INTERNATIONAL CONFERENCE ON COMMUNITY NURSING

PROGRAM AND ABSTRACTS

NIVEL

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WORLD HEALTH ORGANIZATION
COLLABORATING CENTRE FOR
PRIMARY HEALTH CARE

PROGRAM

THURSDAY, MARCH 16th, 1989

9.15 Registration

10.00 Welcome
Cl. Olthoff, chairman of the Netherlands Institute of Primary Health Care

10.05 Opening of the Conference.
D.J.D. Dees, State Secretary of Welfare, Health and Cultural Affairs

10.15 Community Nursing in the Future.
Mrs. E. Veder-Smit, LL.M., Chairman of the Dutch National Cross Association

10.30 Community Nursing and Primary Health Care.
Mrs. M. Farrell, R.N., Ed.D., M.P.H., Regional Officer for Nursing W.H.O., Copenhagen

10.45 Coffee Break

11.15 Home Care as a topic for Nursing Science.
Professor H. Philipsen, Ph.D., Department of Nursing Science, University of Limburg

11.45 Towards Quality Assurance in Community Nursing.
Mrs. Professor R. Bergman, R.N., Ed.D., Department of Nursing, Tel Aviv University, Israel

12.15 Lunch Break

The afternoon session will be dedicated to the comparison of home-care services in different countries. Invited speakers will give lectures on the organization, tasks and the position of community nursing in the health care system in their respective country.

13.30		United Kingdom Mrs. J. Cumberlege, South-West Thames Regional Health Authority, London
13.55	France	D. Artot, Ph.D., Ministry of Health, Conseiller Technique du Directeur des Hopitaux Francaises, Paris
14.20	The Netherlands	Mrs. A. Kerkstra, Ph.D., Netherlands Institute of Primary Health Care
14.45	United States	Mrs. Professor G. Smith, Wayne State University, Detroit
15.10	Tea Break	
15.40	Canada	Mrs. D. Pringle, Ph.D., Research Director VON for Canada
16.05	Norway	Mrs. Quivey, Oslo
16.30		Panel discussion, chairman: Professor J. van der Zee
17.00		Get-Together Reception
19.00		Indonesian Buffet

FRIDAY, MARCH 17th, 1989

9.30 - 12.40 CONCURRENT SESSIONS

SESSION 1 THE ACTIVITIES OF NURSES WORKING IN THE COMMUNITY

Chairman F. Lapré

9.30 - 9.50 The nursing-behavioural-pattern of community-nurses and community-nurses'-aids of the first health care echelon.
H. Masselink, The Netherlands

9.55 -10.15 Which acts do nurses perform in the home-care services?
H. van Loon, Belgium

10.20 - 10.40 Community nursing and home health case management.
G. Shuster & P. Cloonan, U.S.A.

10.45 - 11.05 Method of payment and community nursing functions in a primary health care center.
M. van Dormael, B. Taeymans, F. Veldeman, Belgium

11.05 - 11.30 Coffee Break

11.30 - 11.50 Home support: a program to increase the number of high-risk women starting prenatal care during the first trimester.
J. McFarlane & L. Bullock, U.S.A.

11.55 - 12.15 Assessment of prenatal high-risk behaviors for low birth weight infants.
H.S. Kim, U.S.A.

12.20 - 12.40 The work of a public health nurse in the health care of upper stage comprehensive school pupils: the contents and process of decision making of the public health nurse's work as a starting point.
A. Liukkonen, R. Matero & S. Lauri, Finland

12.40 - 14.00 Lunch Break

9.30 - 12.40 CONCURRENT SESSIONS

SESSION 2 HORIZONTAL AND VERTICAL INTEGRATION

Chairman W.G.W. Boerma

9.30 - 9.50 Multidisciplinary co-operation in primary care for asthmatic children.
I. Mesters, R. Meertens & N. Mosterd, The Netherlands

9.55 - 10.15 Attitudes of care providers of community nursing and home help services towards a proceeding co-operation between these organisations.
R. Ch. Boom & Th.P.B.M. Suurmeyer, The Netherlands

10.20 - 10.40 Patient compliance - whose responsibility?
F.M. Ross, United Kingdom

10.45 - 11.05 Co-ordination of the care for patients with rheumatoid arthritis at home.
H.A. Mostert & R. Starmans, The Netherlands

11.05 - 11.30 Coffee Break

11.30 - 11.50 The Skaevinge project - a model for the primary health care in the future.
L. Wagner, Denmark

11.55 - 12.15 Centres for primary health care - a Danish-Canadian project.
B.W. Christensen & M. Pike, Denmark/Canada

12.20 - 12.40 Community health services and hospital early discharge policy.
L.D. MacDonald, D.A. Hennesy & J.M. Addington-Hall, United Kingdom

12.40 - 14.00 Lunch Break

9.30 - 12.40 CONCURRENT SESSIONS

SESSION 3 NEED FOR NURSING CARE AT HOME

Chairman Mrs. J. Diepenveen-Speekenbrink

9.30 - 9.50 Learned response to chronic illness experience: a comparison between self help class attenders and non self help class attenders.
C.J. Braden, U.S.A.

9.55 - 10.15 Need for nursing care of the elderly person with rheumatoid arthritis living at home.
R.M. Bal, A. van den Bergh-Braam, P.H. Jonkergouw & M. Plug, The Netherlands

10.20 - 10.40 Allocation of community nursing care.
G.A.M. van den Bos, The Nether lands

10.45 - 11.05 Changes in home health nursing resource consumption.
E. Kornblatt Phillips, A. Irvine, M.E. Fisher, J. Torner, P. Cloonan & G. Chase, U.S.A.

11.05 - 11.30 Coffee Break

11.30 - 11.50 Factors influencing professional home care utilization among the elderly.
G.I.J.M. Kempen & Th.P.B.M. Suurmeyer, The Netherlands

11.55 - 12.15 Variables that predict home maintenance of the dependent elder in the home environment.
M.C. Clark, U.S.A.

12.20 - 12.40 Factors related to the use of community nursing services.
A. Kerkstra & T.M.L. Vorst-Thijssen, The Netherlands

12.40 - 14.00 Lunch Break

9.30 - 12.40 CONCURRENT SESSIONS

SESSION 4 METHODOLOGY OF COMMUNITY NURSING (RESEARCH)

Chairman Mrs. M. Grypdonck

9.30 - 9.50 Community analysis research and practice: the Genesis model.
J.K. Magilvy, Ph.R. Schultz & M.H. Stoner, U.S.A.

9.55 - 10.15 Dependent-care agency, concept clarification and instrument development.
N. Mosterd, H. Philipsen, M, Isenberg & J.M.E. Peeters, The Netherlands

10.20 - 10.40 Quality assurance in primary health care: the problem of quality assurance in community nursing.
A. Frias, Spain

10.45 - 11.05 The community nursing record card.
M. Hanrahan, The Netherlands

10.05 - 11.30 Coffee Break

11.30 - 11.50 From philanthropy to payment for services.
A. Brodie, U.S.A.

11.55 - 12.15 Home care the American way: an historical analysis.
K. Buhler-Wilkerson, U.S.A.

12.20 - 12.40 Community nursing: our business.
J. Kruyt & P.H. Jonkergouw, The Netherlands

12.40 - 14.00 Lunch Break

14.00 - 15.35 CONCURRENT SESSIONS

SESSION 1 THE ACTIVITIES OF NURSES WORKING IN THE COMMUNITY

Chairman J. van der Velden

14.00 - 14.20 HIV infection and implication for nursing staff in the community.
S. Bond, United Kingdom

14.25 - 14.45 Knowledge, attitudes, role perception and reported performance of nurses in relation to adolescent health problems.
H. Eshed, Israel

14.50 - 15.10 Nursing in health education for groups of patients with chronic bronchitis.
M. Trabado, M. del Valle Medina, L. Palomares, I. Mangarel, J.V. Ruiz & J.M. Sanchez, Spain

15.15 - 15.35 Selfcare programme for the hypertension patient and his family.
C. Germán, P. Blanco, C. Heierle, E. Ruiz, A. Salas & V. Zunzunegui, Spain

15.35 - 16.15 Tea Break

16.15 PLENARY SESSION
Closing Remarks
Professor J. van der Zee, Scientific Director NIVEL

14.00 - 15.35 CONCURRENT SESSIONS

SESSION 2 HORIZONTAL AND VERTICAL INTEGRATION

Chairman Mrs. N. Mosterd

14.00 - 14.20 How to bridge the gap between hospital and home? Solutions to the problems of continuity of nursing care after hospital discharge in the Netherlands.
T.J.J.M.T. Kersten & W.C.M. Zijlmans, The Netherlands

14.25 - 14.45 Admission of older adults to home care.
J.K. Magilvy, U.S.A.

14.50 - 15.10 Action research to ensure continuity of nursing care.
S. Armitage, United Kingdom

15.15 - 15.35 Conditions for the admission and discharge process.
R. Klop & F.C.B. van Wijmen, The Netherlands

15.35 - 16.15 Tea Break

16.15 PLENARY SESSION
Closing Remarks
Professor J. van der Zee, Scientific Director NIVEL

14.00 - 15.35 CONCURRENT SESSIONS

SESSION 3 NEED FOR NURSING CARE AT HOME

Chairman Mrs. A.H.M. van den Bergh-Braam

14.00 - 14.20 Terminal care in the home and hospital: a comparison of family relationships.
L.K. Birenbaum, U.S.A.

14.25 - 14.45 Needs satisfaction of primary care providers: a comparison of hospice and non-hospice programs of care.
N. Dawson, U.S.A.

14.50 - 15.10 Night nursing services for patients in their own homes.
M. Davies, United Kingdom

15.15 - 15.35 Effects of preventive home visits to the elderly.
H.J.L. van Rossum, C.M.A. Frederiks, J.A.P.M.L. Kil-Van Tierop, P.G. Knipschild, A.J. Mantel, H. Philipsen & J. Portengen, The Netherlands

15.35 - 16.15 Tea Break

16.15 PLENARY SESSION
Closing Remarks
Professor J. van der Zee, Scientific Director NIVEL

14.00 - 15.35 CONCURRENT SESSIONS

SESSION 4 METHODOLOGY OF COMMUNITY NURSING (RESEARCH)

Chairman P.P. Groenewegen

14.00 - 14.20 Depression awareness: a community-based training program for nurses.
T.A. Badger, U.S.A.

14.25 - 14 45 Screening for psychosocial distress: implications for prevention and health promotion.
L.W. Gage & N. Kline Leidy, U.S.A.

14.50 - 15.10 The community health aide as a culture broker in an ethnic community.
D.M. Modly, U.S.A.

15.15 - 15.35 Changing boundaries in the social production of health in the home: the emergence of health domestics.
E. Elliott, U.S.A.

15.35 - 16.15 Tea Break

16.15 PLENARY SESSION
Closing Remarks
Professor J. van der Zee, Scientific Director
NIVEL

ABSTRACTS

CONTENTS page

ACTION RESEARCH TO ENSURE CONTINUITY OF NURSING CARE

Dr. S. Armitage, United Kingdom

A "care-gap" when patients are transferred between hospital and community services has been recognised for some time. In the United Kingdom, attemps to improve continuity of care have included the development of the role of the hospital-community liaison nurse.

The study here described is taking place over four years and is in two phases. The first phase explored the nature of liaison between hospital and community nurses throughout Wales, U.K. The structure and process of liaison schemes were examined by focused interviews. Liaison nurses, senior nurses with joint managerial responsibility for hospital and community nurses in rural community hospitals, and a sample of hospital and community nurses familiar with the liaison schemes were interviewed (N = 196). Organisational, management and educational modifications to improve current practice were indentified.

The findings are now being utilised in a second phase of the study. Three Action Research Groups have been established within one health district. Each group consists of 10-12 hospital and community nurses and their managers, bringing them together in face to face communication at monthly meetings, with the researchers acting as facilitators. Objectives and strategies for change are identified, monitored and evaluated on a regular basis (Susman and Evered, 1978).

Action Research has particular features relevant in enabling realistic change to be made to practice and the paper will focus on describing the nature of this process, drawing examples from the experience of working with the groups. Improving the quality and timing of patient information passed between nurses, an earlier and more realistic assessment in discharge planning and an increase in the understanding of professional roles are just a few of the examples which will be used.

A second feature of the study consists of a small sample of patients interviewed to explore their experience of transfer between hospital and community nursing services. The data are enabling an analysis of patients' expressed needs and satisfaction, to provide an outcome baseline for continuing comparison with nurses' perceived attainment of their objectives.

In this way Action Research enables practitioners not only to use existing research findings but to play an active part in monitoring and evaluating the changes they wish to make in their practice.

DEPRESSION AWARENESS: A COMMUNITY-BASED TRAINING PROGRAM FOR NURSES

T.A. Badger, Ph.D., R.N., H.M. Mishel R.N., Ph.D., L. Biocca R.N., Ph.D., and J.M. Cardea, R.N., Ph.D., U.S.A.

Background and Significance

Depression, one of the most common mental illnesses, will affect one-fifth of the population during their lifetime. Yet, only one in five people suffering from a depressive disorder is treated. Nurses are in the ideal position for both the early detection and treatment of depression; thus, preventing longterm disability and possibly death by suicide. The purpose of the program was to provide information to nurses in direct practice on the most current research related to depression to enhance clinical practice. A five day training program on assessment, referral and monitoring of treatment effects in depression was offered at six sites to primary care nurses working in community health care agencies throughout the state of Arizona. The topics on depression, current issues in classification including an orientation on the DSM 111-R, assessment of major depressive disorders including suicide, pharmacologic and psychotherapeutic treatment issues and referral methods. Cultural and developmental concerns were included with emphasis upon those populations who were overrepresented but underserved in Arizona; Native-American, Hispanic, elderly and adolescent populations. Both didactic and practicum experiences were used to facilitate the trainees application of the course material to clinical practice.

Sample

The trainees were 300 + registered nurses who were in practitioner roles, community health and home health agencies, as well as school health settings. The level of education ranged from associate degrees to masters level preparation, and background experience were highly varied. The sample will be described by age, gender, ethnicity, educational level, employment, position and the clinical population served. Criteria used for selection of trainees included a commitment to complete the five days of trainig, administrative support for released time and participation in both the experiential and evaluation components of the program.

Data Analysis

The training programs were completed in July, 1988. Data analysis, in process, will be completed in the Fall. The evaluation plan used a waiting list control group design and was organized around two objectives: 1) to evaluate the knowledge of the curriculum content and, 2) to evaluate the ap-

plication of the content to practice. To meet objective one, a pre- and post-test was administered. In addition, a computer assisted program will be administered to a subsample of 50 participants and to a matched control sample. To meet objective two, a content analysis of nursing notes will be conducted. Since nursing notes are recognized as a legal record of nursing practice, they must accurately reflect patient care. Content analysis is expected to reflect application of knowledge and includes methods to assess reliability.

NEED FOR NURSING CARE OF THE ELDERLY PERSON WITH RHEUMATOID ARTHRITIS LIVING AT HOME

Drs. R.M. Bal, Prof. Dr. A. van den Bergh-Braam, Drs. P.H. Jonkergouw & M. Plug, The Netherlands

Introduction

About 100.000 people in the Netherlands are suffering from reumatoïde arthritis (R.A.). The emphasis of the medical treatment is to reduce inflammation and to prevent deformity as much as possible. Therefore, prescriptions are given concerning the rest and activity pattern (exercises, splinting, rest, etc.). Research indicates that only few patients manage to integrate these prescriptions in every day life. In every day practice it seems that few patients with R.A. use the services of the community nurse. In a research-project done by De Blécourt (1984) only 17% of R.A. patients reported the use of community nursing care. The majority of these patients were in ARA-functional Class 3 or 4. The Community Nurses' Association defines one of the tasks of the community nurse as: 'helping the patient to learn to live with the consequences of medical treatment and therapy'. The help of the community nurse with the integration of medical regimen in every day life could be useful particularly at the beginning of the disease process. Therefore the community nurse will have to know which problems the elderly person with R.A. encounters, especially with regard to the rest and activity pattern. Beside that she will need to know which factors influence these problems.

Research questions

-What health and dependency problems do elderly people with R.A. living in the community encounter, especially in regard to their rest and activity pattern?

-Which of these problems can be met by the community nurse?

-How many of these problems are actually handled by community nurses?

-What kind of care is given by the community nurse and what is the intensity of this care?

Method

A group of elderly persons with R.A. was randomly selected from a rheumatology outpatient clinic. The patients represented all ARA-functional classes. After informed consent was obtained from 65 of these patients,

they were interviewed at their homes. The interview contains questions about the need for nursing care, actual nursing care given, and factors influencing the need for care. Beside the interview they were asked to keep a diary on their rest and activity pattern. They were further asked if they knew a person of the same age, sexe and neighbourhood without chronic illness of the musculo-skeletal system who would cooperate in the study as a control person. The controls were also interviewed and asked to keep a diary.

After the initial interview all subjects will be re-interviewed and asked to keep a diary after 6 and 12 months (longitudinal design).

Results

During the summer of 1988 the data collection will be completed. The results of the data analysis will be completed by the end of 1988 and available for presentation at the conference.

TERMINAL CARE IN THE HOME AND HOSPITAL: A COMPARISON OF FAMILY RELATIONSHIPS

L.K. Birenbaum Ph.D., R.N., U.S.A.

Background and Purpose

Terminal care in the home is purported to improve quality of life. The purposes of this paper are to compare parents' perceptions of family relationships prior to and after a child's death in two ways: 1) with normative data and 2) between families utilizing home and hospital terminal care.

Methods and Results

A prospective longitudinal design was used to measure parents' perceptions of family relationships. The sample consisted of 48 families with a child in the terminal phase of cancer. Measurements of parents' perceptions of family relationships were taken prior to death and three times for up to one year after the death of the child. Family relationships were measured using the Family Relationships Index's (FRI) three subscales of Cohesion, Expressiveness, and Conflict. The FRI's psychometric properties are well documented in the literature and maintained their properties in this study. The sample size varied at each of the four data points, therefore, multivariate analyses were not conducted. Confidence intervals at 95% and t-tests were used to analyze these data. Parents reported no difference in Cohesion and Expressiveness from a normative sample prior to death. Following death, Cohesion and Expressiveness scores were significantly higher than expected in a normal population. Conflict scores were significantly lower than the norm at all four data points. No differences between home and hospital care families were found prior to death on any of the FRI subscales. Differences were found two weeks and four months after death for Expressiveness, Cohesion, and Conflict subscales. The hospital care group reported higher Cohesion and Expressiveness scores and lower Conflict scores than the home care group. This difference in Conflict was also found at 12-months after death.

Conclusions

These findings of comparing Cohesion, Expressiveness, and Conflict to the norm and between types of care were not in the direction hypothesized. That Cohesion and Expressiveness scores did not differ prior to death, but did after death is supportive of the growth promoting characteristics of a developmental crisis. This interpretation needs to be viewed with caution because the sample itself may have been different after death. In contrast the belief that terminal care in the home is more be-

neficial to family life may not be an accurate reflection of what families experience. Again this interpretation needs to be viewed with caution because there appears to be some difference in the demographic data between the hospital and home care groups. The demographic variations may overshadow the treatment effect and need to be considered in interpreting these findings.

HIV INFECTION AND IMPLICATION FOR NURSING STAFF IN THE COMMUNITY

Dr. S. Bond B.A., M.Sc., Ph.D., R.G.N., F.R.C.N., United Kingdom

In the United Kingdom the care of patients with HIV infection and AIDS currently takes place in specialised units in hospital. In some areas with a concentration of patients with AIDS, social community teams and outreach workers support these units. As the number of HIV positive cases increases, with the associated increased number of patients who have AIDS, and as treatments for the symptoms of AIDS and associated illnesses evolve, then there is likely to be an increased demand for community care by nursing staff who work as members of primary health care teams.

However, given the current uncertainty about the relationship between hospital and community care of patients with AIDS, and as yet, the low prevalence rates over most areas in the United Kingdom, little is known about how rank and file community nursing staff have responded to HIV infection or what the implications are for their work.

The study to be presented is funded by the Department of Health and Social Security. It seeks to ascertain from community nursing staff their work experience with patients and clients who are HIV antibody positive or who have AIDS, aspects of work related to HIV infection, preparation for working with HIV infection and feelings of competence for this work as well as knowledge about the virus and its transmission.

Data are being collected from a national sample of one fifth of all community nursing staff in England, representing district nursing sisters, and enrolled nurses, health visitors, midwives, school nurses and community psychiatric nurses. A multi-stage sampling procedure has been used in order to weight the sample towards regions with a higher incidence of HIV positive cases. Nurses (N = 5000 +) have then been randomly sampled from staff lists provided by their employing authority. A parallel study of General Practitioners is also being conducted by other members of our research unit.

Data are being collected by postal questionnaires during the summer of 1988 and findings will be available in the autumn of 1988. At the time of writing a response rate of over 60 percent has been achieved. This will increase in response to a reminder questionnaire to provide a sample representative of community nursing staff throughout England.

Findings from this major nursing survey will provide a useful marker for planners and educators regarding the current response of community nursing staff to HIV infection and their role in the primary care team.

ATTITUDES OF CARE PROVIDERS OF COMMUNITY NURSING AND HOME HELP SERVICES TOWARDS A PROCEEDING CO-OPERATION BETWEEN THESE ORGANISATIONS

Drs. R.Ch. Boom & Th.P.B.M. Suurmeijer, The Netherlands

Introduction

Both (primary) care providers and government, partly on different motives, wish a more differentiated and more to the needs of the client attuned homecare. For that, a proceeding co-operation between community nursing and home help, being two institutions which deliver a substantial contribution to the homecare, is a very important condition.

This presentation will discuss attitudes of the employees of the abovementioned organisations towards innovations in this co-operation.

Methods

Data have been obtained from interviews (n = 118) with these employees in the province of Friesland (in a nothern part of the Netherlands); besides that 369 employees have filled in a postal questionnaire. These data-accumulations form a part of a comprehensive research on the co-operation between community nursing and home help services in the province of Friesland.

Results

Eighteen % of the community nurses and 38% of the home help employees think that there had to be lots of alterations and improvements before a good co-operation between the two organisations has been achieved. Also the majority of those, who regard the current co-operation as quite positieve, considers that there is much left that should and can be improved. Attuning of care given to communal clients, coping with the difficulties of the everincreasing delay and cancellation of intra-mural admission and improvement of the linking of hospital care with homecare are frequently-mentioned items.

Less agreement there is in which way the organisation of the care should be improved: 63% of the community nurses against 84% of the home help employees forms a favourable opinion of a "combined indication for a well-defined group of clients"; only 26% of the community nurses against 63% of the home help employees wants to persue a "overall indication" and a (partial) fusion of the two organisations. These differences also appear if from a number of tasks is asked under whose responsibility they belong:

for example 45% of the community nurses against 79% of the home help employees consider "psychological problems in relation to diseases" as a communal responsibility; similarly "dying-support" and "co-ordination of assistance" are considered as communal tasks by 51% of the nurses against 82% of the home help employees.

ALLOCATION OF COMMUNITY NURSING CARE

G.A.M. van den Bos, The Netherlands

Introduction

This presentation concerns the results of a major health survey in the City of Amsterdam (the Chronic illness Study Amsterdam: 10.000 respondents, 55-80 years, data-period 1983-1986). Some issues concerning the allocation of community nursing care will be discussed.

Distribution

When considering the needs for community nursing care, several levels of increasing sophistication can be indicated in the planning of this facility: population size, demographic structure and socio-economic inequality in health. These three allocation-criteria produce non-matching distribution-charts of an area. The present norm, based on population figures, results in a relative under-supply in those districts with many elderly people and a lower health level.

Substitution

The aim of substitution is to influence the volume of care. The stimulation of informal care proves to have only a marginal substitution-effect. Many functions of community nursing cannot be substituted and for those functions that can be substituted, the potential of the informal network proves to be exploited to the full. Utilization of professional care does not reduce the amount of informal help but rather consolidates this help. Professional and informal care together can have a substitution effect on the institutional sector. Consequently, the need for community nursing is likely to increase, the more so because of various social developments, (lower infant-rates, emancipation of woman, geographic mobility).

Conclusions

Allocation of community nursing care concerns decisions about distribution and volume. On a district level the number of elderly people and the health level are major (and to policy accessible) parameters in the planning process. The volume of community nursing care cannot be influenced fundamentally by informal care and is likely to increase in the future.

LEARNED RESPONSE TO CHRONIC ILLNESS EXPERIENCE: A COMPARISON BETWEEN SELF HELP CLASS ATTENDERS AND NON SELF HELP CLASS ATTENDERS

C.J. Braden, Ph.D., R.N., U.S.A.

Background/Purpose

The purpose of this descriptive study was to identify the significant characteristics of individuals having a diagnosis of arthritis or an arthritis related condition who had attended some type of community based self help class versus those who had not attended such classes. Review of self help educational programs by Green, et al. (1977) suggests the need for researchers to examine the applicability of self help education for various population groups. This study provides a description of class attenders versus non attenders in terms of significant differences in demographic and in disease related characteristics as well as in learned response to chronic illness experience. Such information informs community health nursing self help promoting interventions.

Theoretical Background

The Self Help Model utilized in this study is a theory derived, empirically supported representation of factors that influence self help behaviour and life quality among the chronically ill. The concepts specified were: Severity of illness, dependency, uncertainty, monitoring, enabling skill, self help and life quality.

Methodology

Descriptive statistics were used to identify demographic and disease related characteristics of class attenders and non class attenders. T-tests and Chi Square tests were used to test for significant differences between the two groups. A correlational descriptive design using causal modeling methodology was used to test specified model relationships for each of the groups. Seven instruments and fourteen single item demographic questions were used to collect data for this study. The seven instruments were: Disease Course Graphic Scale, Reliance Scale, Mishel Uncertainty in Illness Scale, Krantz Health Opinion Survey Information Subscale, Self Control Schedule, Inventory of Adult Role Behaviour and Life Quality. International consistency reliability (Cronbach's Alpha) for the seven scales ranged from a low of .73 to a high of .95. Construct validity estimation through predictive modeling supported all seven scales. A convenience sample consisting of 362 subjects having arthritis or arthritis related con-

ditions responded to a mailed questionnaire booklet, Self Help in Chronic Illness Questionnaire (SHICIQ).

Major Findings and Conclusions

Of the 362 subjects 226 had attended some form of self help class and 136 had not. Significant differences between the groups were found for age, diagnosis, number of years since diagnosis, and involvement in work/school. Uncertainty and dependency had stronger negative relationships with enabling skill among those who had not attended class than among those who had. Monitoring was an important contributor to explanation of enabling skill only among those who had attended class. Among those who did not attend self help class, monitoring was negatively related to perception of dependence on others.

While it is early in the testing of the self help model for making solid, clinical recommendations, some of the differences found between those who had attended self help class and those who had not can provide a basis for developing more effective self help programs, given differing client characteristics.

FROM PHILANTHROPY TO PAYMENT FOR SERVICES

B. Brodie, Ph.D., R.N., U.S.A.

Introduction

The study was designed to explore the difficulties experienced by public health nurses and the Board of Managers of the Instructive Visiting Nurse Association (IVNA) in securing adequate financial support to operate the agency. The origins of United States' nursing are deeply rooted in altruism, religion and a personal sense of dedication to care for the sick, abandoned and the needy. Visiting nurse associations, originating in the late nineteenth century, were begun as philanthropic endeavors by their desire to care for the ill and trained to view financial matters as not in their preview, found it difficult to learn how to financially manage an agency. The Lady Board of Managers, who were charged with the task of acquiring the necessary funds to support the agency, were also ignorant of the principals of fiscal management necessary for a growing health service. The slow transformation from financial ignorance to fiscal competency for both groups is an essential part of the history of public health nursing.

Methodology

The study employed an historical proces to document, verify and analyze primary data sources. The IVNA's official minutes, yearly reports, correspondence and audits served as the major data sources. Secondary sources in nursing and philanthropic history supplemented the archival matter.

Findings and Conclusion

The Board of Managers for the IVNA was drawn from the ranks of the socially prominent women in Richmond. These women, representing the major churches of the city, were committed to serving in useful ways the less fortunate of society. Joining forces with the public health nurses, the IVNA was formed to bring health care into the homes of the poor. New services were undertaken by the nursing staff and then money was sought to finance them. Private donations, church support, and an annual public appeal through a Tag Day served as the major sources of revenue for the agency in its earlier years. After almost ten years of operation the agency did not know what a patient visit cost and only after the Metropolitan Life Insurance Company (MLI) in 1910, employed them to provide health visits to their policy owners, did they address the possibility of charging patients for services. Over time the Board and the nurses began to understand that fund raising activities alone could not generate adequate funds to support the enlarging operations of the agency. In 1914, after MLI informed them

that they would not increase their fees until the agency established a fiscal accounting mechanism and adopted a patient fee service, the Board reluctantly agreed to these measures.

The conflict experienced by nurses between their desire to care for ill patients regardless of financial consideration and the agency's need for fiscal solvency remains an important question in today's world. An examination of the historical factors that contributed to this conflict is particularly helpful in facing current concerns associated with the rising costs of health care in the U.S. including who should pay for public health services.

HOME CARE THE AMERICAN WAY: AN HISTORICAL ANALYSIS

K. Buhler-Wilkerson, Ph.D., R.N., U.S.A.

Today, primarily as a result of annual federal expenditures in excess of one billion dollars, care of the sick at home has become a significant aspect of the health care industry. Unfortunately for both provider and consumer, home care is a confusing assortment of fragmented, duplicative, and competitive services. Most participants, unaware of the circumstances that have shaped this field's history, fail to realize that these contemporary perplexities are not new. For over one hundred years the care of the sick at home has been sponsored by a nearly incomprehensible assortment of organizations that varied from city to city. This paper explores the founding and development of the home care movement in America. The data examined consist of information on all agencies known to employ visiting nurses in 1909 which was collected and published by Ysabella Waters in Visiting Nursing in the U.S., the 1924 and 1931 survey of public health nursing published by the National Organization for Public Health Nursing and extensive primary historical sources.

This historical analysis provides some rather interesting conclusions about the origins of visiting nursing in America. First, we are able to understand the dimensions of sponsorship - who sponsored visiting nursing and how this varied over time, between regions, and in relation to population size. Secondly, we now know a great deal more about the types of agency, region, date established and number of nurses in an agency. Thirdly, we are able to examine the separations of the preventive and therapeutic aspects of these nurses' work. Finally, this analysis clarifies, from a historical perspective, many dilemmas confronting our system of home health care.

CENTRES FOR PRIMARY HEALTH CARE - A DANISH-CANADIAN COLLABORATION PROJECT

Ms. B. Christensen, R.N., M.Ph. & Ms. M. Pike, R.N., B.N., Denmark/Canada

Purpose

The overall purpose of the project is to effect a measurable improvement in the health of selected communities in Newfoundland, Canada, and Denmark through the provision of primary health care services managed and largely provided by nurses.

Background

The project has evolved from a belief that the most effective means by wich to contain the escalating costs of health care services delivery while maintaining and/or improving their quality lies in 1) a greater emphasis on health promotion strategies aimed at mobilizing individual, family and community self-reliance and self-determination in health related matters; and 2) more effective utilization of the knowledge and skills of all health care personnel in meeting the total needs of the individual, family and community. The project embodies the concept and philosophy of primary health care as defined by the World Health Organization at Alma Ata in 1978.

The Nursing Model

Health centres are being established in 5 to 10 selected local communities in Newfoundland, Canada and Denmark. The services provided by the centres will be managed and largely provided by nurses and will address those needs not already being met by existing health care services. The project will aim to coordinate health care services at the community level to ensure the most appropriate care is provided to the client and to prevent duplication of services. The project aims to provide a comprehensive community health service by providing preventive, promotive, curative, supportive and rehabilitative services designed to meet the identified health needs of a selected community/area. The project has been designed to provide services at the individual, family and community levels. At the community level, special emphasis will be given to identifying at-risk groups and providing services to meet the needs of these target populations, i.e. the elderly, the chronically ill, the poor. One centre was opened in the Spring of 1988.

Methods

The demonstration project proposed herewith is designed to provide communities in the province of Newfoundland, Canada and Denmark with the kind of primary health care services envisaged by the Alma Ata Declaration and currently supported by the health authorities in Canada and Denmark and the World Health Organization. It is further designed to provide nurses with the resources needed to give this kind of care. The collaborative approach in project development that has been initiated jointly by the Danish Nurses' Organization and the Association of Registered Nurses of Newfoundland will expand the significance of the project findings to an international level. It provides for the evaluation of the work done in terms of the consumer, the personnel involved and the system into which the services were integrated. It allows for accurate cost accounting and for collaboration and coordination with other services in the community. It has a built-in service-based study research component and provides for the identification and conduct of educational programmes for both providers and receivers of care.

Data relevant to planning, implementation and evaluation of care are collected on individual, family/group and community levels. The project will be evaluated at all three levels, as well. Project specific data collection tools have been developed.

The project will be evaluated annually, and the final evaluation will take place in 1992.

The Significance of the project

The significance of the proposed project in terms of its potential for positive economic and health related outcomes, is immense, Though, as the literature review will demonstrate, the concept of nurses as primary health care providers has been consistently shown to have positive outcomes in terms of costs, quality of care, client satisfaction and acceptance, and professional acceptance, the full potential of nurses as primary health care providers remains unrealized.

The full potential of nurses as primary health care providers will be actualized only through a demonstration project in which accurate quantitative and qualitative research data can be collected to evaluate those aims around which the service component of the project will be developed. It is anticipated that this data will provide the empirical support for greater utilization of nurses as primary health care providers. The primary health care project has been developed with the necessary control mechanisms to ensure that it can be modelled in other communities, provincially, nationally and internationally. This will provide a data base for comparative analysis of the impact of such a service worldwide. In short, it provides an opportunity for the practical testing of the primary health care concept in order to determine its effectiveness as a model of health care services delivery.

A paper describing the model, the implementation and the results of the first community needs assessment in Denmark will be prepared and presented by project director Birgit Westpal Christensen, research assistant Ditte Jespersen and programme manager Tordis Koudal, Denmark.

VARIABLES THAT PREDICT HOME MAINTENANCE OF THE DEPENDENT ELDER IN THE HOME ENVIRONMENT

M.C. Clark, U.S.A.

Purpose

This correlational descriptive study measures variables which reinforce behaviours of lay caregivers in maintaining a dependent elder in the community and represents a first step in developing a theoretical practice mode. A decreased reliance on community resources, improve physical and psychological well being for the caregiver and better care delivered to the elder are all possible benefits of nursing interventions that promote positive learning for the caregiver. Furthermore, there is a need to understand the processes involved in caregiving before appropriate nursing interventions can be proposed.

Theoretical Background

The Caregiving Functional Learning Model tested in this study is a deductively derived and empirically supported representation of factors that facilitate support of dependent elders in the community. A functional model as presented by Stinchcomb (1968) was used to structure model relationships, thus accomodating a feedback loop within the causal linkages and better explaining behaviours that are maintained over time. The Stinchcomb structure was modified to include learning as a major construct and includes the action of discriminate stimulus, behaviours, reinforcers and tension variables. The concepts specified in the model were: Seriousness of Illness (Tension Variable), Learning State (Discriminate Stimulus), Maintenance Ability and Acceptance of the Caregiving Role (Behaviours), Caregiver Overload and Quality of Care (Reinforcers) and Perceived Power (Historical Variable).

Methodology

A correlational descriptive design using causal modeling was used to test the relationships in the caregiving functional learning model. Seven instruments: Caregiving Scaling Index (Clark 1986), Physical Self Maintenance Tool (Lawton and Brody 1969), Burden's Interview (Poulshock and Deimling 1984), Caregiver Power Scale (Phillips and Clark 1988) and Caregiver Knowledge Exam were selected as measures of model variables. A convenience sample consisting of 70 caregivers spending twenty or more hours a week caring for a dependent elder participated in this study. Each respondent took part in an hour interview that included the dependent elder at the elders's home. Four of the seven instruments were left with each

respondent (caregiver) to complete at their convenience. Analysis included 1.) reliability and validity estimations of all measurement scales, 2.) description of the sample, 3.) tests of model relationships through multiple regression analysis, 4.) test of causal modeling and regression statistic assumptions through residal analysis.

Findings and Conclusions

Initial findings support Perceived Power of the Caregiver as a significant predictor in home maintenance and Seriousness of Illness predicts Caregiver Burden. Learning State was a weak indicator of Maintenance Ability but did influence Acceptance of the Caregiver Role. These findings support that the Caregiving Learning Model has the potential to clarify the causal mechanisms that support the home maintenance of a dependent elder in the community. This information can facilitate nurses in planning intervention strategies to assist the caregiver.

NIGHT NURSING SERVICES FOR PATIENTS IN THEIR OWN HOMES

M. Davies, United Kindom

This paper reports three unrelated studies of nursing services provided to patients in their own homes outside the 'normal' range of hours.

Home care nursing services began in the United Kingdom more than a century ago, and since the inception of the National Health Service in 1948, have been available free of charge to all people who need them. The service is used by people of all ages, the acutely ill as well as the chronically ill; however, the major users of the service i.e. 75% are elderly and infirm patients frequently living alone.

Services are normally available between 8.30 am and 5.30 pm. District nurses do not normally work shifts as do nurses in hospitals.

Some districts, however, have established additional services outside these hours to enable patients to be nursed in their own homes and provide support for the carers. In Croydon, a suburban district on the South Western border of London, such a service was begun in 1976 and was managed for one and a half years by the author. The author subsequently moved to West Lambeth, the health district immediately to the north of Croydon, where an evening district nursing service was available but care at night was provided only rarely and on an ad hoc basis.

The first two studies investigated the opinions of the patients and carers who used the services in Croydon and the nurses who provided them. Data were collected from 32 patients and carers by means of a short structured interview and from the nurses by means of a questionnaire. It was found that the service was greatly valued by the users, because it enables them to avoid admission to hospital. The main criticisms expressed were irregular visiting times, varying standards of care and, at times, inadequate information given to patients and carers about the service itself.

The nurses also liked the service because it provided a high level of job satisfaction and the hours were convenient for them as it alowed them to fit in with their own family commitments.

The third study investigated the need for a similar service in a neighbouring area. Two surveys were undertaken using questionnaires and short structured interviews. One survey looked at the quality and quantity of the service that was being provided currently. The sample for this survey was taken from the current users of the evening service. The second survey investigated the need for such a service amongst the patients being visited

by the day district nurses only, and who would have benefited from the evening service, but were not considered a priority by the day staff owing to the limited resources of the current evening service.

NEEDS SATISFACTION OF PRIMARY CARE PROVIDERS: A COMPARISON OF HOSPICE AND NON-HOSPICE PROGRAMS OF CARE

N. Dawson, R.N., Ph.D., U.S.A.

Research comparing hospice and traditional programs of care for the terminally ill has identified few measurable differences in the care provided to patients and their families. Nonetheless, hospice recipients frequently express a higher level of satisfaction with their program of care.

This study compared the ability of hospice and traditional care settings to meet the basic needs of families during a member's dying and death from cancer. In addition, the relationship of basic needs satisfaction, perceptions of the nurse, and overall satisfaction with the program of care were explored.

One hundred bereaved primary care providers completed a mail questionnaire concerning their perceptions of care at the site of a family member's death. The sites were 1) the home, with care provided by a Medicare certified, community-based hospice program; 2) a hospital affiliated with a Medicare certified, community-based hospice program; 3) a hospital with its own hospice program; and 4) a non-hospice (traditional) hospital.

Analyses of quantitative and qualitative data supported two hypotheses about significant differences between hospice and traditional care. The home care group demonstrated the highest levels of basic needs satisfaction, satisfaction with the psycho-social support of the nurse, and overall program satisfaction. The traditional hospital group exhibited the lowest levels on each of these dimensions. Although overall satisfaction with care was consistent across hospice groups, home hospice care provided the highest quality of basic needs satisfaction.

Significant Pearson correlations supported the hypothesis that overall satisfaction is negatively related to unmet basic needs ($\underline{r} = -.692$) and positively related to the psycho-social support received from nurses ($\underline{r} = .735$). Furthermore, rank-ordering of six personnel types demonstrated that nurses were identified as the individuals providing the greatest support to patients and primary care providers in seven or eight categories of evaluation. Only in interactions with primary care providers in the traditional hospital was the doctor ranked highest in importance.

The results of this study emphasize the importance of the nurse in the primary care provider's feelings of satisfaction with a program of care. In addition, the results indicate that families experiencing a grief reaction are

most likely to have basic needs met at home or when inpatient care is within a hospice rather than a traditional hospital.

METHOD OF PAYMENT AND COMMUNITY NURSING FUNCTIONS IN A PRIMARY HEALTH CARE CENTER

M. van Dormael, B. Taeymans, F. Veldeman, Belgium

This paper describes how experimental change from fee-for-service to capitation payment was used by a Belgian multidisciplinary Primary Health Care Center as an opportunity for clarification and development of community nursing functions as well as for research in teamwork development. The framework of analysis was the concept of integrated health center providing comprehensive, continuous and integrated care. Special reference was made to nursing theories (such as Callista Roy) based on broad bio-psycho-social vision of Man.

An action-research process was developed involving the teammembers (general practitioners, nurses, psychotherapist, secretaries, social worker, psychologist) called 'operational researchers' and an 'external researcher'. The aims were (1) to improve care given at the local level and, more specifically, to strenghten adequacy of nursing care to the needs of the registered population and (2) to identify conditions for development of community nursing functions in the Belgian context.

Methodological tools included (1) an extended list of community nursing activities built in order to monitor the nurses' real activities; (2) the internal information system giving data about patients' characteristics and frequency and type of care received; (3) individual interviews of all teammembers before and after change of method of payment; (4) observation of consultations of the Health Center's general practitioners in order to identify in their practice medical-specific, nursing-specific and non-profession-specific functions.

Capitation payment rapidly allowed change in the nurses' attitudes towards their usual patients in terms of increased attention to psycho-social problems and to prevention (e.g. ulcers). However, their patients remained dominantly a small proportion of the registered population, requiring home-care.

In order to develop community nursing functions, proposals were made to increase nurses' responsibilities in areas such as follow up of chronic patients, health education and prevention programs. Subsequent negociation of functions within the team showed that, besides the profession-specific (and mostly technical) functions, a relatively large part of the functions of the health center are not profession-specific; their distribution within the team should be discussed in terms of patients' interests rather than corporatist arguments.

The action-research process remains ongoing and has not exhausted all developments made possible by capitation payment within the health center. Available results suggest that (1) the currently experimented capitation system allows a far more consistent contribution of community nursing to primary health care than does the prevailing traditional fee-for-service system in Belgium and (2) that development of community nursing should not be thought alone in terms of specificity of community nursing but also in terms of interdependency of disciplines in primary health care teamwork.

CHANGING BOUNDARIES IN THE SOCIAL PRODUCTION OF HEALTH IN THE HOME: THE EMERGENCE OF HEALTH DOMESTICS

E. Elliott R.N., M.S.N., U.S.A.

A category of paid women home-based health workers is emerging that indicates the shift in the previously stable line marking the division of labour between informal and trained formal health workers in the home. The purpose of this study is to shed light on their own work identities, the nature of the work itself, and what the boundaries set by the newly constructed lines reveal about the social organization of health care.

The American health care industry has been restructuring over the last five years. Current strategies seem directed at eliminating costly labor intensive services from the hospital while focusing on the highly profitable 'high tech'services.

One such labor intensive service is caring for the physical needs of persons who, through illness, cannot care for themselves. Thus the major caring responsibilities have been moved out of the hospital and back to home, yet remaining in the market. But the reserve labor force of housewives/mothers has been already commissioned for work elsewhere. Another group of women about which little is known appears to be filling a labor niche in the home, the health domestic. Although the clinical part of the domestic work lies outside the jurisdiction of the health care industry, the work is fundamental to maintaining its structure.

Qualitative research methods were used, specifically participant observation and ethnographic interviews, to examine the logic of the respondents work as described in their own accounts. The goal was to show the links between the everyday work world of these women and the processes of formal organizations and the state. A sample of 40 women engaged in direct care in the home of a sick person were interviewed. Included were American Black, Hispanic, Irish, Polish and White-ethnic women.

All of the women interviewed claimed a work identity related to nursing rather than housekeeping. The levels of education varied but most had some post secondary school training, generally beauty school which included care of hair, skin, and nails. All described activities they had performed in the home that are reserved for nurses when performed in the hospital. Lastly, there is an unofficial yet distinct social structure and organization that informs what is a highly mobile group of workers, which is described as 'the agency'.

The essential but invisible work of these women must be included in formulation of state health policy. Nursing must decide whether or not to include these health domestics in their ranks and their quest for professionalization and status. Issues of quality of care need to be studied as well.

KNOWLEDGE, ATTITUDES, ROLE PERCEPTION AND REPORTED PERFORMANCE OF NURSES IN RELATION TO ADOLESCENT HEALTH PROBLEMS

H. Eshed R.N., M.P.H., D.Sc., Israel

Adolescents are believed to be at the prime of health. Yet it is a period when they indulge in risk behaviour, which place them in a category of high risk to develop pathology.

Community health nursing is focused towards high risk groups, therefore, in order to assess whether primary care nursing meets adolescents' health needs, 306 nurses working in primary care settings were studied.

The object of the study was to investigate the knowledge, attitudes, role perception and reported performance of community nurses in relation to adoloscents' behaviour patterns and health.

The study population was a stratified random systematic sample of 306 registered nurses working in different primary care settings.

The research tools developed specially for this study were:

1.A videotape Trigger film, to study reported performance.

2.A self administered questionnaire, prepared on the basis of the literature to assess nurses' knowledge, attitudes and role perception, regarding adolescent behaviour.

The behaviour patterns studied were: smoking, sexual behaviour, drugs, alcohol, eating habits. The clinical issues were hypertension, obesity, anorexia nervosa and other health problems.

The nurses were invited to participate in groups of 15-20 each time. After completion of questionnaire they watched the trigger film and wrote their answers in specially prepared forms, to the questions "what do you do in such a situation?" after each trigger.

Their answers were compared to a "gold standard" specially prepared by a panel of judges.

The results showed that the nurses achieved a low score on their reported performance (20-40%). It was lowest in areas that are considered to be the core of public health nursing.

The mean level of knowledge reached 65% of the total possible score.

Attitudes towards smoking, alcohol and drugs were strict. However those relating to sexual activity were more permissive.

Role perception was "higher". Nurses stated they should be part of the multidisciplinary team treating adolescents and their problems but had no time to do so.

The results indicate that nurses should be taught about adolescent behaviour patterns in all levels of professional training. Adolescent health nursing needs a high priority rating. Resources to develop services have to be allotted. Research should be encouraged and developed.

SCREENING FOR PSYCHOSOCIAL DISTRESS: IMPLICATIONS FOR PREVENTION AND HEALTH PROMOTION

L.W. Gage, Ph.D., R.N., F.A.A.N. & N. Kline Leidy, Ph.D., R.N., U.S.A.

The importance of identifying psychosocial as well as physical health needs of individuals served in primary care settings has been documented in the United States, Great Britain, and developing countries. The aims of this study were to compare the levels of client psychosocial distress in four primary care clinics in the United States and to describe the relationship between psychosocial distress, medical problems and selected demographic characteristics (income, age, gender, education and marital status) of clients served in these clinics. The convenience sample (n = 460) was drawn from consecutive clinic attenders. Phychosocial distress was measured with the Goldberg 28-item General Health Questionnaire (GHQ). Medical problems were documented from record review, and demographic characteristics were recorded on a personal data questionnaire. About two thirds of the clients had fewer than four positive answers, indicating that they were not "at risk"; 13.4% were moderately distressed, and 23.9% were highly distressed. Chronically ill clients were significantly more distressed, and income was the strongest predictor of psychosocial distress. With race and setting statistically controlled, age, income and race (white) accounted for 16% of the variance of GHQ scores. Contrary to other research findings, gender was not correlated with psychosocial distress. The significance of findings for screening all patients in low income hi-volume clinics and the role of the nurse in the prevention of illness, further deterioration of health status and/or the promotion of health through early case finding and treatment are discussed.

SELF CARE PROGRAMME FOR THE HYPERTENSION PATIENT AND HIS FAMILY

C. Germán, P. Blanco, C. Heierle, E. Ruiz, A. Salas & V. Zunzunegui, Spain

Introduction

This study describes a programme of education for the health of the hypertension patient and his family. The programme is carried out in the primary health care centres and surgeries of Andalusia. All members of the primary health care team participate in the programme; doctors, nursing staff and social workers, with the nursing staff and social workers, with the nursing staff having social responsibility for the co-ordination, organization and development of the programme.

Objectives

-to provide information to hypertension patients and their families who need to adopt a healthier lifestyle; eg. eating habits, physical exercise and social life;

-to facilitate the adoption of changes in lifestyle caused by the illness and the achievement of correct self-care in diet, medication, self-observation and the control of blood pressure.

Methodology

Once the hypertension is confirmed the patient recieves information on the changes in his lifestyle he has to make, the help he will receive from the health team and on the support and education that both he and his family can expect from the health centre.

Latterly individual education has been started in which a continuing assessment is made of the ideas, habits and motivation of the patient in the daily health process, and in which he is prepared for group therapy, possibly with the participation of his family or close friends who will be supporting him during the illness.

In the last phase, six educational group sessions were carried out on the following subjects; food and associatied factors, blood pressure and community resources. This last phase normally takes three months but ought not to last more than one year.

An experienced teacher is made available to the patient and to the health team.

Results

The programme is evaluated by means of controlled trial in which the education intervention groups are compared; traditional information and performance model, and the self-care model. The results of similar studies (eg. Silverberg, Israel, 1983, Acedo, Seville, 1985) revealed the following benefits; control of blood pressure, reduction of waiting time, reduction of abandoned cases, and a reduction of various risk factors such as colesterol, overweight and smoking.

THE COMMUNITY NURSING RECORD CARD

M. Hanrahan, M.Sc. R.G.N., The Netherlands

Introduction

This is the result of a pilot study of the practice of recording of community nurses in The Republic of Ireland and The Netherlands. In both countries community nurses combine both preventive and curative nursing duties in their practice. This presentation represents a descriptive analysis of the community nursing record card as it is currently utilised by community nurses in the Republic of Ireland and in The Netherlands in the course of curative nursing practice.

Method

A descriptive study of its current use by community nurses was carried out over a period of six months. Cards were randomly selected from community nurses in both countries, and an analysis was carried out.

Results

The card in Ireland consists of two distinct parts, one dealing with factual information, the other with the process of nursing. In relation to part one, findings include the fact that of the 42 headings only one was used in all cases and 15 headings were used less than 50% of the time. Some parts of the card were largely underused, the relevant information being recorded elsewhere on the card or omitted. Irish nurses reported 211 identified nursing problems. Of these 211 problems identified, 149 had incomplete cycles. Inadequate completion of 'Desired outcome' and 'Evaluation' entries accounted for these failures, together with differing interpretations of the headings involved.

The card in The Netherlands is a document to record the first visit to the family, and subsequent progress notes. No space is provided to record the process of nursing under headings such as nursing problem, outcome, action or evaluation, (process-cycle). Dutch nurses were found to record factual information on the 'family card' correctly, but did not record nursing problems, outcomes, or evaluation. They documented nursing actions and progress notes. Documenting the process of nursing was not generally practised.

In both countries the nurses used medical diagnosis to document the reason of care. The care described on the card was task orientated; nursing orders were noted. Suggestions are made both in relation to training for

card use and the design of the card itself. The extent to which the Community Nursing Record Card archieves its aim is critically examined and recommendations are offered for re-design of the card; suggestions in relation to training and instruction for its use are made on the basis of the findings presented.

FACTORS INFLUENCING PROFESSIONAL HOME CARE UTILIZATION AMONG THE ELDERLY

Drs. G.I.J.M. Kempen & Dr. Th.P.B.M. Suurmeijer, The Netherlands

One of the main questions in a research-project on professional home care is: what are, besides physical limitations, the reasons that some of the elderly will get professional home care and others don't? By professional home care two institutions are meant: community nursing and home help services.

To answer this question we compare a subsample of 60 + years old people where professional home care just started with a subsample of 60 + years old people who didn't get professional home care with more or less the same need, based on physical limitations (= difficulties in performing a number of ADL- and household activities). For the matching-procedure on physical limitations, Mokken Scale analysis for Polchotomous items (MSP) has been used for measuring this variable. The most important factors to compare on are social network variables (range, distance, composition, number of informal care givers) and personal variables (demographic variables, housing conditions, income, feelings of loneliness, depression).

Data for the study have been obtained from interviews with older people (between may 1987 and may 1988) in a northern part of The Netherlands.

FACTORS RELATED TO THE USE OF COMMUNITY NURSING SERVICES

Dr A. Kerkstra & Drs T.M.L. Vorst-Thijssen, The Netherlands

Introduction

The community nursing services in the Netherlands have become all the more important, given the policy of keeping people at home in the community for as long as possible, and the reduction of beds in hospital. Besides the fact that in particular elderly people make use of community nursing services little is known about other characteristics (e.g. diagnosis, living situation) of the recipients of community nursing care and the nature of services provided.

The study to be presented aims to identify the factors important in explaining the nature of community nursing care received by patients. More specifically, this study tried to find answers to the following questions:

-What are the individual characteristics of patients cared for by community nurses at home?

-Which kind of nursing care do these patients receive at home?

-Which individual characteristics of the patients affect the nature of care received?

Method

A sample of 52 community nurses and 23 community nurses assistents at 24 different locations in the Netherlands recorded during a period of two weeks all their activities and tasks undertaken. The study to be presented is restricted to the self-recording of patient care contact at home. Preventive home visits to mothers with young children and to the elderly are not included. In the two weeks period the nurses paid a total number of 4.540 home visits to provide care to 1.391 patients. For each home visit the patients' name, sex, age, living situation, diagnosis, the motives for visiting the patient at home and wether or not the patient is receiving informal care, was recorded. They also recorded the time of arrival and departure, their activities during the home visit, and the degree of stability of the situation of the patient, that is they registrated whether or not they observed new physical symptoms, mental of social problems.

Results

Patients receiving community nursing care were predominantly elderly (68% being over 70), females (65%), and about 43% of these female patients were living alone. A substantial number of patients were suffering from chronic problems limiting their mobility, and more than a fourth of them were suffering from multiple disorders.

More than half of the patients received personal hygienic care or technical nursing care. Besides these more 'traditional' sorts of nursing care, many patients were supported to their psycho-social problems, received health education or were stimulated in realising prescripted therapies. Patients suffering from multiple disorders, those who also received informal care, and those who were visited for a number of reasons were most likely to receive a number of different types of care from the community nurses.

HOW TO BRIDGE THE GAP BETWEEN HOSPITAL AND HOME? SOLUTIONS TO THE PROBLEMS OF CONTINUITY OF NURSING CARE AFTER HOSPITAL DISCHARGE IN THE NETHERLANDS

T.J.J.M.T. Kersten & W.C.M. Zijlmans, The Netherlands

There is a general awareness that many old people especially need further nursing care, after they are discharged from hospital. If there is a partner at home, he or she is also old and not capable of delivering all of the necessary care on his/her own. Professional nursing care is needed to prevent the physical and also mental condition of the patient getting worse instead of better.

Different health care systems have different solutions to guarantee a continuation of nursing care after a patient is discharged from hospital. In countries without a strong primary health care(PHC) system we often see that the hospital nursing staff is in some way responsible for the delivery of aftercare. If there is on the other hand a strong PHC, then the community nursing organization is the first in charge. This is the kind of situation we have in the Netherlands.

The problems in organizing a system whereby the right patient gets the right help at the right time after his discharge have to do with the following topics: 1. selection of patients who need aftercare; 2. transmission of needed information about the patient from hospital to community nurses; 3. adequate resources for the community organization. To solve the two main problems in the Netherlands (1 and 2), requires communication and engagement between hospital (nursing) staffs and the regional community nursing organizations. This is necessary to achieve adequate aftercare nursing procedures. Since the seventies several local projects have been started. In these projects regional community nursing organisations are busy making arrangements regarding the transference of information about the arrival of aftercare patients. Special 'liaison-forms' have been designed to transfer the needed information from hospital to community nurses. A difficult problem seems to be changing the mentality of representatives of both species of the same nursing profession to take a joint responsibility which prevents the patients falling between two stools. Some people think that a special community nurse with a liaison function, a 'continuity-nurse', can do a good job in this respect, others don't. As a result some regional community nursing organizations have employed these continuity-nurses and others have not. There is no overall picture of the solutions mentioned above.

The situation as mentioned above showed the need for a descriptive study which presents a detailed picture of the way regional community nur-

sing organizations have managed to resolve continuity problems. The NIVEL has done this study by sending a questionnaire to all 185 local community nursing organizations. The results show, that a continuity-nurse is working for 60% of these organizations. Mostly the organizations work together in groups with respect to continuity of care. This cooperation is very useful, as there is no one-to-one relationship between a hospital and a regional community nursing organization. Mostly there is a complex network of relationships, which is clearly shown by the fact that the average community nursing organization has to deal with 4 hospitals. In 68% of the cases, community nurses of the regional organizations consult on a regular basis with 'their' hospitals.

Further research is done to describe and compare the results of different procedures that have been developed in favour of continuity of care. The following has been taken into consideration: the number of aftercare patients, the quality of care that bridges the gap between hospital and home, and the possible effect of the procedures on earlier discharge from hospital.

ASSESSMENT OF PRENATAL HIGH RISK BEHAVIOURS FOR LOW BIRTH WEIGHT INFANT

H.S. Kim, Ph.D., R.N., U.S.A.

The high rate of low birth weight infants has remained one of the most persistent and difficult health problems in our society. In general, community health nurses are responsible for providing prenatal care to the sector of the population known to be most at risk for low birth weight infants. One difficulty in providing adequate care to this group has been the lack of an assessment tool that would allow for early identification of high-risk behaviours for low birth weight. This study reports on the development and testing of a comprehensive prenatal appraisal instrument that can be used to assess a pregnant women's level of risk based on selected behaviours. The behaviours included for assessment include dietary habits, activity levels, sexual behaviours, health practice behaviours , and substance abuse. The instrument also includes a section on the assessment of personal resources (instrumental, cognitive, and social) that can be mobilized through nursing intervention over a relatively short period of time to decrease the level of risk for low birth weight outcomes. Our testings of this instrument with ninety high risk pregnant women from an inner city area lends support to the validity and usefulness of this tool in community health nursing. Use of this Low Birth-weight Infant Risk Appraisal tool (LBIRA) at the early stage of prenatal care in community health setting allowed the community health nurses to develop individualized prenatal care plans focusing on life-style behaviours which require change during pregnancy.

CONDITIONS FOR THE ADMISSION AND DISCHARGE PROCESS

Drs. R. Klop & Prof. F.C.B. van Wijmen, The Netherlands

Introduction

A four-year study is currently being conducted into the elucidation of the conditions for an optimal admission and discharge process with regard to the rights of patients, the rights and duties of health workers, (in particular doctors and nurses working in hospital and the community), and government and hospital directives. The study focusses on the transfer or assignment of care between doctors and nurses working in hospital and in the community.

Methods

On the basis of a literature study, in-depth interviews have been conducted with patients, doctors and nurses (11 cases, 55 interviews) to elucidate views on and the personal experience of the admission and discharge process. The interviews have been analyzed by means of qualitative research methods developed by B.G. Glaser and A.L. Stauss (1967), F. Wester (1987) and I. Maso (1987). The results of the in-dept interviews will be submitted to a brains trust (Delphi-technique) in order to generate consensus about the conditions for the admisson and discharge process.

Results

In this paper we will concentrate on the in-depth interviews. These show, among other results, that:

-Patients did not complain about the admission and discharge process, but they were not informed about the information-exchange between nurses working in hospital and in the community, and patients were not involved in the arrangements the hospital nurses made for discharge.

-Community nurses were often not informed about the patient's admission to hospital.

-Nursing devices for the home care were arranged by patients, community nurses and hospital nurses without co-ordination, with the result that not suitable nursing devices were ordered.

Conclusion

Attention should focus on how patients, if they wish, can be involved in the admission and discharge process and how the information-exchange between hospital and community nurses can improve.

CHANGES IN HOME HEALTH NURSING RESOURCE CONSUMPTION

E. Kornblatt Phillips, R.N., M.Ph., Ph.D., A. Irvine, Ph.D., M.E. Fisher, M.S.N., J. Torner, Ph.D., P. Cloonan, M.S.N. & G. Chase, Ph.D., U.S.A.

In an area of cost-containment, shorter hospital lengths of stay, and greater demand for home health care, home health nurses across the United States reported increased needs for patient care. Although most research has focused on changes in hospital care, it is reasonable to assume that a change in the hospital will have an impact in the community, home health arena. Changes there will have implications for community nursing education, manpower, and reimbursement.

We selected approximately 2000 home health cases at random from health department patient logs in one state (Virginia) over a two-year period. We examined changes in nursing resource consumption as indicated by nursing services requested (including number of services and frequency of services), nursing services delivered (including number of billed nursing visits and amount of nursing time delivered), and length of episode (from case opening to closing). Over the period, we observed small but significant (p.05) increases in services requested and services delivered, but not in length of episode, which declined, but not significantly.

The findings do suggest a shift in patient population towards more complex cases which require additional nursing resources. More services being requested and delivered in shorter periods of time describes a more intense pattern of care delivery. This will be important for education in terms of numbers of community and home health nurses needed, and the practice for which they need to be prepared. The skills needed to care for sicker patients in the community are likely to be different than those needed historically. In addition, there are manpower issues, particularly with respect to formulas used to determine community nursing manpower needs. Traditional nurse-to-population ratios are not appropriate if the community population is, on the average, in need of more nursing care. In addition, formulas for reimbursement are also called into question. Payment by the visit is not justified if increasing numbers of services are required per visit. Inefficiency is promoted if agencies are rewarded for making several short visits rather than a single, longer visit.

Studies like ours are important not only for the findings, but also for demonstrating the usefulness of readily available, routinely collected patient data for research. These data are critical for knowledge-based allocation and other essential decision making.

COMMUNITY NURSING: OUR BUSINESS

J. Kruyt & Drs. P.H. Jonkergouw. The Netherlands

Several speakers on the conference will give attention to the numerous tasks of the community nurse and her comprehensive work.

At this moment the community nurses in our country, as in more western countries, think that - given new developments - a reconsideration regarding task and position is necessary.

It concerns developments as:
-changing questions, needs and demands of clients,
-political plans to alter the health care system,
-the threat, working with more and more other disciplines, that it becomes unclear for which the community nurse is responsible.

As the committee for community nurses of the Dutch nurses association "Het Beterschap", we would like to present on the conference our ideas how to cope with the above mentioned.

Starting point for us is the maintenance of a recognisable, integrated, neighbourhood-oriented service delivering (community nursing) generalist.

In succession we will dwell upon the following subjects:

1.The contents of the nursing care at home
-vision of extramural nursing
-distinction/connection medical care
-concrete tasks of the community nurse

2.Conditions to fulfil to give the nursing care
-organization to realize the care
-training and education of community nurses
-refresher courses
-register of community nurses
-quality examination
-honorarium

3.Assurance to realize the wished (quality of) care
-task of the nurses association
-task of the cross association (as provider)
-task of the government
-task of the financiers

4.Place and position of the nurse in the total health care
-accessibility for the client
-relation with other disciplines
-relation with intramural provisions

5.How to realize the desirable changes?

THE WORK OF A PUBLIC HEALTH NURSE IN THE HEALTH CARE OF UPPER STAGE COMPREHENSIVE SCHOOL PUPILS: THE CONTENTS AND THE PROCESS OF DECISION MAKING OF THE PUBLIC HEALTH NURSE'S WORK AS A STARTING POINT

A. Liukkonen, R. Matero & S. Lauri, Finland

The aim of the study was to chart the activity of upper stage PH-nurses in the health care of the pupils. Research problems were:

1.What is the PH-nurse's decision making process like?

2.How are the contents areas of work emphasized?

3.How is cooperation implemented with home, the PH-nurse and other professional groups in school health care?

4.Do the external conditions and the contents of work and the amount of cooperation explain the implementation of the PH-nurse's decision making process?

The total population consisted of 600 PH-nurses of the country. The sample included 200 PH-nurses. The data was collected with a questionnaire.

The PH-nurses experiences that the identification of the youth's needs was carried out best of the stages of decision making process, whereas implementation and evaluation were carried out worst. In the PH-nurses' opinion, they could meet the physical needs of the puberty-aged pupils well, but the psychosocial needs remarkably worse. Most of the PH-nurses had moderate or little collaboration with different professional groups. The study did not discover dependence between work's external conditions, the contents of work, the amount of cooperation and the process of decision making.

In order to develop the process of decision making in school health care, the PH-nurses should concentrate on implementation and evaluation by extensive cooperation.

WHICH ACTS DO NURSES PERFORM IN HOME-CARE SERVICES?

Dr. H. van Loon, Belgium

Since home-care services in Belgium are currently mainly financed via a refund on the fees patients pay to the nurses, it is extremely important to assess the nursing acts for which the patient might possibly get a refund.

Using the cluster-sampling technique, a study was therefore carried out in 30 local sections of the White and Yellow Cross. Over a 4-week period, 669 nurses registered all nursing acts on a special questionnaire tested in advance.

A total of 291.846 acts, covering 65 items, were performed over 221.952 visits at patients' homes. Only 81.5% of these acts were refunded by the health-insurance companies. 3/4 of the remaining 18.5% could be clearly identified.

The study clearly shows that a substantial part of nursing activities is not refunded in the current system. It is argued that a consequent or alternative financial system is needed.

COMMUNITY HEALTH SERVICES AND HOSPITAL EARLY DISCHARGE POLICY

L.D. MacDonald Ph.D., D.A. Hennesy Ph.D. R.N. & J.M. Addington-Hall B.Sc., United Kingdom

Community Health Services (CHS) in the United Kingdom are provided by nurses and paramedicals employed by Health Authorities. They work with general practitioners in primary health care teams. Nearly the entire population is registered with a general practitioner.

One Inner London Health Authority, like others required to improve efficiency despite a reduction of resources, is planning earlier discharges from acute hospital beds. The population served has a large proportion of single-parent families, one-person elderly households, high unemployement, substandard housing and a Standardised Mortality Ratio of 110. It is at elevated risk of illness, with less available family support and more need of community services.

CHS are already financially stretched to give adequate care to the chronically sick and disabled and the frail elderly. They may now also have to provide technically sophisticated nursing for acute patients. It is feared that reduced services and increased re-admissions may result if sufficient resources are not made available to accomodate this change. To examine these issues, acute hospital discharges referred for community care are being investigated.

During the first three months of 1988, 245 Health Authority residents were discharged from acute beds with a referral to CHS or Social Services. They were compared with a randomly selected group of unreferred patients matched for hospital ward and date of discharge. Both groups were followed-up for one month. This was done by using hospital nursing care notes and CHS records and by patient interview.

Initial examination of the first 100 cases in each group showed 66 referrals to CHS and 95 to Social Services. Age varied considerably: 67% of referred patients were over 65 and 52% were over 75, compared with 32% and 15% of the unreferred. More than twice as many referred as unreferred patients lived alone (37% vs 15%). Length of stay was significant. The majority of unreferred patients (69%) were discharged within seven days. Among referred patients, the majority (53%) were discharged after 15 days or longer, 10% having been inpatients for over a month. There were no sex differences between referred and unreferred patients: 56% of discharges in each group were women. Nearly a fifth (18%) of each group were re-admitted within a month of discharge.

These results show that community services are already being directed towards the most vulnerable, with the same re-admission rate as younger, more supported patients. As the early discharge policy is implemented, more resources will be required to provide increased technical nursing in the community instead of in hospital.

HOME SUPPORT: A PROGRAM TO INCREASE THE NUMBER OF HIGH-RISK WOMEN STARTING PRENATAL CARE DURING THE FIRST TRIMESTER.

J.McFarlane, R.N., Dr. P.H. & L. Bullock, R.N., M.S., U.S.A.

Purpose and supporting research for the program

In the US only 75% of women start prenatal care during the first trimester. Infant mortality, pregnancy complications and low birthweight are clearly associated with inadequate prenatal care. Houston is the 4th largest city in the US with a population of over two million; however only 65% of pregnant women start prenatal care during the first trimester. A major barrier to early care is a provider system that does not offer culturally relevant programs or adequate social support.

To document the extent of social support, 600 women attending public clinics were assessed for financial difficulties, death of a family member, legal problems, and physical abuse. Some 35-40% of the women were experiencing several social stresses and 47% of the women listed no source of social support. When the Norbeck Social Support instrument was given to 58 randomly selected pregnant women in public clinics, the women had a small social support network and perceived little social support. Because low levels of social support are associated with more complications of pregnancy as well as premature labor, project HOME SUPPORT was begun.

The program

HOME SUPPORT measures the effectiveness of using volunteer trained neighbourhood mothers to identify and visit women at-risk to not initiating early prenatal care. To initiate the program, one professional nurse uses community assessment data to identify community leaders who inturn identify 40 neighborhood mothers well known and respected by residents. The 40 volunteer mothers receive 8 hour of training that includes information on women at-risk to not starting prenatal care and support measures to increase early entry into the health care system. Support measures include a peer with whom to share problems, information on behaviours associated with a healthier pregnancy and use of community resources, (i.e. public transportation food programs). Each of the 40 volunteer mothers identify and visit 5 women assessed at high-risk; a total of 200 women are visited. Program effectiveness is measured by pre and post-program surveys and number of women who start early prenatal care.

Conclusions

Adaptation of HOME SUPPORT to other settings is discussed along with specific curriculum examples and evaluation instruments.

ADMISSION OF OLDER ADULTS TO HOME CARE

J.K. Magilvy, Ph.D., R.N., U.S.A.

With the advent of prospective payment systems resulting in shorter hospital stays for older adults in the United States, more people are returning home with needs for continued services. Home health care is increasingly an important part of long-term care for the elderly. The purpose of this ethnographic investigation was to discover the process of admission of older adults to home health care services from the perspectives of patients, families, nurses, home care agency and hospital personnel. The specific aims were: to describe the patterns and procedures involved in the admission process; to identify the types of information transferred between hospital or physician and home care agency; to explore patient and family involvement in hospital discharge and admission to home care; and to identify the problems inherent in the admission process.

This study used an ethnographic methodology to explore and discover the admission process as viewed by participants in the 'culture' of home care. Data were collected at two home care agencies in the Western United States, one hospital-based and the other a free-standing proprietary home health care agency. Over 50 hospital discharge planning nurses, home care coordinators, administrative personnel, field nurses, therapists, and clerical staff as well as patients and families comprised the sample for the study. Methods used included tape recorded ethnographic interviews, participant observations, and examination of documents (e.g., patient records, admission, and clerical forms). Field notes, transcripts of interviews and copies of documents were analyzed using ethnographic analytic methods to yield overall themes and categories related to the admission process.

Preliminary results indicate several areas of importance to the process of admission of older adults to home care, including: identification of patients appropriate for home health care; transfer of information about patients from hospital or physician to intake personnel to nurses; patterns of nursing activities in 'opening' new cases; and the role of external reimbursement mechanisms in admission and retention of patients.

This study has implications for nursing and health care delivery systems for older adults in an age of cost containment in health care. Creative and innovative approaches to home health care are dependent upon a smooth process of hospital discharge and home care admission. Nursing leadership in the planning and implementation of home care services can be supported by findings from this and future research in home health care.

COMMUNITY ANALYSIS RESEARCH AND PRACTICE: THE GENESIS MODEL

J.K. Magilvy, Ph.D., R.N., Ph.R. Schultz, Ph.D., R.N., & M.H. Stoner, Ph.D., R.N., U.S.A.

In community health nursing (CHN) planning and intervention strategies are aimed at improving the health of a community or aggregates of persons within the community. Community analysis provides the data on which to base plans and evaluate health care services delivered to these clients. As essential skills in community analysis and development are taught in graduate CHN educational programs, nurses are prepared to offer communities a unique perspective on their health. Project GENESIS (General Ethnographies and Nursing Evaluation Studies in the State) was developed by graduate faculty in the master of science program in CHN at the School of Nursing, University of Colorado Health Sciences Center. A health focused community analysis study, Project GENESIS combines quantitative and qualitative research methods to assess the health needs and quality of life of a community from the perspective of its residents. Incorporating multiple research methods for community analysis and providing the opportunity to implement nursing interventions based on the findings, Project GENESIS has been shown to be significant for clinical practice, research, and graduate nursing education.

This paper will present the research methods and results of two community analyses completed by students and faculty using the Project GENESIS model. Slide photographs taken in the communities will be used to illustrate the findings; these photographs are part of the methodology and an integral part of the presentation of findings back to each community. The GENESIS methodology incorporates the following steps:

1.Collect and analyze previously published data (e.g. census and epidemiological data).

2.Identify and interview community leaders as 'key' informants.

3.Interview community residents as 'primary' informants and conduct participant observations.

4.Combine and analyze secondary and primary data. Identify strengths, weaknesses, and recommendations.

5.Present a written and verbal report back to the community and seek feedback.

Studies conducted in two rural communities in the state of Colorado will be presented, showing how multiple factors such as environment, politics, education, recreation, history, and the health care system influence the health of a community as described and percieved by those who live and work there. The strenghts of Project GENESIS as a research method and significance for clinical practice will be highlighted.

THE NURSING-BEHAVIOURAL-PATTERN OF COMMUNITY-NURSES (CN) AND COMMUNITY-NURSES'-AIDS (CNA) OF THE FIRST HEALTH CARE ECHELON (FHCE)

Drs. H. Masselink, The Netherlands

Introduction

In this research, the work of CN and CNA on micro- and mesolevel of nursing is being examined and analysed. The research is carried out by the 'Stichting voor Verpleegwetenschappelijk Onderzoek' (Foundation Nursing Scientific Research. FNSR), under the auspices of the Dutch Ministery of Health, Social and Cultural Affairs (Ministry of HSC).

The thesis is as follows:

What is, in the opinion of CN/CNA, in the present execution of nursing, considered as the assumed, the actual and the desirable nursing-behaviour of CN and CNA of the FHCE in several rural and urban areas of the Netherlands?

Directly derived from the thesis are the following questions:

-What does the CN/CNA do, assumed, actual and desirable, in direct contact with the patient?

-What does the CN/CNA do, assumed, actual and desirable, besides the direct contact with the patient?

Indirectly derived from the thesis are the following questions:

-In what frequency and with what time-investment are these activities performed?

-With regard to what age-category are the activities in direct contact performed?

-Till how far does the 'Wijkadministratiesysteem' (Community Administration System. CAS.), offer enough space to administrate the activities in direct contact with the patient.

-To what extent does the educational training of CN/CNA align with the present execution of nursing of the FHCE?

The relevance of the answer to the here formulated questions is in:

-Obtaining more insight into the actual nursing-tasks of CN/CNA and the way they are sceduled.

-To contribute to a better alignment between the educational training and the pratical training c.q. the necessary expertise of CN/CNA.

Researchmodel and -planning

The two matrices as developed in the theory of nursing by Mrs. Van den Brink-Tjebbes are the planning-guidelines for the examination and analysing of the behavioural-pattern of CN/CNA. The activities on meso-level are classified by five items.
Eight community-centers, in all 104 CN/CNA partly working in rural areas, partly in urban areas, cooperated in this research.
Chosen is for a survey-investigation. Several questionnaires, constructed according to the two matrices and to the five items on meso-level, are put out.
The data-processing takes place via uni- and multivariate analysing.

Results

The research was started in December 1987 and will be finished in January 1989.
The data-collecting and analysing takes place in the middle of 1988.
The research-paper is in preparation.

MULTIDISCIPLINARY CO-OPERATION IN PRIMARY CARE FOR ASTHMATIC CHILDREN

I. Mesters, R. Meertens & N. Mosterd, The Netherlands

In April 1987 the project 'Protocol development for Patient Education in the Extramural Asthma-care' has started. The aim of this project is to develop a protocol which structures the education addressed to parents of asthmatic children (0-4 years).

In the care for asthmatics several disciplines are involved. Therefore, besides the content of the patient education, the protocol will also regulate the co-operation of different primary providers, such as general practitioners, doctors of infant welfare centers, community nurses and nurses specialized in asthma care. For this reason already existing task conceptions of these health care workers with regard to asthma have been investigated.

Performing a certain task in asthma education requires appropriate knowledge about personal and medical needs of asthmatic children and their parents. The protocol should therefore link up with the existing level of knowledge of the different disciplines. In this study questions on knowledge were added to the final questionnaire to investigate this issue. Having appropriate knowledge about asthma is essential for a person's ability to perform a certain task.

In this presentation the results of the above mentioned questionnaire will be discussed. The introduction into the data will be from the community nurses' point of view. During the last 20 years nurses' tasks have been shifting from prevention of infectious diseases towards early detection and treatment (advise and support) of chronic illnesses. Today community nurses play an important role in the multidisciplinairy care for asthmatic children.

In total 42 questions on task conceptions which were categorized into nine areas, namely co-operation with other disciplines, noticing asthma symptoms and other related problems, adapting homes, co-ordination of care, information on medication and taking an updating course, were posed. Finally, 39 questions on asthma knowledge had to be filled out.

The results show that community nurses consider several tasks in the asthma care as theirs. In addition other disciplines have their opinion on what tasks community nurses should perform. Bottlenecks can be identified and will be reported.

Overall, the mean scores on the knowledge questions are low for all categories of primary care providers. This finding indicates that educating primary care providers is essential before an asthma protocol can be implemented succesfully.

THE COMMUNITY HEALTH AIDE AS CULTURE BROKER IN AN ETHNIC COMMUNITY

D.M. Modly, Ph.D., U.S.A.

The purpose of this paper is to report the results of an eighteen (18) month study of the activities of a community health aide in an ethnic urban community of the Midwest of the U.S.A. A bilingual nurse anthropologist observed and sometimes assited the bilingual community health aide in her work with Hungarian elderly who do not speak the English language adequately to understand and utilize the existing health care system.

The ethnographic interview was the principal research method used. Through observations of activities, discussions, and interviews with the community health aide, the key informant and secondary informants, a picture of a powerful culture broker emerged. The community health aide as the culture broker mediated between the culture of the ethnic community and the scientifically and technically oriented culture of the medical sector in the health care system as well as other human services available for the indigent elderly of Hungarian descent. Caring functions were combined with powerful role qualities to meet the expected and self-imposed objectives of the community health aide. Tensions that existed between the two systems, the consumer and the professional health care provider, sustained the role of the culture broker. A delicate balance resulted principally because flexibility was maintained in the culture broker's role. The culture broker served as a buffer between the two systems while at the same time the role depended on these tensions between the ethnics community and the professional health care system.

A discussion of the community health nurse's role and functions as the potential developer and facilitator of such a intermediary role concludes the discussion.

CO-ORDINATION OF THE CARE FOR PATIENTS WITH RHEUMATOID ARTHRITIS AT HOME

H.A. Mostert, M.S.N., R.N. & R. Starmans, M.D., The Netherlands

In the Netherlands the co-ordination of care at home is in discussion. The National Community Nursing Organisation (N.K.) considers co-ordination of care as a major task for community nurses. The Dutch General Practitioners Organisation (L.H.V.) also claims the co-ordination-task as well as in primary care as for the entrance to specialists. They want the responsibility for all home care including the community nurse. In the plans for a new health care finance system the general practitioner might get a bonus for this co-ordination-task.

The co-ordination function is essential for all patients with several care providers and is closely associated with patient advocacy.

Twentythree patients with reumatoid arthritis at home who are in care of at least the community nurse and the general practitioner have been interviewed. The networks of care with respect to frequency, contents - disgrowths, clothing, washing, farmaceutics and psychosocial aspects- and satisfyingness of the visits of health care providers have been studied.

More intensive, comprehensive and frequent contacts have been shown with the community nurse than with the general practitioner.

These results are discussed with the criteria for the co-ordination function with the models and criteria for patients advocacy from literature.

It is concluded that the general practitioner's claim to co-ordinate this care at home is not realistic in these patients for which 'care' is more important than 'cure'.

DEPENDENT-CARE AGENCY, CONCEPT CLARIFICATION AND INSTRUMENT DEVELOPMENT

N. Mosterd, H. Philipsen, M. Isenberg & J.M.E. Peeters, The Netherlands

Within the conceptual framework of Nursing developed by D.E. Orem, the theory of dependent-care deficit offers, in addition to the theory of self-care deficit, clues for capturing the capacities that non-professional caregivers use to care for their dependents.

Orem does not define nor elaborate the concept 'dependent-care agency' in her theory. This research deals therefore with the clarification and operationalization of this concept. Within this, the focus has been on caregivers of elderly dependents (60 and older).

From the research, four phases can be distinguished.

1.Characterization and definition on the concept.

2.Clarification on the concept at an empirical level:
Fifteen pairs, consisting of a 'dependent-care agent' and a 'dependent person' have been interviewed (semi-structured).

3.Operationalization of the concept:
By combining perceptions from the theoretical and the empirical level, a model of dependent-care agency has been developed. From the model 109 items have been formulated. With regard to the nature of the tool a 5 point Likert scale has been chosen.

4.Validation of the scale:
The 109 items have been reduced to 31 by content validity testing (11 experts). Then the tool has been tested in a population of 73 'dependent-care agents'. The final result was a scale, consisting of 31 items, which can be called sufficiently internally consistent. Cronbach's alpha was 0.87. Factor analysis revealed for the first factor an eigenvalue of 6.0 and 28.6% explained variance. All items had loadings higher than 0.4 on the first factor.

Other reliability and validity aspects will have to be tested in the future.

This research has made a start with the development of a tool which measures Orem's concept 'dependent-care agency' in a valid and reliable way.

QUALITY ASSURANCE IN PRIMARY HEALTH CARE: THE PROBLEM OF QUALITY ASSURANCE IN COMMUNITY NURSING

A.F. Osuna, Spain

Introduction

This is a pilot study being carried out in two health centres in the province of Jaén, one rural the other urban. In the study a methodology of quality assurance, based on the nursing process, the health programme and medical diagnosis procedures (with support systems) is being put into effect. In the first stage priority was given to quality assurance.

Objectives

-to propose a methodology of quality assurance in primary health care;
-to measure the development of the community nursing model in primary health care;
-to identify difficulties arising from health reform in primary health care.

Methodology

1st Stage: description, selection of priorities and standards, consultation with experts, nominal group techniques, lineal scale survey and priority techniques.

2nd Stage: application of the methodology of quality assurance in the healthcentres, rural & urban. Techniques: observation, collection of personal and family data, interviews with centre managements.

Analysis: assessment of centres by means of comparison proportion tests in demographical variables; age, sex, pathology and other registrered variables, eg. nursing diagnosis, health education, development etc.

Results

The present phase of the work consists in the analysis and selection of standards and the commencement of data collecting for the second phase.

The work is to be completed in September of this year when the results will be presented.

PATIENT COMPLIANCE - WHOSE RESPONSIBILITY?

Dr. F.M. Ross, United Kingdom

The misuse of medication by old people is a growing problem facing the primary health care team, particularly in the light of demographic change and community care policies. While compliance studies have been influential in this area, little work has been done on the nature and reliability of inter-disciplinary knowledge, and its implications for the patient's access to information.

This study addresses this problem by comparing patient, doctor and nurse knowledge of prescribed medication.

The aims of the study were first, to compare the patients', general practitioners' and district nurses' knowledge of prescribed medication; and second to test a method of improving patient and professional knowledge through the use of a drug guide. The prescribed medication of elderly patients receiving domiciliary nursing care was studied in an inner London group practice. Information on each patient's medication was obtained independently from the patient's doctor, district nurse and from the patient herself. Serious differences were identified in the knowledge of doctors, nurses and patients about the drugs each believed the patient was taking.

A personal drug guide was introduced for a four month period and was studied by measuring changes in these disagreements over medication, between doctors, nurses and patients. The drug guide was associated with an improvement in patient knowledge of drugs, a reduction in disagreements between doctors and nurses, and an improvement in the organisation of drug information in the medical record. The collaborative review of medication that took place between general practitioners and district nurses was central to the design of the study, and possibly influenced some of the changes that occurred.

These findings have implications for: health promotion in patient care; and problems of teamwork in respect of the exchange of information between general practitioners and district nurses. A key issue is the challenge made to the assumption of patient culpability in compliance. It is argued that this is a simplification, which overlooks important factors such as inadequate communication and lack of knowledge on the part of doctors and nurses as well as the difficulties the patient may have with the regime.

EFFECTS OF PREVENTIVE HOME VISITS TO THE ELDERLY

H.J.L. van Rossum, C.M.A. Frederiks, J.A.P.M.L. Kil-van Lierop, P.G. Knipschild, A.J. Mantel, H. Philipsen & J. Portengen, The Netherlands

There is a tradition in the Netherlands of preventive home visits to the elderly by public health nurses. But there is no agreement about the effectiveness of these visits; until now no study has been done on this topic in the Netherlands. Studies from other countries however (Hendriksen et. al. 1984, Vetter et. al. 1984) suggest a beneficial effect: viz. a reduction in mortality and hospital admissions.

At the moment a randomised controlled trial is investigating the effect of home visits in the Netherlands. The study, which is a joined effort of the State University of Limburg and the Provincial Public Health Nurses Association, is carried out in the province of Limburg.

Through a postal questionnaire background information is gathered about 1550 elderly of between 75 and 84 years of age, who are living at home. Besides informed consent is obtained. Of them, 600 elderly, who at that moment do not receive care from a public health nurse, are selected for the study. Probands are randomly allocated to an intervention and a control group.

The elderly in the intervention group (n = 300) will be visited by a public health nurse every three months during a period of three years. The home visits are carried out according to a protocol. No physical examination will be performed during the visits. If necessary the nurse will advise on (further) care. The control group (n = 300) is left 'untouched' during these three years, though all regular services are open to them.

After three years the intervention and control group will be compared as to the following effect-measures:

primary effect-measures: (i.a.) well-being, self care agency, perceived status of health, functional and mental state and mortality.

secundary effect-measures: utilization of health care and welfare services; i.a. home nursing, home help, institutional care.

tertiary effect-measures: cost effectiveness of the visits and utilization of services.

The home visits started in may 1988. Preliminary findings from the postal questionnaire as well as experiences with the home visits will be presented.

COMMUNITY NURSING AND HOME HEALTH CASE MANAGEMENT

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The concept of case management offers great promise for community nursing; nowhere is there greater potential for case management than home care where Diagnosis Related Groups and advances in health care technology have combined to create a rapidly expanding need for services. Health Care at Home, an American Nurses' Association publication (1978) describes case management; as used in this study, it includes client problem assessment, treatment planning, implementation and evaluation of the care as well as identification, brokering, and coordination of needed services. This process requires both direct management activities (care directly involving the client) and indirect management activities. One purpose of this study was to identify and examine the type and duration of direct and indirect home health nursing case management activities. A second purpose was to examine the effects of home health agency organizational factors on these activities.

This study used a nonexperimental, cross-sectional design with a convenience sample of nurses (n = 143) from 24 home health agencies. Qualitative and quantitative data were collected over a seven month period. Nurses completed a self-reported Nursing Time-Activities questionnaire that provided data for 10 consecutive work days totalling 1450 separate nurse-client contact days. Descriptive data about staff and agency characteristics were also collected. Data were coded and analyzed using the Spssx statistical package with nursing case management activities measured both in minutes and as a percentage of the nurses clinical day. Reported in minutes here, results indicate home health nurses spend their clinical time in a wide variety of case management activities including direct care activities (146 minutes); and indirect activities including travel (91 minutes), charting (93 minutes), telephone calls (30 minutes), and a number of other indirect case management activities (such as utilization review, multidisciplinary conferences, and administrative paperwork (151 minutes). Considered as a group, nurses only spent 33% of their clinical day involved in direct client care. However case management activities were differentially affected by agency organizational characteriatics. For example, non-profit agency nurses spent significantly more time in direct care than for-profit agency nurses ($F = 3.92$, $df = 1/143$, p.05).

This study suggests that for every minute of direct care nurses spend two minutes on indirect activities - one for paperwork and the second involving indirect case management activities. These data are important not only in defining case management, but also in considering resource utilization and productivity issues. With reimbursement based on the number of visits (di-

rect care) these data raise important questions about the present reimbursement mechanism. Additional case management data and its implications for nursing will be presented.

NURSING IN HEALTH EDUCATION FOR GROUPS OF PATIENTS WITH CHRONIC BRONCHITIS

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In Occidental countries obstructive chronic bronchitis is suffered by 10 to 25 percent of the adult population. The characteristics of this illness produce anxiety to the patient and great demand for sanitary services as well as high economical costs to the National Health Services.

The experience to be presented is currently taking place at an area of 12000 inhabitants in the town of Motril (Granada, Spain). This area is characterized by a high rate of both unemployment and illiteracy as well as low income. This experience is part of a program that is being developed in our Health Center with the cooperation of several associations belonging to the area.

Health education is given to all the patients being attended in our Health Center and having some degree of bronchial obstruction by means of a series of open lectures delivered by a nurse. Groups of patients are organized according to their age and social and cultural characteristics. Degree of evolution of their illness is also taken into account.

In order to assess this experience, patients are evaluated on the following parameters before and after the series of open lectures:

1.Degree of knowledge of their illness.

2.Degree of morbidity.

3.Life quality.

4.Degree of dependence on the sanitary services.

5.Degree of acceptance of their illness.

So far our data show a significant change in these parameters as a result of the lectures delivered.

THE SKAEVINGE PROJECT - A MODEL FOR THE PRIMARY HEALTH CARE IN THE FUTURE

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Over the past four years, a project including the reorganization and co-ordination of services and facilities for the elderly has been conducted in a Danish municipality. The project was started in June 1984 when a conceptual framework was developed to establish the foundation for the design of the project. The concept of self-care and WHO's strategy "Health for all by the year 2000" were central aspects of the framework. Self-care is the process of choosing and deciding over our own bodies and lives. In a more institutionalized health care system, citizens are often not able to take part in the decision-making process, or only with difficulty.

A survey study was conducted to assess the social and health service needs and wishes of persons over 67 years of age. Comprehensive interdisciplinary training of staff was carried out. During the latter part of this period, a 24 hour service was planned, and the former nursing home was converted into a health care centre, with sheltered flats, guest flats and a day centre, open to all citizens, irrespectively of age. Out of consideration for both the inhabitants of the former nursing home and the staff, who were to test both the new ways of working together and the new working methods the changes were initiated slowly with careful preparation and co-ordination among the respective parties.

The health care department was placed in the former nursing home; an emergency and information unit was also established there, to which citizens not previously known to the health care department could telephone between 8 o'clock a.m. and 4 o'clock p.m. and receive information and advice. The project has succeeded in creating more flexible care and housing options which better fit the needs of the elderly. The proportions of elderly living independently with greater autonomy and more opportunities for decision making and activities of daily life has been achieved without increasing the cost of services.

The selected health care services were systematically compared "before and after" the project period started, and a cost effectiveness analysis indicated: More people get more out of the same resources (in terms of staff and expenditure).