The development of a theory based nursing assessment format for generalist community health nurses working within the Illawarra Area Health Service

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THE DEVELOPMENT OF A THEORY BASED NURSING ASSESSMENT FORMAT FOR GENERALIST COMMUNITY HEALTH NURSES WORKING WITHIN THE ILLAWARRA AREA HEALTH SERVICE

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Non-theory Based Nursing Assessment Form

Theory Based Nursing Assessment Form

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Phase 2: Round Two Delphi Technique

Phase 3: Client Questionnaires and Letters
DISCLAIMER

The views and recommendations expressed in this research project are entirely my own. They do not represent the views of either the Illawarra Area Health Service or the University of Wollongong.

This thesis has not been submitted to another university or institution.
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EXECUTIVE SUMMARY

Generalist community health nurses work according to the primary health care model with an emphasis on needs based care, self-determination and health promotion. Despite this, the nursing assessment form used by generalist community health nurses employed by the Illawarra Area Health Service, has been developed according to the reactive Problem Oriented Medical Records Policy. This policy identifies problems after they occur and limits the nursing process. In contrast the Modeling and Role-Modeling Theory developed by Erickson, Tomlin and Swain (1983) focuses on a client centred approach, is closely aligned to the primary health care model and enhances the nursing process. The following literature review outlines the definition, philosophy and importance of primary health care to community health nurses. Also identified are the benefits of combining the nursing process with nursing theory and more specifically, the Modeling and Role-Modeling Theory, in the implementation of the primary health care model.

This quantitative research project evaluates a nursing assessment format developed for generalist community health nurses, based on the Modeling and Role-Modeling Theory. The methodology involves postal questionnaires and incorporates the use of the delphi technique and a panel of experts. A comparison is made with the non-theory based nursing assessment form currently used, in terms of ability to encourage the provision of primary health care, personalised holistic care, development of nursing care plans and nursing judgements. Unlike the currently used non-theory based nursing assessment format, a significant number of respondents perceived the theory based nursing assessment as encouraging primary health care and personalised holistic care. Views from nurse managers, resource personnel and the client population, were also obtained. The experts were found to support the use of theory based clinical practice. This research therefore identifies important issues for nurses working within the primary health care model to consider, particularly in order to maintain credibility and ensure best practice principles of care.
"It frees us from assuming inordinate responsibility to remember that, however great our concern and goodwill for our clients, making a decision to change is ultimately their prerogative and should be done according to their time line...”

(Erickson, Tomlin and Swain 1983: 97)

Nursing care has traditionally been based on the sickness model for health care, with nurses having limited decision-making opportunities and being dependent upon the medical profession to determine client care (Hunter 1983; Clarke 1986). The continuing acceptance of the general community to regard doctors as the utmost authority on health care belies the autonomous nursing practice provided by community nurses. Current theories of nursing challenge the predominant medical ideology of health care based on a limited sickness model and now include a positive perspective of health, based on a wellness model. Community health nursing is indicative of this proactive approach, in terms of the particular emphasis given in assisting the client to achieve optimum levels of health and wellbeing.

Community health nursing, an essential element of community health services, is government funded which obliges nurses to consider their actions in terms of outcomes and benefits to the consumers of care. According to Webster(1993) the
basis of future health services will be control, choice, service provision and outcomes. The "passive patient" will become the active participant and "consumer" of health care (Webster 1993: 100). Those receiving the services will determine the terms of reference not the professionals or bureaucracies. The most appropriate form of nursing care for the future is therefore client centred, client controlled and outcome driven.

Such control and the ensuing responsibility, are vital components of primary health care. Although primary health care has been provided for many years the concept had assumed little or no importance until regarded by the World Health Organisation as the principle strategy by which to effect Health for All by the Year 2000. As a direct result of this, governments throughout the world, including Australia, are now expecting the primary health care model to play a significant role in health care (South Australian Health Commission 1988).

Generalist community health nurses presently rely on the nursing process rather than nursing theories to guide clinical practice. This is despite the ability of nursing theories to provide essential information which is lacking from the nursing process (Meleis and Price 1988). Combining the nursing process and nursing theory then allows for improved justification of nursing actions (Aggleton and Chalmers 1986; Lewis 1988).

The generation of new information for the nurse and improvements in nursing care to effect positive outcomes for the clients, are important considerations for the implementation of theoretical nursing. Theories of nursing also provide outlines to facilitate the application of the knowledge gained, thereby resulting in the most appropriate care for the client. Regardless, few nurses have incorporated even those theories which are client centred into clinical practice.
Nursing theories however, rarely include the community as the major focus although as Hanchet (1988) suggests some could easily be extended to incorporate this field of nursing. The theoretical framework chosen for generalist community health nurses however, needs to have a major commitment to the factors of personalised, holistic care which is intrinsic to primary health care. According to Lewis (1988) introducing a theory which follows the guidelines already in practice increases the likelihood that the theory will be accepted by those who will ultimately use it. The Modeling and Role-Modeling Theory developed by Erickson, Tomlin and Swain (1983) is one theory which could easily be adapted to community health nursing and primary health care because it is based on a client centred, holistic approach to health.

Nursing assessment formats used by generalist community health nurses in the Illawarra, are based on a problem oriented medical records policy and a problem solving approach. The expectation however, is that generalist community health nurses provide primary health care which attempts to prevent problems occurring.

In order to overcome this basic incongruence, a nursing assessment form based on the Modeling and Role-Modeling Theory, was trialed by generalist community health nurses and evaluated as a research project. The intention was to provide a theory-based nursing assessment format which utilised a philosophy consistent with community health nursing and primary health care. The Modeling and Role-Modeling Theory has a major focus on client control and self responsibility with care related to the needs of the individual, as perceived by the individual. The Modeling and Role-Modeling Theory is therefore well suited to generalist community health nurses, as primary health care also places great emphasis on these concepts.
CHAPTER TWO
LITERATURE REVIEW

2.1 Community Health

Community health is concerned with the health and welfare of individuals, families and community groups. Care takes into account common needs, the cultural aspects and diversity of the particular community involved and the resources available. From a nursing perspective the community involves personal and environmental perspectives and their inter-relationships. The individual as the basic unit of the community remains the central focus and is encouraged to assume responsibility for health (Coombs 1989; Rice 1989; Rorden and McLennan 1992; Haggart 1993; McMurray 1993).

Community health nursing is just one aspect of the community health services offered to mothers, babies, children and adolescents, the aged and chronically ill, the emotionally, mentally and socially disadvantaged, culturally specific groups and the general community. Community health centres have varying numbers and types of professionals working from the centres such as nurses, social workers and ethnic health workers with both outreach and ambulatory components.

Although activities such as health promotion, illness prevention and early detection, receive high priority by generalist community health nurses practicing primary health care, this does not preclude the care of those who are ill (Vuori 1984; South Australian Health Commission 1988; Commonwealth Department of Health, Housing and Community Services 1991). Community health nursing and primary health care are inextricably linked because of the similar emphasis on the individual and the community. O'Connor (1974) identified community health nurses in NSW as practicing primary health care prior to 1974 (Quoted by
Rice 1989: 22). This was shortly after the implementation of the Community Health Program which utilises primary health care goals as the basis for care(South Australian Health Commission 1988; Coombs 1989; Fry 1994).

Despite this, Sax(1990) considers community health lacks the organisational structure to facilitate and achieve primary health care. According to Thompson(1990) however, nurses hold the key to primary health care as they comprise the largest group of health care workers and work closely with the community. This view is supported by the World Health Organisation(WHO) and the Australian Nursing Federation(Australian Nursing Federation 1990). Primary health care is therefore well within the grasp of community health and generalist community health nurses. It is imperative that generalist community health nurses continue to provide and succeed in the provision of primary health care as failure will result in increased and longer duration admissions to hospitals and nursing homes(Sax 1990).

2.2 Primary Health Care
Thompson(1990) suggests that primary health care is the oldest form of health care and that such care has been provided by nurses since nursing began, because of the first line of contact involved. Regardless, it is the general practitioner rather than the nurse who is generally considered by the community as the first point of contact within the Australian health care system(South Australian Health Commission 1989; Starfield 1992; Fry 1994). Primary health care is not restricted to community health nurses or general practitioners. Chemists, herbalists, chiropractors and physiotherapists are also involved, as are community members, teachers, community self-help groups and local government health officers, such as health surveyors. Primary health care is considered to involve "...anyone who can make a contribution to the health of a community"(Australian Council of Community Nursing Services 1989: 9).
Such diversity in the providers of primary health care requires a flexible and collaborative approach. Without intersectorial cooperation, the provision of continuity of care, essential to the primary health care model, is not achievable (Commonwealth Department of Health, Housing and Community Services 1991; Starfield 1992; Haggart 1993; Health Ministers’ Forum 1994; NSW Health Department 1994).

Primary health care has been defined according to levels of care and the organizations providing health care. Three organizational levels of health care were initially described by Lord Dawson of Penn, in Great Britain in 1920, as primary health centres, secondary health centres and teaching hospitals (Starfield 1992: 4). The primary level of care is the first line of contact within the health care system and is generally provided within the community. The second and third levels relate to care given in hospitals. General hospitals provide secondary level care with the large, specialised hospitals offering tertiary care (Bullough and Bullough 1990; Rorden and McLennan 1992; Starfield 1992; Fry 1994).

Emphasising the levels of care when defining primary health care, has the potential to create a narrow focus and inappropriately equate a primary level of care with primary health care. Whilst it is acknowledged that the majority of first line contact is provided by community health services, initial contact is also offered by some secondary levels of care. Casualty and outpatient departments, day care clinics and some obstetric areas exemplify the provision of primary health care.

Vuori (1984:224) describes primary health care as a “combination of a level of care, strategies to organize care and a set of activities by caregivers” which fall within a philosophy of care. A philosophy of primary health care is also espoused by the South Australian Health Commission (1988) and the Australian Council of Community Nursing Services (1989).
The following concepts have been incorporated into the definition and philosophy of primary health care:

- **Social Justice and Equality**
- **A Social View of Health**: a relationship between health and society
  - cultural, political and economic values affect and reflect the health of the individuals
  - a broad view of health
- **Self Responsibility**
- **International solidarity**: developing countries are encouraged to provide primary health care by those countries with more resources.


The aim of primary health care according to the Australian Council of Community Nursing Services (ACCNS) (1989:3) is to improve quality of life, as perceived by the individual concerned. This aim is enhanced by the ACCNS principles of primary health care which include:

- Health care should be related to the needs of the population
- Consumers should participate, both individually and collectively in the planning and implementation of health care.
- Effective and efficient use of available resources
- Primary health care as the nucleus of a comprehensive health care system

(1989: 11-14)
The aim and principles of primary health care espoused by the Australian Council of Community Nursing Services (ACCNS) are based on the World Health Organisation's (WHO) interpretation of primary health care.

Primary health care as advocated by WHO in the Alma-Ata Report and Declaration of 1978 is "...essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community" (ACCNS 1989: 1). (Emphasis added by this author).

One of the key elements in the above definition is essential health care. This is the provision of basic health services which maintain good health for the entire community. The crucial elements include peace, shelter, safe water, food, sanitation, education, income and a stable eco-system (South Australian Health Commission 1988; Coombs 1989; Department of Community Services and Health 1991; Health Ministers’ Forum 1994).

Access in health care is closely linked with equity. Improvements in social equity result in decreased inequalities in health status among different sections of the population and ensure equal opportunity for all to achieve good health. The provision of affordable health care also ensures access to all individuals (South Australian Health Commission 1989). Essential, affordable care which is accessible implies a responsibility on behalf of those in power. This illustrates the concepts of Social Justice and Equality and A Social View of Health previously described within the philosophy of primary health care.
Full participation requires both acceptance of the health care offered and advocacy on behalf of the client if goals are to be maximally achieved. Clients are now encouraged to be their own advocate, fully participating in the maintenance and protection of their own health and that of the community in which they live and work (Tomlin 1983; Rice 1989; ANF 1990; Rorden and McLennan 1992). This is only possible when the consumers of health care are fully informed (Health Ministers' Forum 1994). The frail aged, mentally disadvantaged or the very ill may find full participation, equity and access to services difficult to achieve (Commonwealth Department of Health, Housing and Community Services 1991). The advocacy role of the generalist community health nurse therefore becomes crucial to the care of the client in circumstances where such participation is not a viable option. Acceptance of care and full participation assumes some responsibility on behalf of the individual receiving the care.

The concept of responsibility is regarded by Coombs (1989) as central to community health. All matters of health and illness within defined geographical locales are considered the responsibility of regionalised community health services. This is misleading as it may be construed that community health personnel take the responsibility away from the individual or group when the converse is true. Self responsibility, one of the concepts within the philosophy of primary health care is encouraged by health care workers, especially generalist community health nurses. The challenge of primary health care therefore, is to enable and empower people to be self reliant in their own and their community's health (Commonwealth Department of Health, Housing and Community Services 1991; McMurray 1993).

Supported by the community, the government has previously given more attention to the highly technical and specialised care given to individuals in
hospitals (Vuori 1984; Rorden and McLennan 1992). Since the Alma Ata Conference, governments have focused on improved co-ordination of health care services with a greater emphasis on primary health care (Vuori 1984). Although slow to respond, the Australian Health Ministers' Advisory Council finally established the Health Targets and Implementation Committee in 1987. This committee, formed to develop national goals to achieve "Health for All by the year 2000" recommended a policy and implementation plan be developed for primary care (Commonwealth Department of Health, Housing and Community Services 1991).

Training and research in public health and primary health care, essential to accomplish the national goals will be provided by the Federal Government's "New Deal for Public Health". These are considered strategies by which to achieve primary health care. The Review of the Community Health Program is a further attempt to promote the concept of primary health care (South Australian Health Commission 1988).

The palliative care service in the Illawarra, funded through the Commonwealth Medicare Incentive Scheme is a needs based service with a major community component and is typical of the primary health care approach. As with all health care in Australia however, primary health care is subject to the constraints of availability and resources, especially during the financially restrictive times currently experienced.

The recent emphasis on primary health care in relation to policy development has resulted in a subsequent increase in funding. From a mere 3% in the late 1980's (Sax 1990), 7% of the NSW health budget was allocated to the community and hence to primary health care for the year 1991/2 (NSW Health
Department 1994). Webster(1993) predicts that hospitals, supported by state government departments, will eventually divert services to the community to allay budgetary constraints. Shorter lengths of stay for hospital admissions are evidence of the implementation of this concept. This will lead to increased referrals to community health inevitably creating budgetary restrictions, thereby impacting on clinical care(Fry 1994).

The resultant limited resources for primary health care services can affect priorities and choices, thereby causing varying levels of efficiency, effectiveness and acceptability(Sax 1990). One possible outcome of continued financial constraints particularly within primary health care, is the abuse of self-responsibility. The imposition of self-reliance in inappropriate circumstances may result from this(Vuori 1984).

Primary health care has the potential to benefit the entire community because of the focus on wellbeing for the individual within their environment(Rice 1989). Society however still values the care of the sick over health promotion and illness prevention although the reasons for this are diverse, complex and often not understood(Coombs 1989; Thompson 1990). Primary health care activities such as the “Me No Fry” and “Quit Smoking” campaigns may eventually change society's attitudes to health care.

Health promotion, illness prevention campaigns and advances in technology are of little importance for those with disabilities or a life-threatening illness. Improvements in the quality of life are generally of more concern in these circumstances(Sax 1990). Improvements in the quality of life embody the aim of primary health care and are especially important in the evaluation of health outcomes(Commonwealth Department of Health, Housing and Community
Services 1991). With Australia having an increasingly older population the trend toward quality of life issues is likely to continue. Such priorities emphasise the importance of needs based health care and have a direct bearing on the primary health care provided by generalist community health nurses.

Care planned according to needs prioritised by the client or the community illustrates a principle of primary health care, namely “Health care should be related to the needs of the population” (Australian Council of Community Nursing Services 1989:11). Nurses utilising a client-centred approach, encompassing client prioritised needs, have the potential to affect funding decisions and policies. Such professional practices can conceivably be very powerful change agents, especially in the political arena.

Community nurses in the Illawarra have the opportunity to incorporate a theoretical nursing approach based on client-centred care and client needs, into their professional practice. The use of theory is important in community health, since for primary health care to be effective and beneficial it needs a scientifically sound data base, involving high quality research that leads to new knowledge (South Australian Health Commission 1988; Rice 1989; Health Ministers’ Forum 1994).

2.3 Theoretical Nursing

Theoretical nursing, as described by Meleis and Price (1988) is an attempt to guide nursing practice using theoretical statements and concepts such as nursing theories. Individual nursing theories attempt to describe and explain the basic concepts such as health, the individual and nursing as well as their inter-relationships. In an attempt to improve nursing, most theories have drawn from other fields such as psychology, sociology and communication (Aggleton and
Chalmers 1984). This does not detract from nursing's unique body of knowledge as may at first be thought. According to McFarlane(1976) it is the application and testing of the theories which gives the uniqueness to nursing not the origin of the theory(Quoted by Nolan and Grant 1992: 222).

Theoretical nursing does not presume to tell the clinician what has to be done, but rather to influence the way the clinician thinks about nursing and nursing practice. There is a potential therefore, for theoretical nursing to reduce the gap between nursing theory and nursing practice. Nolan and Grant(1992) describe this gap as an alienation of practitioners by theorists, based on differing priorities. Theorists were found to give theory and conceptual bases a high priority, whereas practitioners regarded theory as having little relevance to nursing practice. Miller(1985) goes further in stating that the gap between nursing theory and practice is widening with one group of nurses caring for the patients and the other group teaching nurses.

Emden and Young(1987) also researched the disjunction between nursing theory and practice. They found that the majority of nurses interviewed thought the gap, although historical, would eventually diminish as nurses became more familiar with theory and theoretical nursing. Some participants however, thought it important to maintain a gap between nursing and theory in order to generate new ideas.

To regard a gap between nursing and theory as essential to creativity assumes that applying theoretical nursing creates a narrower focus on behalf of the nurse. This assumption is invalid. According to Lewis(1988) nursing theory has the ability to enhance the skills of the nurse and to allow them to express themselves professionally. The use of theoretical nursing results in applied analytical skills.
Such critical appraisal then enables nurses to legitimately challenge existing health care practices (Aggleton and Chalmers 1986; Speedy 1989; Ingram 1991). This in turn encourages not only new ideas, but more specifically, those ideas which will ultimately benefit the client. The use of nursing theory and subsequent theoretical nursing indirectly benefits nursing and nurses because of the potential for more deliberate nursing actions which enhance professional autonomy and empowerment (Aggleton and Chalmers 1986; Ingram 1991).

With such disagreement within the profession it is not surprising that few nurses have incorporated theoretical nursing into practice. Limited resources currently hold such a high priority that the debate regarding the benefits of theoretical nursing to the profession and the clients alike is not encouraged. According to Ingram (1991) it is not the disjunction between theory and practice which should be discussed, but whether theory can improve practice.

Theoretical nursing encourages the development of responsible action through critical, reflective thinking. This results in continual modification and refinement of practice with subsequent improvements to nursing, nursing care or the health of the client (Aggleton and Chalmers 1986; Clarke 1986; Fawcett and Downs 1986; Meleis and Price 1988; Moore 1990; Spence 1994). Fawcett (1992) considers it mandatory for nursing to use and test nursing theory if the profession is to continue to provide consumers with a service.

When research proves that theoretical nursing can result in improved practice, ethical issues are raised if nursing theory is not routinely incorporated into practice (Ingram 1991). If for example, use of nursing theory results in improved health outcomes for the client, nurses subsequently have a moral duty to combine theoretical nursing with nursing practice. According
to Kim(1993) nursing theory should encompass the ethics of responsible action and decision making with nurses conscious of the consequences of their actions and morally committed to caring.

Basing health care on sound knowledge encourages research within the health care system, with the actions of the health care worker organised according to accepted methodology such as a well tested nursing theory. Research enables evaluation and the continuance of best practice principles and is considered by the Commonwealth Government as a priority within a national health policy(South Australian Health Commission 1988; Health Ministers’ Forum 1994). This benefits the discipline of nursing, the individuals and communities receiving care and the politicians who make policy decisions.

Useful nursing theories have the ability to logically explain practice and predict outcomes. When evaluation of theoretical nursing is continuous, nursing provides not only reflective, thoughtful nursing practice but also knowledge development. Benefits to the nurse include legitimacy to practice and a sound knowledge base, leading to autonomy in practice and eventually recognition of professional practice(Fawcett and Downs 1986; Kristjanson, Tamblyn and Kuypers 1987; Lewis 1988; Meleis and Price 1988; Fawcett 1992; Nolan and Grant 1992). The client however, should be the ultimate beneficiary of the application of nursing theory to practice, rather than the nurse or nursing. If for example, client outcomes do not equal client expectations, the theoretical basis on which care is provided, can then be questioned(Fawcett 1992).

According to Kim(1993) there are two difficulties with theoretical nursing. The first is the development of nursing theory, the second is the application. To apply the theory requires preferential choice, only possible with full knowledge of a number of theories. The chosen theory then needs to be accessible in order to be
incorporated into practice and is dependant on feedback from practitioners. Fawcett and Downs (1986) suggest the use of nursing assessment formats to assist the practical application of theory.

Nurses on the surgical ward at the University of Michigan Hospitals in America for example, have directly influenced practice through the application of the Modeling and Role-Modeling Theory. After intensive staff education, theoretical nursing was implemented in a practical way through the development of a theory based nursing assessment. Initially the nurses used the Modeling and Role-Modeling Theory to care for their clients. This in turn, identified a flaw in the nursing assessment format previously used as the most appropriate information, required to plan and implement holistic care, was not elicited. As a consequence, an assessment format based on the Modeling and Role-Modeling Theory was developed and implemented. A study was then carried out to establish the usefulness of the assessment format in terms of establishing nursing diagnoses. The use of the theory based nursing assessment format is reported as having a positive effect on the clients, nurses and physicians involved (Campbell, Finch, Allport, Erickson and Swain 1985).

2.4 Nursing Process

Nursing assessment, one of four phases of the nursing process, is a simple, formal problem solving process which aims to collect and analyse data in order to implement practices to achieve set goals. The other phases include planning, implementation and evaluation. The impression of separate phases is misleading as the process is an ongoing exchange of information and interactions (Erickson, Tomlin and Swain 1983; Aggleton and Chalmers 1984; De Meester, Lauer and Neal 1986; Coombs 1989; Alfaro 1990). The process was developed in the early 1960s in an attempt to reduce the gap between theory and practice according to Miller (1985) and Rorden and McLennan (1992).
Nursing assessment involves gathering data using observation, smell, feeling and hearing. Assessment includes previous health problems of the client, attitudes and beliefs, family interaction, supports, client response to the nurse and progression toward goals. Community health nursing assessment extends this to include the client's views regarding their lifestyle, home and work and the environment in which the client lives. The client's ability to deal with subsequent stressors which evolve from the inter-relationships of all these elements is also important. Individuals are seen within their own environment and are facilitated to adapt to their particular circumstances with the support of the generalist community health nurse (Erickson et al 1983; Coombs 1989; Rice 1989; Bullough and Bullough 1990; Kozier, Erb and Olivieri 1991; Rorden and McLennan 1992).

The assessment phase of the nursing process, is profoundly important as during this phase actual and potential problems are identified and form the basis of subsequent nursing care (Alfaro 1990; Bullough and Bullough 1990; Rorden and McLennan 1992).

The nursing process however is not nursing specific and can be used by anyone, to apply to any situation and does not encourage a scientific mode of thought (Erickson et al 1983; Lewis 1988). As Lewis (1988:345) states: "The nursing process may tell you the stages of solving a problem, but it does not tell you how to act". In limited support of this view, Rorden and McLennan (1992), who have written extensively on community health in Australia, developed a model to complement the nursing process. The model is set along a continuum and involves concepts such as the individual, health and wellness, familiar to many theories. There is however, no in-depth explanations by the authors of the inter-relationships of the concepts within the model nor their impact on community nursing practice.
Unlike the model suggested by Rorden and McLennan (1992), the Modeling and Role-Modeling Theory "...addresses the complex interrelatedness among the satisfaction of basic need, the development of psychological and cognitive subsystems, and the individual's ability to cope effectively with stressors to maintain a state of holistic health and well-being" (Stein 1989: 331-2). Also included in the theory, are guidelines on how the concepts link and relate to nursing, the client and the practical aspects of care, including the incorporation of the nursing process into theoretical nursing. Erickson et al (1983) outline precisely the way in which nurses can combine the traditional nursing process with the Modeling and Role-Modeling Theory thereby enhancing the care provided by nurses.

2.5 The Modeling and Role-Modeling Theory
The Modeling and Role-Modeling Theory was developed by Helen Erickson and Evelyn Tomlin, both nurses with backgrounds in psychiatric nursing and education, with the assistance of Mary Swain who is a psychologist with extensive experience in educating nurses (Caldwell-Gwin, Carr, Harmon, Jarlsberg, McCormick and Noone 1989). The theory synthesizes developmental concepts from theorists such as Maslow, Erik Erikson, Piaget and Milton Erickson (Caldwell et al 1989; Stein 1989; Kline Leidy 1990).

According to the Modeling and Role-Modeling Theory, care is based on the client's perception of their problems, their lifestyle and the environment in which they live. Modeling refers to the individual's own perception of their world and is based on the client's life experiences and subsequent interpretation of the situations encountered. Modeling is the process of determining and understanding the client's world "...within the client's framework and from the client's perspective" (Erickson et al 1983: 95).
Role-Modeling occurs following analysis of the client's world, therefore after modeling. It is the "...facilitation of the individual in attaining; maintaining or promoting health through purposeful intervention"(Erickson et al 1983: 95). Role-Modeling is regarded as being the "essence of nurturance"(Erickson et al 1983: 95) and encompasses the predictive and prescriptive components of the theory. Care is planned according to the client's view or model and at the client's own pace.

This is parallel to the primary health care model with care integrated within the person's normal pattern of living according to their requirement and participation(Australian Council of Community Nursing Services 1989).

2.5.1 Major Concepts

The major concepts which form the basis of the Modeling and Role-Modeling Theory include:

❖ Holism
❖ Affiliated-Individuation
❖ Self Care
❖ Adaptation
❖ Health
❖ Facilitation
❖ Nurturance
❖ Unconditional Acceptance

2.5.1/1 Holism

The Modeling and Role-Modeling Theory emphasises the difference between holism from a nursing perspective and wholism from a medical point of view. The whole, in holism is "...greater than the sum of the parts" whereas in wholism, the whole is "equal to the sum of the parts"(Erickson et al 1983: 45). Those
'parts' are described by Erickson et al (1983) as the biophysical, psychological, social and cognitive subsystems which are in dynamic equilibrium. Each subsystem impacts on the other and is dependent on the inherent bases of genetics and spirituality. These multiple interacting subsystems assume equal importance with conscious and unconscious processes.

Such a view of holism is consistent with a community health focus which is based on the total person within their environment (McMurray 1993). This differs markedly from the medical perspective where the individual is often removed from familiar surroundings with care dependent on the disease or illness (Rorden and McLennan 1992).

2.5.1/2 Affiliated-Individuation

Erickson et al (1983) describe affiliated-individuation as the need of the individual to feel close to another person whilst continuing to maintain their autonomy. This is an important dichotomy as it is often thought that autonomy, or independence negates a closeness with others. The concept of affiliated-individuation is in line with primary health care and the philosophical concept of self responsibility. Self responsibility is only possible when the client maintains their autonomy whilst continuing their relationships with the total environment.

According to Coombs (1989) one of the nurse's functions is to encourage client independence. The long-term relationships which community nurses often have with clients, have the potential to create client dependence and in turn can reduce the client's ability to cope with their stressors, thus causing more problems (Rorden and McLennan 1992). According to Gibson (1991) the view that the professional knows best for the client, can also foster dependence. Affiliated-individuation is therefore an important concept for generalist community health nurses to consider incorporating into their care.
2.5.1/3 Self care

One of the goals of nursing within the Modeling and Role-Modeling Theory is to nurture and support self care which is divided into knowledge, resources and action. Self care action utilizes both self care knowledge and self care resources to achieve optimum well-being. The authors regard the person as knowing innately what has made them ill and how they can improve their well-being and promote growth. Clients then utilize this knowledge and their resources, in providing the action required to achieve the goals of holistic health (Erickson et al 1983).

Self care and responsibility have long been goals of nursing and are important in the provision of primary health care (Hunter 1983; McMurray 1993). The encouragement of parents keeping personal records for children, as well as an emphasis on ambulatory care for diabetics and self monitoring and self medication for asthmatics are indicative of self care and responsibility (Webster 1993). Self care combines both knowledge and action to achieve a positive result (South Australian Health Commission 1988; Sax 1990). By encouraging individuals to participate in decisions regarding their own health, they then acquire the skills, information and motivation to promote both their own health and that of the community (South Australian Health Commission 1988).

2.5.1/4 Adaptation

Adaptation is the response of the individual to their present circumstances, as defined by the person concerned. Individuals continually respond to positive and negative stressors, however the response is determined by the resources available and the person's ability to mobilize those resources. There is the possibility of potential growth or improved health if adaptation occurs as a response to a stressor. The way in which a person responds to a stressor, is due to their interpretation of the event, based on previous experience. As a result a challenge
to one, may be a threat to another. Maladaption occurs when one subsystem uses another subsystem to deal with stress thereby causing increased vulnerability. The individual then has a reduced capacity to effectively deal with further stressors (Erickson et al 1983).

In community nursing adaptation is achieved by assisting the client to maintain harmony with their environment. Both internal and external factors are involved, as is a dynamic and flexible relationship between the health professional and the client. The client constantly adapts to situations and to their environment in an attempt to meet the goals they have either consciously or unconsciously set and hence improve their wellbeing. Adaptation skills are considered important for the client to achieve optimum well-being and are enhanced by growth and awareness (Rorden and McLennan 1992). This ties in very closely with the concepts outlined by Erickson et al (1983).

2.5.1/5 Facilitation

One of the roles of the nurse within the Modeling and Role-Modeling Theory is that of facilitation. The nurse/client relationship is regarded as an interactive, interpersonal process which helps the client mobilize resources to achieve optimum benefit (Erickson et al 1983). These are also the principles of primary health care and community nursing.

The Ottawa Charter for Health Promotion encourages nurses to advocate, enable and mediate for the client in an effort to achieve the principles of Health for All by the Year 2000. This is identified as helping the client realise their aspirations; satisfy the needs of the client and help them deal with and adapt to their environment (Australian Nursing Federation (ANF) 1990). The ANF does not elaborate on how such an assessment should be done. The Modeling and Role Modeling Theory suggests a number of complementary ways of assessing the
client. Maslow's hierarchy of needs could for example, identify the client's basic need satisfaction which is important when determining individual or community aspirations.

2.5.1/6 Nurturance

As described previously, nurturance is the essence of the term Role-Modeling. It involves an interactive, interpersonal and collaborative approach between the client and the nurse. The nurse "...seeks to know and understand the client's personal model of his or her world and to appreciate its value and significance for that client from the client's perspective"(Erickson et al 1983: 49). In effect, this is defining the needs of the client from their perspective, a principle of primary health care.

2.5.1/7 Unconditional Acceptance

The Modeling and Role-Modeling Theory encourages the nurse to accept the individual as unique, worthwhile and with respect. Such acceptance has the potential to encourage mobilization of appropriate resources, including the individual's resources and results in individualised care according to client needs(Erickson et al 1983). These are the fundamental pre-requisites for building rapport. This concept is parallel to the non-judgemental actions of the generalist community health nurse and the Social Justice and Equality philosophy of primary health care.
2.5.2. Aims for Nursing Intervention

There are five aims for nursing intervention outlined within the Modeling and Role-Modeling Theory which provide nurses with a means of applying theoretical nursing and providing individualised care:

- Build trust
- Promote client's positive orientation
- Promote client's control
- Affirm and promote client's strengths
- Set mutual goals that are health directed

(Erickson et al 1983: 186)

Within the Modeling and Role-Modeling Theory trust relates to the individual's need for affiliated-individuation, developmental stages and basic need satisfaction. There is an emphasis on the promotion of self worth and hope. A positive orientation focuses on achievable goals and influences the client's willingness to improve their situation, hence their motivation (Erickson et al 1983).

Motivation is regarded as a major component of the care offered by generalist community health nurses as it impacts on their ability to improve self, grow and achieve. By motivating and supporting clients in this manner, the individual is encouraged to improve both their own health status and that of their community. Individuals have the power to direct their own destiny although they may need some guidance and direction. Empowerment is the encouragement of individuals to utilise their internal and external resources in the most appropriate manner to achieve wellness, thus promoting a client's positive orientation (Rice 1989; Gibson 1991; Rorden and McLennan 1992).
The Modeling and Role-Modeling Theory uses a client-centred approach with the principle of care being the maintenance of client control. The client needs to perceive they have control over their lives and their environment. The client is regarded as the head of the health care team and is an active participant in their own care. There is a deliberate use by the authors of the term client instead of patient, to ensure control is conferred to the person receiving care (Erickson et al 1983).

This approach to health care challenges the doctor who has long been regarded as the head of the team. To confer control to the client in such a way also challenges generalist community health nurses who are regarded as case managers, for theoretically, the client then becomes case manager. This may be difficult for nurses who prefer the medical model or who feel the need to control clients for their own personal unmet needs. When the individual is not significantly involved in their own care, despite the best intentions of the caregiver, goals are imposed and client control eroded (Tomlin 1983). The Australian Council of Community Nursing Services (1989: 4) states specifically that the client has the "...right to remain in control of their life".

Gibson (1991) suggests that the individual can be helped by the nurse to achieve empowerment, a direct consequence of having control, through development of appropriate skills and the use of resources. Ultimately however, the individual must want to empower themselves and their community (McMurray 1993). This too is in line with the Modeling and Role-Modeling Theory which states that everything must be done according to the client's time (Erickson et al 1983).

The authors of the Modeling and Role-Modeling Theory regard people as having an innate drive to be as healthy as possible. Achievable, health directed goals become a possibility when they are firmly set within the client's perspective.
According to the theory, care is based on the client's perception of their problems, lifestyle and environment. The practitioner and client develop an appropriate course of action based on mutual goal setting (Erickson et al 1983).

There is an obvious similarity between the major concepts and aims of the Modeling and Role-Modeling Theory and the aim, principles and philosophy of primary health care as described by Vuori (1984), the South Australian Health Commission (1988), and the Australian Council of Community Nursing Services (1989).

2.5.3 Theory Evaluation
The main approach of the Modeling and Role-Modeling Theory is eclectic, as described by Kim (1993) in that the major focus is on the client and their problems. Kristjanson et al. (1987) regard the use of an eclectic theory as essential to provide quality nursing according to client need. Generalist community health nurses offer primary health care, based on client need, therefore it is appropriate and justified for nurses working in community health to incorporate the Modeling and Role-Modeling Theory into clinical practice.

The theory has, as a minor component, a focus on the practitioner which is termed by Kim (1993) as an integrative approach to theory application. There is potential within the Modeling and Role-Modeling Theory for both the practitioner and the client to grow from the relationship and this is acknowledged, indeed encouraged by the developers of the theory. The standards outlined by the Australian Council of Community Nursing Services (1989) include a similar approach with the nurse/client relationship considered a partnership, beneficial to all involved.
The Modeling and Role-Modeling Theory has also been influenced by practice theory which proposes that professional disciplines have theory firmly grounded in practice (Stein 1989). Erickson et al (1983) continually use examples to relate the Modeling and Role-Modeling Theory in terms of practical application within nursing and the subsequent benefits which are possible to achieve (Stein 1989).

The Modeling and Role-Modeling Theory is also a developmental theory of adult functioning because of the emphasis on the varying developmental stages of the individual (Stein 1989). The use of theoretical concepts from other disciplines allows nurses to expand their interpretation of a given situation. The importance lies not in the borrowing of theories from other disciplines, but how the theory is then used within a nursing context and whether or not such use can be validated (Moore 1990). The developmental concepts, including their inter-relationships are used by Erickson et al (1983) to explain the similarities of people, from a nursing perspective. This information is important in the assessment and planning of nursing care for the individual.

It is not sufficient however, to choose a theory, however appropriate for an area of nursing, if it has not been analysed. Kim (1993) provides guidelines by which to assess nursing theories. One way of determining the adequacy of a theory is by the ‘best tested’ or ‘well tested versus not tested’ method.

Although there is a scarcity of published literature on the testing of the Modeling and Role-Modeling Theory, extensive research has been carried out. Caldwell-Gwin et al (1989:271-272) cite a considerable number of research projects which have either tested or are currently testing the theory.

Erickson and Swain (1982) developed and tested the Adaptive Potential Assessment Model (A.P.A.M.), which has been incorporated into the Modeling
and Role-Modeling Theory to explain some of the differences between individuals. The A.P.A.M. is a synthesis of the grief response associated with attachment and loss, as defined by Engel and the response to stress known as the General Adaptation Syndrome, first described by Seyle. The authors claim the A.P.A.M. provides nurses with a model to predict the individual's ability to cope with stressors. Three coping potential states are identified and include: arousal; equilibrium and impoverishment (Erickson et al 1983: 80-81).

Using established, reliable measurement scales for anxiety and hope, Erickson and Swain (1982) identified those individuals in a stress state from those in a non-stress state. A significant difference in the length of stay of hospital patients was identified between the two groups. Those in the stress group had an average hospitalisation of 17.2 days, as compared with 9.4 days for the non-stress group (Caldwell-Gwin et al 1989: 100). The ability to mobilize self care resources is thought to be directly dependent on the particular coping state of the client. The A.P.A.M. therefore enabled nurses to identify individuals in a state of stress and predict the individual's ability to effectively mobilize resources. Such assessments can then directly impact on nursing care and management plans.

The Adaptive Potential Assessment Model (A.P.A.M.) is currently being tested within a totally different context. Hansen, Harter and Ozbolt developed a prototype expert system called ADAPT, for IBM compatible computers based on the A.P.A.M. Preliminary testing indicates this computer information tool is able to provide "credible adaptive potential scores...and states" (Ozbolt and Graves 1993: 421). If the tool is found to be reliable it would prove useful within diagnostic related groupings. Those individuals found to be frail could then be differentiated from the more robust clients for example thereby providing more accurate groupings than is currently available (Ozbolt and Graves 1993).
Research by Kline Leidy (1990) involved the inter-relationships of the concepts outlined in the Modeling and Role-Modeling Theory with specific reference to the effects of chronic illness. Whilst it is acknowledged by Kline Leidy that the severity of the disease is an important element, findings suggest that basic need satisfaction; perceived stress and psychosocial attributes affect the way in which people respond to chronic illness. Klein Leidy proposes that a serious chronic illness causes constant stress to the body's subsystems. The client is then vulnerable to acute symptoms, exacerbations or stressful stimuli.

It was found that a client with low levels of need satisfaction for example, assessed using Maslow's hierarchy of needs, could be encouraged to view the chronic illness as a challenge. Such a change in perception would reduce the client's level of stress, provide symptomatic relief and result in improved quality of life. Theoretically the client could then deal more effectively with negative stressors encountered. The mind/body/stress/illness linkage, a major component of the Modeling and Role-Modeling Theory, was found to be upheld by this research according to Kline Leidy (1990).

The Modeling and Role-Modeling Theory has been analysed by Caldwell-Gwin et al (1989) and Stein (1989) who consider the theory to challenge and encourage nurses to practice theoretical nursing. They regard the theory as having the potential to guide nursing practice and predict outcomes. The theory also allows for an understanding of the elements relevant to nursing, generates new ideas, and differentiates the nursing profession from other professions. The Modeling and Role-Modeling Theory was found by Caldwell-Gwin et al (1989) and Stein (1989) to require refinement, specifically in the area of a definition of environment. The Modeling and Role-Modeling Theory, although one of the youngest nursing theories currently utilised, is considered by Stein (1989) as a valuable asset to nursing.
According to Fawcett (1992) every interaction between the nurse and the client is a means of assessing credibility of a theory. Theory however, should not be used because of the idiosyncracies of the nurse or for no apparent scientific reason or benefit. Taken one step further, nursing care and the corresponding forms should not be used for these reasons either. The current assessment form for generalist community health nurses in the Illawarra Area Health Service is based on the nursing process and was developed to ensure uniformity of documentation for nurses undertaking client assessments. This is no longer an acceptable rationale and is reason enough to challenge the existing format.
CHAPTER THREE
METODOLOGY

Statement Of Research Problem:

Documentation within the Illawarra Area Health Service (I.A.H.S.) is non-theory based, does not espouse the philosophy, aim and goals of the primary health care model and is therefore inconsistent with the professional and clinical practice of generalist community health nurses.

Hypotheses:

1. Generalist community health nurses working within the I.A.H.S. will identify differences between non-theory based and theory based nursing assessment formats.

2. Managers and resource personnel, as experts for generalist community health nurses are aware of the benefits of theoretical nursing.

3. Clients assessed using a client centred, theory based nursing assessment format can identify holistic and individualised care.

Specific Aim:

To evaluate a theory based nursing assessment format developed specifically for generalist community health nurses working within the I.A.H.S. in terms of a comparison with the non-theory based nursing assessment form currently in use.
3.1 History:

The non-theory based nursing assessment form used by generalist community health nurses up to and including 1994, was instigated in the late 1980's as a direct result of management wanting to create uniformity within the service. Prior to this, generalist community health nurses had no outline by which to base their work (McGarry 1994). The current non-theory based nursing assessment format consists of five (5) pages of tick boxes and checklists, with a small area for comment by the nurse conducting the assessment (Refer Appendix A).

The current non-theory based nursing assessment form is inadequate in terms of:

♦ competency restriction - it reduces the ability of the generalist community health nurse to practice according to the aim, philosophy and principles of the primary health care model.

♦ it encourages a narrower focus on behalf of the generalist community health nurse, resulting in reduced nursing judgements and restricted problem lists

♦ utilisation of a problem solving framework. The present assessment format is based on the nursing process, which is a problem solving approach and is no longer sufficient for generalist community health nurses.

♦ inconsistency with the principles and the philosophy of primary health care as it is grounded in the problem oriented medical records approach.

According to Erickson et al (1983) the problem oriented approach excludes the individual's strengths. The focus remains on deficits, weaknesses and problems and is heavily influenced by the medical model. Problem oriented medical records, on which the non-theory based assessment form was developed, do not recognise the importance of self care knowledge and have an implied assumption
that the health professional knows best. In contrast, primary health care utilises a client centred, proactive approach with an emphasis on health promotion and illness prevention in an attempt to reduce problems occurring.

Based on anecdotal evidence, a Nursing Assessment Forms Committee (N.A.F.C.) was established to develop a new assessment format for generalist community health nurses. The N.A.F.C. consisted of the Assistant Director of Nursing, Nurse Unit Managers, Quality Assurance Clinical Nurse Consultant and those Clinical Nurse Specialists with an interest in developing a new assessment format.

This researcher became involved after a member of the committee requested information regarding different types of assessment forms particularly those based on client centred care. The opportunity presented to incorporate a theoretical nursing approach into clinical practice using a practical application. A preliminary format presented to the committee for perusal was met with positive assertions. An assessment format specifically for the generalist community health nurses working for the Illawarra Area Health Service was developed based on a nursing assessment format designed by Campbell et al (1985). Campbell et al's assessment is grounded in the Modeling and Role-Modeling Theory and as previously described in the literature review, utilises concepts consistent with the primary health care model advocated by generalist community health nurses.

3.2 Development of the Theory Based Nursing Assessment Form

The assessment format designed for generalist community health nurses refines and expands the nursing assessment format developed by Campbell et al (1985). At the top of the theory based assessment form (Refer to Appendix B), below M.R.N. (Medical Record Number) is "Source" to identify the person with whom
the nurse conducts the assessment. Family involvement is incorporated into each section of the assessment when appropriate, as determined by both the client and the nurse. Unlike the format by Campbell et al (1985) no division has been made between family and client in the assessment format. When the client remains in the home, generalist community health nurses assess the client in terms of the entire family unit and the support available.

3.3 Design

3.3.1 Psychosocial Form Description:

In contrast to the assessment form by Campbell et al (1985) there are two distinct, but not separate components of the nursing assessment for generalist community health nurses. These segments incorporate psychosocial aspects and a general physical assessment outline (Refer to Appendices B and C). The format by Campbell et al (1985) required modifications to suit the particular circumstances of community health nursing. Also, the Nursing Assessments Forms Committee thought a separate Data Base was required for other health professionals, therefore demographical information was withdrawn from this assessment format.

3.3.1/1 Description of the Situation:

In order to keep the questioning informal, thought to be more appropriate in the home situation, question one of Campbell’s form was changed to “Describe your situation for me”. This section was also extended to include the following questions: “Is there anything you need help with?” And “Do you have any concerns at the moment? Things you are worried about?”. These were included to ensure all areas of the situation were discussed from the client’s point of view. In the community, issues seemingly unrelated to health status are vitally important sometimes. For example, a client seen by a generalist community health nurse for follow-up following the death of her husband, was concerned
that there was no-one to clean the gutters of her house and she could not afford to pay for it. It was a simple matter of providing the client with a contact number of a local voluntary agency who provided such services. Situations such as this may be of major concern to the client and because of the increased stress involved, have the potential to affect the health status of the individual concerned.

3.3.1/2 Expectations/Responsibilities
The assessment form by Campbell et al (1985) required expansion for the inclusion of responsibilities. In primary health care there is an onus of responsibility for both the client and the nurse. In hospital, the setting for the Campbell et al (1985) form, expectations have a different connotation. It is important to clarify, from the outset, the client’s expectations of the service. ‘Client Brochure’ has been included as the I.A.H.S. is in the process of developing a pamphlet which outlines the responsibilities of the service to the client.

3.3.1/3 Support Resources
Support resources are those resources which the client identifies and uses to deal with stressors. These questions were adapted to remove the hospital context and provide a community perspective. Beliefs/values were included in this section as they can be a form of support for the client, especially during times of serious illness.

3.3.1/4 Health Status
The approach by Campbell et al (1985) required modification because of the decision by the Nursing Assessment Forms Committee to use a separate data base.
3.3.1/5 Strengths
Goals were included as they are regarded as strengths of the client. If for example, a client has a goal to continue to go away as they have done for the past ten years, this gives the client an incentive, or strength, to achieve optimum wellness in a specific time frame. Such a positive approach then becomes an important component of care which builds on the strength of the individual.

3.3.1/6 Professional Support Network Referrals
This is a new section included to identify other health professionals and relevant organisations also involved in the care of the individual. Primary health care is often multifaceted, requiring the input of many disciplines, however information regarding the exact organisations involved is not always documented.

3.3.1/7 Client’s Report on Medications Used
The report on medications by Campbell et al(1985) was adapted to include the word ‘Client’ and reworded to provide a less formal approach.

3.3.1/8 Health Professional’s Report on Medications Used
Some clients, when at home, take medications according to their own interpretation of what is best for them. This may lead to a discrepancy between what is actually taken and the medications prescribed. For this reason a separate section for the health professional was included.

3.3.2 General Physical Assessment
The nursing assessment format evaluated in this research, includes a physical assessment component(Refer to Appendix C). The assessment form by Campbell et al(1985) is deficient in that physical assessment has not been addressed. Erickson et al(1983) propose that a physical assessment conducted by a nurse is often a duplication of the doctor’s role therefore not always necessary to provide
care and achieve nursing goals. The value of this can be seen in hospitals where all admissions are provided with medical intervention. This does not apply in a community setting however, where the generalist community health nurses are often the most available and accessible to the client.

It is acknowledged that the client does not always need a full physical assessment. The extent of assessment is dependent on the professional discretion of the nurse based on assessment information and on the client's approval and participation. A knowledge of both health and disease and what is normal for the particular client is therefore essential. Based on observed changes, only possible by conducting physical assessments, the nurse is then able to either suggest or organise appropriate medical intervention. “Highly developed assessment skills, particularly physical assessment skills, are therefore required for primary health care to be delivered effectively to the client and the community” (Australian Council of Community Nursing Services 1989:10).

Individuals living in their own home, especially alone, are expected to function at particular performance levels known as activities of daily living (Rorden and McLennan 1992). Presently, functional level is determined according to the individual generalist community health nurse’s experience and education. In order to reduce subjectivity and provide a consistent approach, the concise and simple functional level codes developed by Gordon (1987), were included in the theory based nursing assessment form (Refer to Table One). Although Gordon (1987) provides a complete psychosocial and physical assessment format, only the format appropriate to physical assessment was included.
### Functional Level Codes

<table>
<thead>
<tr>
<th>Level</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>Independent</td>
</tr>
<tr>
<td>Level I</td>
<td>Requires use of equipment or device</td>
</tr>
<tr>
<td>Level II</td>
<td>Requires assistance or supervision from another person</td>
</tr>
<tr>
<td>Level III</td>
<td>Requires assistance or supervision from another person and use of equipment</td>
</tr>
<tr>
<td>Level IV</td>
<td>Dependent and unable to participate</td>
</tr>
</tbody>
</table>

**Table One: Functional Level Codes**

(Rordon 1987: 148)

Rorden and McLennan (1992) regard activities of daily living as time consuming, care intensive and expensive in financial, emotional and physical terms for the carer involved. To overcome this, other services such as home care services and volunteers are assisting in the care of the client in the home. These services offer practical support for the carer and are less expensive than providing care by a registered or enrolled nurse. For the maintenance of holistic care however, it is essential for one person to maintain an overall view of the care given and by whom, so that care does not become fragmented. Table Two was adapted from Gordon (1987), for easy reference for generalist community health nurses to identify those who assist the client in the home according to the activities of daily living.

*Refer to Table One for Functional Level Codes*  
(Adapted from Gordon 1987: 110)

**Table Two: Activities of Daily Living According to Function, Code and Assistant**

<table>
<thead>
<tr>
<th>Function</th>
<th>Code*</th>
<th>Assisted By</th>
<th>Function</th>
<th>Code*</th>
<th>Assisted By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td>Feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed mobility</td>
<td></td>
<td></td>
<td>General Mobility</td>
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<tr>
<td>Home maintenance</td>
<td></td>
<td></td>
<td>Shopping</td>
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<tr>
<td>Cooking</td>
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<td>Grooming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td>Toileting</td>
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<td></td>
</tr>
</tbody>
</table>
3.4 Implementation Process

3.4.1 Development of the Educational Package

In order to provide a basic grounding in the Modeling and Role-Modeling Theory and for the opportunity for clarification of issues, inservice was provided to generalist community health nurses. The inservice was based on a specifically developed Education Package (Refer to Appendix D) and given prior to the trial of the theory based nursing assessment. Approximately 60% of generalist community health nurses attended the program which consisted of one session, of approximately 100 minutes duration. Only the researcher and one assistant were involved in the education to ensure consistency in the approach, increase content validity and reduce biases.

The Education Package was developed according to Lewis’ Model of the Learning Process, described by Waring Rorden (1987) and the statement: “Learning is a dynamic process consisting of three basic phases: readiness to learn; acquisition of new knowledge, attitudes or skills; and a resulting ability to change behaviour” (Waring Rorden 1987: 27).

Readiness to learn is associated with the unfreezing phase of Lewin’s Model. In this instance generalist community health nurses had not made the decision to improve the non-theory based assessment form, nor had they had input into the trial of the theory based assessment form. There was a subsequent lack of awareness for both the need to change and a readiness to learn, thereby hindering the unfreezing phase. The lack of choice in decision making and in becoming a student would likewise affect the nurses’ readiness to learn new concepts such as a theory of nursing and their opinion of the theory.

The attitudes of the generalist community health nurses to the theory based assessment form would subsequently impact on their evaluation. Consequently included in the inservice is a short period of discussion regarding the non-theory
based assessment including both positive and negative attributes. The aim was to encourage the nurses to critically analyse the forms that they were currently expected to use and those to be trialled. Acquisition of new knowledge in this instance was only partial as one inservice was insufficient to provide a thorough understanding of the Modeling and Role-Modeling Theory.

The trial is considered the Moving Phase of Lewin’s Model, when the participant learns how to change and tries out the new behaviour. There was limited opportunity to change behaviour because of the short term nature of the trial, one calendar month. Refreezing, that is incorporating the theoretical aspects into clinical practice, requires further education regarding the theory and extended time for trialling the form. The refreezing phase was instrumental in the decision to choose the Modeling and Role-Modeling Theory and Gordon's Functional Health Pattern. They were considered to be close to the current nursing practice within community health thereby negating the need for dramatic change. This strategy is recommended by Lewis (1988) as it encourages the acceptance of a theory into clinical practice.

3.4.2 The Setting:
The project was carried out within the community health service of the I.A.H.S. and incorporated both the Illawarra and Shoalhaven areas.

3.4.3 Phase 1 - Generalist Community Health Nurses Evaluation

3.4.3/1 Population/Selection of Participants:
All generalist community health nurses employed by the I.A.H.S. for twelve months or more, working in both the Illawarra and Shoalhaven Areas, identified using the Area Community Nursing Staff List (1994) were invited to participate. The total number of questionnaires sent via the I.A.H.S. courier system was
seventyfive (75). A letter inviting participation, explaining the purpose and assuring confidentiality, accompanied all questionnaires, as did a consent form (Refer to Appendix E).

The employment time frame stipulation was included because it is generally acknowledged that some orientation time is required for the nurse to become familiar with the documentation and unique circumstances involved with working alone and generally unsupervised in community health.

3.4.3/2 Instrumentation:
Phase 1 consisted of Part A which involved the evaluation of the non-theory based nursing assessment format and Part B, the evaluation of the theory based form.

Whilst a checklist may be considered an inappropriate format by the Nursing Assessment Forms Committee, the tickbox format currently in use may be the preferred mode for the majority of generalist community health nurses. It became evident that a survey of the nurses regarding the non-theory based form was essential, prior to the trial of the theory based form.

A simple questionnaire was developed for this purpose, incorporating structured, close-ended, collectively exhaustive questions (LoBiondo-Wood and Haber 1994). Questions 1-4 also used a 5 point likert scale with provision for comments from generalist community health nurses. Questions 7-10, rather than using a likert scale involved yes/no/undecided answers. 'Undecided' was included as generalist community health nurses may have been unfamiliar with some of the concepts or had varying definitions of the terms, depending on their experience and education.
Part B. Evaluation of the theory based nursing assessment form.

For comparison purposes, the questions and format used in Part A were repeated in Part B. The theory based nursing assessment form was trialled for one calendar month and evaluated at the conclusion of the trial.

3.4.3 /3 Pilot Testing of the Questionnaire

Although Amenta(1992) chose not to test the questionnaire, a pilot test was considered important by Duffield(1993) to avoid ambiguity and to ensure simplicity, clarity and face validity. Four Registered Nurses were therefore asked to review the questionnaires for Phase 1. The assessors included the following: a generalist community health nurse; an hospital nurse providing primary health care; a community nurse considered an authority within community health on primary health care, familiar with the delphi technique and a nursing academic. Phase 1 was assessed as satisfactory and required no changes.

All phases involve purposive sampling which uses highly specific criteria to identify the participants involved in the research(Wilson 1989; LoBiondo-Wood and Haber 1994). The nature of the study determined the sample(Moody 1990) in that the assessment format was developed for generalist community health nurses working within the I.A.H.S. Therefore, participants in phases 1 and 2 had to be employed by the I.A.H.S. within community health and in the case of phase 2, be experts, that is managers or resource personnel, within community health nursing. Also important was the need for the participants to be knowledgable about the issues under study in order to test the new instrument(Polit and Hungler 1985), namely the theory based nursing assessment form. Participants in phase 3 must have been assessed by the generalist community health nurse using the theory based nursing assessment format.
3.4.4 Phase 2 - Experts / Delphi Technique

3.4.4/1 Population/Selection of Participants

A total of forty (40) questionnaires were sent via the I.A.H.S. courier system to all nurses regarded as experts in community nursing (Refer to Appendix F for the letters and consent). The managers and resource personnel were identified using classifications as outlined in the Area Community Nursing Staff List (1994).

Panel participants in the delphi process are chosen according to varying terms of reference. In the Australian study involving community based nurses conducted by Anderson (1986) panel participants were included in the delphi technique because they worked in community health. Participants in research by Hitch and Murgatroyd (1983) and Amenta (1992) were included because of their interest in the particular areas of hospice nursing and oncology nursing respectively. According to other researchers however, inclusion in the delphi technique is dependent on the known experience and presumed expertise of the participants. Only senior and experienced staff members within the organisation who have professional credibility, not just expertise in the area, should therefore be included in the panels (Harper, Ward, Westlake and Williams 1988; Duffield 1991; Knight and Knight 1992a; 1992b).

Expert can be defined as “one who has special qualification, skill or knowledge” (Garmonsway and Simpson 1987:270). It was therefore more appropriate to select panel participants on the basis of professional credibility rather than interest or because they might provide better responses than non-experts as Goodman (1987) incorrectly suggests.

The panel in this research therefore comprised nurse managers and nurses regarded as resource personnel for generalist community health nurses. Expert status implies both a responsibility for their own and their profession’s credibility and legitimacy in providing representation on behalf of their peers.
Panel Participants/Experts

Managerial Involvement

Those considered as managers within the nursing profession, such as the Assistant Director of Nursing, the Sector Managers who are nurses, and the Nurse Unit Managers were included in the panel as they have the capacity to implement changes. This is considered important by Duffield (1993) so that changes if required, can be implemented by those with the power to do so.

Peer Involvement

The panel also included Clinical Nurse Consultants (CNC) and Clinical Nurse Specialists (CNS). CNC and CNS must meet specific criteria as defined by the NSW Nurses Association and should be prepared to accept the responsibilities which are aligned with the positions such as being resource personnel for their peers. Special qualifications, skill or knowledge are required for this to occur.

3.4.4/2 Instrumentation: The Delphi Technique

The delphi technique is a structured group communication process developed by the Rand Corporation in the early 1950's to predict future defense needs. It is named after the Greek God, Apollo Pythios who, as the master of Delphi could predict the future (Helmer 1975; Goodman 1987). Participants involved in the delphi technique are requested to comment on and rate, statements pertaining to a particular subject or area of interest. In this instance theoretical nursing and the major concepts of the Modeling and Role-Modeling Theory were evaluated. Following analysis of the information, feedback is given to the participants providing them with the opportunity to revise their opinion and debate the issues (Helmer 1975; Goodman 1987; Duffield 1989; Crotty 1993). According to Hitch and Murgatroyd (1983) and Duffield (1993), feedback is a vital component of informed decision making and the delphi technique. It was therefore anticipated that two rounds would be involved.
The delphi process provides a systematic alternative when gathering and collating informed judgements is difficult to obtain (Goodman 1987). In this instance the difficulty was not in the collation of data but in getting the panel participants together. The technique was chosen as it enabled a relatively large number of nurses working in geographically distant areas, namely the Illawarra and Shoalhaven areas, to be involved. According to Duffield (1989) reliability in the delphi technique improves with the inclusion of a large number of individuals.

Subjectivity is regarded by Duffield (1993) as a major flaw of the delphi technique. All qualitative methodology, of which the delphi technique is one method, assumes some subjectivity by its very nature. At issue is whether or not those who have been asked to participate and provide their views on a subject are actually representative of the group for which they assume representation. The managers and resource personnel can be considered representative of generalist community health nurses. They are given expert status because of their knowledge of community health nursing and their clinical experience in the area.

**Development/Design of the Delphi Questionnaire**

**Delphi Round One**

Delphi questionnaires involve closed-ended questions or statements and often include a section for participants' comments (Duffield 1989; Whitman 1990). Harper et al (1988) and Amenta (1992) utilised statements developed by the researchers, rather than the panelists. Participants in this research were provided with a number of broad statements and asked to rationalise their views.

In line with Bartu, Nelson, Ng, McGowan and Robertson (1991) and Duffield (1991 and 1993) a 5 point likert scale was also included. It was
anticipated that those statements achieving >50% consensus by the panel, a cut-off also used by Goodrich(1982), would be excluded from round two of the delphi process as no further discussion would then be required.

Development of Specific Statements:

Delphi Round One

Round 1 of the delphi questionnaire commenced with a section on theory (Refer to Appendix G). If the managers and experts within the organisation did not regard nursing theory as important to nursing care and essential with regard to autonomy and professionalism in nursing, it would be impossible to implement a theory based nursing assessment.

Questions 1.1-1.4 inclusive related specifically to the possible benefits of theoretical nursing for clinical practice, described in the literature review, as espoused by the following authors:

Question 1.3. Ingram(1991: 352)
Question 1.4. Clarke(1986: 8)

Question 1.5. concerned the relationship of a theory of nursing to the primary health care role of generalist community health nurses. Nurses should be able to identify these concepts and acknowledge their importance, if expected to work under the principles, aim and philosophy of primary health care.

Question 1.6. was designed to establish whether the effective integration of theory into practice is dependent on the acceptance of the theory in relation to the individual nurse's philosophy of nursing.
Statements in Sections 4 and 5 of the delphi questionnaire, were developed based on the pertinent areas of the theory based assessment namely: 'Description of the Situation; Expectations/Responsibilities; Support Resources; Strengths'. An important consideration for the introduction of a theory based assessment format for generalist community health nurses is for the underlying concepts of the theory to be in accordance with the care provided by the nurses.

Delphi Round 2.

Initially Round 2 was to provide feedback from Round 1, however the response rate was inadequate for this(See Results). The questionnaire utilised in Round 1 was therefore modified in Round 2 to incorporate a simple one page layout using a 5 point likert scale. No rationale or comments were requested(Refer to Appendix H).

Statements 1-3 were formulated according to the fundamental issue of client centred care and client control. Statements 4-6 identified basic components of theoretical nursing. Included in this was whether or not a gap between theory and nursing existed as has been identified by others and discussed in the literature review. Statements 7-10 regarded the nurses' attitudes to their profession and whether they perceived that nurses had the power to incorporate change, not only for their profession but also for the client. Policy and funding were included as these decisions are crucial to the ongoing care of clients and as McMurray(1993) suggests, nurses have the potential to make a positive contribution in this area.

3.4.4/3 Pilot Testing of the Questionnaires:

The assessors involved in Phase 1 were also involved in assessing Phase 2. Clarity of content was not an issue regarding Round One. All however, were concerned by the length of the questionnaire and the anticipated time involved to provide rationale. Round two required only minimal changes to ensure clarity.
3.4.5 Phase 3 Client Evaluation

3.4.5/1 Population/Selection of Participants:

A random selection of three (3) nurses from each sector within community health were asked to give the questionnaire to one client assessed using the theory-based assessment form. The nurses were asked to select a client who they were to follow-up in the course of their work. This was to ensure the nurse did not perceive an extra and unnecessary visit was required to deliver the questionnaire. The I.A.H.S. requested that the nurses distribute the questionnaires in order to maintain the confidentiality of the clients involved. Fifteen (15) questionnaires were sent via the I.A.H.S. courier service to the generalist community health nurses who had been randomly selected. The questionnaires were accompanied by a stamped, addressed envelope for return (Refer to Appendix I for questionnaire, letters and consent form).

Casual clients were excluded as they routinely do not undergo extensive nursing assessments and were therefore not assessed using the theory-based nursing assessment format.

3.4.5/2 Instrumentation:

The client questionnaire developed included only closed-ended questions with a 5 point Likert scale. The theory-based assessment form is client-centred therefore it was considered important to have some feedback from the clients. Hitch and Murgatroyd (1983) perceived that their research would have improved if the opinions, thoughts, and values of clients with cancer had been included in their sample rather than the assumptions and interpretations of the workers involved in their care. As Rice (1989) indicates, assumptions by workers are often incorrect.
3.4.5/3 Pilot Testing of the Questionnaire:
Phase 3 was assessed to ascertain ambiguities and inconsistencies. 4 individuals participated: a client undergoing care by a generalist community health nurse; a community member not currently undergoing care; a generalist community health nurse and a nursing academic. This questionnaire required no refinement.

3.5 Ethical Considerations:
Generalist community health nurses, Nurse Managers, Clinical Consultants and Specialists working in the Illawarra and Shoalhaven areas of the I.A.H.S. were the major participants in the study. A small number of clients, assessed by the generalist community health nurses were also invited to participate.

Ethical considerations were directed toward:

☆ Gaining approval from the University of Wollongong Ethics Committee and the Director of Health Services Development, I.A.H.S.

☆ Gaining support from the Director of Community Services, the Assistant Director of Nursing and the Nurse Unit Managers.

☆ Providing assurance to be guided by the protocols of both the I.A.H.S. and the University of Wollongong.

☆ Ensuring anonymity to all participants involved in the study.

☆ Maintaining the confidentiality of all information gained.

☆ Providing an explanation of the purpose and usefulness of the project and then gaining consent from participants.

☆ Maintaining integrity and honesty in all submissions and processes during the study and its reporting.
4.1. Phase 1: Generalist Community Health Nurses Evaluate Non-Theory & Theory Based Assessment Forms

22 responses (32%) were received to Phase 1a involving the evaluation of the non-theory based nursing assessment form. 19 responses (25.3%) were received for Phase 1b, the evaluation of the theory based assessment format. Two responses from Phase 1b included demographic data. The majority of the respondents were female (95.8%) who had been employed in community health for more than 2 years (83.3%). Most respondents (58.9%) worked in the Central and Shoalhaven sectors of the I.A.H.S (Refer to Table Three).

Table Three: Demographics of Generalist Community Health Nurses (N=24):
(Shown as a percentage of total respondents)

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male: 4(4.2%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female:</td>
<td>23(95.8%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work:</th>
<th>Part time: 5(20.8%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fulltime:</td>
<td>19(79.2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time in service:</th>
<th>2yrs &lt; 5yrs</th>
<th>&gt; 5yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>12mths &lt; 2yrs</td>
<td>4(16.7%)</td>
<td>8(33.3%)</td>
</tr>
<tr>
<td>2yrs &lt; 5yrs</td>
<td>3(12.5%)</td>
<td>12(50%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age:</th>
<th>40-49yrs</th>
<th>50+yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30yrs</td>
<td>1(4.2%)</td>
<td>7(29.2%)</td>
</tr>
<tr>
<td>30-39yrs</td>
<td>11(45.8%)</td>
<td>5(20.8%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Responses According to Sectors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
</tr>
<tr>
<td>11(32.4%)</td>
</tr>
</tbody>
</table>
Level of Professional Education:

23 of the 24 respondents had Hospital Certificates. The sole respondent who did not, had a degree in nursing and had done two other health related courses. Almost 70% (16) of respondents with hospital certificates had done no further education in a health related field. Only one of the remaining 7 respondents, had a degree in nursing, although 1 person had partially completed a degree in nursing. None had converted their hospital certificate to a diploma in nursing. One respondent had complemented their certificate with a diploma of social science (Child Development), another a graduate diploma in public health. 6 of the 7 respondents had completed certificates including one respondent who has a domiciliary community health certificate; another has a generalist community certificate; one holds a child and adolescent certificate and one holds a psychiatric certificate. 5 had done 2 or more courses not all of which are slanted toward community health: one respondent had done a diploma in advanced practical obstetrics; 4 had midwifery certificates and one a certificate in intensive care.

All participants were requested to include their Registration number as a code so that matching could take place. 26 included their registration number; 6 used another code; 9 used no codes. It was possible to match only 6 responses. Only one person commented that they did not wish to sign the consent or give their registration number.

Questions 1 to 4 were analysed using non-parametric tests, as they were assumed not to result in a bell shaped curve due to the small numbers involved. Data, which were nominal, were separated into two groups with different tests applied to each group. The first group was the matched group who were known to have replied to both questionnaires. Sign test was used because the small number (N=6) involved were related. All other replies were regarded as independent therefore a Mann Whitney U Test was applied (N=29) (Polit and
Hungler 1985; LoBiondo-Wood and Haber 1994). Both p values were then combined using the Inverse Chi Square Method (Hedges and Olkin 1985:37). The results are shown in Table Four. 63.6% of respondents viewed the non-theory based assessment format as easy to very easy to use. In comparison only 26.3% thought the theory based format was easy to use which was a significant difference. No difference could be determined between the two formats regarding the other categories.

Table Four: Results of Questions 1-4 - Comparison of Non-Theory with Theory Based Assessment Forms

<table>
<thead>
<tr>
<th>Ease of Use</th>
<th>Sign test N = 6</th>
<th>Mann U Test N = 29</th>
<th>Inverse Chi Square Method (Significant difference &gt; 9.488)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>p=0.0312</td>
<td>p=0.0306</td>
<td>Sig (13.9082)</td>
</tr>
<tr>
<td>Appropriateness of Information</td>
<td>p=0.625</td>
<td>p=0.7104</td>
<td>Not Sig</td>
</tr>
<tr>
<td>Usefulness of Form</td>
<td>p=1.0</td>
<td>p=1.0</td>
<td>Not Sig</td>
</tr>
<tr>
<td>Appropriateness for All Clients</td>
<td>p=0.625</td>
<td>p=0.0703</td>
<td>Not Sig</td>
</tr>
</tbody>
</table>

50% and 47.3% of respondents to Phases 1a and 1b (non-theory and theory) respectively chose the mid-range for Appropriateness of Information. 40.9% viewed the non-theory assessment as ‘not useful’, whereas only 31.6% thought this of the theory based assessment. The majority of respondents chose the mid-range for ‘usefulness of the form’ with regard the theory based format. One respondent chose not to answer Question 3 but did not supply an explanation for
this. Most generalist community health nurses regarded both the non-theory and the theory based formats as not appropriate for all clients. Table Five shows the mean scores and ranges for the first 4 questions of Phase 1.

Table Five: Mean Scores and Range of Questions 1-4 - Comparison of Non-Theory with Theory Based Assessment Forms

<table>
<thead>
<tr>
<th></th>
<th>NonTheory Based Assessment</th>
<th>Theory Based Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Scores</td>
<td>Range</td>
</tr>
<tr>
<td>Ease of Use</td>
<td>3.6</td>
<td>2-5</td>
</tr>
<tr>
<td>Appropriateness of Information</td>
<td>3.07</td>
<td>2-5</td>
</tr>
<tr>
<td>Usefulness of Information</td>
<td>2.77</td>
<td>1-5</td>
</tr>
<tr>
<td>Appropriateness for ALL Clients</td>
<td>2.32</td>
<td>1-4</td>
</tr>
</tbody>
</table>

Generalist community nurses were also asked to evaluate the nursing assessment forms in terms of their ability to encourage Personalised Holistic Care; Primary Health Care; Development of Nursing Care Plans and Nursing Judgements/Decisions related to care(Questions 7-10). The categories were divided into Yes and Not Yes. The categories ‘Not Sure’ and ‘No’ were combined into ‘Not Yes’ to ensure an adequate frequency for chi square analysis(Wilson 1989:549). A comparison was then made between the Non-theory based nursing assessment and the Theory based nursing assessment(Refer to Table Six.).
Table Six: Respondents Views to Questions 7-10 - Comparison of Non-Theory with Theory Based Assessment Forms

<table>
<thead>
<tr>
<th></th>
<th>Non-Theory Based (n=22)</th>
<th>Theory Based (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Not Yes</td>
</tr>
<tr>
<td>Personalised Health Care</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Developing Nursing Care Plans</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Nursing Judgements/Decisions</td>
<td>13</td>
<td>9</td>
</tr>
</tbody>
</table>

Data were analysed using the Chi Square Method of analysis with scores from matched participants (6 individuals) excluded as it falsely implied 41 participants had replied. 29 responses were therefore analysed (Refer to Table Seven). The chi-square method of analysis was chosen as the nominal data were once again assumed to be nonparametric because of the small numbers and to test the proportions involved (Polit and Hungler 1993; LoBiondo-Wood 1994).

Table Seven: Results of Questions 7-10 - Comparison of Non-Theory with Theory Based Assessment Forms

<table>
<thead>
<tr>
<th></th>
<th>Chi Square</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalised Health Care</td>
<td>$x^2=11.023$</td>
<td>Sig</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>$x^2=3.804$</td>
<td>Sig</td>
</tr>
<tr>
<td>Development Nursing Care Plans</td>
<td>$x^2=0.165$</td>
<td>Not sig</td>
</tr>
<tr>
<td>Nursing Judgements/Decisions</td>
<td>$x^2=0.698$</td>
<td>Not sig</td>
</tr>
</tbody>
</table>
Personalised health care was found to be significantly different between the two groups with $\chi^2 = 11.023$ ($p = 0.001; \text{df} = 1$). It can be seen from Figure One that the majority of generalist community health nurses regard the Theory Based Nursing Assessment Form as supporting their practice of personalised holistic care, whereas the Non-Theory Based Form does not.

Almost 80% (78.9%) regarded the theory based assessment form as encouraging personal holistic care to be incorporated into the assessment, whereas only 27.3% of the respondents viewed the Non-Theory Based assessment form in this manner.

Primary health care was also found to be significantly different with $\chi^2 = 3.804$ ($p = 0.051; \text{df} = 1$). (C.V. of 3.84 where $p = 0.05$). The majority of generalist
Community health nurses regarded the theory based assessment form as enabling them to provide primary health care. Conversely, most viewed the non-theory based assessment form as not providing this (Refer to Figure Two).

50% of respondents viewed the non-theory based assessment form as not supporting primary health care, with a further 9.1% unsure. Only one participant (5.3%) thought the theory based assessment form did not support primary health care, with 21% undecided. 73.7% supported the view that the theory based assessment form allowed for primary health care.

![Primary Health Care](image)

**Figure Two: A Comparison of Respondents’ Views Regarding Primary Health Care**

No significance was found in either the development of nursing care plans or nursing judgements/decisions related to care. As can be seen in Figure Three most participants thought both the non-theory and the theory based assessment forms allowed for the development of nursing care plans.
3 respondents (15.8%) regarded the theory based assessment as not allowing for the development of nursing care plans, whereas 6 (27.3%) thought this about the non-theory based assessment form. One respondent marked "Yes" the non-theory based assessment form did allow for the development of nursing care plans, but clarified this by adding "but not always"!

![Developing Nursing Care Plans](chart)

Figure Three: A Comparison of Respondents' Views Regarding the Development of Nursing Care Plans

Respondents’ views of the ability of the assessment forms to allow for Nursing Judgements/Decisions were similar to the Development of Nursing Care Plans (Refer to Figure Four). Once again the majority of respondents supported the non-theory and the theory based assessment forms in allowing for nursing judgements/decisions. Just under 60% (59.19%) of respondents agreed that the non-theory based form did allow for nursing judgements, whereas almost 75% (73.78%) thought this of the theory based assessment.
Generalist community health nurses were also asked: "What do you like about the form?" and "What do you dislike about the form?". The following pages have specific comments and percentages of respondents choosing those comments.

What was liked by some with regard to the non-theory based assessment format was disliked by others. For example, the simple layout/tickbox was considered by some as an advantage as not much had to be written and yet others thought this was unsatisfactory. Both assessments were regarded as being time consuming, lengthy to complete and inappropriate at times. Only the theory based assessment form was considered to be client centred, allowed for professional discretion and was multi-faceted.
Generalist community health nurses were asked: “What do you like about the form?” and “What do you dislike about the form?”.

<table>
<thead>
<tr>
<th>Non-Theory Based Nursing Assessment Form (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What was liked:</strong></td>
</tr>
<tr>
<td>*Like the format(tick box)/</td>
</tr>
<tr>
<td>don't have to write much-3(13.6%)</td>
</tr>
<tr>
<td>*Suitable if client healthy/</td>
</tr>
<tr>
<td>or has no problems-2(4.5%)</td>
</tr>
<tr>
<td>*Suitable for the elderly-1</td>
</tr>
<tr>
<td>*Not too time consuming-1</td>
</tr>
<tr>
<td>*Familiar to use-1</td>
</tr>
<tr>
<td>*&quot;Nothing&quot;-1</td>
</tr>
</tbody>
</table>

* "Good as a reminder to assess holistically". This nurse marked "not sure" on the same page when asked whether the assessment allowed for personalised holistic care.

* "Does not centre on client...does not encourage any form of assessment skills to be developed by the nurse"
Generalist community health nurses were asked: “What do you like about the form?” and “What do you dislike about the form?”.

<table>
<thead>
<tr>
<th>Theory Based Nursing Assessment Form (N=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What was liked:</strong></td>
</tr>
<tr>
<td>* Allows for holistic care/ Multifaceted-5(21%)</td>
</tr>
<tr>
<td>* Professional discretion-3(15.8%)</td>
</tr>
<tr>
<td>* Improves with familiarity-2(10.5%)</td>
</tr>
<tr>
<td>* Client as a decision maker/ freedom for clients to say what is important to them”-2</td>
</tr>
<tr>
<td>* Provides clarification of client’s condition-1“</td>
</tr>
<tr>
<td>* “Nothing”-1</td>
</tr>
<tr>
<td>* May take over 3 visits to acquire this information”</td>
</tr>
</tbody>
</table>

* “I use my professional discretion assessing short-term clients/General headings - where I choose what is relevant”

* “Some clients became anxious with some questions - I also felt uncomfortable and anxious having to ask them”

* “Clients found it difficult”// “I didn’t feel comfortable in asking the clients...”
4.2 Phase 2: Delphi Technique and Expert Panel

Round 1 resulted in a poor response rate of only 10%, 4 respondents, despite the faxed reminder to return the completed questionnaires sent one week after the date the completed forms were due in. No responses were received following the fax.

The response rate of 42.5%(17) for round 2 showed a sharp increase from Round 1. No demographic data was obtained in round two however respondents could be identified according to sectors. Table Eight shows actual numbers and percentages according to the number of resource personnel and nurse managers in each sector. For example, in Central Sector, there is a total of 10 resource personnel and nurse managers according to the Area Community Staff List, dated 12 July 1994. Of these 10 personnel, only 4 responded, that is 40%.

Table Eight: Number of Respondents to Round Two Delphi According to Sector

<table>
<thead>
<tr>
<th>Central</th>
<th>Northern</th>
<th>Southern</th>
<th>Western</th>
<th>Shoalhaven</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>40%(10)</td>
<td>80%(5)</td>
<td>0%(9)</td>
<td>16.7%(6)</td>
<td>80%(10)</td>
</tr>
</tbody>
</table>

Shown as actual numbers and percentages of total resource personnel according to sectors.

The statements and responses to Round 2 of the delphi process are shown in Table Nine. The responses clearly indicate that the experts in community health nursing support a theory base for nursing assessment and that a client centred approach is important for generalist community health nurses. Although 14 of the 17 respondents considered a client centred approach would not threaten the case manager, not all thought the client should determine their own care.
Table Nine: Respondents Views to Round 2 Delphi (n=17)

<table>
<thead>
<tr>
<th>Q</th>
<th>Str. Agree</th>
<th>Str. Disagree</th>
<th>Mid-range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. Client Centred Approach (CCA) is important to nursing assessment</td>
<td>16</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Q2. CCA would threaten the role of the case manager</td>
<td>1</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Q3. Clients should determine the care they receive</td>
<td>9</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Q4. Nursing assessment should have a theory base</td>
<td>15</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Q5. Research should be an essential part of the role of the clinical nurse</td>
<td>14</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Q6. There is a gap between nursing practice &amp; theory</td>
<td>6</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Q7. Nurses can influence policy decisions</td>
<td>13</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Q8. Nurses are professionals</td>
<td>17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Q9. Most community nurses work autonomously</td>
<td>14</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Q10. Nurses can influence funding decisions</td>
<td>10</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Experts responded unanimously to the statement that nurses are professionals, with most regarding community nurses as working autonomously. There was an obvious disagreement between whether or not a gap exists between theory and practice with 6 agreeing, 7 disagreeing and 4 unwilling to commit
themselves. 14 respondents thought research should be an essential part of the clinical role. The majority of experts who responded also thought that nurses could influence both policy and funding decisions.

One respondent, rather than marking the likert scale for questions 3, 4 and 5 underlined the word ‘should’, but provided no clarification. This respondent also commented that the theory/practice gap existed (Question 6) “Only in theory” and strongly disagreed with the statement that there was a gap.

One participant thought the client “should be allowed to accept or not accept care”, but that the nurse should decide on “appropriate” care and then “educate the client as to the reasons for their decision”. This same respondent considered the theory-gap to be dependent on the theory used. Another respondent changed the word ‘would’ in Question 2 to “could” and wrote “be involved” in the care (Question 3), rather than ‘should determine that care’.

4.3 Phase 3. Client Evaluation

Only 3 questionnaires were received which was a 20% response rate. Table Ten outlines both the statements and the responses. One generalist community health nurse informed the researcher that because of being a weekend, part-time worker there had been no opportunity to use the theory-based assessment form. This worker was therefore unable to ask a client to evaluate the assessment.
<table>
<thead>
<tr>
<th>Question</th>
<th>Str Disagree/Disagree</th>
<th>Str Agree/Agree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. The questions were difficult to answer</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Q2. The questions were relevant to my situation</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Q3. I found I gave more information than I expected</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Q4. There is no other information I feel I need to give the nurse at the moment.</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Q5. I have some more questions to ask the nurse as a direct result of the assessment</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Q6. The questions were too personal and invaded my privacy</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Q7. I felt the questions showed the nurse was prepared to listen to my viewpoint.</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Q8. The questions made me feel I was being cared for &amp; in good hands.</td>
<td>1</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Q9. I was asked far too many questions.</td>
<td>2</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Q10. I feel very satisfied with the assessment</td>
<td>1</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>
CHAPTER FIVE
DISCUSSION

The philosophy, aims and major concepts of the Modeling and Role-Modeling Theory, on which the theory based nursing assessment format was developed, have clearly been shown in the literature review to be consistent with the primary health care model. In contrast, the non-theory based form, developed according to the problem oriented medical records policy and problem solving approach creates a narrow and deviated focus for primary health care workers, namely generalist community health nurses.

The problem-oriented approach, as previously described, excludes the individual's strengths, with the main focus on deficits and problems. Problem oriented medical records do not recognise the importance of self-care knowledge and have an implied assumption that the health professional knows best (Erickson et al 1983). It remains surprising therefore, that whilst at odds with the philosophy, aim and strategies of primary health care, the problem oriented medical records approach receives such favour. Similarly the problem solving approach, whilst useful, is now inadequate for professional nurses (Erickson et al 1983; Lewis 1988; Meleis and Price 1988). The problem solving approach can however, be enhanced by the use of appropriate nursing theories such as the Modeling and Role-Modeling Theory.

5.1 Phase 1: Generalist Community Health Nurses Responses
The results of this study support the hypothesis that generalist community health nurses working for the I.A.H.S. will identify differences between non-theory based and theory based nursing assessments. Significantly more nurses identified the theory based assessment format as allowing them to provide both personalised holistic care and primary health care. Conversely, the majority of
respondents consider the non-theory based assessment form currently in use, does not encourage personalised holistic care or primary health care. This research has therefore highlighted a deficiency in the documentation for generalist community health nurses who are expected to provide primary health care.

There is an expectation that nurses, as professionals will use and be provided with formats which not only complement, but enhance their work practices. The assessment phase of the nursing process for example, is the basis on which nursing care plans are developed and nursing decisions are made (Alfaro 1990; Bullough and Bullough 1990; Rorden and McLennan 1992). Despite this a number of respondents were either unsure, or thought the non-theory based nursing assessment format did not allow for the development of nursing care plans or nursing judgements/decisions. If the non-theory based nursing assessment form does not encourage the development of such fundamental concepts of nursing practice there is an obvious need for a change to the present format.

Although a number of generalist community health nurses had the same view of the theory based assessment format, this may have been due to unfamiliarity of the form which was trialled for one month only. The same could not be said of the non-theory based assessment form which had been used for more than five years. Further use and evaluation of the theory based assessment form is required to ascertain whether such a format is considered the most useful format for the development of nursing care plans and nursing judgements/decisions.

It was not surprising that the non-theory based assessment form was considered by generalist community health nurses as significantly easier to use than the theory based assessment form. 50% of respondents had afterall, worked in community health for more than 5 years and the non-theory based assessment form has been in use since the late 1980’s.
It is reasonable to assume that if the generalist community health nurses trialled the theory based nursing assessment form for a longer period of time, there would be a corresponding increase in ease of use. This was in fact identified by some respondents who acknowledged that the theory based assessment form “...becomes easier...” and “...improves with familiarity...”.

The research identified that both the non-theory and theory based assessment formats are not appropriate for all clients. From the comments outlined in the results, both are considered inappropriate for short term clients requiring for example, dressings. A specific, condensed version of the theory based nursing assessment form may prove more appropriate for short term clients, especially if the data base is incorporated into the format. Although some respondents considered the theory based assessment was inappropriate for clients with dementia, the format is designed for interviewing either the client or the family/carer, thereby overcoming this difficulty. This also was identified by one respondent who stated that “I use my professional discretion”. Extended use of the theory based assessment form would clarify this issue.

It is interesting to note that approximately 50% of respondents scored in the mid-range for “appropriateness of information” for both formats. Similarly, 40.9% thought the non-theory based assessment form was “not useful” and 31.6% thought this of the theory based assessment form. Most respondents in fact chose the mid range for the theory based assessment form. This may be expected from a format never previously used such as the theory based format, but definitely not from one used for some time, such as the non-theory based nursing assessment format. This provides added impetus to change the non-theory based assessment form presently used by generalist community health nurses.
From a total of 14 generalist community health nurses in central sector, 11 responses were received. This was by far the highest response according to sectors and is indicative of the familiarity with the researcher who is located within that sector. Although 9 responses were received from the Shoalhaven area this represented only 36% of the total number of generalist community health nurses located in that sector.

There is an impression that many generalist community health nurses have not attended tertiary education. This has been identified within this research with over 66.7% of respondents having done no further education in a health related field since achieving their hospital certificate. The majority of generalist community health nurses who responded have chosen not to continue health related studies, despite changes in the client population. Of particular concern is that 75% of the respondents without further education in a health related field have the potential for > ten years left in the workforce, with 50% having more than 20 years.

This is an important consideration for the managers of community health when regarding the shortened throughput of hospital inpatients who will subsequently require more intense community nursing (Webster 1993; Fry 1994; NSW Health Department 1994). Respondents were not asked if they anticipated doing further education in a health related field which may have been an important oversight. Education does however take time to be incorporated into clinical practice. It would have been preferable if generalist community health nurses had been undergoing further education, particularly in primary health care in a more proactive capacity.

Analysis of the Area community Nursing Staff List (1994) revealed that of the 75 generalist community health nurses (GCHN) who were sent questionnaires, 20 have CNS status. Overall this is one CNS for every 3.75 generalist nurses, a
ratio of 1:3.75(CNS:GCHN). There is however, a distinct difference in ratios between sectors. Two sectors have for example, ratios below 1:2(CNS:GCHN), whilst two sectors have ratios above 1:3.75(CNS:GCHN) It is debatable as to whether a ratio below 1:2 exemplifies good use of resources and is indeed required for professional and experienced generalist community health nurses.

5.2 Phase 2: Experts Responses

The hypothesis that experts in community health nursing, namely the managers and resource personnel for generalist community health nurses, are aware of the benefits of theoretical nursing was supported by this research. Round one of the delphi was inadequate because of the lack of response however, round two clearly indicates that the experts support a theory base for nursing assessment and a client centred approach to care.

Although 14 of the 17 respondents considered a client centred approach would not threaten the case manager, not all thought the client should determine their own care. Five respondents were not prepared to take a stance either way. This is an interesting anomaly considering the primary health care role has a significant emphasis on self-determination and self reliance in health care(Vuori 1984; Rice 1989; ANF 1990; Commonwealth Department of Health, Housing and Community Services 1991; Rorden and McLennan 1992). If experts in community health are not sure if the client should determine their own care, how can they advocate on behalf of the client or encourage self-determination?

The managers and resource personnel for generalist community health nurses act as role-models and disseminate information. If the experts’ interpretation of the primary health care role for generalist community health nurses is inadequate, it follows that there would be a similar difficulty with the definition by generalist community health nurses. It would seem therefore, that further education in the primary health care model is required. The statement that “Clients should
determine the care they receive” may have been interpreted as the client being able to decide the type of nursing care given. This may be a design flaw as the statement was meant to imply that the client determines the extent to which the care or advice is taken, that is to determine their care.

Also interesting to note are the number of managers and resource personnel who considered nurses to have an impact on policy and funding decisions. The policy decisions may have been interpreted as policies for nurses within the Illawarra Area Health Service or involve a broader perspective to include policy decisions by governments. In hindsight, this is failing in the design of this particular statement. It does however, beg the question: If a large majority of experts in community health nursing consider themselves autonomous professionals, capable of influencing policy and funding decisions for health care, have they been involved in decision making, especially at government levels? Decisions made in these areas do after all impact on the care of the client and the clinical practice of nurses. As McMurray(1993) suggests, nurses can have an impact on these decisions, therefore it is increasingly important for all nurses to consider incorporating this into their roles.

The inability of experts in community health nursing to agree on the existence of a gap between nursing practice and nursing theory supports the discrepancy highlighted in the literature review. According to Emden and Young(1987) for example some nurses thought the gap was increasing, others thought it decreasing. It would be interesting to ascertain whether the views held by the respondents correspond with their level of professional education. The demographic questionnaire was not recirculated with round two, therefore this information is not available. As Lewis(1988) suggests however, the discussion should centre around whether theory can improve practice, not the disjunction.
The majority of managers and resource personnel respondents agree that research should be an essential part of the clinical role. There is a need therefore, to ascertain procedures within community health, I.A.H.S. to encourage research. This is especially important, given the importance of research involving primary health care by the Commonwealth and State governments (South Australian Health Commission 1988; Health Ministers' Forum 1994). A research project officer within community health for example, could highlight productivity and efficiency gains as well as evaluating both quality service and health outcomes, thereby proving cost effective over the long term.

5.2.1 Delphi Technique
Given the ideal it would have been preferable to use the delphi technique to ascertain the concepts and components considered important for an assessment form for generalist community health nurses. An evaluation of the Modeling and Role-Modeling Theory could then have been undertaken to establish the appropriateness of the theory, prior to the development of the theory based nursing assessment form.

There are two possible options for the poor response to round one of the delphi technique in this research. A poor response may have been due to either a lack of interest in the area of theoretical nursing or the underestimation, by the researcher, of the demands involved with the questionnaire.

Amenta (1992) suggests that individuals don't usually respond to questionnaires unless the area of research matters to them. The increased number of responses to round two as well as the views of the respondents, dispute the suggestion that the respondents were not interested in the area of study. According to the experts' responses in round two, theory and research are considered important aspects in community health nursing.
According to Duffield (1989) and Whitman (1990) ignoring or underestimating the demands of the delphi technique especially when rationale is also asked for, is a common cause of failure of the technique. Round one involved a more intense and time consuming process of evaluation than the questionnaire generalist community health nurses were asked to complete. This was despite the experts having higher responsibilities because of their expert status. As described in the development of the questionnaires, the assessors also thought round one of the delphi was too involved. It would seem therefore, that the questionnaire in round one was considered too time consuming for the workloads the nurses carried at the time.

5.3 Phase 3: Client Evaluation

Clients were not asked to evaluate the assessment form, but rather their response to the assessment interview. It is acknowledged that this is influenced by the individual nurses and their approach to assessment. Such an influence cannot be avoided. Gaining a small insight into the perceptions of the client and the assessment is never-the-less important and necessary for a client-centred approach to care as suggested by Hitch and Murgatroyd (1983) and Rice (1989). Fawcett and Downs (1986) acknowledge that the introduction of theory based practice should be in line with the expectations of the clients, if not it should be discarded.

It is difficult to ascertain whether the questionnaires in Phase 3 were in fact distributed to the clients because of the nurses issuing the questionnaires. No conclusions can be drawn from the responses as three replies are not representative of the client population. Benefit would be gained however, from an extensive evaluation of how theoretical nursing can affect care and effect improved health outcomes.
5.4 Limitations of the study

The study was restricted to generalist community health nurses working for the I.A.H.S. in the Illawarra and Shoalhaven areas. There is only limited generalizability therefore, because of the small group involved within a unique situation. Generalist community health nurses within NSW however, are expected for example, to practice according to the principles and philosophy of the primary health care model. It would be interesting to do a comparison between their documentation and the Illawarra's to ascertain the extent of input from the problem oriented medical records approach.

Another limitation of the research was that not all the generalist community health nurses could trial the form. A certain number for example, are on leave and others, because of their part-time employment status did not have enough time to trial the use of the form. A longer period of time for trialling the form would prove beneficial. This would also allow increased familiarity with the form.

There was also a limited time for inservice due to work constraints of both the researcher and the participants. Generalist community health nurses have varied and possibly limited knowledge of the Modeling and Role-Modeling Theory, depending on their level of education. This would undoubtably have affected their response to the form. A thorough understanding of the principles of the theory and how these principles can be incorporated into practice, prior to trialling the form may have made a substantial impact on both the use of the theory based nursing assessment format and the subsequent evaluation.

Only a brief summary of the theory has been given to date because of the relatively short time allocated for inservice of staff in relation to the Modeling and Role-Modeling Theory. The inservice conducted for this research was an adjunct to normal work practices and is therefore unsatisfactory.
Factors which must be considered if further inservice is to be attended include resources involved in the education of staff and the cost associated with the implementation (Fawcett and Downs 1986). Acceptance of a new assessment form and acknowledgement of the benefits of theory to nursing and nursing practice bring with it an obligation for thorough inservice so that the assessments are carried out using the concepts of the theory, not just a form developed around the theory.

5.5 Conclusion
The specific aim of this study was to evaluate a theory based nursing assessment form developed for generalist community health nurses working for the I.A.H.S. in comparison with the non-theory based form presently used. The theory based nursing assessment format has been shown to have distinct advantages over the non-theory based assessment form for professional nurses. If the theory-based assessment form is to be implemented, further inservice will be required for staff to become familiar with the theory, its benefits and the practical application of the Modeling and Role-Modeling Theory.

Positive verbal responses to the theory based assessment form were given by the generalist community health nurses during the inservice, although there was an immediate reaction by some who thought it may have "taken too much time" to do the entire assessment. In reality assessment is done continuously and new information added on an ongoing basis (Erickson et al 1983; Aggleton and Chalmers 1984; De Meester et al 1986; Coombs 1989). The professional nurse also determines the appropriateness of questions according to the specific circumstance of the client and the interaction.

Overall the research clearly established that the present non-theory based nursing assessment format is inadequate for generalist community health nurses working for the I.A.H.S. The non-theory based assessment form did not allow for primary
health care and personalised holistic care for the majority of generalist community health nurses who responded to the study. In contrast, the theory based nursing assessment did just that. Whilst the majority of nurses thought the non-theory based assessment form allowed for the development of nursing care plans and nursing judgements, a considerable number thought otherwise. Fewer nurses thought this of the theory based nursing assessment form despite the brief use.

As previously noted, every interaction between the nurse and the client is a means of assessing credibility of a theory according to Fawcett(1992). Nursing is not just a service but has the potential to provide knowledge development through research and evaluation. If client outcomes do not equal client expectations, the theoretical base can be questioned. This provides reflective, thoughtful nursing practice(Fawcett 1992). The benefits to the client should transcend the benefits to the nurse. Benefits to the nurse include legitimacy to practice and a sound knowledge basis, leading to autonomy in practice and eventually recognition of true professional practice but ultimately resulting in improved nursing care(Fawcett and Downs 1986; Kristjanson, Tamblyn and Kuypers 1987; Lewis 1988; Meleis and Price 1988; Fawcett 1992; Nolan and Grant 1992).

It can be seen therefore that whilst generalist community health nurses are expected to practice according to the primary health care model this care is at present limited by a lack of theoretical nursing. Professionals providing nursing care to the community are obliged to implement best practice care for their own integrity and for the ultimate benefit of the clients whom they care for.
5.6 Recommendations

There are a number of recommendations that have been identified by this research:

☆ Replacement of the Non-Theory Based Nursing Assessment Form. The non-theory based nursing assessment form needs to be replaced with a nursing assessment format consistent with the aim, philosophy and principles of primary health care.

☆ Refine the Theory Based Nursing Assessment Form to include:
  - an integrated Data Base
  - a condensed version for short term clients

☆ Extend inservice to enable generalist community health nurses to thoroughly understand the major concepts of the Modeling and Role-Modeling Theory and how they relate to clinical practice.

☆ Extend the Trial of the Theory Based Nursing Assessment Form to allow familiarity, increased use and improved clinical implementation.

☆ Research Officer for Community Health.

☆ Research to establish changes in clinical practice as a direct result of the introduction of the Modeling and Role-Modeling Theory into clinical practice within community health in the I.A.H.S.

☆ Research to establish improvements in the health outcomes of the clients who are to be cared for by generalist community health nurses practicing theoretical nursing.
REFERENCES


Area Community Nursing Staff List. 1994. 12 July. Illawarra Area Health Service.


APPENDIX A

NON-THEORY BASED NURSING ASSESSMENT FORM
<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To be free from pain or discomfort.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the client free from subjective signs of pain or discomfort? (e.g. complains)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the client free from objective signs of pain or discomfort? (restlessness)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>To breathe normally.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>can the client breathe without undue effort?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the rate of breathing within normal limits?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the client free from cough?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>To have healthy skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the skin free from lesions or bruising?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the skin free of cyanosis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the skin free of pressure sores?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the skin free from rash?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>To be able to utilise all special senses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>can the client hear adequately?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>can the client see adequately?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>is the client's sensory perception normal? (e.g. free from areas of anaesthesia due to nerve damage and/or vascular problems)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>does the client have normal taste and smell sensation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>To eat and drink satisfactorily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is the client on a normal diet?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is the client able to prepare own meals and drink?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is the client able to feed him/herself?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is mastication of food satisfactory?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is diet balanced to include all five food groups in adequate amounts?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is his/her weight normal in relation to height?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is fluid intake in each 24 hours adequate? Estimate amount.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To eliminate normally</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is the client free from constipation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is the client free from diarrhoea?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>is the client free from incontinence of faeces?</td>
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<tr>
<td>is the client free from incontinence of urine?</td>
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<tr>
<td>is the client free from urinary retention?</td>
<td></td>
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<tr>
<td>is the client free from signs of urinary tract infection?</td>
<td></td>
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<tr>
<td>is the client free from oedema?</td>
<td></td>
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<tr>
<td>is the client free from nocturnal frequency?</td>
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<tr>
<td>To be mobile</td>
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<tr>
<td>is the client able to walk unaided?</td>
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<tr>
<td>can the client transfer unaided?</td>
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<tr>
<td>can the client sit up from a lying position unaided?</td>
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<tr>
<td>is the client able to assist the lifting personnel – during phases of movement?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>To rest and sleep satisfactorily</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>does the client get adequate rest and sleep (e.g. does not complain of insomnia)</td>
<td></td>
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<tr>
<td><strong>To be able to dress and undress</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1) is the client free from needs for special clothing (e.g. corsets, trusses)</td>
<td></td>
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</tr>
<tr>
<td>2) is the client able to dress/undress him/herself unaided?</td>
<td></td>
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</tr>
<tr>
<td><strong>To be able to maintain home environment</strong></td>
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<tr>
<td>3) is the home fitted with adequate heating facilities?</td>
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<tr>
<td>4) does the home have an adequate and safe hot water supply?</td>
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<tr>
<td>5) is the client able to maintain own housekeeping?</td>
<td></td>
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</tr>
<tr>
<td><strong>To be able to keep the body clean and well groomed</strong></td>
<td></td>
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<tr>
<td>6) is the client able to maintain his/her own body hygiene?</td>
<td></td>
<td></td>
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<tr>
<td>7) is the client able to cope with his/her own laundry?</td>
<td></td>
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</tr>
<tr>
<td><strong>To be able to avoid or plan dangers</strong></td>
<td></td>
<td></td>
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<tr>
<td>8) is the house free from obvious accident hazards? (e.g. loose mats, steep steps without rails, dangerous appliances)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9) does the client/family take necessary steps to ensure their continued health and safety?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10) are suitable mechanical aids and transfer equipment in use?</td>
<td></td>
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<tr>
<td>11) is access and space adequate?</td>
<td></td>
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<tr>
<td><strong>To be able to communicate</strong></td>
<td></td>
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<tr>
<td>12) is the client able to speak?</td>
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<tr>
<td>13) is the client able to communicate without the aide of an interpreter?</td>
<td></td>
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<tr>
<td>14) does the client feel able to discuss his/her feelings and/or problems?</td>
<td></td>
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<tr>
<td>15) does the client have sufficient communication to prevent feelings of isolation and loneliness?</td>
<td></td>
<td></td>
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<tr>
<td>16) is the client able to understand written/verbal instruction?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----</td>
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<tr>
<td>To experience satisfying socialisation and recreation</td>
<td></td>
<td></td>
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<tr>
<td>does the client engage in leisure activity that passes his/her time satisfactorily?</td>
<td></td>
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<tr>
<td>does the client have contact with other people outside his/her home?</td>
<td></td>
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<tr>
<td>To be motivated to be well</td>
<td></td>
<td></td>
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<tr>
<td>is the client keen to learn about his/her condition?</td>
<td></td>
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<tr>
<td>is the client motivated to gain control of his/her situation and make decisions relating to it?</td>
<td></td>
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<tr>
<td>To be able to comprehend the environment</td>
<td></td>
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<tr>
<td>does the client have a “normal” mood pattern in the circumstances?</td>
<td></td>
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<tr>
<td>is the client orientated in time, place and person?</td>
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<tr>
<td>is the client able to remember things which happened long ago?</td>
<td></td>
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</tr>
<tr>
<td>is the client able to remember recent events? (e.g. yesterday and last week etc)</td>
<td></td>
<td></td>
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<tr>
<td>is the client able to concentrate for long enough to learn simple facts and procedures?</td>
<td></td>
<td></td>
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<tr>
<td>does the client have a realistic concept of his/her own situation?</td>
<td></td>
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<tr>
<td>does the client receive adequate emotional support?</td>
<td></td>
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<td></td>
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<tr>
<td>To be free from stress</td>
<td></td>
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<tr>
<td>is the client successfully resolving any bereavement or significant loss? (e.g. death, divorce, mastectomy etc.)</td>
<td></td>
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<tr>
<td>is the client’s environment conducive to good health? (e.g. living arrangements)</td>
<td></td>
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<tr>
<td>is the client free from anxiety regarding his/her health status? (e.g. ageing, loss of independence, fear of dying, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>is the client maintaining his/her social status as acceptable to him/her? (e.g. cultural loneliness etc.)</td>
<td></td>
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<tr>
<td>18. To be able to manage medical condition</td>
<td></td>
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<tr>
<td>------------------------------------------</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a) is the client able to physically care for his/her own wounds or outcome of surgery?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>b) is the client aware of possible complications and able to make appropriate action?</td>
<td></td>
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<tr>
<td>c) is the client able to administer and be responsible for his/her own medications?</td>
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<tr>
<td>d) is the client aware of possible side effects of medications and treatment and able to take appropriate action?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>9. To have access to a supportive and supported carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) is the carer physically able? (e.g. are there any pre-existing medical conditions which may affect their ability to care?)</td>
</tr>
<tr>
<td>b) does the carer appear free from anxiety?</td>
</tr>
<tr>
<td>c) does the carer have relief from caring?</td>
</tr>
<tr>
<td>d) does the carer receive the domiciliary nursing care benefit?</td>
</tr>
</tbody>
</table>

Signature: __________________________
Date: __________________________
APPENDIX B

THEORY BASED NURSING ASSESSMENT FORM
1. Description of the situation
   a. Describe your situation for me:
   
   
   
   
   
   
   
   
   
   
   
   
   b. What do you think has caused the situation to occur?
   
   
   
   
   
   
   
   
   
   
   
   
   c. What do you think will improve the situation?
   
   
   
   
   
   
   
   
   
   
   
   
   d. Is there anything you need help with?
   
   
   
   
   
   
   
   
   
   
   
   
   e. Do you have any concerns at the moment? Things you are worried about?
   
   
   
   
   
   
   
   
   
   
   
   
   

2. Expectations/Responsibilities
   a. What are your expectations of the Service?
   
   
   
   
   
   
   
   
   
   
   
   
   
   b. Are you aware of your responsibilities? Eg. When to contact the CHN? What to do if you are unable to attend a prearranged meeting?
   
   
   
   
   
   
   
   
   
   
   
   
   
   c. Client Brochure given? Yes / No
3. Support Resources
   a. Who do you usually talk things over with?

   ____________________________
   ____________________________
   ____________________________

   b. Is she/he available often?

   ____________________________
   ____________________________
   ____________________________

   c. Beliefs/Values?

   ____________________________
   ____________________________
   ____________________________

4. Health Status
   a. How would you describe your general health?

   ____________________________
   ____________________________
   ____________________________

   b. Previous health problems?

   ____________________________
   ____________________________
   ____________________________

   c. Any current health problems other than those previously described?

   ____________________________
   ____________________________
   ____________________________

   d. How do you usually handle stressful situations?

   ____________________________
   ____________________________
   ____________________________

5. Strengths
   a. What do you see are the healthy, or positive aspects of yourself?

   ____________________________
   ____________________________
   ____________________________

   b. Is there anything else you would like to tell me?

   ____________________________
   ____________________________
   ____________________________

   c. Goals - Current and Future

   ____________________________
   ____________________________
   ____________________________

6. Professional Support Network Referrals (Please tick)
   G.P.; Social Worker; Physiotherapist; Occupational Therapist; Palliative Care; Meals on Wheels;
   Home Care; Community Options; Private Nursing Service; Ethnic Health Worker
   Other: (Please specify)
7. Client's Report on Medications Used

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number Taken</th>
<th>How Often Is Med'n Taken</th>
<th>Time Med'n Last Taken</th>
<th>Reason for Taking Medication</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

8. Health Professional's Report on Medications Used

(The Psychosocial Nursing Assessment is based on Modeling and Role-Modeling by Erickson, Tomlin and Swain, 1983 and adapted from the Assessment Form by Campbell, Finch, Allport, Erickson and Swain 1985, 112)
APPENDIX C

PHYSICAL ASSESSMENT FORM
A. Nutritional/Metabolic Pattern: Client's usual pattern of food and fluid consumption relative to metabolic need.
Assessment:

B. Elimination Pattern: Describes pattern of excretory function (bowel, bladder and skin).
Assessment:

Wound Chart: Yes / No

C. Activity and Exercise Pattern: Describes pattern of activity, functional ability, leisure, recreation, occupation.
Assessment:

<table>
<thead>
<tr>
<th>Function</th>
<th>Code*</th>
<th>Assisted By</th>
<th>Function</th>
<th>Code*</th>
<th>Assisted By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td>Feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed mobility</td>
<td></td>
<td></td>
<td>General mobility</td>
<td></td>
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</tr>
<tr>
<td>Home maintenance</td>
<td></td>
<td></td>
<td>Shopping</td>
<td></td>
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<tr>
<td>Cooking</td>
<td></td>
<td></td>
<td>Grooming</td>
<td></td>
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<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td>Toileting</td>
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</tr>
</tbody>
</table>

*Functional Level Codes - see over

D. Sleep - Rest Pattern
Definition: Describes pattern of sleep, rest and relaxation
Assessment:

E. Cognitive-Perceptual Pattern
Definition: Describes sensory perceptual and cognitive pattern
Assessment:

Pain Chart: Yes / No
INTERPRETATION

General Physical Assessment

A. Nutritional/Metabolic Pattern: Usual pattern of food and fluid consumption relative to metabolic need.
- Temperature
- Appetite
- Identification of feeding problems
- General body status
- Weight (including loss/gain)
- Diet (including restrictions)
- Daily food and fluid intake, including alcohol/drugs
- Healing potential of skin wounds/lesions

B. Elimination Pattern: Describes pattern of excretory function (bowel, bladder and skin)
- Bowel elimination pattern or problem (including frequency, consistency/colour, laxatives, discomfort, colostomy)
- Urinary elimination pattern or problem (including frequency, colour, discomfort, uridome, catheter)
- Perspiration pattern or problem (including skin condition, night sweats)

Wound Chart: Yes / No

C. Activity and Exercise Pattern: Describes pattern of activity, functional ability, leisure, recreation, occupation
- Limitations in mobility/ambulation
- Leisure and exercise pattern
- Energy level/Fatigue level
- Perceived ability (using Functional Codes)

*Functional Level Codes*

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>Independent</td>
</tr>
<tr>
<td>Level I</td>
<td>Requires use of equipment or device</td>
</tr>
<tr>
<td>Level II</td>
<td>Requires assistance or supervision from another person</td>
</tr>
<tr>
<td>Level III</td>
<td>Requires assistance or supervision from another person and use of equipment or device</td>
</tr>
<tr>
<td>Level IV</td>
<td>Dependent and unable to participate</td>
</tr>
</tbody>
</table>

D. Sleep - Rest Pattern: Describes pattern of sleep, rest and relaxation
- Usual bedtime
- Rest times
- Rested or not rested after sleep
- Hours of sleep
- Sleep problems
- Use of sleep aids

E. Cognitive-Perceptual Pattern: Describes sensory perceptual and cognitive pattern
- Sensory status: visual, auditory, olfactory, tactile, gustatory
- Hearing
- Ability to read and write
- Mental acuity
- Intelligence
- Sight
- Heat/cold sensitivity
- Memory
- Pain or discomfort

Pain Chart: Yes / No

(Physical Assessment Form based on and adapted from Gordon's Functional Health Patterns in Nursing Diagnosis: Process and Application (2nd Ed.) (Gordon 1987; 91-133))
APPENDIX D

EDUCATION PACKAGE
INTRODUCING A NURSING ASSESSMENT

BASED ON THE

MODELING AND ROLE-MODELING THEORY

AN EDUCATION PACKAGE

FOR COMMUNITY-BASED REGISTERED NURSES

BY

SUE M. BROWN

SUE M. BROWN, RN, BN, (Wollongong)

(Onc Cert; Bereavement Counselling Cert., Crisis Counselling Cert.)
A NURSING ASSESSMENT BASED ON THE
MODELING AND ROLE-MODELING THEORY

INTRODUCTION:

The aim of this package is to familiarise community registered nurses with the Modeling and Role-Modeling Theory and the assessment form developed and based on this theory.

INTEREST/NEED:

Assessment of the client is the basis for planning and implementing nursing care. It should be determined from the client's perspective, with the client maintaining control and encouraged and facilitated by the nurse to take responsibility for their care. It is preferable for the assessment to be done in a systematic way, using a sound knowledge base.

OBJECTIVES:

At the end of the session participants will be able to:

1) Discuss and evaluate the assessment form currently in use by community RN's.
2) Recognise and understand the concepts inherent in the assessment form based on the Modeling and Role-Modeling Theory.
3) Apply the concepts
4) Conceptualise the theory
5) Verbalise their response to the theory
6) Adapt their techniques of assessment to incorporate the theory
7) Recognise the importance of documenting all information gained from the client.

Levels of Learning: Knowledge - 1,2,3,
                 Attitudes - 2,4,5,7
                 Skills - 6

LINK:

Nursing practice based on nursing theory holds more credibility than other types of practice.

LENGTH OF SESSION: 2 hours
BODY OF THE SESSION:

INTRODUCTION:

- History of the development of the form
- Overview of session

Time allocation: 10 minutes

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>TEACHING STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Assessment Form</td>
<td>Discussion re:</td>
</tr>
<tr>
<td>(Tick Box Format)</td>
<td>- extent of information gathered</td>
</tr>
<tr>
<td>* history and use</td>
<td>- restrictions of form</td>
</tr>
<tr>
<td>Time allocation: 20 minutes</td>
<td>- development of care plans</td>
</tr>
<tr>
<td></td>
<td>O/H 1</td>
</tr>
<tr>
<td>Current Assessment Form Evaluation</td>
<td>Questionnaire and Consent</td>
</tr>
<tr>
<td>Time allocation: 10 minutes</td>
<td>(Stress confidentiality)</td>
</tr>
<tr>
<td>Benefits of a theory for nursing.</td>
<td>Discussion re:</td>
</tr>
<tr>
<td></td>
<td>- definition</td>
</tr>
<tr>
<td>Time allocation: 10 minutes</td>
<td>- medical vs nursing model</td>
</tr>
<tr>
<td></td>
<td>- new and old concepts of nursing</td>
</tr>
<tr>
<td></td>
<td>O/H 2</td>
</tr>
<tr>
<td>Modeling and Role-Modeling Theory</td>
<td>Discussion re:</td>
</tr>
<tr>
<td>* philosophy</td>
<td>- own philosophy of nursing</td>
</tr>
<tr>
<td>* concepts including theory bases</td>
<td>Handouts 1 &amp; 2</td>
</tr>
<tr>
<td>* advantages and disadvantages</td>
<td></td>
</tr>
<tr>
<td>* Adaptive Potential Model</td>
<td>O/H 3</td>
</tr>
<tr>
<td>Time allocation: 40 minutes</td>
<td></td>
</tr>
<tr>
<td>Application of the theory</td>
<td>Case Review</td>
</tr>
<tr>
<td>Time allocation: 20 minutes</td>
<td>Handouts 3 &amp; 4</td>
</tr>
</tbody>
</table>

CONCLUSION:

- Questioning: directed and non-directed
- Discussion
- Difficulties with implementation?
- Importance of documentation, assessment, theory?
- Suggested readings

Time allocation: 10 minutes
PERCEIVED FACTORS INFLUENCING CHANGE:

* reluctance for change - security with familiar ways ~ threat with new
* reluctance for perceived increased workload ~ emphasise importance of
  complete documentation of all information from legal perspective. (What is
  not documented = not done/not known)
* reduced time allocation and importance of documentation
* varying levels of tertiary education
* varying levels of commitment to nursing
* ambivalence toward theory/theories in general
* varying levels of knowledge re: theories
* varying attitudes for combining theory with practice

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Emden, C. and Young, W. 1987. Theory development in nursing: Australian nurses
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Erickson, H.C., Tomlin, E. M. and Swain, M.A.P. 1983. Modeling and Role-
Hall, Inc.

ATTITUDES TO NURSING

"[Nursing puts] us in the best possible conditions for Nature to restore or to preserve health - to prevent or to cure disease or injury.... Health is not only to be well but to be able to use well every power we have to use. Sickness or disease is Nature's way of getting rid of the effects of conditions which have interfered with health. It is Nature's attempt to cure - we have to help her....Nursing is therefore to help the patient to live.
Florence Nightingale, 1893.

Nursing...it's object is not only to cure the sick and heal the wounded but to bring health and ease, rest and comfort to mind and body, to shelter, nourish and protect and to minister to all those who are helpless or handicapped, young, aged or immature. Its object is to prevent disease and to preserve health....The nurse finds herself not only concerned with the care of the individual but with the health of a people.
Bertha Harmer, 1922.

Nursing requires the application of scientific knowledge and nursing skills...[it includes] helping the patient to adjust to unalterable situations, such as personal, family and economic conditions, teaching him and others in the home and the community to care for themselves, guiding him in the prevention of illness through hygienic living, and helping him to use the available community resources to these ends.
Hester Frederick and Ethel Northam, 1938.

Nursing is primarily assisting the individual (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. It is likewise the unique contribution of nursing to help the individual to be independent of such assistance as soon as possible.

...to facilitate the efforts of the individual to overcome the obstacles which currently interfere with his ability to respond capably to demands made of him by his condition, environment, situation, and time.
Ernestine Weidenbach, 1964.

(Erickson et al, 1983: 26-29)

PHILOSOPHY:
Nursing is the holistic helping of persons with their self-care activities in relation to their health. This is an interactive, interpersonal process that nurtures strengths to enable development, release, and channeling of resources for coping with one's circumstances and environment. The goal is to achieve a state of perceived optimum health and contentment."
(Erickson et al, 1983: 49)

NB. Describes what nursing is, how it is accomplished and the goal of nursing. Not concerned with the tasks of nursing!!
PRIMARY HEALTH CARE

- WHO 1978 - Alma-Ata (USSR) - International Conference on PHC.
"Health for All by the year 2000"
Basis for this is PHC

* individuals, family and the community
* full participation
* client responsibility; spirit of self-reliance/self-determination
* promote own well being
* acceptable to the client
* culturally sensitive
* address major health needs
* affordable
* practical, scientifically sound and socially acceptable


"Ottawa Charter"- First International Conference on Health Promotion (1986)
Charter for action to achieve "Health for All by the Year 2000"

Enabling people to
* increase control over and to improve their health
* realise aspirations
* satisfy needs

Advocate
- for health - political, social, economic, cultural, environmental, behavioural and biological dimensions

Mediate
- co-ordinated action for pursuit of health
- change/cope with their environment

PURPOSE:

To provide a theoretical framework by which Community Health Nurses can assess clients.

GUIDING PRINCIPLES

❖ RIGHTS

 Clients and staff have the right to be treated with dignity and respect, irrespective of diagnosis, gender, culture, belief, disability, age and sexuality.

❖ RESPONSIBILITY

 The emphasis is at all times on the clients as the principle decision makers with regard to their health. In situations where this is not possible, advocacy is conferred to a significant other in preference to a health professional.

❖ ACCOUNTABILITY

 Community Health Nurses offer services which are accountable to and appropriate for the client and families they serve.
AIMS:

- Build trust
- Promote client's positive thinking
- Promote client control
- Affirm and promote client strengths
- Compensate for client weakness
- Set mutual goals that are health directed

MAJOR CONCEPTS:

- **Holism** - a complete functioning system
- **Adaptation** - the ability to cope
- **Nurturance** - respecting the client's world views and values
- **Unconditional acceptance** - mutual respect and consideration
- **Self-care** - the ability to look after one's self
- **Facilitation** - improving the ability of the client to deal with circumstances
- **Affiliated Individuation** - having friends/professionals you can rely on to help you
- **Health** - a resource for living

Adapted from Modeling and Role-Modeling: A Theory and Paradigm for Nursing
(Erickson, Tomlin and Swain, 1983: 44)
CONCEPTS AND THEORETICAL BASES

# HOLISM
Nurses need to know:
* what is normal and abnormal
* similarity of individuals and uniqueness of individuals
(Refer back to model of holism)

CONCEPTS RELATING TO HUMAN NATURE:

# HEALTH:
* "...a state of physical, mental and social well-being, not merely the absence of disease or infirmity"(WHO, Constitution of World Health Organization, The Chronicle, 1947: 29-43)

# LIFETIME AND GROWTH:
* needs motivate action
* innate ability/desire to achieve full potential of self
* growth and development occurs during entire life span
* dynamic process - constantly changing and adapting to situations as they occur

Growth - "...changes in body, mind and spirit that occur over time"(p.46)
  - leads to development i.e. "holistic synthesis of body, ideas, social relations etc.

Abraham Maslow - hierarchy of needs (O/H)
  - "basic needs are only met when the individual perceives they are met"(p.57)
  - "...all human beings have basic needs that can be satisfied but only from within the framework of the individual"(p.58)

Teaching Client: Ascertaining Need to Know Versus Fear of Knowing
(Refer to O/H)

Lifetime Development
  a) Psychological Stages - Erik Erikson
  * 8 stages of psychological development
  * each stage = developmental task = turning point.
  - virtues = attitudes
  - progressive eg. young adult = intimacy vs isolation - throughout life
    eg. trust vs mistrust - infant - through life
  b) Cognitive Stages - Piaget
  * 4 periods: sensorimotor, preoperational, concrete operations, formal operations
  * several substages within these periods
  (Refer to Handouts)

# AFFILIATED INDIVIDUATION
* dependent on support systems i.e. sense of being taken care of and cared for
* independence i.e. autonomy; having a will of their own, control over themselves
  * occurs simultaneously
  * close to but separate from another
  - does not have to be reciprocated, therefore different to interdependence
  - innate need for attachment and response to loss

Similar to and implied in works by Winnicott, Kline, Mahler, Bowlby and Engel.
Engel - loss whether real, threatened or perceived => grief response

Erickson, Tomlin and Swain (1983)
# ADAPTATION
* positive and negative stressors are essential
* can cause either: a) harm b) growth

Adaptation - "ability to respond to internal and external stressors in a health and growth directed manner"(p.47)

Maladaptation - use of one subsystem at the expense of another.
  eg. Psychological stressor - inability to teach or lecture in front of others/ inability to call on adequate coping => biophysical response such as n/v, diarrhoea, stutter
  eg. Cognitive stressor - exam => poor writing ability/failure
  eg. Social stressor - shy, wallflower - body stance/not noticed => think no good

Crisis - danger and opportunity (Chinese), therefore a Turning Point
  One person's danger, is another's challenge - dependent on perception, resources.

# SELF CARE:
* Knowledge - innate knowledge of what is good for self, what is needed to promote health, provided given the opportunity
* Resources - internal and external
* Action - "develop SCK and utilise and mobilise SCR in order to gain, maintain, and promote an optimum level of holistic health"(p.48)

CONCEPTS RELATING TO THE NURSES' ROLES

Aim: to establish a trusting and functional relationship

# FACILITATOR:
- interactive, interpersonal relationship
- help the client recognize and mobilize own resource/strengths or develop if required

# NURTURANCE:
- nurse seeks to know and understand the client's personal model of their world
  => appreciation of the value and significance for the client, from their perspective
  => role-models the client's world in other interactions resulting in growth and health(p.49)

# UNCONDITIONAL ACCEPTANCE:
* unique, worthwhile and important individual - important when client developing own potential
* acceptance and respect

Erickson, Tomlin and Swain (1983)
FIGURE 3-3  A wholistic model
FIGURE 3-2  A holistic model

Erickson, Tomlin and Swain 1983:45
FIGURE 4-1  Maslow's hierarchy of needs

Erickson, Tomlin and Swain (1983:57)
FIGURE 4-2  Erikson's developmental stages

1. TRUST versus MISTRUST
   - TASK: DRIVE
   - STRENGTH: HOPE
   - VIRTUE

2. AUTONOMY versus DOUBT
   - TASK: SELF CONTROL
   - STRENGTH: WILLPOWER

3. INITIATIVE versus GUILT
   - TASK: DIRECTION
   - STRENGTH: PURPOSE

4. INDUSTRY versus INFERIORITY
   - TASK: METHOD
   - STRENGTH: COMPETENCE

5. IDENTITY versus ROLE CONFUSION
   - TASK: DEVOTION
   - STRENGTH: FIDELITY

6. INTIMACY versus ISOLATION
   - TASK: AFFILIATION
   - STRENGTH: LOVE

7. GENERATIVITY versus ABSORPTION
   - TASK: PRODUCTION
   - STRENGTH: CARE

8. INTEGRITY versus DESPAIR
   - TASK: RENUNCIATION
   - STRENGTH: WISDOM

Erickson, Tomlin and Swain (1983:62)
<table>
<thead>
<tr>
<th>AGE</th>
<th>PSYCHO-SOCIAL STAGE</th>
<th>POSITIVE RESPONSE</th>
<th>NEGATIVE RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>First year</td>
<td>trust v. mistrust</td>
<td>Faith in self and others</td>
<td>Sense of deprivation, suspicion of others and fear of future</td>
</tr>
<tr>
<td>Second year</td>
<td>autonomy v. shame and doubt</td>
<td>Sense of confidence and self-control</td>
<td>Compulsive need to control environment, lack of confidence</td>
</tr>
<tr>
<td>Third to fifth year</td>
<td>initiative v. guilt</td>
<td>Enthusiasm for trying new things</td>
<td>Jealous rivalry or guilt over thoughts and behaviour</td>
</tr>
<tr>
<td>Sixth year to puberty</td>
<td>Industry v. inferiority</td>
<td>Application to learning tasks and skills</td>
<td>Sense of inadequacy and inferiority to others</td>
</tr>
<tr>
<td>Adolescence</td>
<td>identity v. role confusion</td>
<td>Sense of one’s self as integrated person, selection of an occupation</td>
<td>Confusion over one’s abilities and future</td>
</tr>
<tr>
<td>Early adulthood</td>
<td>intimacy v. isolation</td>
<td>Willingness to commit oneself to others in love and friendship</td>
<td>Inability to share oneself and to develop affectionate bonds</td>
</tr>
<tr>
<td>Middle adulthood</td>
<td>generativity v. stagnation</td>
<td>Ability to guide and teach next generation</td>
<td>Increasing self-centredness</td>
</tr>
<tr>
<td>Ageing years</td>
<td>ego identity v. despair</td>
<td>Sense that life has been meaningful and worthwhile</td>
<td>Dissatisfaction with life and fear of death</td>
</tr>
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</table>

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<tr>
<th>STAGE</th>
<th>AGE</th>
<th>CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sensorimotor</td>
<td>0–2 years</td>
<td>Develops concept that objects have permanence and an identity of their own. Begins to use symbols to represent activities.</td>
</tr>
<tr>
<td>2. Preoperational</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Preconceptual</td>
<td>2–4 years</td>
<td>Use of concepts is incomplete and illogical. Reasoning is 'transductive', going from one particular instance to another without linking them logically.</td>
</tr>
<tr>
<td>b. Intuitive</td>
<td>4–7 years</td>
<td>Thinking is dominated by perception rather than reason. Events are interpreted only from the child's point of view (egocentrism).</td>
</tr>
<tr>
<td>3. Concrete operations</td>
<td>7–11 years</td>
<td>Can apply rules of logic to classes of objects and their special relationships and to numbers, but not to objects or events that are not 'concrete', i.e. those within own experience or ability to imagine.</td>
</tr>
<tr>
<td>4. Formal operations</td>
<td>11–15 years</td>
<td>Able to reason from the hypothetical to the real or from the actual to the hypothetical. Imagination and idealism are characteristic of this stage.</td>
</tr>
</tbody>
</table>
NEED TO KNOW

For Knowledge's Sake

Become wiser, richer, more mature

GROWTH

Method of Coping With Fear and Anxiety

Meets safety and security needs

SURVIVAL

Fear of Knowing

Feel safe, avoid anxiety

THREAT

Lack of growth

Basic need deficit

Challenge

ANXIETY

Threat to individual

Preparation for growth

Defensive state

BALANCE OF RESOURCES REQUIRED

CHALLENGE < THREAT

Adapted from Erickson, Tomlin and Swain (1983)
APPENDIX E

PHASE 1: GENERALIST COMMUNITY HEALTH NURSES’ QUESTIONNAIRES AND LETTERS
RN Demographic Data:

1. How long have you been working in the Community within the I.A.H.S.?
(Please tick)
- Less than 12 months □
- 12 mths -< 2 yrs □
- 2 yrs -< 5 yrs □
- > 5 yrs □

2. Age:
- <30 yrs □
- 30-39 yrs □
- 40-49 yrs □
- 50+ yrs □

3. Gender:
- Male □
- Female □

4. Level of Professional Education:
- Hospital Certificate □
- Degree in Nursing □
- Diploma of Nursing □
- Other Health Related Studies (Please specify):

5. Do you work:
- Part-time □
- Fulltime □
Nursing Assessment Form Questionnaire

For the purposes of statistical analysis only, please include your Registration No: ____________

Please mark a cross on the scale which best fits your opinion of the nursing assessment currently used in Community Health within the Illawarra Area Health Service.

1. To use this assessment form is:

   | 1 | 2 | 3 | 4 | 5 |
   | Very Difficult | Very Easy |

Comments: ________________________________________________________________________________

2. Information obtained using this form is:

   | 1 | 2 | 3 | 4 | 5 |
   | Very Inappropriate | Very Appropriate |

Comments: ________________________________________________________________________________

3. What is your opinion of this form?

   | 1 | 2 | 3 | 4 | 5 |
   | Not Useful | Very Useful |

Comments: ________________________________________________________________________________

4. Using this form for ALL clients is:

   (excluding casual clients)

   | 1 | 2 | 3 | 4 | 5 |
   | Very Inappropriate | Very Appropriate |

Comments: ________________________________________________________________________________

5. What do you like about the form?

__________________________________________________________________________________________

6. What do you dislike about the form?

__________________________________________________________________________________________

Please circle the answer which best suits the following:

Using this assessment form allows for:

7. Personalised Holistic Care: Yes No Not Sure

8. Primary Health Care: Yes No Not Sure

9. Development of Nursing Care Plans: Yes No Not Sure

10. Nursing Judgements/Decisions related to care: Yes No Not Sure

Please feel free to add any further information which you think may be relevant:

__________________________________________________________________________________________

Please return by September 2nd, 1994 to:
Sue Brown, Wollongong Community Health Centre.
Thank you for your participation and promptness.
Nursing Assessment Form Questionnaire

In the purposes of statistical analysis only, please include your Registration No:

[ ] Please mark a cross on the scale which best fits your opinion of the THEORY-BASED NURSING ASSESSMENT CENTLY TRIALED in Community Health within the Illawarra Area Health Service.

To use this assessment form is:

1 Very Difficult
2
3
4
5 Very Easy

Comments:

Information obtained using this form is:

1 Very Inappropriate
2
3
4
5 Very Appropriate

Comments:

What is your opinion of this form?

1 Not Useful
2
3
4
5 Very Useful

Comments:

Using this form for ALL clients is:

1 Very Inappropriate
2
3
4
5 Very Appropriate

Comments:

What do you like about the form?

What do you dislike about the form?

[ ] Please circle the answer which best suits the following:

[ ] This assessment form allows for:

Personalised Holistic Care: [ ] Yes [ ] No [ ] Not Sure
Primary Health Care: [ ] Yes [ ] No [ ] Not Sure
Development of Nursing Care Plans: [ ] Yes [ ] No [ ] Not Sure
Nursing Judgements/Decisions related to care: [ ] Yes [ ] No [ ] Not Sure

[ ] Feel free to add any further information which you think may be relevant:

Please return by October 14th, 1994 to:
Sue Brown, Wollongong Community Health Centre.
Thank you for your participation and promptness.
August 15th, 1994

Dear Nurse

I am currently in the final year of my Master of Nursing at the University of Wollongong which involves a research component. Over the last 18 months I have developed a theory-based nursing assessment which will be trialed within the Illawarra Community Health. My research involves evaluating the nursing assessment form.

The essential element in this research is feedback from the nurses who will be trialing the form. Any change for nurses should be implemented by the nurses involved with that change. The more responses obtained the more democratic the process involved. I ask that you therefore become a willing participant and provide me with as much constructive criticism as possible and return all questionnaires within the specified time period.

There are three phases involved in the evaluation. I have included an outline of the phases for you:

PHASE 1:

1.1. All registered nurses conducting client assessments will be asked to participate in phase 1. A questionnaire is enclosed regarding the assessment form currently in use by generalist community nurses. Please complete this questionnaire if you are a Registered Nurse and have been employed in Community Health within the Illawarra Area Health Service for 6 months or more.

1.2. Following an in-service for all Registered Nurses, the nursing assessment form will be introduced for a trial period for the month of September. A questionnaire will then be distributed to RNs regarding the theory-based assessment form. A comparison between phases 1.1. and 1.2 will then be made.

PHASE 2:

Phase 2 involves nurses who are regarded as resource personnel in community health, such as CNS's, NUMs and CNCs. A survey, using the Delphi Technique will be distributed to them to elicit their views on the theoretical components involved with nursing theory and nursing practice.

PHASE 3:

Phase 3 surveys 3 clients from each sector, who have been assessed using the theory-based assessment form. It is an attempt to ascertain the client's perspective of the assessment, not to discuss aspects of care or aspects of future care. As case managers some of you will be asked to take these questionnaires to the client. This is to maintain privacy and confidentiality. You are not expected to participate in any other way. It is then up to the client to choose to complete the questionnaire and return it to me.

All participants, are free to withdraw at any time. All information obtained will remain confidential and anonymous. You are asked to record your registration number so that comparisons can be made between your view of the current and new forms. I cannot use this number nor identify you with it. The University of Wollongong requests that you sign the consent form and return it to me as well.

Thank you in anticipation.

Yours faithfully,

Sue Brown
Palliative Care Liaison Nurse(Acting)
Wollongong Community Health Centre.
NURSE INFORMATION

This study will be conducted by Sue Brown to satisfy the research component of Master of Nursing at the University of Wollongong, under the supervision of Ms Judith Leacock and Mr John Sibbald from the Nursing Faculty at this university.

The purpose of this study is to evaluate the effectiveness of the theory-based psychosocial and physical assessment forms that have been developed for generalist community health nurses working in the Illawarra Area Health Service.

This will involve anonymous survey questionnaires that will be sent out over a time period of approximately three months.

Information supplied by each participant by way of questionnaires, for the purposes of this study, will remain confidential. No names or personal details will be used. The use of the Registration number is for statistical purposes only.

Participants are free to withdraw at any time.

Any complaints regarding the conduct of this research may be directed to the Secretary of the University of Wollongong, Human Research Ethics Committee (214457).

Please sign below, detach and return in separate envelope

NURSE CONSENT FORM

I have read the above description of the study and understand what is expected of me. I understand that all information obtained will remain anonymous and confidential.

I am free to withdraw from this study at any time.

SIGNED __________________________ DATE /
APPENDIX F

PHASE 2: EXPERTS' LETTERS

Dear Nurse

I am currently in the final year of my Master of Nursing at the University of Wollongong which involves a research component. Over the last 18 months I have developed a theory-based nursing assessment which will be trialed within the Illawarra Community Health. My research involves evaluating the nursing assessment form.

The essential element in this research is feedback from the nurses. The more responses obtained the more democratic the process involved. I ask that you therefore become a willing participant and provide me with as much constructive criticism as possible and return all questionnaires within the specified time period.

There are three phases involved in the evaluation and you are invited to participate in phase 2.

PHASE 2:
Phase 2 involves nurses who are regarded as resource personnel in Community Health, such as CNS's, NUMs and CNCs. A survey, using the Delphi Technique is included. You are asked to give your views on the statements provided. It is anticipated that two rounds will be involved. Following analysis of the first round, some statements will be recirculated, along with pertinent comments made by you. You will then be asked to reconsider the statement in view of the comments.

All participants are free to withdraw at any time. All information obtained will remain confidential and anonymous. The University of Wollongong requests that you sign the consent form and return it to me as well.

Thank you for your participation,

Yours faithfully,

Sue Brown
Palliative Care Liaison Nurse(Acting)
Wollongong Community Health Centre.
NURSE INFORMATION

This study will be conducted by Sue Brown to satisfy the research component of Master of Nursing at the University of Wollongong, under the supervision of Ms Judith Leacock and Mr John Sibbald from the Nursing Faculty at this university.

The purpose of this study is to evaluate the effectiveness of the theory-based psychosocial and physical assessment forms that have been developed for generalist community health nurses working in the Illawarra Area Health Service.

This will involve anonymous survey questionnaires that will be sent out over a time period of approximately three months.

Information supplied by each participant by way of questionnaires, for the purposes of this study, will remain confidential. No names or personal details will be used. The use of the Registration number is for statistical purposes only.

Participants are free to withdraw at any time.

Any complaints regarding the conduct of this research may be directed to the Secretary of the University of Wollongong, Human Research Ethics Committee (214457).

Please sign below, detach and return in separate envelope

NURSE CONSENT FORM

I have read the above description of the study and understand what is expected of me. I understand that all information obtained will remain anonymous and confidential.

I am free to withdraw from this study at any time.

SIGNED ___________________________ DATE
October 5th, 1994.

Dear Nurse,

Enclosed is the second and final round of Phase 2 of my research, as outlined to you previously.

Thankyou for your participation.

Yours sincerely,

Sue Brown.
APPENDIX G

PHASE 2: ROUND ONE DELPHI TECHNIQUE
Delphi Demographic Data:

1. How long have you been working in the Community within the I.A.H.S.? (Please tick)
   < 2yrs □  2yrs - < 5yrs □  5yrs - < 10yrs □  10yrs or more □

2. Age:
   <30yrs □  30-39yrs □  40-49yrs □  50+yrs □

3. Gender:
   Male □  Female □

4. Level of Professional Education:
   Hospital Certificate □  Degree in Nursing □  Diploma of Nursing □
   Other Health Related Studies (Please specify):
   ________________________________________________________
Please read the following statements then mark a cross on the scale beside each statement which best fits your opinion. Please provide a short rationale for making this decision.

1. Theory Based Statements:

1.1. The benefit of applying theory to practice is that nursing action then becomes more efficient and effective, thereby improving quality of care.

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<tbody>
<tr>
<td>Strongly disagree</td>
<td>Strongly agree</td>
<td></td>
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</table>

Reasons for decision:


1.2. Nursing theory provides knowledge, enhances nursing's power, provides rationale when challenged and provides professional autonomy.

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</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>Strongly agree</td>
<td></td>
<td></td>
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</table>

Reasons for decision:


1.3. Nursing theory provides a good basis for challenging existing health care practice and will develop new analytical skills that allow the nurse to act deliberately.

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<tbody>
<tr>
<td>Strongly disagree</td>
<td>Strongly agree</td>
<td></td>
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</table>

Reasons for decision:


1.4. Nursing theory which arises from practice and in turn modifies it, assumes an importance equal to that of practice.

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<tbody>
<tr>
<td>Strongly disagree</td>
<td>Strongly agree</td>
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Reasons for decision:


1.5. It is essential that any nursing theory adopted by community health nurses have the same underlying concepts as that of Primary Health Care.

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<tbody>
<tr>
<td>Strongly disagree</td>
<td>Strongly agree</td>
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</table>

Reasons for decision:
1.6. The underlying concepts of a theory must be understood and be integrated into the nurse's own philosophy of nursing to ensure the theory is applied effectively to practice.

Reasons for decision:

2. Description of the situation:
2.1. The client's perception of the situation allows the nurse to develop a client model of the situation and to ascertain their stressors.

Reasons for decision:

2.2. One of the most effective ways of building trust is to listen to the client and develop an understanding of their perception of their world.

Reasons for decision:

2.3. Whilst each person is uniquely different in the way they have interacted and responded to their world they are also alike in the way in which they wish to achieve potential through predictable developmental stages and with the basic needs that motivate their behaviour.

Reasons for decision:

3. Expectations/Responsibilities
3.1. Identifying both the client and the nurse's expectations and responsibilities alleviates inconsistencies and enhances the probability that the client's resources and available energy will be maintained.

Reasons for decision:
3.2. The nurse's goals and expectations for the client must also be considered in the promotion of client control providing incredible power for mutual personal growth.

Reasons for decision:

4. Support Resources
4.1. Identifying the client's social support network and eliciting the client's perception of these individuals is important to ensure energy is directed toward the well-being of the client and not to family dynamics.

Reasons for decision:

5. Strengths
5.1. An understanding of an individual's current ability to mobilize coping resources facilitates the nurse's planning of health care and the individual's ability to contend with current and future stressors.

Reasons for decision:

5.2. Determining the goals of the client helps identify basic-need deficits as well as allowing for development of future directions for and with the client.

Reasons for decision:

5.3. Encouraging clients to have a sense of control of their situation promotes hope and future expectations which in turn promotes healing and enhances their existing state of health.

Reasons for decision:
5.4. Nursing involves helping the individual consider stressors as a challenge or self-fulfillment, rather than as a threat to basic needs.

Reasons for decision:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5.5. Interventions designed to facilitate the client in perceiving control are most effective when they are designed within the framework of the client's model/perception of their world.

Reasons for decision:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please include any further comments which you think may be useful for this investigation

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please return these forms to: Sue Brown by September 2nd, 1994
Wollongong Community Health Centre

Your response and comments are invaluable and I thank you for your time, interest and response.
APPENDIX H

PHASE 2: ROUND TWO DELPHI TECHNIQUE
Please mark a cross on the scale which best fits your opinion of the following statements:

1. A client-centred approach is important to nursing assessment.

2. A client-centred approach would threaten the role of case-manager.

3. Clients should determine the care they receive.

4. A nursing assessment should have a theory base.

5. Research should be an essential part of the role of the clinical nurse.

6. There is a gap between nursing practice and nursing theory.

7. Nurses can influence policy decisions.

8. Nurses are professionals.

9. Most community nurses work autonomously.

10. Nurses can influence funding decisions.

Please return to Sue Brown
Wollongong Community Health Centre
By October 21st 1994 Thank you.
APPENDIX I

PHASE 3: CLIENT QUESTIONNAIRES AND LETTERS
CLIENT QUESTIONNAIRE

Please mark a cross on the scale which best fits your opinion of the nursing assessment recently conducted by the nurse from the Illawarra Area Health Service:

1) The questions were difficult to answer.

2) The questions were very relevant to my situation.

3) I found I gave more information than I expected.

4) There is no other information I feel I need to give the nurse at the moment.

5) I have some more questions to ask the nurse as a direct result of the assessment interview.

6) The questions were too personal and invaded my privacy.

7) I felt the questions showed the nurse was prepared to listen to my point of view.

8) The questions made me feel I was being cared for and in good hands.

9) I was asked far too many questions.

10) I feel very satisfied with the assessment.

Please return completed questionnaire to Sue Brown in the stamped, self-addressed envelope provided. Thank you.

Dear Nurse,

Enclosed are the forms for phase 3 of my research at the University of Wollongong which involves client evaluation of the nursing assessment form recently trialed. As outlined in the previous letter this is not to discuss aspects of nursing care.

You are asked to give the questionnaire and accompanying letters to an English speaking client who has been assessed using the Theory-Based Nursing Assessment Form and who you will be seeing as a matter of course during the next week. This is to ensure their confidentiality and anonymity.

You are not expected to assist the client in any way however you are requested to outline the following to the client:

❖ anonymity and confidentiality is guaranteed
❖ clients are not obliged to participate
❖ non-participation will not affect nursing care
❖ it is a request of the University of Wollongong that the consent form be signed

Two envelopes are provided so that the questionnaire and consent will remain separated, thereby guaranteeing anonymity.

Thank you for your involvement.

Yours sincerely,

Sue Brown
August 7th, 1994

Dear Client

Nurses working in Community Health in both the Illawarra and Shoalhaven areas have recently been trialing a nursing assessment form developed specifically for their use. The nursing assessment is client based.

It is important to have feedback from those who are ultimately affected by any nursing assessment done by the nurse. For this reason you are invited to participate in an evaluation of the nursing assessment form from the client's perspective.

Information obtained from this form will be used by Sue Brown, a nurse studying at the University of Wollongong who developed the assessment form, to complete her Master of Nursing. All information will remain anonymous and confidential.

You are under no obligation or pressure to participate. If you are happy to contribute please return the completed form to Sue in the stamp addressed envelope provided.

Yours sincerely,
**CLIENT INFORMATION**

This study will be conducted by **Sue Brown** to satisfy the research component of Master of Nursing at the University of Wollongong, under the supervision of Ms Judith Leacock and Mr John Sibbald from the Nursing Faculty at this university.

The purpose of this phase of the study is to evaluate the effectiveness of the initial nursing assessment, from the client's perspective. The assessment form has been specifically developed for generalist community health nurses working in the Illawarra Area Health Service.

The questionnaire which I would like you to fill in, is intended to gain information regarding the assessment form only. Information supplied by each client will remain confidential. No names or personal details including medical history will be used, only codes.

Clients are free to withdraw at any time.

Any complaints regarding the conduct of this research may be directed to the Secretary of the University of Wollongong, Human Research Ethics Committee (214457).

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*Please sign below, detach and post in envelope provided*

**CLIENT CONSENT FORM**

I have read the above description of the study and understand what is expected of me. I understand that all information obtained will remain anonymous and confidential.

I am free to withdraw from this study at any time.

SIGNED________________________________ DATE