for patients and assurance of competent care. Nurses must be involved directly and indirectly in assuring patients their human rights. Respect for patient's rights and a commitment to safeguarding them can be instilled early in a nurse's education through nursing curricula designed to develop awareness in students of their responsibility to the patient and his rights. (NLN Pub. No. 11-1671)

Evaluation of Nursing Care by Consumers

Asking patients to evaluate medical and nursing services in the

area is not new. In an older, but classic study, Abdellah and Levine (1957) developed a instrument to measure satisfaction of patients with the nursing care received. In the process of developing the tool, patients were asked to force-sort the satisfactory or unsatisfactory occurrences identified during hospitalization as a means of weighting the events for scoring purposes. The three events selected by patients as being of the very most importance to the quality of care were:

"Couldn't get anything from the nurse for pain."

"No answer to call for nurse for a long time."

"Had to wait a long time to use the bathroom." (p. 107)

An outcome of this study showed that patient satisfaction with nursing care increased in direct proportion to the number of registered nursing hours of care provided.

Ewell (1967) conducted a study of 100 patients in a hospital to discover what patients really thought about their nursing care. Outcomes of his study revealed that patients wanted greater personal care by all workers. Of the patients studied, none mentioned noise, food, or other hospital annoyances. One terse comment summed up the general feelings brought out by the study. "The nurses don't take care of you--all they do is give you medical care" (p. 108). According to the study, the area of nursing needing the most emphasis was personal, nonmedical bedside care and attention.

Caplan (1966) asked 400 patients to rank important variables which led to satisfaction with outpatient services. The major important variables were: 1) the belief that they were receiving quality medical care, 2) positive staff-patient relationships, and 3) positive feelings about clinic procedures. According to the author an interesting finding

of this study was that the nurse's role permeated the entire range of the patient's experience with the clinic. Contact with the nurse contributed both directly and indirectly to the patient's general satisfaction with the medical treatment and procedures. The study was not designed to identify the nursing behaviors which influenced the patient's positive attitudes.

White (1972) went a step further by identifying and listing nursing activities according to the following categories: 1) physical care, 2) psychosocial care, 3) observing, reporting, and implementing medical care, and 4) preparing for discharge. Three hundred patients and 100 nurses were then asked to rank these activities according to importance. Nurses tended to underrate the importance of physical care as compared with the rank given to this factor by patients. Nurses rated psychosocial care much higher than did patients. White's study was of value to this investigator because of the specificity of the nursing activities described.

Irwin (1973) asked other professionals to specify nursing behaviors which were helpful to the grieving. Twenty nurses, doctors and clergymen were asked to compile a list of statements which they perceived as being supportive. Twenty relatives of fatally ill persons were asked to rank these statements from most important to least important. The findings supported the idea that specific behaviors could be identified as being helpful when assisting those who are grieving. Examples of the high ranking statements appearing in the study were:

> Be honest with me
> Give me a clear explanation of what is being done and why
> Keep me informed of my relative's condition
> Always try to make my relative comfortable
> Show interest in answering my questions (p. 123).

Because of the focus of competency based education at MHCC, Irwin's study was important to this study in two ways: first, it clearly identified specific helpful behavior to be performed; and second, the study showed the need to examine in detail many facets of nursing care as a means of identifying the behavior in the goal of competency based nursing education. Appendix B lists the characteristics of competency based education and of the nursing program at MHCC.

Summary

The review of the literature addressed the participation of consumers in decision making regarding education and performance criteria for personnel in health services. Specifically, no reports could be found in which consumers directly influenced the development of curricula or the statements of terminal behaviors desired in nursing.

Nursing and medical spokesmen agreed that consumers must participate in matters concerning health care "...at all levels..." (Conway, 1965, p. 1786), and that curriculum revisions must show responsiveness to stated consumer needs. The Oregon State Board of Education recommended strongly that consumers have direct access to decision making in the nursing and allied health education programs at MHCC.

In 1957, Abdellah and Levine asked patients to describe nursing activities as a means of constructing a tool for evaluation satisfaction with nursing services. A result of that study showed that patient satisfaction with nursing care was in direct proportion to the number of Registered Nurses on duty. Studies by Ewell (1967), Hulka (1971), and Kane (1972) showed that consumers were concerned that they be given 'personal care', and the patients in White's study (1972) ranked aspects of physical care more highly than psychosocial aspects of care.

As a result of federal legislation (Economic Opportunity Act of 1964, and the Health Maintenance Organization Act of 1973) consumers began participating in planning and administering health service programs. The effectiveness of consumer participation is evident, yet no studies have been reported in which consumers were directly involved in the planning of educational preparation of health professionals, including nurses.

Purpose of the Study

The purpose of this study was to identify, with the assistance of a consumer advisory committee, those nursing activities which were perceived by them as being helpful, supporting, and/or important in health care situations. The findings were expected to provide information to meet objective number five in the MHCC project titled, "Investigation of the Cost Benefits and Consumer Outcomes Related to Competency Based Education in a Nursing Program". These statements were then compared with the program-product outcomes in the nursing curriculum at Mt. Hood Community College.

The following questions were considered important to the study and were the basis for the method of study:

1. How do members of the consumer advisory committee perceive the practice of the nurse?

    1.1 Do the opinions of the committee members remain constant regarding the practice of the nurse after participating in a process of defining nursing behaviors?

    1.2 Are there significant differences in the opinions of the committee members regarding the practice of the nurse as compared to the opinions of a larger group of consumers?

2. What is the relative value placed on the desired outcomes of nursing care as seen by patients?

3. To what extent do the statements of the desired nursing behaviors generated by the consumer advisory committee compare with the MHCC nursing program course behaviors and terminal behaviors as specified by faculty?

CHAPTER II

METHODOLOGY

Selection of Advisory Committee

A consumer advisory committee was chosen to provide statements of supportive nursing behavior. The types of medical and nursing care experiences and demographic variables to be represented by the members of the committee were determined by the nursing faculty of Mt. Hood Community College. The following list was derived:

Health care setting

- Psychiatric clinics and wards
- Priviate physician or group offices
- Community or neighborhood clinic
- Maternity clinics and wards
- Visiting nurse home visits
- Nursing homes
- Pediatric clinics or wards
- Medical-surgical wards

Type of illness experience

- Acute or short term
- Life threatening
- Chronic or long term

Population variables

- Representative of socio-economic groups
- Representative of minority groups
- Equal male-female representation
- Age range from 11 - 65 (or older)

Faculty members, using the above criteria, agreed to contact individuals known to them who might be willing to serve on an advisory committee. Specific agencies were also contacted by the investigator requesting a representative for the committee from that agency. All persons who gave affirmative responses were telephoned by the investigator to explain the project further, to answer any questions the

prospective committee member might have, and to discuss best time and day for meetings. A letter followed the telephone call, again explaining the project and thanking them for their willingness to participate (see Appendix C).

There were no representatives from pre-teen, or aged groups and none from nursing homes. A number of contacts were made by faculty members and the investigator to pediatrician's offices, pediatric departments, nursing homes, churches and senior citizen's centers without success. However, of the members selected, several had aged relatives who were recently hospitalized or in nursing homes. One member had several children who had experienced severe, long-term illnesses and who had used a number of children's services, both private and public. Appendix D summarizes the characteristics of the twelve individuals who were selected for the advisory committee.

Perception of the Nurse's Practice

An instrument was constructed in which the advisory committee members were asked to give their perceptions of certain dimensions of the practice of the nurse using a 5-point Likert-like scale (1932). Appendix E provides samples of the instructions, clinical facility protocol and the survey tool "Perception of the Nurse's Practice." Nine dimensions of the nurse's practice were developed as follows: 1) Visivility--How obvious are nurses relative to others; 2) Urgency--how important is it that the nurse do what she does, when she does it; 3) Necessity--how necessary are the nurse's activities in relation to other health care agents; 4) Scope--what proportion of patients are cared for by nurses; 5) Impact--what proportion of patient's problems receive care from nurses; 6) Value--relative to the

contributions of others, how much of the final outcomes of health care are determined by what nurses do; 7) Independence--how independently do nurses direct their own activities in providing health care; 8) Responsibility--relative to the responsibility of others, how much are nurses "at fault" if things go wrong; 9) Accessibility--how easy, compared to the accessibility of other personnel, is it for a patient to "get to" nurses. In addition, they were asked to respond to the following questions using the same scale: 1) Compared to the man on the street, how knowledgeable are you about nursing? and 2) Can you readily distinguish a registered nurse from other health care personnel? Verbal and written instructions specified that "nurse" would mean registered nurse.

This survey was given to the selected advisory committee members at the beginning and at the end of the group sessions. Their perceptions on each item on the survey were tested for consistency using a simple sign test for differences (Kerlinger, 1964,pp. 260-263).

As a means of determining if this small, select advisory committee could be considered a representative sample of consumers, MHCC students and faculty distributed the same survey instrument to a number of patients receiving health care in a variety of settings. The only criteria for receiving a form were: availability, willingness and ability to complete the form. The differences in median responses of each group to each item on the survey were compared using the sign test. If there had been a significant difference in the results of the two surveys, confidence that the data collected from the advisory committee was representative of consumer perceptions would have been reduced.

Group Work Sessions

Over an eight month period the participants met eight times. Table 1 summarizes the adtivities, number in attendance, and the date of each meeting. Those in attendance from the college included the project director, research assistant, secretary and a faculty person (the investigator). Other college representatives attended on occasion. The agenda for each session follows:

Session 1. Project staff, the coordinator of MHCC nursing program and the investigator introduced themselves and expressed their belief in the importance of the consumer advisory committee to nursing education. The committee members were then asked to introduce themselves and give a brief description of their health care experiences.

Explanation of desired outcomes of the project was given. An effort was made to emphasize that the MHCC nursing faculty viewed the consumer advisory committee as a powerful source of information for defining patient-nurse relationships. It was stressed that their feelings, thoughts, and experiences, both positive and negative, in health care settings were valid and needed to be reflected in nursing instruction.

Teaching session: The skills necessary for the advisory committee to specify their reactions to nursing care experiences in desired nurse behaviors were first outlined in an educational strategy by Lindsley (1964). This strategy is referred to as Precise Behavior Management or Precision Teaching. The specific portion of this strategy used in teaching the advisory committee was termed "pinpointing". Five rules apply as a test for a properly pinpointed behavior: 1) It must be a complete movement, (have a beginning and an end); 2) it can be repeated; 3) it can be observed by others (the only exception

TABLE 1

Summary of Consumer Advisory Committee Group Sessions
For Generating Desired Nursing Behaviors

Session	Date	**Number in Attendance	Activities
1	15 Nov 73	11	1) Introduction; 2) explanation of the desired outcomes of project; 3) teaching session 1; 4) homework assignment; 5) pre-group process perception survey
2	6 Dec 73	12	Reviewed homework lists and recorded all statements and ideas (3 subgroups)
3	13 Dec 73	11	1) Teaching session 2; 2)restated items negatively pinpointed, clarified items too broadly stated (3 subgroups)
4	3 Jan 74	7	Refined previously stated behaviors that did not meet pinpoint rules (2 subgroups)
5	24 Jan 74	8	1) Categories presented, reviewed, and suggestions received; 2) ranked categories with no setting specified; 3) began ranking specific behaviors within categories (2 subgroups)
6	31 Jan 74	8	1) Continued ranking specific behaviors within categories (2 subgroups); 2) ranked general categories considering the hospital the setting
7	7 Feb 74	8	1) Ranked general categories when office is considered as the setting; 2) completed ranking behaviors within categories; 3) ranked categories when community is the setting. (Post-group process perception survey mailed to members after this session)
8	6 June 74	7	Presented results of study and asked for conclusions the group might draw from the information

**Those absent tended to be the same persons leaving a nucleus of eight who attended all the meetings.

to this rule is "feelings" which are observable only to oneself); 4) it must pass the "dead man's test" (must show active, not passive behavior); 5) it must pass the "stranger test" (more than one person could agree on demonstrated instances).

During the teaching session, examples of common, everyday behavior, such as managing children, were used to illustrate the pinpointing technique. A video-tape was shown and the group was asked to describe the activity on the film using pinpointed statements. Finally, participants were given opportunity to practice pinpointing nursing behavior. There was enthusiastic response during this teaching session and all members had at least two opportunities to practice pinpointing. A homework assignment was given in which committee members were asked to list as many nursing behaviors as possible for the next session. They were encouraged not to be limited by rules 3,4, and 5 as stated above. A tape recording was made of the teaching session in order to provide an absent member with similar preparation for the second session.

Session 2. For this session, committee members were randomly assigned into three groups of four members each. Each group had a nursing/project staff member acting as a recorder. The entire two hours was devoted to recording statements and ideas resulting from the homework assignment. No attempt was made to elicit nor refine statements made by the committee members during this session.

During the week following the second session, the statements were reviewed by the investigator and adequately pinpointed statements were listed. In addition to desired performance, there was also a very long list of negatively stated behaviors. In other words, nurses were doing things of which the patients disapproved. Since the focus of the

study was on the behaviors to teach nursing students, it was necessary that these negative statements be reworded positively by the committee members. A number of very broadly stated ideas were also recorded which would need defined in more detail.

Session 3. Homework statements which were insufficiently pinpointed were used as teaching examples. The pinpointing rules were reviewed and the committee members again practiced pinpointing the behaviors in the statements from the second session which needed further refinement.

Using the same three groups and recorders, the advisory committee spent the remainder of the session restating and clarifying statements from the previous session. Appendix F provides examples of negatively stated behaviors and the subsequent rewording by the advisory committee.

Session 4. Two subgroups of the advisory committee (bad weather kept one-third of the members home) continued the refinement process. From the last two sessions, some obvious categories of nurse behavior were observed; for example: 'teaches' and 'explains'. Advisors were asked to expand these ideas. The group also continued working on nonspecific ideas such as 'is adaptable' and 'tries to remedy patient's problems'.

Although the refinement process could have continued, staff found that attempts to get more information in certain categories produced a decrease in participation. For that reason, the refinement and generation process was discontinued. Some of the behaviors were not as clearly defined as desired but met, for the most part, a minimum level of acceptable specification.

In the interval between meetings, all nursing behaviors were listed by the investigator under twelve general categories which were suggested by the statements of the advisory committee. See Appendix G for complete lists of statements within each category.

Session 5. A portion of the time was given to the advisory committee to review and discuss the general categories and the lists of behaviors compiled since the last session. They were invited to suggest changes in both categories and items listed under each category. There were no changes forthcoming so the members were asked to rank the twelve general categories according to importance with twelve the highest and one the lowest.

Each of the behaviors generated by the consumers was typed on a separate 3x5 card, and decks of these cards were made up for each category of behaviors. Using two subgroups, each deck of cards was arranged in order of relative value to the consumer. It was necessary for the subgroup to gain consensus on the relative value of each behavior. The utilization of two groups reduced the likelihood that one member would, by persuasion or status in the group, bias the relative value of individual behaviors. Possibly it also took less time for a smaller group to gain consensus.

The mechanics of this Q-sort technique were as follows: 1) the behaviors under each category were initially sorted into eight stacks with stack number eight having the most important, and stack number one having the least important behaviors; and 2) the cards were sorted so that each of the eight stacks contained an equal or specified number of behaviors. Table 2 shows the minimum and maximum number of allowable cards for each of the eight stacks. For example, the category 'Provides

TABLE 2

List of Behavior Categories Showing the Number of Behaviors Within Each Category and the Number of Behaviors to be Sorted into Eight Ranks

Category Name	Behaviors in Category	Behaviors Allowed Under Each Rank Minimum	Maximum
Makes Patient Feel Important	40	5	5
Provides Individualized Care	39	4	5
Works Safely	8	1	1
Gives Physical Care	38	4	5
Teaches	17	2	3
Is Adaptable	3	0	1
Explains	28	3	4
Has Pleasant Manner	14	1	2
Respects Privacy	12	1	2
Gives Support to Grieving and Terminally Ill	8	1	1
Relays Information	11	1	2
Positively Interprets and Follows Agency Policy	6	0	1

Individualized Care' contained 39 behaviors which were to be divided into eight piles. There was to be at least four cards in each pile and some piles would contain five cards. In retrospect, the Q-sort seemed a prudent methodology since the initial tendency of the group was to place all behaviors in the highest rank. The cards were not ordered within each of the ranks. Examples of ranking sheets are provided in Appendix H.

Session 6. The entire session was spent ranking the behaviors within categories as described in Session 5. At the close of that session, committee members were asked to rank the general categories again, this time in order of importance with the hospital specified as the setting.

Session 7. At the beginning of this last work session, the committee members were asked to rank the general categories of behavior with the doctor's office specified as the setting. They were then asked to complete the task of ranking the behaviors within categories. The procedures for ranking behaviors and categories of behavior were the same as has been previously described.

At the conclusion of the session, the consumers were asked to rank the behavior categories with the community specified as the setting. See Appendix E for the protocol for designating a particular health care agency as either hospital, office or community setting. The rankings for general categories according to the three settings and with no setting specified were analyzed for agreement by computing a coefficient of concordance (Kendall's W, Kerlinger, 1964, pp. 267-270).

Because members were expressing fatigue with the session, it was decided that the post-group process perception measure would be mailed to the participants. Using the same form as that used at the first

session, the committee members gave their opinions regarding the value of the nurse's practice in order that their responses could be compared for change as a result of being a member of the group. A sign test was computed for differences in opinion on each item on the survey (Kerlinger, pp. 261-263).

Examination of the information obtained by ranking and the impression of the research staff regarding committee consensus appeared, at first, to reveal a discrepancy between the value of behaviors achieved by ranking and the advisory committee's statements about what was desirable. On the one hand, physical care items were designated as most important, yet most conversation by the committee members involved personalization aspects of care. For this reason it was decided to divide the behavior categories into two groups, one of which would reflect personalization behaviors and the other, technical aspects of care. The categories of behavior were divided as follows:

Personalization categories

Makes patient feel important
Provides individualized care
Teaches
Explains
Respects privacy
Gives support to grieving and terminally ill

Technical categories

Relays information
Works safely
Gives physical care
Has pleasant manner
Positively interprets and follows agency policy

The percentage of personalization and technical behaviors appearing within each value group were plotten on a graph. The result of this maneuver did help to clarify the questions regarding the outcomes of the study as well as results of White's study (1972) cited in the literature.

Relationship of Specified Behaviors to MHCC Program

It was the purpose of the study that the MHCC faculty compare the statements of desired nursing behavior generated by the advisory committee with the course and terminal behaviors in the curriculum in nursing. In order to achieve this purpose, it was necessary to obtain two pieces of information in addition to the statements of desired nurse behaviors. First, did course content include the behaviors desired by consumers and second, did the students perform desired behaviors in their clinical practice?

Comparison with Course Content

Each behavior generated by the advisory committee was printed on a 3x5 card and faculty were asked to indicate which term and in which course a particular behavior was introduced. The items were tallied by school term and plotted on a graph for the eight terms of the program.

Students Perform Desired Behaviors

Project staff and faculty felt it would not be possible for students to adequately monitor their performance of all 225 behaviors which were generated by the advisory committee. For this reason it was decided by the project staff to monitor 20 of those in the highest rank and 20 in the lowest rank. Each behavior was assigned a numerical value based on the product of its category ranking (the mean of the ranking by the advisory committee) and its within category ranking (the mean of the ranking by the two committee subgroups). For example, a behavior with a high ranking number within categories (8) multiplied by the high category ranking (10.55) would equal 84.4. A behavior ranked 1 within its category multiplied by the mean rank of its category

(5.7) would equal 5.7. The 225 behaviors were then listed according to numerical value from most important to least important and the 20 highest and 20 lowest valued behaviors were selected for students to monitor in a clinical setting (see Appendix I). The students kept a daily record of correct performances and "learning opportunity" (LO) performance of the selected behaviors as indicated over a seven week period during spring quarter, 1974. MHCC nursing faculty had defined a learning opportunity performance as: 1) error made in performance of behavior, 2) opportunity missed to perform behavior, or 3) added information gained during performance of behavior.

To guard against skewing of the data by including behaviors first year students had not learned, each class was divided in half, one half monitoring lower valued behaviors and one half monitoring higher valued behaviors. Students were not informed of any value by the consumer group. Group A was the higher valued group and Group B was the lower valued group of behaviors.

The type of clinical sites used by first year students during the data collection were psychiatry, obstetrics and pediatrics; by second year students, psychiatry, obstetrics, pediatrics, nursing home and medical-surgical wards. Appendix J provides a sample of the form used by students for tallying their performance of valued behaviors.

Each week the students submitted the tally sheets to the project secretary. She totaled the number of performances of the most and least valued behaviors and plotted an average daily frequency on graphs. (See Appendix K). The graph used for this project was a semi-logarithmic, six cycle graph allowing 120 days of data to be recorded. This graph was

the same as that used by the MHCC students and faculty to monitor daily frequencies of course and program product behaviors. The students monitored only 200 minutes of the total time spent during a clinical experience day. The graph reflected the actual student average frequency for 200 minutes as well as estimated daily frequency. Appendix K gives an explanation of the method of interpreting data points on the graph.

CHAPTER III

RESULTS

The report of the results of this study was divided into three sections: 1) the comparison of the advisory committee opinions concerning a nurse's practice before and after the group process and with the opinions of a larger group of consumers; 2) the listing and ranking of supportive nurse behavior as generated by the consumer advisory committee; and 3) the comparison of the advisory committee generated statements of important nurse behaviors with curriculum objectives and student performance.

How do the Members of the Consumer Advisory Committee Perceive the Practice of the Nurse?

The data for this section were examined for: 1) the responses of consumer advisors regarding their perception of the nurse's practice in hospital, office and community settings; before and after the group process, and 2) significant differences between these responses and the responses of a larger sample of consumers.

The overall rating of the practice of the nurse was defined as a composite of nine dimensions by which the nurse could be perceived by the consumer. These were: 1) Visibility - how obvious are nurses relative to others; 2) Urgency - how important is it that the nurse do what she does, when she does it; 3) Necessity - how necessary are the things the nurse provides care for in relation to other health care agents; 4) Scope - what proportion of patients are cared for by nurses; 5) Impact - what proportion of patient's problems receive care from nurses; 6) Value - relative to the contribution of others, how much of the final outcome of health care is determined by what nurses do; 7) Independence - how

independently do nurses direct their own activities in providing health care; 8) Responsibility - relative to the responsibility of others, how much are nurses "at fault" if things go wrong in each setting; 9) Accessibility - how easy, compared to other personnel is it for a patient to "get to" nurses in each setting. The overall rating was derived by tallying the number of responses given for each scale value (1 through 5) for all the dimensions on the survey. The totals were plotted on a graph for each scale value. See Appendix L for responses to individual items on the survey.

According to the data, the advisory committee members gave high ratings to the practice of the nurse in a hospital setting. Sixty-two responses were given for ratings 4 and 5, while only twelve were given for the low ratings. There were 46 middle (3) responses. Opinions regarding a nurse's practice in office and community settings were essentially evenly distributed. There were forty high (4 and 5) ratings and forty low (1 and 2) ratings in the office setting and the community setting showed 22 to 26 responses for all rating numbers except one Only three items were rated very low in the community setting.

Analysis of individual items on the opinion survey showed that in all items except one, the nurse's practice in the hospital was judged very important by the advisory committee. For the item "Impact" (What porportion of patient's problems receive care from nurses?) in a hospital setting, the consumers showed no polarity; giving predominately middle (3) responses.

For each item in the community setting, there was considerable variation in opinion as to the importance of a nurse's practice. For items Visibility, Responsibility, Accessibility for a 'feelings' problem, the

group indicated consensus that the function was unimportant. In other words, nurses were seldom visible; they were not responsible when something went wrong; they were seldom available for help with a 'feelings' problem.

Analysis of each item in the office setting showed sharp polarity, resulting in a middle rating by the total group. Those items given low ratings were: Impact; Value for a physical problem; Independence, Responsibility, and Accessibility for a 'feelings' problem. The data implied that there was consensus by the advisory committee that in an office settings; 1) a small proportion of patient's problems received care from registered nurses; 2) nurses contributed little to the outcomes of health care for a physical problem; 3) nurses were more dependent on others to direct their activities; 4) nurses were not at fault if something went wrong; and 5) nurses were not very accessible to patients for help with a 'feelings' problem. However, the average difference between dimensions was not sufficient to alter the conclusions which were drawn by examining the distribution of overall ratings.

Examination of the response of the advisory committee concerning their ability to distinguish a nurse from other health care personnel showed that they were sure who was a nurse only in the hospital setting. Two persons on the advisory committee felt that they could not distinguish a registered nurse in a hospital setting; nine were sure they could. However, in the office and community settings, there was no consensus about ability to distinguish a nurse. Despite confusion over a nurse's practice and distinguishability in office and community settings before the group process had occurred, the advisory committee members rated

themselves more knowledgeable about nurses than the average person.

Do the Opinions of the Committee Members Remain Constant Regarding the Practice of the Nurse After Participating in a Process of Defining Nurse Behaviors?

Comparison of the advisory group's responses to the value of the practice of the nurse at the end of the project shows very little change in distribution for the three settings (Figure 1). The sign test for differences showed no significant difference between the responses of the advisory group before and after the group process. The data in Figure 1 showing before and after distribution of responses to the survey, suggests that subsequent to working as a group, a slightly higher rating of the nurse's practice occurred in all settings. Even with the slight difference in rating, these data would suggest that the perception

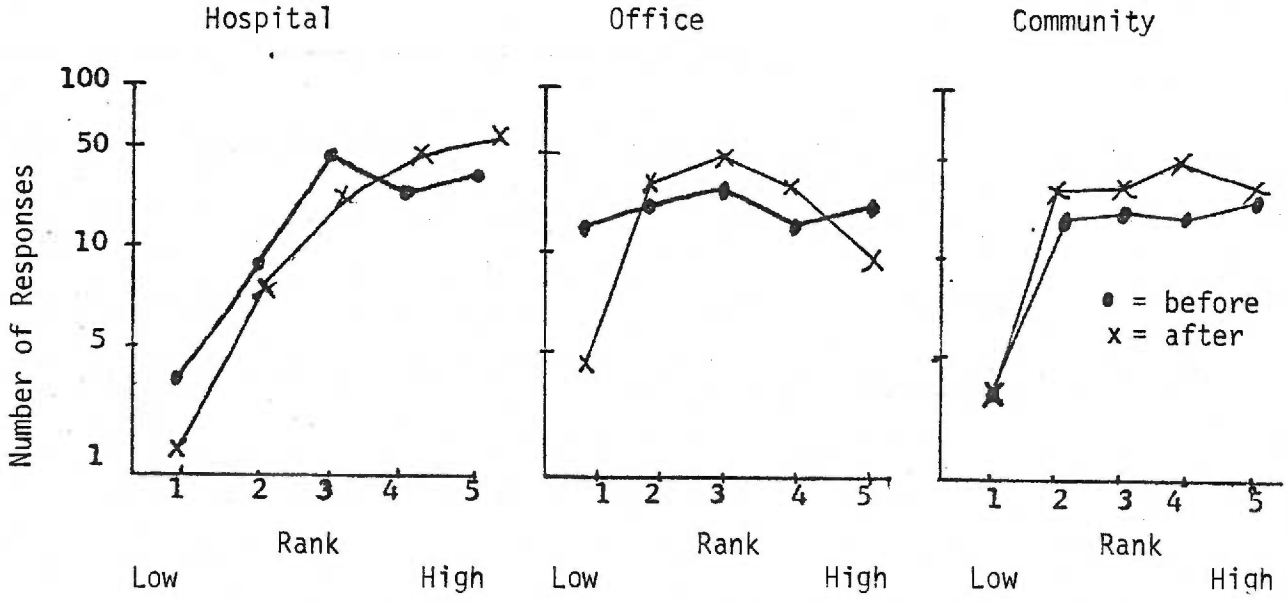

Figure 1. Distribution of consumer advisory group responses to the overall value of the nurse's practice in hospital, office and community settings before and after the group experience.

of the consumer advisory committee regarding the practice of the nurse remained remarkable stable. These surveys were administered three months apart and during the intervening time the participants were generating and ranking important nurse behaviors.

Are There Significant Differences in the Opinions of the Committee Members Regarding the Practice of the Nurse as Compared to the Opinions of a Larger Group of Consumers?

The following data provide a comparison of the perceptions of those persons who derived the list of nursing behaviors with the perceptions of a larger sample of consumers. In addition to comparing responses on the survey instrument, the two consumer groups were also compared as to demographic characteristics. Appendix D summarizes the demographic information collected on both groups.

Distribution of the ratings given for the nine dimensions of the nurse's practice follow the same general pattern for both groups in all settings. Both groups gave high rating to nursing practice in the hospital setting, but showed less ability to gain consensus when office and community settings were considered. The larger consumer sample showed a tendency toward unimportant ratings for the nurse's practice in these latter two settings; giving 92 low responses and 85 high responses to the items on the survey for the community setting, and 115 low responses and 89 high responses for the office setting (see Figure 2). The sign test (Kerlinger, 1964, p. 261), computed for differences in median responses to each item on the survey tool by both consumer groups showed no significant difference at 0.05 level of significance.

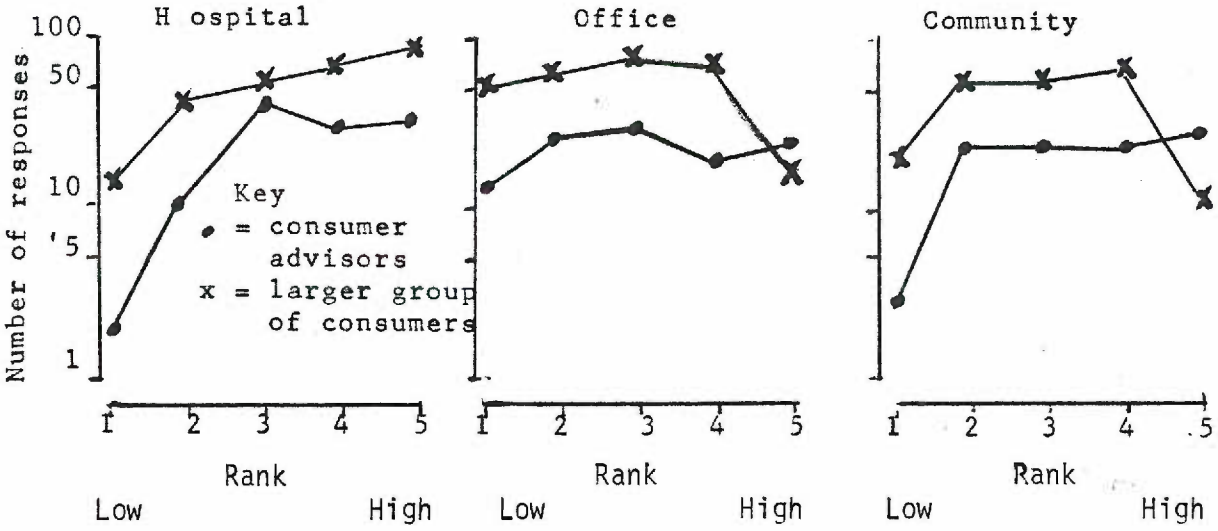

Figure 2. Distribution of responses of consumer advisors and a larger group of consumers regarding the nurse's practice in hospital, office and community settings.

The larger consumer group, along with the advisory group, indicated that they were confident that they could distinguish a registered nurse in the hospital settings. They also agreed with the advisory group in that they were not sure that they could distinguish a nurse in the community and office settings. As a matter of fact, the larger group indicated that they could not distinguish a nurse in the community setting; giving 10 low responses and 7 high responses to the item. Despite the fact that both groups showed some indecision regarding the nurse's practice and her distinguishability, they rated themselves more knowledgeable about nurses than the average person (Figure 3).

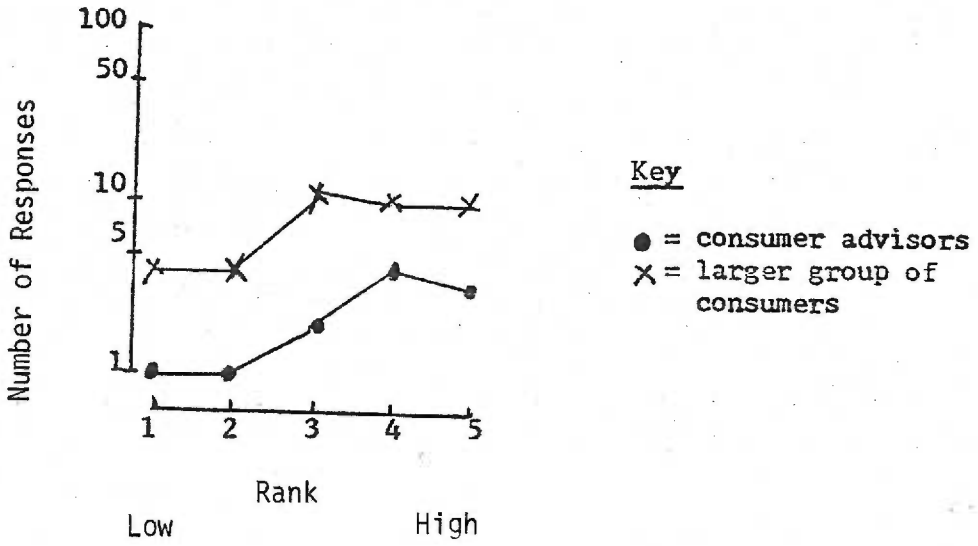

Figure 3. Distribution of consumer responses to the question "Compared to the man on the street, how knowledgeable are you about nursing?"

What is the Relative Value Placed on the Desired Outcomes of Nursing Care as Seen by Patients?

The consumer advisory committee met for seven sessions for the purpose of generating and placing a relative value on each desired nursing behavior. The committee generated 225 different nursing behaviors (see Appendix G). These behaviors were grouped into twelve descriptive categories and the categories were ranked for relative importance when considered in relationship to: hospital, office and community settings, and with no setting specified. Table 3 provides a listing of the categories of nursing behavior and the ranking given by the advisory committee for all settings.

TABLE 3

Listing of General Categories of Nursing Behavior and Ranks Given These Behaviors According to Setting and with No Setting Specified.

CATEGORIES	RANK BY SETTING			
	None Specified	Hospital	Office	Community
Gives Physical Care (relieves discomfort)	12	12	12	5
Works Safely	11	11	10	9
Provides Individualized Care	10	9	11	12
Makes Patient Feel Important	9	10	9	11
Gives Support to Grieving and Terminally Ill	8	6	7	6
Teaches	7	2	3	10
Explains	6	8	5	7
Respects Privacy	5	4	8	8
Has Pleasant Manner	4	7	6	4
Is Adaptable	3	1	2	1
Relays Information	2	5	4	3
Positively interprets and Follows Agency Policy	1	3	1	2

A rank order correlation coefficient (Kendall's Coefficient of Concordance: W) was computed for consistency of ranking among the consumer advisory committee members for the three settings and when no setting was specified. Table 4 summarizes these coefficients. There was no significant correlation when the categories of desired nursing behaviors were considered in an office or community setting. Only when no setting was

specified or in a hospital did the advisors agree to the relative value of the categories of behavior.

TABLE 4

Rank Order Correlation Coefficient (Kendall's W) for Consistency Between Consumer Advisory Committee Members Values of General Categories of Behavior When Considering: Hospital, Office, Community Setting, and None Specified.

Location	Correlation Coefficient	Unrelated at .01 Level of Significance
Hospital	.29	rejected
Office	.18	accepted
Community	.10	accepted
None Specified	.34	rejected

In addition to ranking the categories of behavior, the consumer advisors ranked individual behaviors within categories from high to low. Since two subgroups of the committee produced a rank for each behavior, a mean rank was computed. By taking the product of the mean rank for general categories of behavior and specific behaviors within categories, it was possible to assign a numerical value for each behavior generated. Appendix I lists each behavior, ranked in order of value with group 1 containing the highest valued behaviors and group 10 the lowest valued behaviors. Included in Appendix M is a summary of individual behaviors as distributed within the value groups.

The largest number of behaviors of the 22 higher valued behaviors

are within the category "gives physical care". That category also contains the third greatest number of items. The categories "provides individualized care" and "makes patient feel important" contain the behaviors most widely distributed over the ranked list of important behaviors and constitutes 36 per cent of the total number of behaviors generated.

As a result of a seeming discrepancy between the results of ranking behaviors and conversation by consumers about what was important in nursing care, the categories were divided into two groups, one showing personalization behaviors and the other relating to technical aspects of care. Figure 4 clearly shows that of the highly valued behaviors in group one, 74 per cent relate to technical aspects of care. However, after initial high rating for technical skills, the proportion of personalization behaviors predominate in all groups.

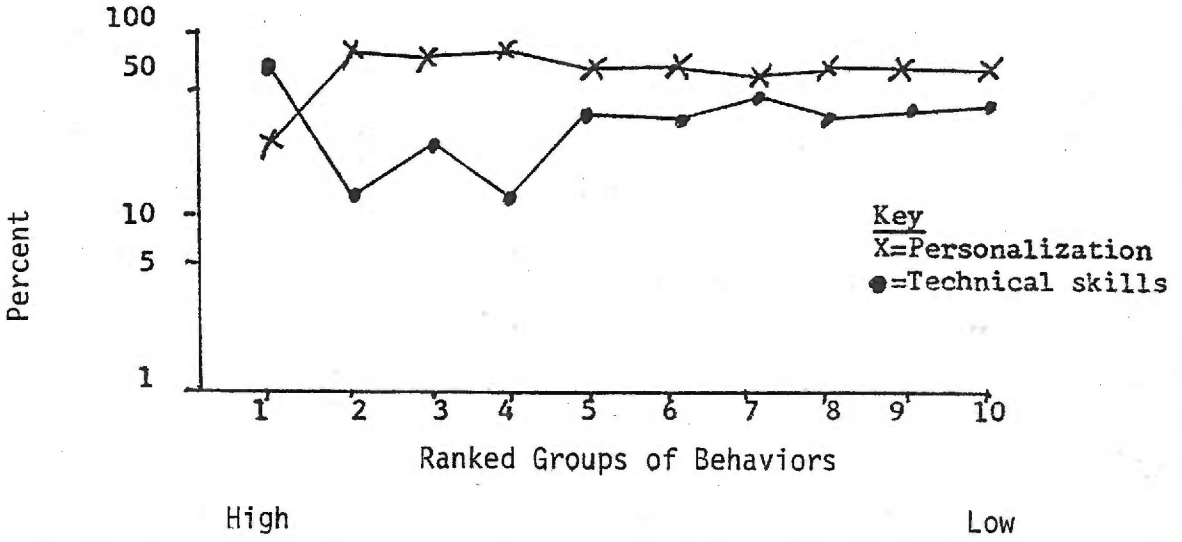

Figure 4. Proportion of Personalization Behaviors and Technical Skills in Each of 10 Groups of Behaviors Generated by the Consumer Advisory Committee and Ranked from High to Low.

To What Extent do the Statements of the Desired Nursing Behaviors Generated by the Consumer Advisory Committee Compare to the MHCC Nursing Program Course Behaviors and Terminal Behaviors as Specified by Faculty?

Faculty Assessment of Course Content

Examination of the relationship of the nursing behaviors generated by the consumer advisory committee to the Mt. Hood Community College nursing program revealed that only one of the behaviors could not be found in materials relevant to the nursing curriculum. The behavior not found in the nursing curriculum was: " Retire if nursing becomes just a job".

Figure 5 shows the distribution by quarter and year during which identified behaviors were introduced into the nursing curriculum. By the end of the second quarter, 85 per cent of the behaviors were already identifiable in the curriculum. By the end of the fourth quarter, 93 per cent of the behaviors had been introduced, leaving only seven per cent of the behaviors unique to the second year of the nursing program. Of the fifteen behaviors remaining to be introduced during the second year, ten of them were from the four highest valued groups of behaviors.

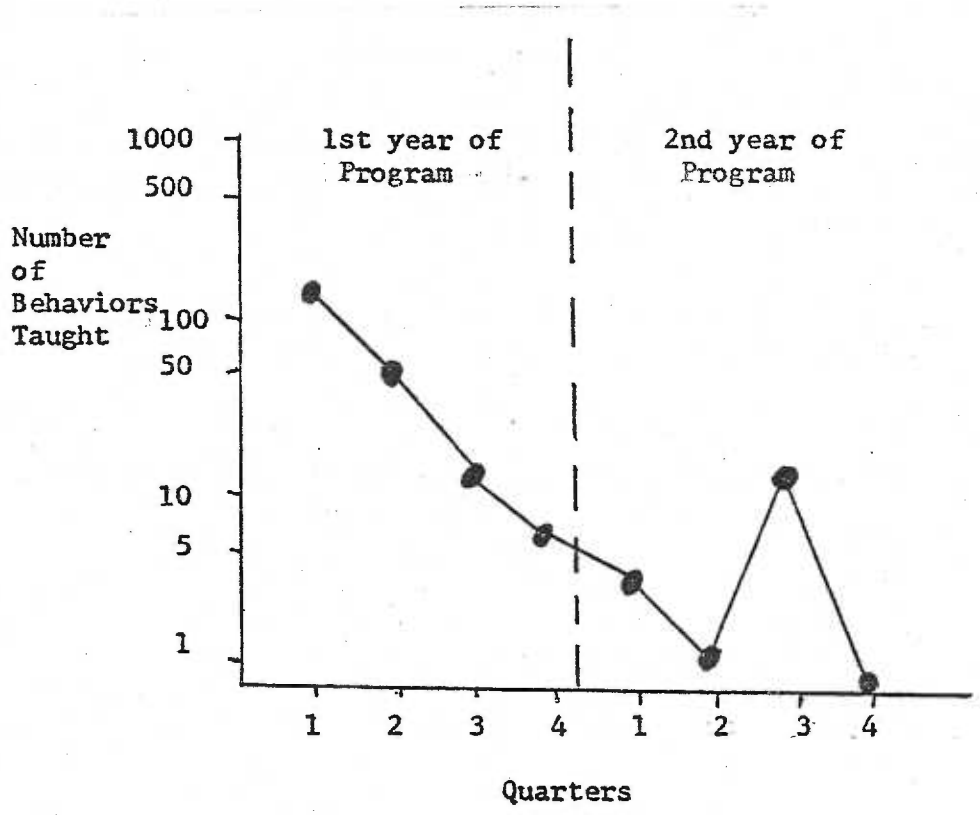

Figure 5. The occurrance of behaviors identified by the consumer advisory committee distributed by quarter and year in which they were introduced in the nursing program at Mt. Hood Community College.

Student Performance Monitoring of Behavior

Figure 6 shows combined frequencies for behaviors performed correctly as well as "Learning Opportunity" performance. The average daily frequency for all students of the most valued behaviors (see Appendix J for data sheet and list of specific behaviors) was 90 performances per day per student (19 in 200 minutes) at the beginning of the monitoring period. The mid-rate of the first and seventh week was reported. Some days the behaviors were performed up to 200 per day per student or 40 in 200 minutes, as shown in the third week of data in

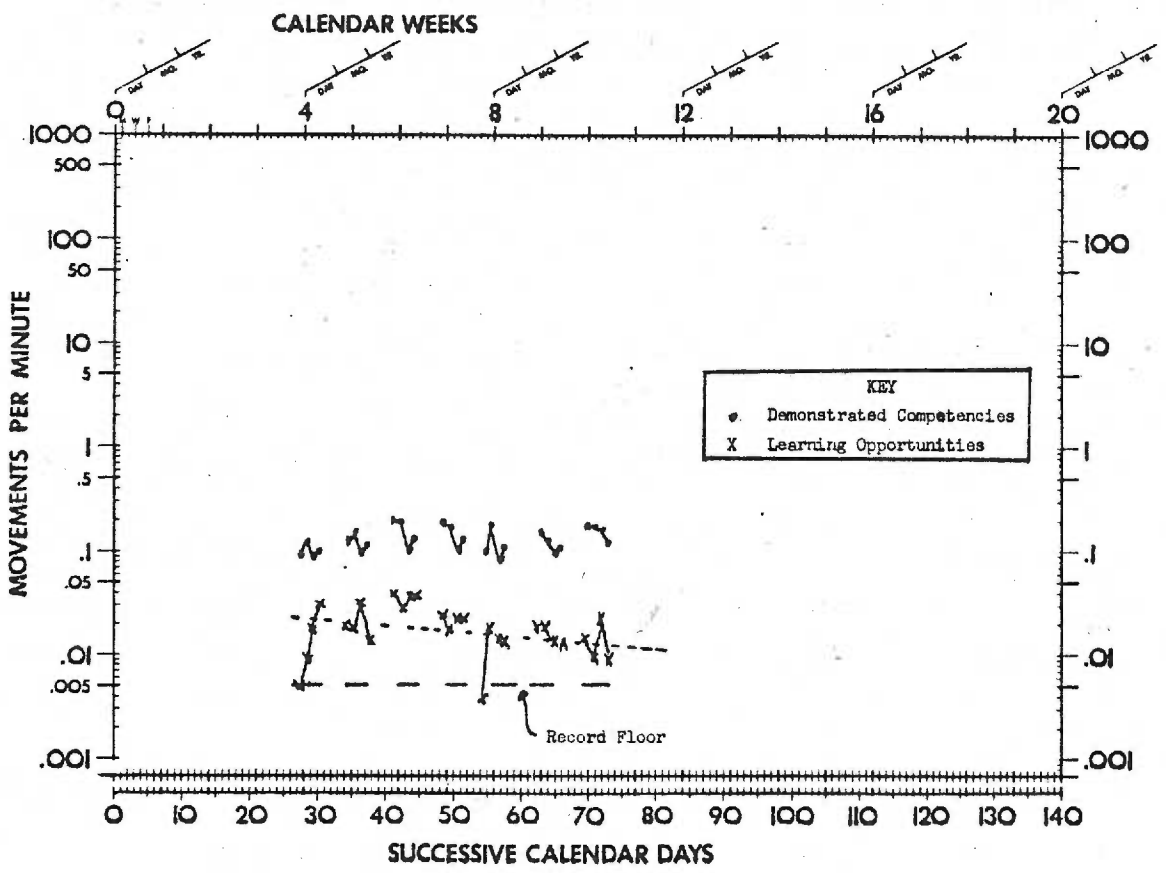

Figure 6. Average daily performance of all student nurses for the most valued consumer generated nursing behaviors

Figure 6. In other words, each student's average performance of the desired behaviors was once every 7 to 10 minutes. The students were increasing their performance of the desired behaviors 1.1 times each week. Learning opportunity performance was reported by all students at 10 to 12 times per day per student. At the end of the monitoring period, students were averaging 170 performances of the valued behaviors each day, or 34 in 200 minutes. Explanation of the daily behavior chart and charting conventions are contained in Appendix L.

The performance of second year students for most valued behaviors averaged 120 correct performances per student per day throughout the

monitoring period (or 22 in 200 minutes), and they reported seven learning opportunity performances per day or about one in every 160 minutes. There was a great deal of variability from day to day for second year students, which may reflect the different sites of clinical experience (see Appendix K).

First year students increased from 90 to 170 correct performances of the most valued behaviors per student per day over the seven week period (or 18-33 performances in 200 minutes). This amounts to a growth rate of 1.15 per week. Their learning opportunity performance decelerated (1.3 per week) during the same period.

Examination of the performance of the twenty least valued behaviors showed that for all students combined, correct performances was 150 behaviors per day per student, or one every 7.5 minutes at the beginning of the term (see Figure 7). By the seventh week they were performing 280 behaviors per day, or one every 4.25 minutes. Students were involved in monitoring for 200 minutes during clinical experience and were selecting their own sample time. Students selected the time during which interaction with patients was most frequent. Additionally, it must be understood that the actual performance by students is that which occurred during 200 minutes of monitoring. The daily frequency reported is a prediction based on the 200 minute sample.

The results by year in the program demonstrated that second year students and first year students' performance of least valued behaviors showed similar frequencies except for slight growth by the first year students. Frequencies for first year students accelerated

from 160 per day to 270 per day (32-54 in 200 minutes) over the seven week period, while second year students maintained a frequency of 190 performances per day averaged over seven weeks. They showed greater variability from day to day as well. (See Appendix K.) Explanations and speculations for the differences in frequency, celeration and variability will be offered in the following section of this paper.

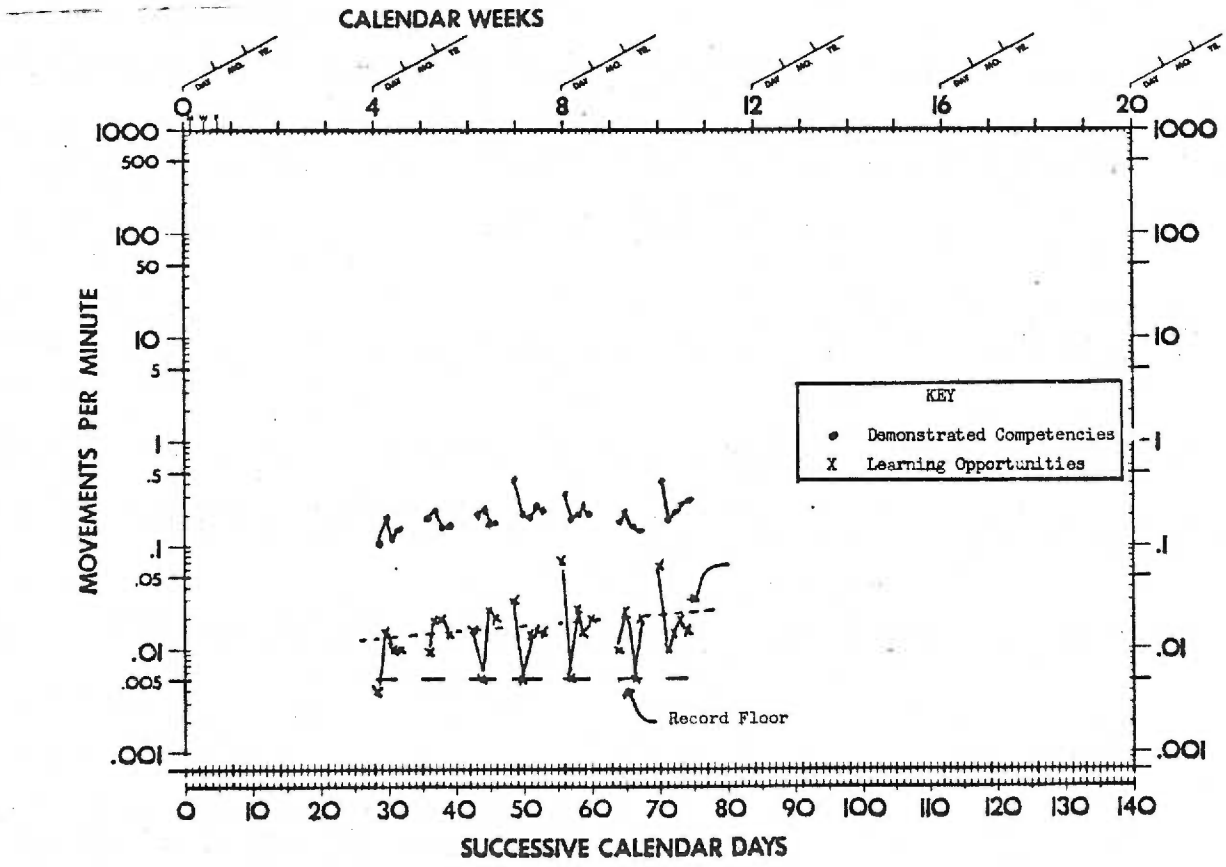

Figure 7. Average Daily Performance of all Student Nurses for the Least Valued Consumer Generated Nursing Behaviors.

CHAPTER IV

DISCUSSION

This study was a part of a larger study done by Mt. Hood Community College titled "Investigation of the Cost Benefits and Consumer Outcomes Related to Competency Based Education in a Nursing Program: (1972). A consumer advisory committee was charged with identification of nursing behaviors which they considered helpful, supportive, and/or important in health care situations. These statements were compared with course behaviors and student performance in the nursing program at MHCC. The discussion follows the sequence of questions posed in the statement of the problem after brief discussion of methodological considerations.

The concern of the project staff throughout the study was that there be reliable information to report. The advisory committee was, of necessity, small since the project staff wanted to have free discussion and opportunity to teach the committee members a technique of specifying behavior called "pinpointing". The method of selecting participants of the committee could not be considered random since the project staff and MHCC nursing faculty set criteria for participants and then suggested persons who would fit the criteria. Some members were known to the faculty and others were suggested by health care facilities personnel who recommended consumer members for the committee. However, the tests conducted during the study showed the committee to be representative of a larger population and able to contribute reliable data.

Using the survey tool at the beginning and end of the consumer advisory session, it was found that the opinions of the committee members did not change significantly as a consequence of working on the committee. This implied, in effect, that the project staff provided

very little bias from the original opinion and did not appreciably sway the opinions of the committee during the process of identifying nurse behaviors. It is true that only one of the project staff working with the committee was a professional nurse. The very slight change toward increased value of the nurse's practice in the post session survey was not statistically significant.

The opinions of the advisory committee regarding the practice of nursing was also compared with the opinions of a larger group of persons currently receiving medical care. There was no significant difference in the opinions of the two groups. Given the method used of passing out surveys to anyone able and willing to fill them out; in clinics. hospitals, doctor's offices, community agencies, it seemed reassuring that there were so many similarities between the two groups. Confidence in the selected advisory group as a viable source of curricular information was strengthened by the outcomes of this comparison and in the pre and post survey of the advisory committee. This result suggests that the complex method of assembling and working with this group might, in the future, be unnecessary. Apparently, useful and reliable data can be obtained using a single or short-term approach.

How Do the Members of the Consumer Advisory Committee Perceive the Practice of the Nurse?

The Perception of the Nurses Practice Instrument described nine dimensions of nursing practice. The responses of the consumer advisory committee showed that nurses were only identifiable as nurses in the hospital setting. This finding occurred in spite of the fact that these participants considered themselves quite knowledgeable about nurses.

When one considers that the most valued behaviors for nurses are more frequently performed by nurses in the hospital setting, this finding does not seem so contradictory. The variability of analysis of each item in the other settings suggests that nursing may need to better educate the public of its role in settings other than the hospital. This seems particularly appropriate in light of changes occurring in health care delivery systems.

What are the Desired Outcomes of Nursing Care as Seen by Patients; and the Relative Value they Place on Them?

Examination of the information collected and the impression of the research staff regarding committee consensus appeared, at first, to reveal a discrepancy between the value of behaviors achieved by ranking and the advisory committee's statements about what was desirable. On the one hand, the physical care category was given the highest rank, yet most conversation by the committee members described personalization aspects of nursing care. By dividing the behavior categories into two groups, one of which would reflect personalization behaviors, and the other, technical aspects of care, the data showed that of the 23 behaviors most highly valued, 17 of them related to physical care skills (74 per cent). However, the proportion of personalization behaviors predominated in the remaining groups of behaviors.

It appears that patients assume and expect technical competence when they are cared for by nurses. It is of highest importance to them that their physical integrity be maintained. After that, the relationships with nurses which become most important are those which meet the patient's personal needs and enhance his feelings of self-worth.

These data may help explain the results of White (1972), who found that patients valued physical care more highly, while nurses valued more highly and believed patients wanted psychosocial aspects of care. Obviously, patients value both aspects of care very highly. Nursing is a blend of the two and not easily separated. Yet, when asked to rank important behaviors patients rated as most important those behaviors affecting their physical well-being.

To What Extent are the Statements of the Desired Nursing Behaviors Generated by the Consumer Advisory Committee Similar to the MHCC Nursing Program Course Behaviors and Terminal Behaviors as Specified by Faculty?

It was interesting to discover that 83 per cent of the 225 important behaviors which the advisory committee generated, had been introduced by the end of the first two terms of the nursing program (aide level). Two conclusions were drawn from this data: 1) persons receiving health care want certain behaviors demonstrated toward them by all levels of nursing personnel, and 2) MHCC faculty had appropriately incorporated these behaviors into the curriculum early.

By the end of the fourth term, there remained only seven per cent of the committee generated behaviors which had not been introduced to students in their nursing courses. Students were by that time, eligible to take the licensing examination for practical nurses. Those behaviors remaining to be introduced were in the area of leadership, advanced skills, decision-making, referral, and patient advocacy. Because these behaviors are the responsibility of registered nurses, the placement of these behaviors in the second year of the MHCC program was considered appropriate

The performance monitoring by students of the behaviors generated by the advisory committee was carried out during a term when students were in the specialty areas of obstetrics, pediatrics and psychiatry. It was feared that the results would show false low frequencies in many instances, by virtue of students not having opportunity to perform specific behaviors. However, the data revealed that the average performance of desired behaviors was consistently high.

The consistency with which the behaviors occurred appears to demonstrate that the consumer generated behaviors are such that they are applicable to nursing practice regardless of specialty area. This study confirms the findings reported in studies of patient expectations in the practice setting (White, 1972).

First year students showed more growth (acceleration) over time than did second year students. It seems reasonable to expect that first year students would be more actively seeking to apply the many new concepts they had learned and that second year students were stabilizing their performance. Also, the fact that only seven per cent of the behaviors were judged by faculty as unique to the second year would tend to level out the frequency of performance of the behaviors to a maintenance level.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Since the 1967 Economic Opportunity Act, the consumer has been taking an increasingly prominent role in planning, implementing and setting policies for health services. While professionals have stated that patients have a great deal to contribute, nursing education has yet to devise a mechanism whereby consumers can have direct access to the process of curriculum development.

Mt. Hood Community College, in an attempt to evaluate and refine a competency based nursing program, created a consumer advisory committee whose task was to state nursing behaviors they viewed as important in health care situations. Two hundred twenty-five behaviors were listed under twelve general categories. The categories were ranked according to three settings: hospital, office and community, and with no setting specified. The data revealed that the consumers were in agreement about the ranking of nursing behaviors for hospital setting and when no setting was specified, placing the category "Gives Physical Care" highest in order of importance. However, they could not agree about the ranking of nursing behavior for the office and community settings. Of the 225 behaviors generated, physical care items initially ranked highest, but subsequently those behaviors related to personalization of nursing care were given higher rank. Consumers wanted to be treated as individuals and be given all the support and information needed for successful health care experiences. Along with personalized care, they assume technical competence, which if not provided, caused great anxiety. For this reason, the

advisory group in this study and possibly patients in other studies (White, 1972), rated those behaviors relating to physical care above personalization behaviors initially.

All the behaviors except one were found in the competency statements of the nursing curriculum, and 93 per cent of them were introduced by the end of the first year. Daily recording by students in the MHCC program of the twenty highest ranked behaviors showed that students performed those behaviors at a high average daily frequency.

Conclusions

Based on findings of the study, the following conclusions were warrented:

1. Consumers are willing and able to give valuable information concerning health care and should provide input about health education and service situations.
2. Consumers feel most confidence in nurses who combine technical competence with skill in psychosocial aspects of nursing care.
3. Course competency statements at MHCC fulfilled to a high degree the important nurse behaviors as seen by consumers.
4. The faculty at MHCC needed to incorporate competencies which test for attitudes, leadership, professionalism and self evaluation.
5. Competency based nursing education is a valuable means of ensuring the inclusion of learning activities related to those behaviors considered important to consumers.

Recommendations

Two recommendations to be made should this study be replicated are: 1) Select a committee with wider representation from ethnic groups, and 2) have students monitor performance of behaviors selected at random from the entire list of consumer generated behaviors, rather than the 20 highest and 20 lowest ranked behaviors.

A third recommendations for further study would be to identify different behaviors in specialty areas of nursing practice.

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APPENDICES

APPENDIX A

Glossary

Terms Used in Project Objectives

Acceleration -- shows increase in frequency of any behavior over time and can imply growth or learning. Using a six-cycle, semi-logarithmic graph, students plot daily frequencies for program product behaviors. At the end of the specified period of time, they draw a line of best fit using the quartersect method (Pennypacker, (1972). The upward slope is acceleration and indicates learning or it can also indicate an increase in frequency of undesired behaviors. The downward slope is deceleration which can indicate loss of desired behavior (regression) or it can also mean that the student has decreased performance of undesired behavior. A straight line shows maintenance. Students always monitor and graph a negative and positive pair (or an opposite pair) in order to more clearly define what is happening (i.e., "personalizes patient care" and "depersonalizes patient care".

Competency -- refers to the scientific and technological adequacy and to the judgment, integrity, skills and capability to utilize currently available knowledge in health care.

Course Behaviors -- the outcomes of nursing courses in which expected behavior (performance) is stated with expected speed and accuracy criteria.

Frequency -- the daily behavior chart used at MHCC allows a student to graph movements (behaviors) per minute per day. It allows for accumulation and assessment of absolute number data as well as the averaging data.

Patient Outcomes -- those behaviors which consumers (patient, client, employers) desire and expect from nurses who care for the health needs of others.

Program Product Behaviors -- curriculum outcomes of the nursing program. They are the feelings which demonstrate sensitive caring relationships and the behaviors in which the student has demonstrated proficient performance. They are divided into the following categories:

1. Interpersonal relationships

2. The use of nursing concepts. Concepts stressed at MHCC are: assessment, safety, efficiency, personalization, teaching, intervention and comfort.

3. Feelings about patients, the nursing profession, and nursing care given by students.

APPENDIX B

Characteristics of

Competency Based Education

Characteristics of Competency Based Education

1. Instruction designed in such a way that the educational goals are specified as the behavior for the learner to achieve.
2. Attainment by the learner of some specified criteria or level of proficiency of the specified behaviors.
3. Providing the learner opportunity to acquire and demonstrate specific behavior.
4. Defining required behaviors necessary for any given competency according to logical sequence.
5. Pre-testing the learner in relationship to a sequence of behaviors.
6. Providing an instructional system that will allow the student to self-pace.
7. Post-testing the learner for a measure of his knowledge and skill in relation to specific functions.

Characteristics of Mt. Hood Community College Nursing Program

Mt. Hood Community College embraces the concepts of the above behavioral approach and at the time of this study was further characterized by:

1. Frequency and celeration (change in frequency over time) measurement of behavior in classroom and simulation settings.
2. Direct and continuous frequency measurement of specified behaviors in field practicum settings.
3. An emphasis on doing as opposed to write or say behavior.
4. Analysis of the effect of the instructor, instructional settings, and instructional events on learner performance (competence).
5. Multiple entry, multiple exit components.
6. Opportunities for students to design a portion of their curriculum.
7. A career ladder approach to nursing at the Aide, Practical Nurse and Associate Degree Nurse levels.

APPENDIX C

Letter to Prospective Committee Members

November 2, 1973

Dear

We appreciate very much your agreement to participate on a Consumer Advisory Committee. The efforts of this Committee, with your help, will enable us to examine a very important health care issue. This issue is related to those nursing activities which are seen by patients as being helpful during health care situations.

The results of the information gathered will play an important part in a project that is attempting to refine the Mt. Hood Community College Nursing Education Program. If we are successful in doing this, there can be obvious improvements made in health care.

Since this effort is supported by an HEW grant, we are fortunately in a position to reimburse you at the rate of $15.00 per meeting, to help offset any expenses incurred as a consequence of your participation on this Committee.

There are two stages to this task, the first of which must be completed by November 30. This first stage will be compiling lists of nursing activities that you see as important in health care situations. This will require that we meet approximately 6-7 times for two to three hour periods.

The second stage will involve testing with patients the lists compiled by the Committee. During this testing period further meetings will be held. The help you will give at this time will be of a more advisory nature in which we would ask you for your comments and suggestions on the results.

Ms. Gene Crumpton, who is on the nursing faculty at Mt. Hood Community College, will coordinate our efforts in reaching our goal as a group. She can be contacted at Mt. Hood, 666-1561, Ext. 122. You are invited to contact her about any concerns you might have about this project.

We will follow this letter immediately with a telephone call to find out what would be the best time to meet for our first meeting.

We are looking forward to working with you.

Sincerely,

Gene Crumpton,R.N.
Instructor, Nursing Program

Martin Waechter, Ph.D.
Project Director

Diane H. Dean,R.N., Ph.D.
Coordinator, Nursing Program

APPENDIX D

Personal Information Sheet

and

Summary of Personal Data

Consumer Advisory Information Sheet

1. Name _____

2. Address _____

   _____

3. Age _____

4. Sex _____

5. Marital Status _____

6. Number of Children _____

   _____

   age sex age sex age sex

   _____

   age sex age sex age sex

7. Describe your most recent illness _____

   _____

   a. length of care _____

   b. check where health service was delivered:
      home _____
      hospital _____
      office _____
      community facility:
         private _____
         public _____

   c. if your stay was in a hospital, were you considered a teaching patient:
      yes ____ no ____

   d. was your illness covered by insurance?
      yes ____ no ____

8. Occupation _____

9. Educational history (circle one):

   elementary school high school college bachelor degree

   advanced degree

Summary of Personal Data for
Advisory Committee and Larger Consumer Sample

	Advisory Committee	Larger Consumer Sample
Number	12	32
Age -- Median	42	40
Range	17-65	17-65
Marital Status --		
Married	11	
Single	1	
Sex -- Male	6	16
Female	6	16
Service Received --		
Hospital	10	30
Office	3	15
Community	4	13
Length of Care --		
Median	39 days	19 days
Range	4-105 days	2-360 days
Teaching Patient --		
Yes	1	12
No	10	19
Education --		
Elementary	2	5
High School	4	15
College	1	12
B.A.	3	5
Advanced	2	5
Occupation --		
Professional	2	8
Skilled	1	9
Unskilled	1	4
Student	3	5
Housewife	4	3
Retired	1	5

List of Illnesses Incurred by Survey Participants

Consumer Advisory Group

- Run over by a dump truck
- Pneumonia
- Heart Disease
- Diabetic
- Open Heart Surgery
- Stomach Pains
- Skull Laceration
- Leg Amputation
- Mastectomy
- Mental Illness
- Hysterectomy
- Kidney Transplant

Larger Consumer Sample

- Birth of Child
- Heart Problems
- Prostate Problems
- Ulcer-related Problems
- Gall Bladder Operation
- Broken Hand
- Back Surgery
- Body Operation
- PPD Test
- Ulcer
- Kidney Cyst
- Cataracts
- Broken Clavicle
- Broken Leg
- Pneumonia
- Burns
- Back Operation
- Heart Failure
- Tremor
- Ulcer
- Bladder Repair
- Hysterectomy
- Traction for Back
- Cirrhosis of the Liver
- G.I. Bleeding
- Pancreatitis
- Pre-natal Care
- Emphysema
- Illness
- Osteoarthritis
- Broken Leg
- Broken Wrist
- Hypochondria
- Sciatic Nerve Pain

APPENDIX E

Perceptions of the Practice of the Registered Nurse

Protocol for Health Care Settings

Hospital

General Hospital
Specialty Hospital (i.e., maternity)
Extended Care Facility
Nursing Home
Home for the Elderly
Hospital Out-Patient Department
Emergency Room, Diagnostic/Therapeutic Department,
i.e., Physical Therapy, X-Ray

Office

Private Physician's Office
Private Physician in Group Practice
Health Maintenance Organization Office or Clinic (Kaiser)

Community Service

Neighborhood Clinics
Federal, State, County Health Clinics
Public Health Nurse
Home Care

Mt. Hood Community College Nursing Project
Consumer Survey

Considering all those responsible for delivery of health care (doctors, aides, therapists, etc.), how would you see (rate) the registered nurse in the following areas:

1. Visibility (How obvious are nurses, relative to others)

   a. Hospital — LO 1 2 3 4 5 HI
      (never visible) (always visible)

   b. Office — 1 2 3 4 5
      (never visible) (always visible)

   c. Community — 1 2 3 4 5
      (never visible) (always visible)

2. Urgency (How important is it that the nurse do what she does, when she does it, on time, etc.)

   a. Hospital — 1 2 3 4 5
      (not important) (very important

   b. Office — 1 2 3 4 5
      (not important) (very important)

   c. Community — 1 2 3 4 5
      (not important) (very important)

3. Necessity (How necessary are the things the nurse provides care for in relation to other health care agents.)

   a. Hospital — 1 2 3 4 5
      (unnecessary) (very necessary)

   b. Office — 1 2 3 4 5
      (unnecessary) (very necessary)

   c. Community — 1 2 3 4 5
      (unnecessary) (very necessary

4. Scope (What proportion of patients are cared for by nurses.)

a. Hospital

LO HI
1 2 3 4 5
(none) (all)

b. Office

1 2 3 4 5
(none) (all)

c. Community

1 2 3 4 5
(none) (all)

5. Impact (What proportion of patient's problems receive care from nurse.)

a. Hospital

1 2 3 4 5
(none) (all)

b. Office

1 2 3 4 5
(none) (all)

c. Community

1 2 3 4 5
(none) (all)

6. Value (Relative to the contributions of others, how much of the final outcomes of health care are determined by what nurses do)

Physical Condition:

a. Hospital

1 2 3 4 5
(none) (all)

b. Office

1 2 3 4 5
(none) (all)

C. Community

1 2 3 4 5
(none) (all)

6. Value (continued)

Feelings of Patients:

a. Hospital

LO 1 2 3 4 5 HI

(none) (all)

b. Office

1 2 3 4 5

(none) (all)

c. Community

1 2 3 4 5

(none) (all)

7. Independence (How independently do nurses direct their own activities in providing health care.)

a. Hospital

1 2 3 4 5

(dependent on others) (act independently)

b. Office

1 2 3 4 5

(dependent on others) (act independently)

c. Community

1 2 3 4 5

(dependent on others) (act independently)

8. Responsibility (Relative to the responsibility of others, how much are nurses "at fault", as you see it, if things go wrong in each setting?)

a. Hospital

1 2 3 4 5

(not at fault) (totally at fault)

b. Office

1 2 3 4 5

(not at fault) (totally at fault)

c. Community

1 2 3 4 5

(not at fault) (totally at fault)

9. Accessibility (How easy compared to the accessibility of other personnel is it for a patient to "get to" nurses in each setting?)

For a Physical Problem:

a. Hospital

LO 1 2 3 4 5 HI
(very difficult) (very easy)

b. Office

1 2 3 4 5
(very difficult) (very easy)

c. Community

1 2 3 4 5
(very difficult) (very easy)

For a Feelings Problem:

a. Hospital

1 2 3 4 5
(very difficult) (very easy)

b. Office

1 2 3 4 5
(very difficult) (very easy)

c. Community

1 2 3 4 5
(very difficult) (very easy)

10. I can readily distinguish a registered nurse from other health care personnel in a service delivery setting.

a. Hospital

1 2 3 4 5
(never) (always)

b. Office

1 2 3 4 5
(never) (always)

c. Community

1 2 3 4 5
(never) (always)

11. Compared to the "man on the street", how knowledgeable are you about nursing?

1 2 3 4 5
(less knowledgeable) (more knowledgeable)

12. What is the most important activity in which a nurse engages?

APPENDIX F

Examples of Negatively Stated Behaviors and Revisions made by Consumer Advisors

Examples of Negatively Stated Behaviors
and Revisions made by Consumer Advisors

Ignored patient	Direct entire attention to patient when with him
Was unsympathetic	Offers sympathy but not too much
Didn't offer explanation without patient asking	Takes time to explain things to patient
Gave patient feeling she was too busy to take care of needs	Visit patient early to ask about his needs
Makes patient feel guilty at requesting services she should automatically give	Offer services without being asked
Not helpful in giving directions within hospital	Explains hospital routines, equipment, call light, meal times
Made patient feel as though she was begging for medication	Offers pain medication
Slow in getting work done	Does care on time, quickly, not rushed
Depend on patient for instruction	Acts confident when doing treatments
Too many nurse changes	Assign same nurse to patient when possible
Challenged family helping patient	Allow family to participate in care
Questioning finances	
Laughed at patient's questions	Consider all questions seriously
Feels uncomfortable with patient's questions	(several responses given)
Making unexplained comments	
Evades questions by saying, "I'm not allowed to tell you" and "Ask your doctor"	Replies honestly to questions

APPENDIX G

List of Important Nursing Behaviors as Generated by Consumer Advisory Committee

General Category 1: Makes Patient Feel Important

Visit without being asked
Use patient's name
Ask for preferred name
Offer services without being asked
Touch patient to communicate concern and caring
Notice changes in appearance (make-up on)
Refer to previous conversations
Ask preferences when options exist
Waves and smiles greetings
Do errands (writes letters, mails letters, get magazines)
Talk to patient
Listen to patient
Get patient to talk about himself
Speak to and make friendly remarks when doing tasks
Keep promises (to call doctor, to call family, to return)
Praise accomplishments
Make follow-up phone call to patient's home
Share patient troubles, listen to concerns
Deliver phone message to and from patient
Remember patient needs
Spend extra time with patient to talk, to play cards
Answer light promptly
Do treatments on time or else explain reason for delay
Make extra bed changes (for diaphoresis) cheerfully
Disregard financial situation as a criterion for giving good care
Show interest in patient and family (comments about pictures, etc.)
Find out about special interests of patient
Apologize when unkind or short
Tell patient vital signs if he asks (rather than insult intelligence by withholding)
Speak kindly
Let patient feel less helpless (allow patient to help with own care)
Recognize that dirt does not necessarily mean poverty
Allow patient and family to participate in decisions regarding costly tests or treatments
Check out with patient on financial matters, rather than assume
Verbalize that she understands problem, feelings
Listen to patient complaints
Direct entire attention to patient when with him
Is physically present often
Interfere on patient behalf when doctors or others would disturb unnecessarily to do excessive examinations
Minimize waiting time (in office)
Retire if nursing becomes just a job

General Category 2: Provides Individualized Care

Talk when patient wants to talk, is quiet when patient doesn't want to talk
Respond to idiosyncracies - gives hot water to drink, gets another nurse to care for patient, gives coffee at bedtime
Perform routine care on a flexible time schedule
Learn patient preferences and acts in light of them
Ask patient what he wants
Find out what patients know before offering explanation
Find out about previous hospitalization if any
Provide private room if needed and possible to do
Provide juices at different hours
Allow family to participate in care if comforting
Include patient in planning care
Consider importance of family and include as source of information about patient
Visit early in shift and ask patient about his needs
Let patient walk when they can (be more independent)
Assign rooms according to needs of patients
Give choice of wakeup time - allow to sleep later, provide later breakfast, do blood tests later in day
Ask patient about what he likes to eat
Ask patient how he feels about care
Ask patient if prescription helps
Ask patient if he wants follow-up services
Limit visitors if patient doesn't feel well
Bring extra cup of coffee
Work to find solution to problems rather than avoid
Creative in choice of fluids, e.g., substitute ice chips for water for fluid allowance
Assign same nurse to patient when possible for security and comfort
Participate with patient during labor
Volunteer help for sleeplessness
Include parent when dealing with child
Get down to child's level
Place articles within reach of patient
Check for right or left handedness when arm casted
Relate personal experiences if would put patient at ease
Offers sympathy but not too much
Changes response to patient according to patient's emotional or physical state
Acknowledges depression - doesn't ignore
Reorients the confused as often as patient seems to require
Reassure often that you are present and available
Anticipates fears that patient may have for unknown or unusual

General Category 3: Works Safely

Checks orders carefully
Checks identification rigidly
Ensures patient will not be alone in delivery room
Pays attention to food restrictions, allergies
Observes patient several times at night
Charts pertinent facts
Protects from hot liquids if sleepy, aged, child
Teach safety factors to patients

General Category 4: Gives Physical Care

Gives warm bath
Gives warm enema
Gives gentle enema
Offers a drink
Handles patient gently
Helps patient cough and do lung exercises
Holds pillow on abdomen to ease pain
Requires patient to do activities necessary for healing
Uses enough help to lift a heavy person
Recognizes that some people "hurt" easily and need gentler handling
Takes time with enema
Inserts needle quickly, holds steady during injection
Monitors vital signs
Checks I.V's., adjusts
Checks dressings
Checks drainage tubes
Does physical care on time, quickly (though not rushed)
Acts confident when performing treatments
Assists to change position
Volunteers help
Attends to detail in routine or special care
Serves meals promptly
Assists to eat if necessary
Checks during meal on eating (especially if child)
Prepares for meal
Get warm food if tray gets cold
Gives medicine on time
Change bed
Transports patient gently
Washes hair when dirty
Treats rashes
Treats sore hemorrhoids
Treats sore backs
Anticipates patient pain
Offers pain medication
Adjusts pillows
Gives back rubs
Washes face often (in ICU)

General Category 5: Teaches

Exercises for home care, help practice
How to breathe in labor
How to breast feed
How to position baby for comfort during feeding
Safety factors (not to walk on floors in bare feet)
Nutrition
Family how to deal with problems at home
Specific procedures and skills for home use
Demonstrates skill to be learned
Allows patient to practice new skill
Responds to patient need to feel comfortable about learning a strange skill
Teaches responsibility associated with birth control, not just techniques
Teaches new mother about baby - how noises affect him
Gives instructions kindly
Teaches self care for some things in hospital
Ascertain what needs to be taught before teaching
Teaches IPPB

General Category 6: Is adaptable

Has possible solution in mind when unusual situation arises
Copes with patients' emotions
Offers distractions from problems for child: a) plays games with child; b) reads books; c) uses T.V.; d) gives treats

General Category 7: Explains

Answers questions thoroughly and directly
Considers all questions seriously
Admits ignorance
Replies honestly to questions
Replies when unable to give complete answer with response other than "You will have to ask your doctor" or "I can't tell you that"
Interprets vital signs and test results
Tell what to expect when undergoing diagnosis or prescription procedure
Gives as much detail as possible about roommate who "goes bad"
Explains unusual or emergency situations occurring to other patients on ward if asked
Explains unusual equipment
Explains why unable to give more pain medication
Explains hospital routines, equipment, call light, meal times
Takes time to explain things to patient
Explains reasons for all prescriptions
Gives preventive explanation
Explains reason for rushed interaction
Informs family of changes in condition
Makes explanation as often as necessary (time of day)
Explains why unable to wash hair (or do anything)

General Category 7: Explains (continued)

Checks for knowledge, understanding before giving explanation
Explains side effects (blood transfusions)
Explains possible changes in life style
Gives information about community agency help which may be needed or wanted
Relates to patient limits of nurses practice
Explains nurses role in explanation of test results
Explains why pain occurs
Explains loss of appetite
Explain need for walking despite pain
Gives suggestions for possible solution to problems

General Category 8: Has Pleasant Appearance (Mannerisms)

Dresses neatly
Uses makeup sparingly
Uses perfume sparingly
Smells clean
Keeps long hair up
Looks happy
Smiles
Practices good hygiene
Looks rested, relaxed
Has good posture (stand straight, walks tall)
Wears clean uniform
Shows sense of humor - shares funny happenings, laughs, listens to patients' jokes, laughs at self, uses humor appropriately, teases patient if appropriate
Responds in pleasant manner, not flippant
Avoids showing dislike or boredom

General Category 9: Respects Privacy and Modesty of Patient

Assigns male to male bath if patient unusually sensitive
Leaves when patient washes dentures
Pulls curtains before giving treatment or exam
Knocks on door before entering
Exposes only necessary parts for treatment
Leaves room when patient uses bedpan or toilet
Leaves alone when family present
Keeps opinion of patient's affairs to herself
Discusses case only with medical persons involved
Uses quiet voice during personal discussions
Closes door during care
Respect patient's right to be silent about private life

General Category 10: Gives Support to Grieving and Terminally Ill

Allows family of deceased to be with body
Greet relatives of deceased with dignity
Prepares for grieving family members - don't act shocked
Voices sorrow
Acts calm and quiet with grieving
Teaches families of dying what the dying need
Obtains additional education or skill for work with dying if needed
Approaches rather than avoids terminal patient

General Category 11: Relays Information

Delivers phone messages from family to patient
Communicates with other shifts concerning changes in care and special needs so patient does not have to repeat
Verbalizes patient concerns to administrators
Gives as much information to relatives as possible when they inquire
Lets patient know if he is doing right thing
Informs family of changes in condition (especially when worse)
Provides clock for patient to see in ICU
Informs doctor of patient concerns
Tell child when parent will return
Gives progress report to patient and family
Reports back on call to doctor or when asked to find out something

General Category 12: Interprets and Enforces Hospital Policy

Lets visitors stay longer
Lets children visit parents sometimes
States and responds to intent of policy rather than policy itself
Initiate change in policy if archaic
Allows late hour T.V. if not disturbing to others
Uses common sense with red tape

APPENDIX H

Ranking Sheets

Data Sheet for
Ranking General Categories of Nurse Behaviors

Rank the following general categories of nurse behaviors using number 1 through 12, with 12 being the most valuable to you, and 1 being the least valuable.

Rank	Item
_____	Makes patient feel important
_____	Provides individualized care
_____	Works safely
_____	Gives physical care (relieves discomfort)
_____	Teaches
_____	Is adaptable
_____	Explains
_____	Has pleasant mannerisms
_____	Respects privacy and modesty
_____	Gives support to grieving and terminally ill
_____	Relays information
_____	Positively interprets and follows agency policy

Data Sheet for
Ranking Behaviors Within Categories

Category #_____

Rank

1 2 3 4 5 6 7 8

Behavior #

_____

_____

_____

_____

_____

_____

Category #_____

Rank

1 2 3 4 5 6 7 8

Behavior #

_____

_____

_____

_____

_____

_____

APPENDIX I

Consumer Generated Behaviors

Listed According to Rank

Key to Category Abbreviations:

Physical Care	Gives physical care
Individual Care	Provides individualized care
Important Patient	Makes patient feel important
Safe	Works safely
Support Grieving	Gives support to grieving and terminally ill
Pleasant	Has pleasant appearance (mannerisms)
Respect privacy	Respect privacy and modesty of patient
Inform	Relays information
Policy	Interprets and enforces agency policy
Adapt	Is adaptable

Consumer Generated Behaviors
Listed According to Rank

Behavior	Category
Group 1	
Check I.V. and adjust	Physical Care
Help patient cough and do lung exercises	Physical Care
Anticipate patient's pain	Physical Care
Offer pain medication	Physical Care
Handle patient gently	Physical Care
Require patient to do activities necessary for healing	Physical Care
Check dressings	Physical Care
Give medicine on time	Physical Care
Monitor vital signs	Physical Care
Check drainage tubes	Physical Care
Transport patient gently	Physical Care
Include parent when dealing with child	Individual Care
Answer light promptly	Important Patient
Disregard financial situation as a criteria for giving good care	Important Patient
Use enough help to lift a heavy person	Physical Care
Recognize that some people hurt easily and need gentler handling	Physical Care
Treat sore hemorrhoids	Physical Care
Check identification	Safe
Anticipate fears that patient may have for unknown or unusual	Individual Care
Approach rather than avoid terminal patient	Support Grieving
Assist to eat if necessary	Physical Care
Treat sore backs	Physical Care
Include patient in planning care	Individual Care
Group 2	
Listen to patient	Important Patient
Remember patient needs	Important Patient
Allow patient and family to participate in decisions regarding costly treatments	Important Patient
Listen to patient complaints	Important Patient
Learn patient preferences and act in light of them	Individual Care
Allow family to participate in care if comforting	Individual Care
Work to find solutions to problems rather than avoid them	Individual Care
Reassure often that you are present and available	Individual Care
Take time with enema	Physical Care
Do physical care on time, quickly (though not rushed)	Physical Care

Group 2 (contd.)

Behavior	Category
Offer services without being asked	Important Patient
Ask preferences when options exist	Important Patient
Keep promises	Important Patient
Speak kindly	Important Patient
Assign rooms according to needs of patient	Individual Care
Place articles within reach	Individual Care
Change response to patient according to patient's emotional state	Individual Care
Tell what to expect when undergoing diagnosis or prescription	Explain
Do errands	Important Patient
Talk to patient	Important Patient
Verbalize that she understands problems, feelings	Important Patient
Give gentle enema	Physical Care

Group 3

Hold pillow on abdomen to ease pain	Physical Care
Check during meal (especially child)	Physical Care
Treat rashes	Physical Care
Obtain additional education or skill for working with dying if needed	Support Grieving
Check orders carefully	Safe
Ensure patient will not be alone in delivery room	Safe
Avoid showing dislike or boredom	Pleasant
Teach family how to deal with problem at home	Teach
Consider importance of family and include as source of information about patient	Individual Care
Visit early in shift and ask patient about his needs	Individual Care
Ask patient if he wants follow-up services	Individual Care
Participate with patient during labor	Individual Care
Acknowledge depression - don't ignore	Individual Care
Use patient's name	Important Patient
Pull curtains before giving treatment or exam	Respect Privacy
Respect patient's right to be silent about private life	Respect Privacy
Teach specific procedures and skills for home use	Teach
Explain unusual equipment	Explain
Eplain why unable to give more pain medication	Explain
Give information about community agency help which may be needed or wanted	Explain
Perform routine care on a flexible time schedule (baths)	Individual Care

Behavior	Category
Group 4	
Ask patient what he wants	Individual Care
Give choice of waking time, allow to sleep later, provide later breakfast	Individual Care
Ask patient how he feels about care	Individual Care
Ask patient if prescription helps	Individual Care
Respond in pleasant manner, not flippant	Pleasant
Praise accomplishments	Important Patient
Share patient troubles, listen to concerns	Important Patient
Do treatments on time, or explain reason for delay	Important Patient
Make extra bed changes cheerfully	Important Patient
Apologize when unkind or short	Important Patient
Tell patient vital signs if he asks	Important Patient
Let patient feel less helpless (allow to help with own care)	Important Patient
Interfere on patient's behalf when doctors or others would disturb unnecessarily to do excessive examinations	Important Patient
Spend extra time with patient to talk, play cards, etc.	Important Patient
Greet relatives of decreased with dignity	Support Grieving
Allow patient to practice new skill	Teach
Reply when unable to give complete answer with response other than "you will have to ask your doctor", or "I can't tell you that".	Explain
Inform family of changes in condition	Explain
Give suggestions for possible solution to problems	Explain
Pay attention to food restrictions, allergies	Safe
Observe patient several times at night	Safe
Respond to idiosyncracies	Individual Care
Group 5	
Limit visitors if patient doesn't feel well	Individual Care
Assign same nurse to patient when possible for security and comfort	Individual Care
Volunteer help for sleeplessness	Individual Care
Relate personal experiences if it would put patient at ease	Individual Care
Expose only necessary parts for treatment	Respect Privacy
Keep opinion of patient's affairs to herself	Respect Privacy
Smile	Pleasant
Offer a drink	Physical Care

Group 5 (contd.)

Behavior	Category
Insert needle quickly, hold steady during injection	Physical Care
Assist to change position	Physical Care
Attend to detail in routine or special care	Physical Care
Teach nutrition	Teach
Respond to patient need to feel comfortable about learning a strange skill	Teach
Interpret vital signs and test results	Explain
Explain possible changes in life style	Explain
Explain hospital routines, equipment, call light	Explain
Take time to explain things to patient	Explain
Explain need for walking despite pain	Explain
Direct entire attention to patient when with him	Important Patient
Have possible solution in mind when unusual situation arises	Adapt
Inform family of changes in condition (especially when worse)	Inform
Shows sense of humor	Pleasant
Inform doctor of patient concerns	Inform

Group 6

Demonstrate skill to be learned	Teach
Answer questions thoroughly and directly	Explain
Consider all questions seriously	Explain
Explain reasons for all prescriptions	Explain
Provide private room if needed and possible to do	Individual Care
Get down on child's level	Individual Care
Check for right or left handedness when arm casted	Individual Care
Offer sympathy but not too much	Individual Care
Reorient the confused as often as patient seems to require	Individual Care
Teach families of dying what the dying need	Support Grieving
Check with patient on financial matters rather than assume	Important Patient
Is physically present often	Important Patient
Act confident when performing treatments	Physical Care
Volunteer help	Physical Care
Change bed	Physical Care
Look happy	Pleasant
Practice good hygiene	Pleasant
Cope with patient's emotions	Adapt
Teach exercises for home care, help practice	Teach

Group 6 (contd.)

Behavior	Category
Teach new mother about baby; how noises affect him	Teach
Bring extra cup of coffee	Individual Care
Chart pertinent facts	Safe
Protect from hot liquids if sleepy, aged, child	Safe

Group 7

Act calm and quiet with grieving	Support Grieving
Give as much information to relatives as possible	Inform
Tell child when parent will return	Inform
Leave room when patient uses bedpan or toilet	Respect Privacy
Leave alone when family present	Respect Privacy
Use quiet voice during personal discussion	Respect Privacy
Close door during care	Respect Privacy
Wear clean uniform	Pleasant
Teach responsibility associated with birth control, not just techniques	Teach
Give instructions kindly	Teach
Teach self care for some things in hospital	Teach
Teach IPPB	Teach
Offer distractions from problems for child	Adapt
Communicate with other shifts concerning changes in care and special needs so patient does not have to repeat	Inform
Give progress report to patient and family	Inform
Report back on call to doctor or when asked to find out something	Inform
Serve meals promptly	Physical Care
Wash face often (in ICU)	Physical Care
Look rested and relaxed	Pleasant
Prepare for grieving family members - don't act shocked	Support Grieving
Talk when patient wants to talk, be quiet when patient does not want to talk	Individual Care
Find out what patient's know before offering explanation	Individual Care
Let patients walk when they can (be more independent)	Individual Care

Group 8

Teach how to breathe in labor	Teach
Explain unusual or emergency situation occurring to other patients on ward if asked	Explains

Group 8 (contd.)

Behavior	Category
Give preventive explanation	Explain
Make explanation as often as necessary	Explain
Explain why pain occurs	Explain
Notice changes in appearance	Important Patient
Speak to and make friendly remarks when doing tasks	Important Patient
Deliver phone messages to and from patient	Important Patient
Find out about special interest of patient	Important Patient
Initiate change in policy if archaic	Policy
Knock on door before entering	Respect Privacy
Discuss care only with medical persons involved	Respect Privacy
Dress neatly	Pleasant
Smell clean	Pleasant
Teach how to breast feed	Teach
Reply honestly to questions	Explain
Give warm bath	Physical Care
Give warm enema	Physical Care
Get warm food if tray gets cold	Physical Care
Give backrubs	Physical Care
Ask patient what he likes to eat	Individual Care
Touch patient to communicate concern and caring	Important Patient

Group 9

Get patient to talk about himself	Important Patient
Show interest in patient and family	Important Patient
Minimize waiting time (in office)	Important Patient
Deliver phone messages from family to patient	Inform
Voice sorrow	Support Grieving
Let children visit parents sometimes	Policy
State and respond to intent of policy rather than policy itself	Policy
Use common sense with red tape	Policy
Keep long hair up	Pleasant
Find out about previous hospitalizations	Individual Care
Use creativity in choice of fluids	Individual Care
Recognize that dirt does not necessarily mean poverty	Important Patient
Prepare for meal	Physical Care
Wash hair when dirty	Physical Care
Teach safety factors	Teach
Give as much detail as possible about roommate who "goes bad"	Explain
Explain reasons for rushed interaction	Explain
Relate to patient the limits of a nurse's practice	Explain

Group 9 (contd.)

Behavior	Category
Explain nurse's role in explanation of test results	Explain
Explain loss of appetite	Explain
Provide juices at different hours	Individual Care

Group 10

Ascertain what needs to be taught before teaching	Teach
Visit without being asked	Important Patient
Wave and smile greetings	Important Patient
Make follow-up phone call to patient's home	Important Patient
Use make-up sparingly	Pleasant
Use perfume sparingly	Pleasant
Verbalize patient concerns to administrators	Inform
Allow family of deceased to be with body	Support Grieving
Adjust pillows	Physical Care
Let visitors stay longer	Policy
Allow late hour TV if not disturbing others	Policy
Teach how to position baby for comfort during feeding	Teach
Explain why unable to do a requested task	Explain
Check for knowledge, understanding before giving explanation	Explain
Let patient know if he is doing the right thing	Inform
Assign male to give male bath if patient is unusually sensitive	Respect Privacy
Have good posture	Pleasant
Ask for patient's preferred name	Important Patient
Refer to previous conversations	Important Patient
Retire if nursing becomes just a job	Important Patient
Provide clock for patient to see in ICU	Inform
Admit ignorance	Explain
Leave when patient washes dentures	Respect Privacy

APPENDIX J

Student Data Collection Sheet

NURSING PINPOINTS GROUP A
TALLY SHEET

FORM I

Behaver _____ Constant Record Floor of: _____

Pinpoints	COR	LO	S	COR	LO	S	COR	LO	S	COR	LO	S
1. Checks IV's, Adjusts												
2. Helps patient cough and do lung exercises												
3. Offers pain medication												
4. Handles patient gently												
5. Requires patient to do activities necessary for healing												
6. Checks dressings												
7. Gives medicine on time												
8. Monitors V.S.												
9. Checks drainage tubes												
10. Transports patient gently												
11. Include parent when dealing with a child												
12. Answers light promptly												
13. Uses enough help to lift a heavy person												
14. Treats sore hemmorrhoids												
15. Checks identification												
16. Anticipates fears that patient may have for unknown or unusual												
17. Approaches rather than avoids terminal patient												
18. Assists to eat if necessary												
19. Treats sore backs												
20. Includes patient in planning care												
TOTALS												
DATE												

Chart frequency of total on a behavior chart

Turn in weekly to Sonya; she will give you a new sheet for the next week

Setting Key	
K	Kaiser
P	Providence
S	Salem
H	Hillhaven
W	Woodland Park

APPENDIX K

Graphs Showing Averaged Frequency

of Student Nurse Performance of

Consumer Generated Nursing Behavior

Explanation of the Standard Behavior Chart

The Standard Behavior Chart is an unique device developed to aid in the attempts to record and describe behavior. It is called a standard chart because it records with equal sensitivity any and every countable human behavior, and it uses two dimensions common to all behavior measurement, time and number.

Identification --

The series of labelled blanks at the bottom, when properly completed will tell exactly what behavior is being charted and most importantly, who is involved and to what degree, in the efforts to study the behavior.

The blanks to the right identify the person (behaver) and the behavior (movement) in question. The blanks on the left identify the persons who are involved (if any) with the behavior on a daily, weekly, or monthly basis.

Day Lines --

The vertical lines correspond to the days of a twenty week period of time. Every seventh one is darker and corresponds to Sunday on the calendar. Across the top, the numbers divide the chart into four week (approximately one month) intervals. Charts can be synchronized groups of people by beginning all charts on the same day.

The numbers along the bottom divide the chart into ten day intervals. The vertical lines are all equal intervals.

Frequency Lines --

Frequency is defined as the number of times a behavior occurs divided by the amount of time recorded or available for its occurrence.

The frequency lines on the chart range from .001 at the bottom to 1000 at the top. The frequency measure used on the chart is Movements per Minute (M/m). A frequency of .001 means that one movement was observed in a one-thousand minute (960 minutes equal 16 hours or one day) time sample. A frequency of .1 ($^{1}/_{10}$) means that on the average, one movement was observed during each ten minutes of recording.

The frequency lines are not equal intervals, but equal-ratio. The chart contains six logarithmic cycles and is known as a equal ratio or multiply-divide chart. Multiplying or dividing by a given amount moves an equal distance anywhere on the scale. The ratio of 500 to 50 is the same as the ratio of 100 to 10.

Charting Frequencies --

Frequency = $\frac{\text{number}}{\text{time}}$ or $\frac{5}{200}$ = .025. Find correct frequency (.025) and a day line; place dot on chart where the frequency line and day line intersect. In this case the dot will be placed between the .02 and the .03 line. For ease of charting, a counter has been devised which does away with math computations to finding each frequency line.

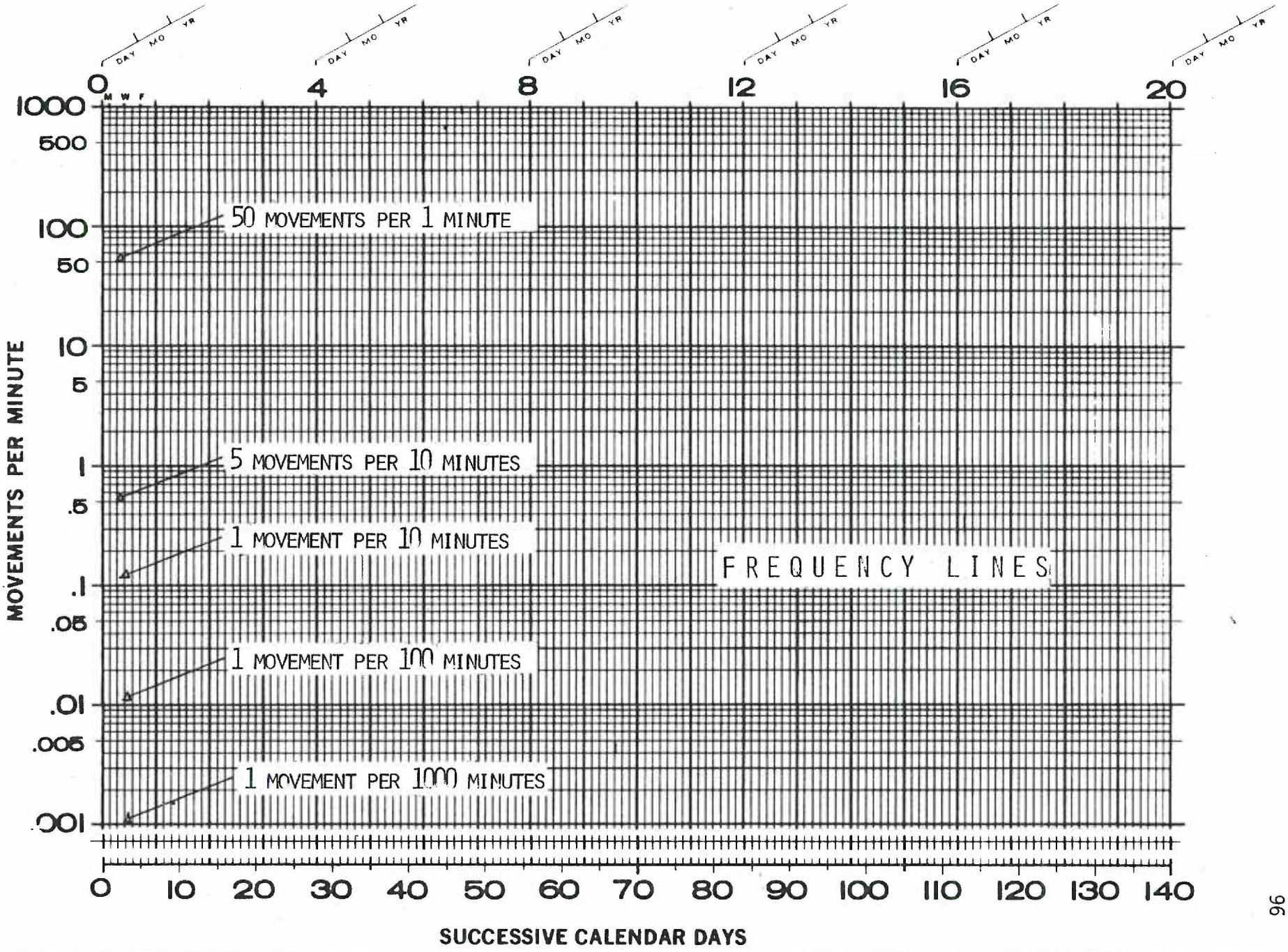
Record Floor --

The lowest behavior frequency the recording procedure allows the observer to detect. It may be calculated as:

$$\frac{1}{\text{number minutes spent recording}} \quad \text{or} \quad \frac{1}{200} = .005.$$

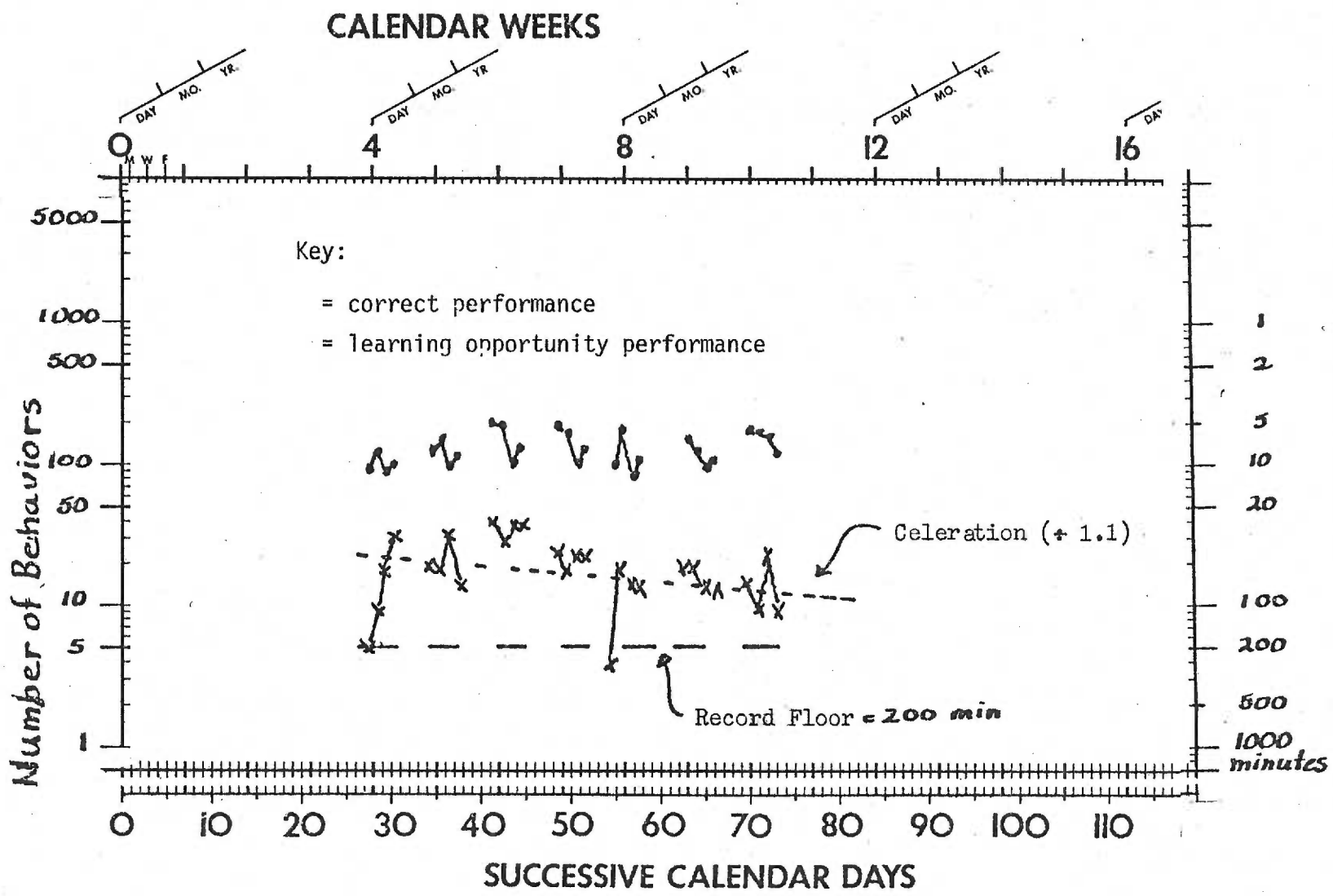
Record floor is denoted by a horizontal line that corresponds to the value computed. Zero is charted just below the record floor line to indicate that no behavior was observed during that time period.

The charts following, on which student data has been graphed, have been modified somehwat in order to make interpretation easier.

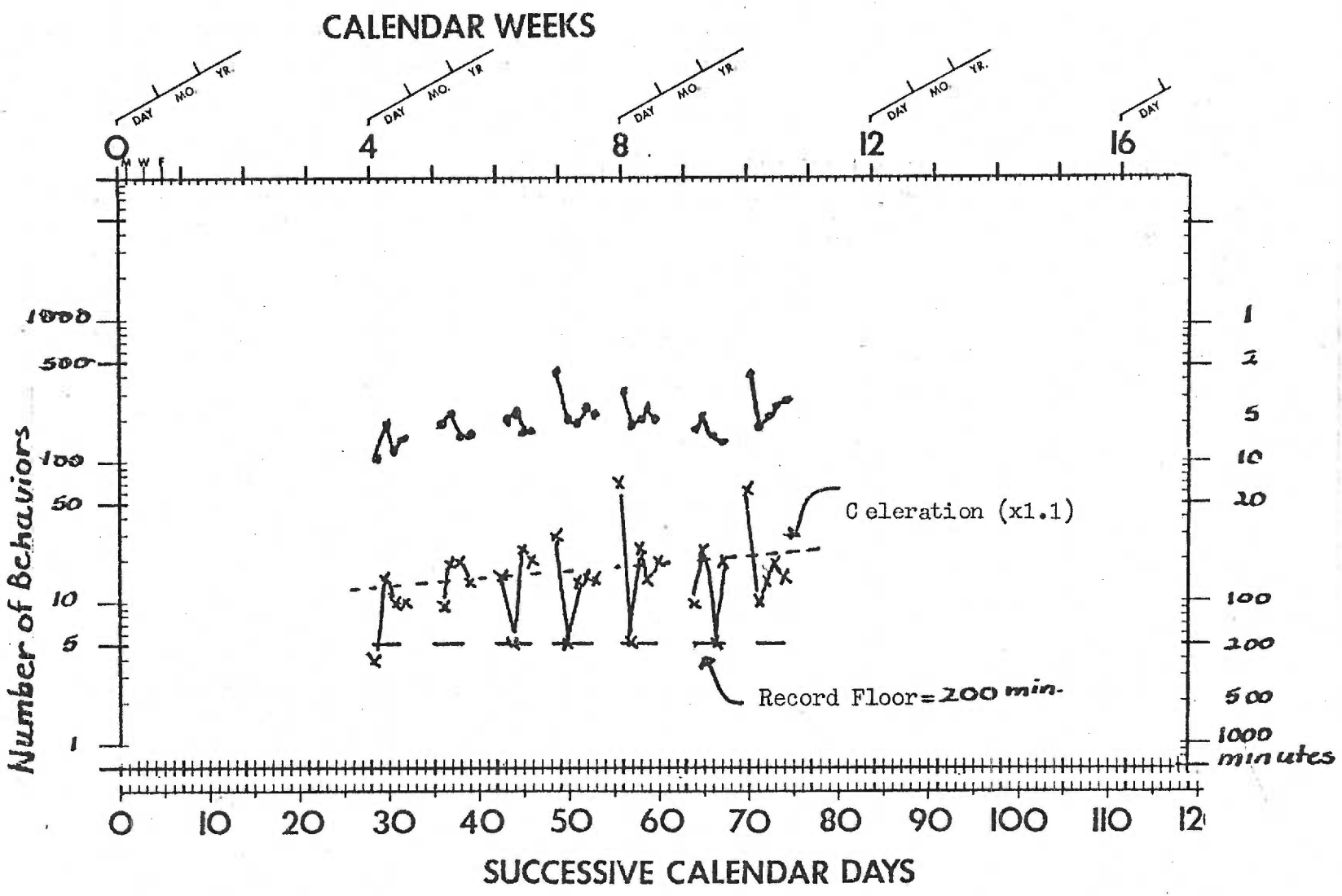


96

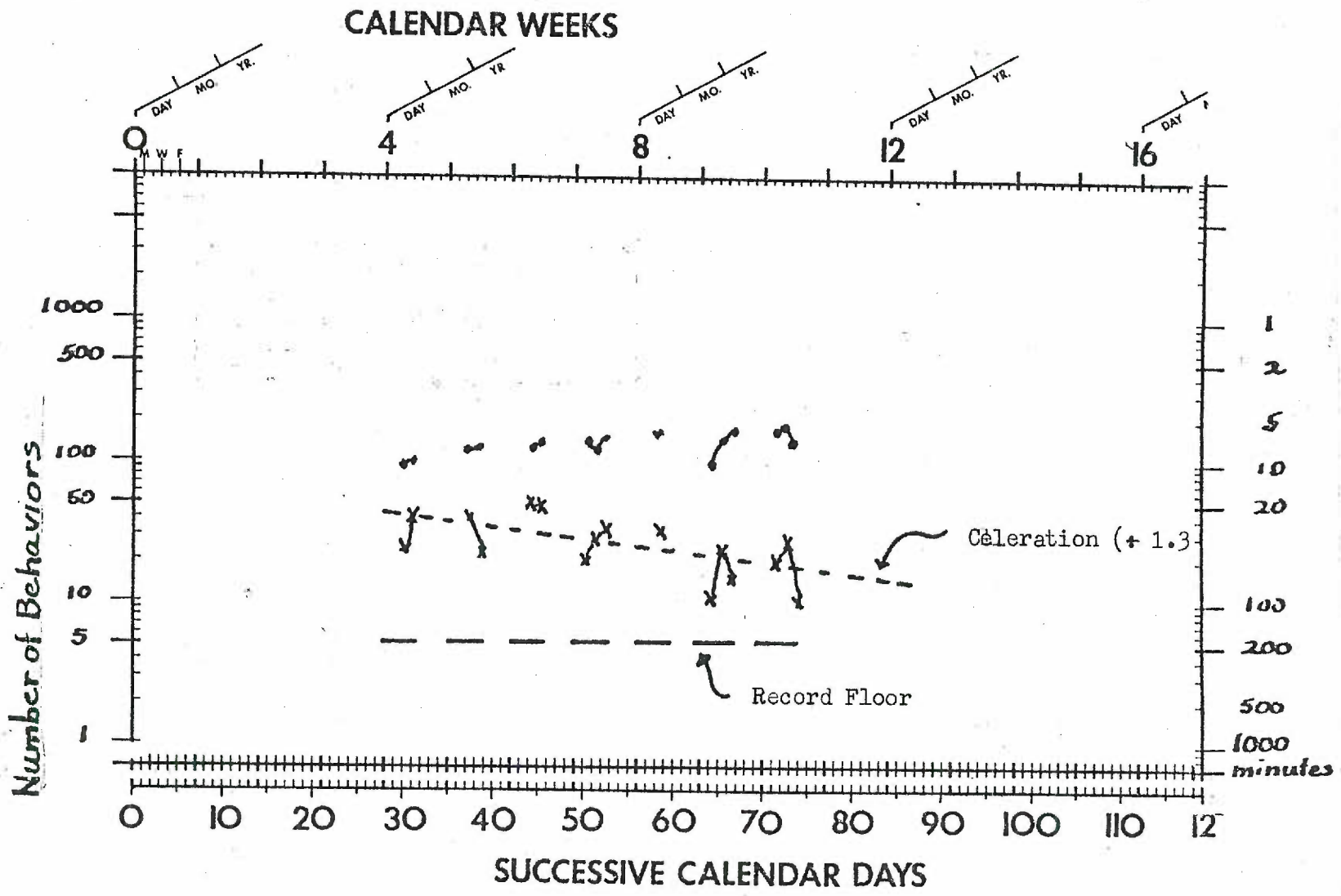
SUPERVISOR	ADVISER	MANAGER		BEHAVER	AGE	LABEL	MOVEMENT
DEPOSITOR	AGENCY			CHARTER			



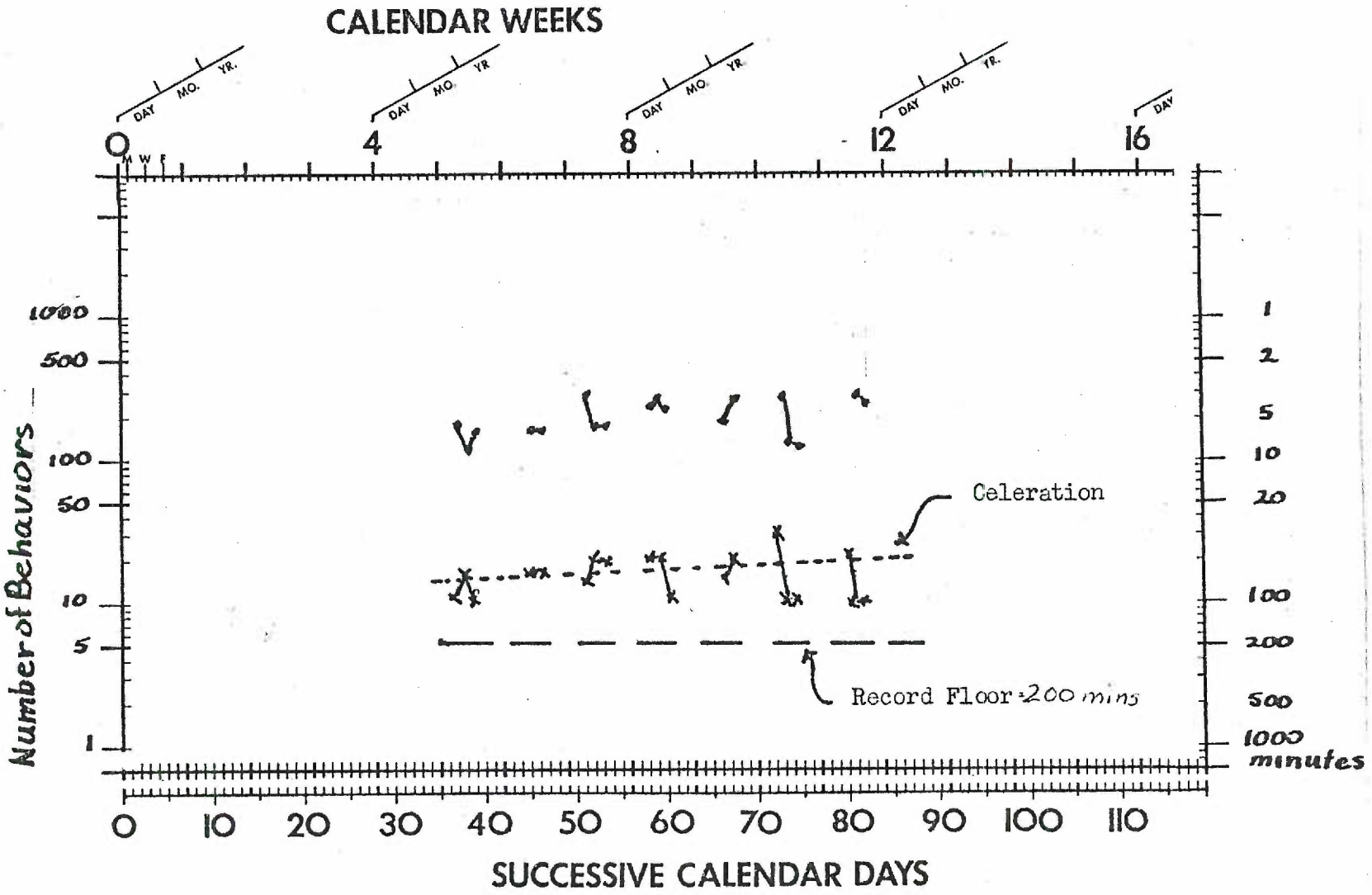
Average daily performance of the most valued consumer generated nursing behaviors by all student nurses.



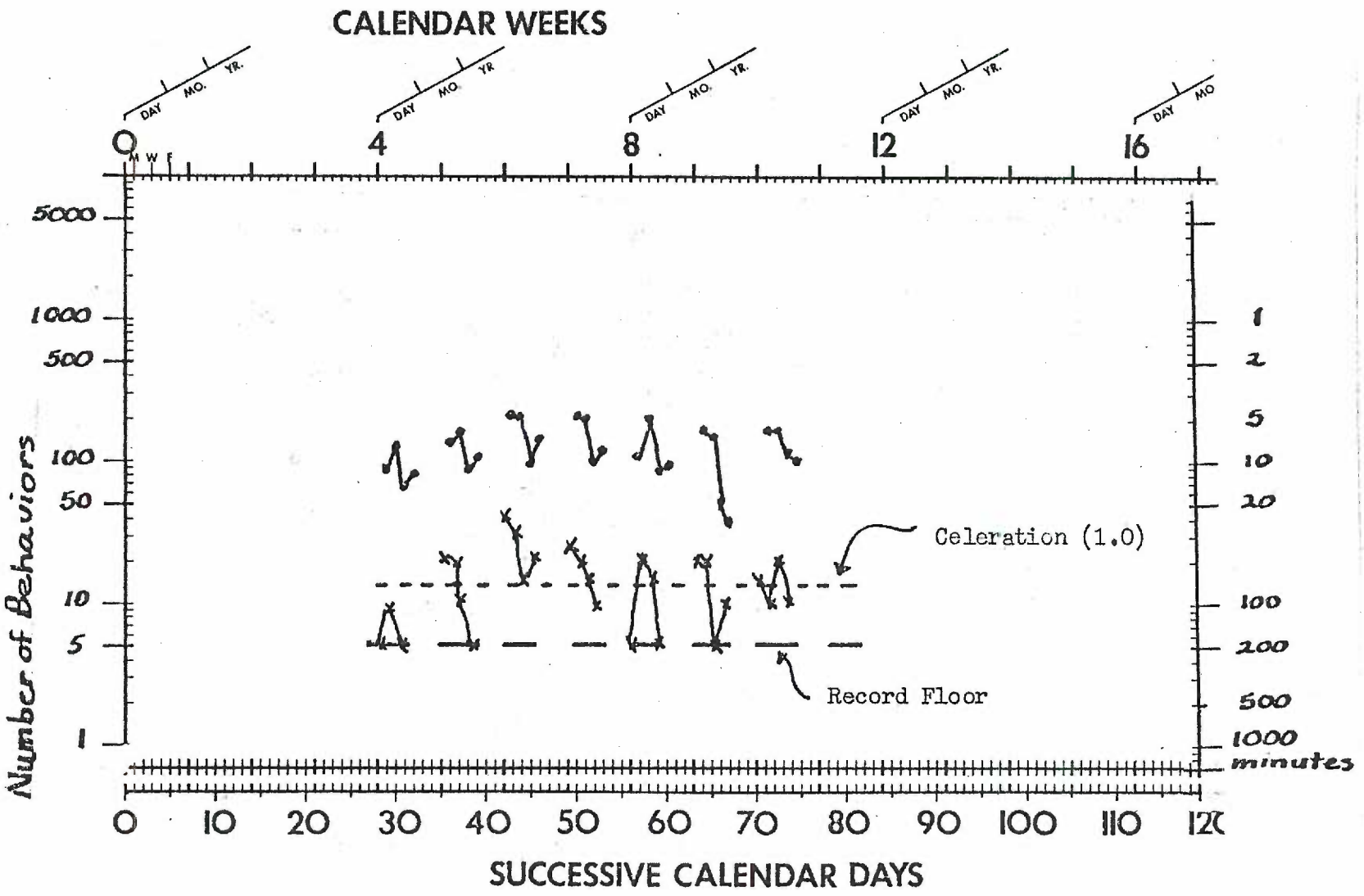
Average daily performance of the least valued consumer generated nursing behaviors by all student nurses.



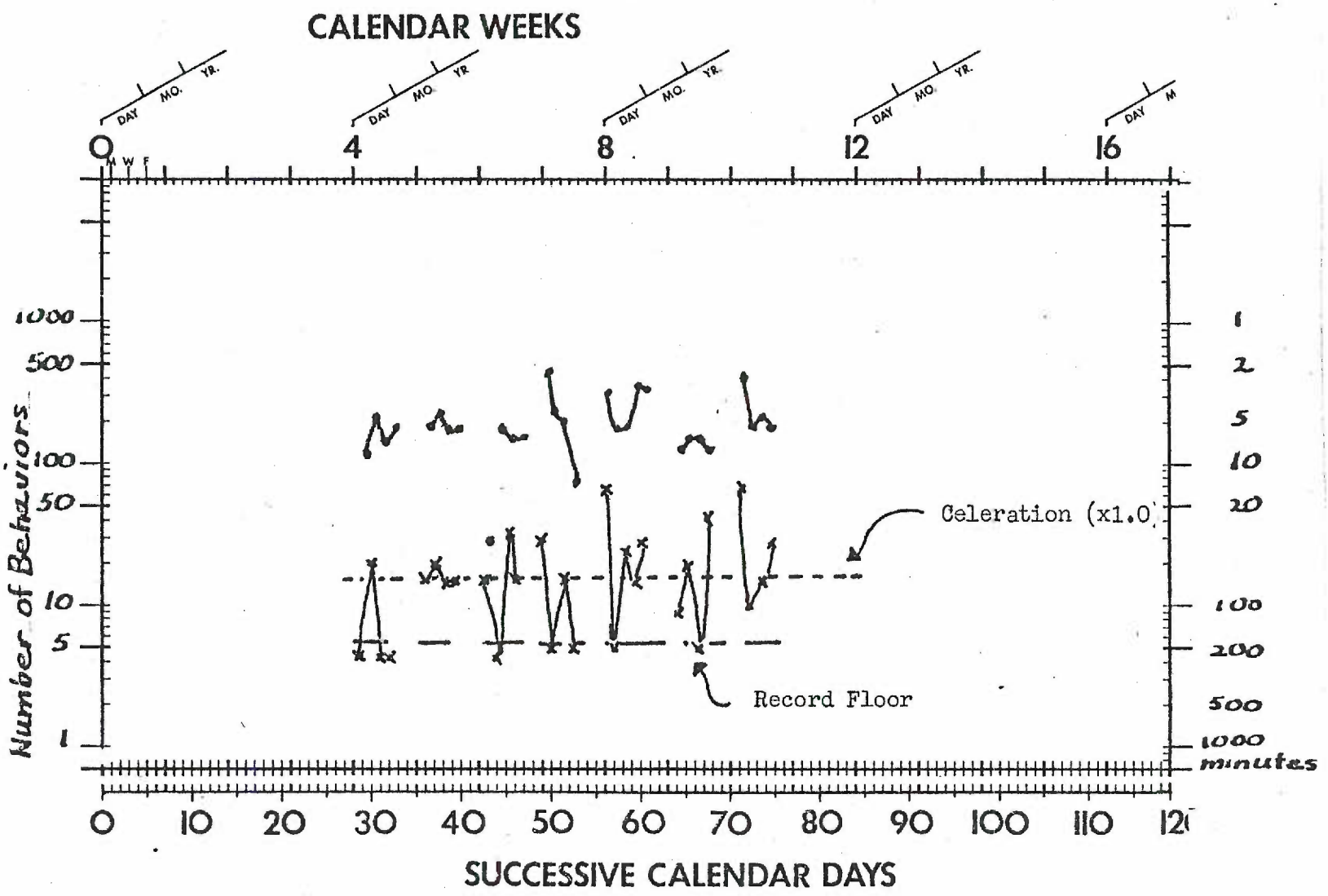
Average daily performance of most valued consumer generated nursing behaviors by combined first year students.



Average daily performance of least valued consumer generated nursing behaviors by combined first year students.



Average daily performance of most valued consumer generated nursing behaviors by combined second year students.



Average daily performance of least valued consumer generated nursing behaviors by combined second year students.

APPENDIX L

Responses to Individual Items on Consumer Survey

Responses by Consumer Advisory Committee to Each Dimension on Survey Concerning the Nurse's Practice in Hospital, Office and Community

		RATING					
DIMENSION		1	2	3	4	5	N
Visibility	H	0	0	5	3	3	11
	O	1	2	2	2	3	10
	C	0	5	1	2	0	8
Urgency	H	0	0	1	1	9	11
	O	1	1	1	2	5	10
	C	1	0	0	2	4	7
Necessity	H	0	0	1	2	8	11
	O	1	0	3	2	4	10
	C	0	1	1	3	3	8
Scope	H	0	2	3	3	3	11
	O	0	4	1	3	2	10
	C	1	2	3	1	2	9
Impact	H	0	2	7	1	1	11
	O	3	4	1	1	1	10
	C	0	3	2	1	3	9
Value	H	0	1	7	2	1	11
Physical	O	2	2	5	0	1	10
Problem	C	0	1	3	2	2	8
Value	H	1	0	3	5	2	11
Feelings	O	2	1	4	3	0	10
Problem	C	1	0	1	3	4	9
Independence	H	0	1	6	2	2	11
	O	3	2	2	2	1	10
	C	0	0	3	4	2	9
Responsibility	H	0	3	4	3	1	11
	O	1	4	3	0	1	9
	C	0	3	2	1	1	7
Accessibility	H	0	0	4	3	4	11
Physical	O	0	3	3	3	1	10
Problem	C	0	4	2	2	2	10
Accessibility	H	1	1	5	4	0	11
Feelings	O	1	3	3	1	2	10
Problem	C	0	3	4	1	1	9

APPENDIX M

Number of Behaviors from Each Category

Found Within Each Value Group of Behaviors

General Categories Ranked High to Low		Number of Behaviors										N
12.	Gives Physical Care	16	3	3			3	2	4		1	38
11.	Works Safely	1		2	2		2			1		8
10.	Provides Individualized Care	3	7	6	5	4	6	3	1	3		38
9.	Makes Patient Feel Important	2	11	1	9	4	2		5	4	6	41
8.	Gives Support to grieving and terminally ill	1	1	1	1		1	2		1	1	8
7.	Teaches			2	1	2	3	4	2	1	2	17
6.	Explains		1	3	3	5	3		5	5	3	28
5.	Respects Privacy			2		2		4	2		2	12
4.	Has Pleasant Manner			1	1	2	2	2	2	1	3	14
3.	Is Adaptable					1	1	1				3
2.	Relays Information					2		5		1	3	11
1.	Positively Interprets and Follows Agency Policy								1	3	2	6
		1	2	3	4	5	6	7	8	9	10	
		High								Low		

Ranked Groups of Valued Behaviors

AN ABSTRACT OF THE CLINICAL INVESTIGATION OF

Gene Graham Crumpton

for the Master of Nursing

Date of receiving this degree: June 9, 1978

Title: RELATIONSHIP OF COURSE OUTCOMES TO CONSUMER PERCEPTIONS OF SUPPORTIVE NURSE BEHAVIOR IN AN ASSOCIATE DEGREE PROGRAM

Approved: _____
(Professor in Charge of Clinical Investigation)

Since the 1967 Economic Opportunity Act, the consumer has taken an increasingly prominent role in setting policies for health services. Professionals have agreed that patients have a great deal to contribute to the planning and implementing of care to meet their needs. However, nursing education has yet to devise a mechanism whereby consumers can have direct access to the process of curriculum development.

Mt. Hood Community College, in an attempt to evaluate and refine a competency based nursing program, created a consumer advisory committee whose task was to identify nursing activities they viewed as important in health care situations. Two hundred twenty-five behaviors were listed under twelve general categories. The categories were ranked according to three settings: hospital, office, community and with no setting specified. The data revealed that the consumers were in agreement about the ranking for hospital setting and when no setting was specified, placing

the category "Gives Physical Care" highest in order. However, they could not agree about the rank for the office and community settings, implying that they were not fully informed of nursing function in those settings. When the 225 behaviors generated were recategorized, those behaviors related to personalization of nursing care were given highest rank.

All of the behaviors except one were found in the competency statements of the nursing curriculum, and 93 per cent of them were introduced by the end of the first year in the nursing program. Direct measurement by students of the twenty highest ranked and twenty lowest ranked behaviors showed that students performed those behaviors at a high average daily frequency.