BIBLIOGRAPHY

COMMUNITY NURSING

compilation: C. van Campen

February 1989

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CIP-GEGEVENS KONINKLIJKE BIBLIOTHEEK

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Bibliography Community Nursing
C. van Campen. Utrecht: Stichting NIVEL
ISBN 90-6905-091-9
SISO 613.7 UDC 614.2(01)
Trefwoorden: community nursing ; home care

Contents

Introduction

This bibliography contains a survey of articles, reports and books on research into community nursing, published in the eighties. For reasons of size, the scope is restricted to home care and the work of district nurses. The publications are divided into chapters on structure & organization, tasks & procedures, education, collaboration, substitution of home care for intramural care, continuity of care, and use of home care. This means that seven of the eight chapters deal with the supply of community nursing, the last chapter deals with the demands of patients.

Only English publications are admitted in the bibliography. Consequently, most publications discuss the situation in the United Kingdom and the United States. Relatively few articles describe the situation in other countries. The generally used concepts, dealt with in most publications, will be discussed here, in order to introduce the reader into the present state of community nursing.

United Kingdom

The coordinating organization of home care in the United Kingdom is the **National Health Service.** Until 1974 the National Health Service was a tripartite organization of: family practitioners services, hospital services, and community services. These groups were financed differently. After the reorganization in 1974 some difficulties were solved. Several publications refer to this reorganization. Community services include district nursing, basic health care, social work, and residential care for the elderly, chronically ill and handicapped. These services are financed by local taxation, supplemented by government money.

The term **community nurse** which is frequently used refers to district nurses, health visitors and nursing auxiliaries. The health visitor works in the field of prevention, mainly with mothers and children. The district nurse provides direct, nursing care, not always at the home of patients (who are in most cases elderly). This bibliography focuses on general nursing. Accordingly more attention is paid to the work of district nurses than of health visitors in the literature.

The task of the district nurse can be circumscribed in two ways: in relation to a limited geographical area, or in terms of attachment to a general practitioner. An increasing number of district nurses are attached to GPs practice to improve cooperation between practitioners and district nurses in primary health care. In several areas there is a shift towards a focus on a geographical area, because attachment has turned out to be less effective. The cost-effectiveness factor played the principal role in this decision.

An important development, since the Public Health Act of 1968, has been that increasing contact between district nurses and clients take place outside the client's house. Several other nurses may operate under responsibility of a district nurse. **State enrolled nurses** are employable for all nursing activities. **Nursing auxiliaries** can do supportive and technical jobs, and **home helps** are asked for domestic help and personal care.

The panel of Assessors for District Nursing Training made recommendations - in view of the changing mortality rates, earlier discharge from hospital and the strong increase of the ageing population - for a new structure and curriculum for district nurse education. These recommendations have changed the curriculum since 1981. One important change is the introduction of the **nursing process**, a problem-oriented approach, which is more frequently used by different types of nurses. The nursing process is built up of assessment, planning, implementation and evaluation.

United States

The American health care is a complex system as a result of the range of different organizations. This bibliography will consider several types of nurses. The general term for medical, nursing and social care is home health care. In an attempt to conceptualize home health care, the American Hospital Organization distinguishes three levels (Stewart, no. 8):

1. **Coordinated home care** for acutely ill people who would otherwise be nursed in a hospital. The care is provided by multidisciplinary teams. Members visit the patient frequently during a relatively short period.
2. On the intermediate or rehabilitation level are those clients recovering and recently discharged from hospital. The team

includes nurses, a practitioner, a physiotherapist, and other therapists.

3. On the basic level, care is provided to patients who are not able to live at home autonomously. Continuous supervision and careful information and education are necessary. The nurse has an increased responsibility. **Home health aide services** provide supportive services. The durational home care is longer at this level than at the other two.

Different categorizations of home health care agencies are used in the literature. A global, but frequently used division is into **hospital-based** and **community-based** agencies. The three levels of home care cannot be divided into these two types of agencies. Community-based agencies however, relate more directly to the second and third level and hospital-based agencies to the first level. Furthermore, as a result of the work of 'diagnosed related groups' and more short-term hospitalization, the tendency is for hospitals to care more for patients at the second and third levels. In this bibliography more attention will be paid to community based home care. These services are not associated with intramural health care. In 1977 about 90% of the agencies were home based.
Community-based agencies can be further divided into:

- official agencies (on local, state and federal level), financed by taxation;
- voluntary organizations (autonomous agencies), financed by private funds;
- combination of voluntary and official;
- profit or non-profit private agencies.

The government influences home care by financing **Medicare** and **Medicaid** (a type of national health insurance). **Third-party reimbursement** is the designation used for allowances paid by these funds and private insurance companies. Irrespective of the former division there are agencies which are **Medicare-certified** or not as the case may be.

Official home care programmes are normally part of **community health nursing services.** The number of workers within one programme varies from one **public health nurse** (or **community health nurse**) to a team of practitioners, nurses, social workers, physiotherapists et cetera. The main tasks are prevention and control of infectious diseases. Voluntary agencies, especially the local **Visiting Nursing Associations**, often provide direct nursing care. Their teams include nurses, social workers

and therapists, who take care for chronically ill and handicapped for a long-term period.

Composition of the bibliography

This bibliography is an adapted and updated version of an original Dutch bibliography, titled 'Extramurale verpleging in het buitenland' (Extramural nursing abroad) (no. 20, 1988, Nivel, Utrecht), written by Klaas Dijkhuis. I was pleased to be allowed to use his introduction and bibliography.

Chapters one to eight proceed from global reviews of structure and organization to specific caring relations between the community nurses and patients. Chapter one includes general introductory books on the state of the art and general reviews of recent developments.[1]
More specific literature on organization and structure has been collected in chapter two. Aspects like financing and the place of community nursing within the structure of primary health care are discussed. In chapter three the attention of the reader is drawn to the daily work of community nurses. This chapter is divided into three parts: tasks and work in general, prevention, and care for terminally ill people. Training for these tasks will be dealt with in chapter four on education. Chapter five looks at the social environment of community work and treats the mutual collaboration among community nurses and collaboration with general practitioners, health visitors and other nurses; their functioning in primary health teams and health centres is also discussed in this chapter. Collaboration at another level between hospital and community nurses is an important condition for the substitution of extramural for intramural care, which is the focus of chapter six. 'Extramural care' refers to the type of homecare such as 'hospital based home health agencies' in the US and 'hospital at home projects' in the UK. Comparative studies of intramural and extramural care are also included. Chapter seven contains publications on continuation of care in the home after discharge from hospital. In the last chapter, the attention will shift from supply of care to the demands for care by patients.

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[1] Much of the literature deals with home health care in general. Only those publications are included which devote considerable space to the role of district nurses. This criterion applies to all publications in this bibliography.

The literature included is the result of research in different library systems, viz.: the library of the 'Deutsches Institut fuer Medizinische Dokumentation (DIMDI), the DIALOG-database of 'Nursing & Allied Health', the Medical Library at Randwijck in Maastricht and the database of the NIVEL institute. A further selection was made in order to present a recent overview of research in the field. All the libraries which provided the literature are listed at the back of this bibliography. Every publication is given with an abbreviation, which refers to this list. The publications are classified by chapter alphabetically by name of the first author. An author index is to be found at the back. For research on a specific subject, a subject index, including country names, are also included.

1. General

1
ALMIND, G.
Primary health service for the elderly.
Danish Medical Bulletin; 29, 1982, no. 3, p.128-30, 2 ref.
knaw nivel (C2065)

Article on the use of the primary health services by the elderly. In Denmark, the elderly have the same options for choice of general practitioner and the same sickness insurance as other age groups. Home nursing services are administered by the municipality and mainly serve the elderly. Both medical assistance and home nursing services are free. The municipal council decides whether a nursing home will have a permanent nurse and doctor or whether it is to be served by visiting nurses and the clients' own doctors. In general elderly people's reasons for seeking medical aid do not differ from those of other age groups, but are of course characterized by often complex chronic diseases, special social conditions, and psychological problems.
The dissociation of natural ageing processes from illness creates some problems for the elderly and for their doctors as well. Social solutions play a decisive part with regard to efforts of the health services. Dying at home has become a rare occurrence in Denmark, although there seems to be a widespread wish for this among elderly, which demands efforts of the primary health professions.

2
BAKER, G., J.M. BEVAN, L. MCDONNEL, B. WALL.
Community nursing: research and recent developments.
New York: Croom Helm, 1987. 310 p. ± 360 ref.
nivel (B1803)

This book contains an investigation into the recent literature (since the reorganization of the National Health Service (NHS) in England in 1974) on developments and research of community nursing. This summary concentrates on district nurses, one of the categories of community nurses in addition to health visitors, treatment room nurses and practice nurses.

Chapter one describes the education and tasks of the different categories of community nursing. All except the practice nurses are direct employees of the NHS and form part of the total nursing services of a district health authority. More than ever before, health visitors and district nurses are attached to a general practitioner instead of a geographical area.
The context in which developments in community nursing have taken place since 1974 is described. The ratio of district nurses per head of the population increased to 1:3.243 (general practitioners 1:2.116; health visitors 1:4.838). Although attachment to a general practices is the norm, it was reported in 1981 that particularly in urban areas, health authorities have reverted to a geographical pattern of working (because attachment was less effective in their circumstances). Other developments in community nursing are the growth of the primary health team, management arrangements, health service priorities, limits and costs; and record systems.
Chapter three contains 32 reports and policy statements relevant to the development of community nursing in the last decade.
Chapter four deals with developments in different categories of community nursing and proposes some ideas for the future. In the part on district nursing, developments in organization, service out of normal hours, elderly, pediatric home nursing, day surgery, early discharge, intensive home nursing, terminal care and support from specialist and other services are discussed. Studies including ideas for future developments are reviewed.
The authors classify evaluative research on developments in community nursing in chapter five. The criteria are: year of publication, journal or publisher, author type, location of study, pilot or preliminary study, experimental design, population etc. The classification is presented in tables.
Priorities for future research are discussed in chapter six. The selected fields of research are: management structures in community nursing, attachment versus geographical deployment of community nurses, roles of (different categories of) community nurses, and out-of-hours services provided by district nurses. The authors discuss three fields apart, which cover the whole field of community nursing: one is investigation of intensive home care programmes (chronic or terminally ill people).
In chapter seven a framework is presented for examining research into developments in community nursing. Strengths and weakness of research done so far is evaluated within this framework. Most

research is in the form of preliminary studies which stress the introduction and feasibility of 'new' ideas. Studies with an experimental design are rare.

3
COOMBS,E.M.
A conceptual framework for home nursing.
Journal of Advanced Nursing;9, 1984, no.2, p.157-63.
WVC

Home nursing is characteristically dismissed as a series of tasks, limited in range and basic in nature. The present article describes research which repudiates this view while presenting a conceptual framework for home nursing which captures the dynamics and impact of this form of nursing upon the patient. Though it uses the approach of 'grounded theory' the present stereotype was found to be deficient. Home nursing was observed to be far more complex and challenging than generally acknowledged. Whilst the development of a conceptual framework was the primary aim of the research, the author has compared the home nursing studied in Australia to the observations of Kratz (1976,1978) upon district nursing in England. It was found that the home nurse plays a central role in the patient's response to chronic illness. Lawrence & Lawrence have described in 1979 how nursing intervention can produce, through adaptation to the stress of long-term illness, a higher form of human functioning than that existing before the onset of the disorder. Surprisingly, this process has never been examined in relation to home nursing which, more than ever, is caring for increasing numbers of patients experiencing chronic illness and disability. The present study found that different variables and parameters which exist in home nursing but not in acute facilities affect the nursing intervention. If a body of nursing knowledge is to be developed and maintained on the basis of which nursing education can be coordinated, understanding of different nursing situations and the variables in each is essential. It is hoped that this inductive study will be expanded by future research which will examine the concepts identified, and establish links between them so that a theory of home nursing can be developed.

4

DAVIDSON, S.V.

Community nursing care evaluation.

Family and Community Health; 1, 1978, no.1, p.37-53, 68 ref.

nivel (C 1754)

This article contains six parts: evaluation in home health agencies, nursing quality assurance, components of quality assurance, Nursing Care Evaluation, general aspects of community NCE studies, the formulating of NCE criteria and responsibilities for NCE. Evaluation activities in home health agencies are influenced by Medicare, Professional Standards Review Organizations (PRSO), consumers and professional nurses. The programme-evaluation discriminates between structure, process and results.

Quality assurance is designed to determine the extent to which a professional practice achieves selected objectives based on specific criteria and norms. Self-regulation to assure quality of performance is stressed. The National League for Nursing also started with intercollegiate testing. An exhaustive system of quality assurance contains the following components:

- nursing care evaluation, the combined analysis of concurrent and retrospective nursing review.
- continuing education, based on the problems or deficiencies identified during the review process.
- profile analysis: evaluation of the effectiveness of nursing review components, the identification of review priorities, and comparison with other local nursing groups.

Above mentioned elements of quality assurance are discussed in detail. This article is concluded with goals and criteria for research and NCE registration.

5
HACHETT, E.S., P.N. CLARKE.
Nursing theory and public health science: is synthesis possible?
Public Health Nursing, 5(1), 1988, p.2-6, 40 ref.
knaw

The American Public Health Association (APHA) and the American nurses' Association (ANA) have gone on record to define public health nursing as a synthesis of knowledge (APHA) and practice (ANA) from nursing and public health. If this synthesis is to be consistent with nursing, knowledge will have to be congruent with the concepts of nursing's meta-paradigm. Disease is not included within the concepts of person, environment, health, and nursing. The focus of the public health tradition is reflected in the concepts of the epidemiologic model (agent, host, environment). Disease and its prevention are the focus of public health science. Reformulation of concepts from public health to be consistent with concepts of person and environment, replacing the concept of illness with that of health, and using methods for study of aggregates are strategies for achieving a synthesis of these two bodies of knowledge.

6
LEFROY, R.B.
Community support services for elderly people.
Australian Family Physician; 11,1982,no.10, p.753-56, 9 ref.
nivel

A review is presented of the main services of community support. Physical disability is the criterion for community nursing. In addition to domestic support, social support and medical assistance are essential. Further, the author discusses the role of family, practitioners, home care nurses, home helpers, social workers, welfare officers and special therapists in community support. The practitioners has a key role in support services; many of the services require his active initiative. The home care nurse should be skilled in assessment including many facets of diagnosis which have traditionally been the domain of the doctor. His/her interests should include physical disabilities, as well as mental and social ones, in

the view of the author. Community support is increasingly becoming a multi-disciplinary activity. The home care nurse is in the right position to implement these multi-disciplinary tasks.

7
SHAMANSKY, S.L. (ed.)
Home Health Care
The Nursing Clinic of North America, 1988, 23(2).
nzi

This issue is devoted completely to 'home health care'. The editor writes that the articles are a collage, a snapshot of home care today. The authors, experts in the field of home care practice, administration, education and research, were charged to describe the current status of home care, to explore its promises and pitfalls, to suggest future directions, and to ask thought-provoking questions. Subjects like standards of care, relationships between technology, treatment, and palliation, relationships between education, practice and research, the macro-environment of home care and financial responsibilities are discussed.
Three articles, discussing innovative developments, of the twelve articles are summarized here.

K. Martin, 'Research in home care'.
This article describes a sampling of 12 innovative home care research studies with summaries of purposes and findings. The range of studies involves specific population or programme, agency-wide, and industry-wide concerns. Each home health and/or public health nursing study offers potential application to nurses and clients. Furthermore the studies increase the research base of nursing practice, a trend that is expected to continue and increase.

D.L. Liszewsky (commentary by E.I. Griffith), Diversification and corporate restructuring revisited: back to square one?
An historical overview of corporate restructuring in the health care industry is presented. Initial reasons for forming multi-corporate structures centered on avoiding regulations governing certified home health agencies and maximizing third party reimbursement. As competition increased, home care agencies employed diver-

sification strategies for survival and reorganized their single corporate structures to launch new business and engage in profit-making activities. Corporate restructuring is a time-consuming and complex endeavour that should only be undertaken as a part of an agency's strategic plan. Evaluating an agency's corporate structure is a continual process and the criteria for evaluating change over time. The current experience with diversification in the health care industry suggests that the proliferation of multi-corporate structures is being stemmed as health care providers begin to refocus on their core business.

E.M. Freitag, 'Marketing in home health care: a practical approach'. This article describes marketing approaches for home health. Special emphasis is given to describing the importance and use of the external and internal assessment to determine the wants and needs of the market. The home health agency, must distinguish between the wants and needs of the decision maker, the purchaser, and the user. Viewing intake and customer service as products provides the opportunity for the organization to develop a distinctive competence apart from technical quality of service.

8
STEWART, J.E.
Home Health Care.
St. Louis etc.: The C.V. Mosby Company, 1979, 183 p., 151 ref., appendices.
rul

This book presents practices in the field of home health care and major professional and economic influences affecting practices. Chapter one presents home health care - its objectives, value, and cost - and contains a brief historical review of major events that have influenced home health practices. Chapter two discusses the types of agencies providing care (official, voluntary, private) and how they differ by methods of organization, administration and financing. The different agencies providing home health care services reflect the diversity among providers in the health care delivery system at large. The most noticeable difference between te types of agencies is their ownership, rather than their source of funding, administration, or location. In contradiction with public health nurses, who traditionally work in the field of health educa-

tion, home health nurses provide services on the whole range of health/illness and combine prevention with physical nursing care. Direct care, indirect care and the role of the case manger are discussed among others.
Chapter five describes methods of financing home health care and the effect of third-party financing on the industry. Medicare is discussed in detail.
Chapter six discusses basic methods of providing coordinated, continous care at staff level. Although the problem of fragmentation of services at state and national levels is mentioned, the focus this of chapter is on assuring, continous care at client level.
Chapter seven is devoted practices and problems in home health and its outlook for the future (in 1979).

9
SULLIVAN, J.A.
Directions in Community Health nursing.
Boston, Blackwell, 1984, 663 p.
rul

This book defines practice via its conceptual roots and then describes these concepts as they have evolved in current practice. Part I presents a conceptual approach to the definition of key components that describe the nature and direct the future of this field of practice within the context of its history. Chapter one and two adress the development over time of concepts generic to community health nursing and the construction of conceptual frameworks reflecting current-day practice experience. It also presents clinical approaches to the three levels of clients for which the community health nurse has responsibility: the individual, the family, and the community. Chapters three, four and five were written by clinician-scholars in active practice. These three chapters include conceptual frame works that directed the selection of relevant theory, processes, and content explicated at the community, family, and individual levels.
Part II covers the research base of the recent past, from which research and program evaluation can be designed for the future. chapter six begins with a review of recent research in community health nursing, with a commentary on its status. Chapter seven provides direction for increasing methodological rigor in research

in this field. Chapter eight outlines general principles of program evaluation.

Part III describes basic material on the strategies of power, politics, and economics to use in advancing this field of practice. In many areas, nurses have now opened private practices, begun home health agencies, and started local and state health department programs. Chapter nine deals with the buidling blocks necessary to develop the kind of power base that can be felt within a community, region, or state. Through concerted actions taken by community health nurses leaders, political influence and economic support can be garnered to form health care structures based on the nusing model, as elucidated in chapters ten and eleven. Chapter twelve points the way toward capitalizing on this strenght for the betterment of healh of all people.

10
ACCREDITATION STANDARDS COMMITTEE
Criteria and standards for NLN/APHA accreditation of home health agencies and community nursing services.
New York: National League for Nursing, 1980, 48 p.
Nivel (C2021)

Accreditation criteria and standards for home health agencies and community nursing services have remained the same since their formulation in 1961. They have three major purposes, which are:

- To assist an agency to develop, interpret, improve, and evaluate all aspects of its operation.
- To provide the basis for accreditation decisions.
- To assure consumers that the agency has met predetermined standards relative to quality control.

The criteria contain six major groups:

1. Community assessment: the agency bases its philosophy, purpose, and objectives on assessed community health needs.
2. Organization and administration: services are coordinated with other community services. There is a governing body accountable for the management of the agency. Citizen groups participate in determining policies and programmes.
3. Programmes: these are planned and provided with the community health needs.
4. Staff: administrative, supervisory, direct service and supportive personnel are essential for effective delivery of health services. The professional staff has the responsibility for planning, providing and supervising services to patients and families and for coordinating the activities of multidisciplinary personnel.
5. Evaluation: the agency is accountable to the community for the quality of its care. Accountability is insured by an effective evaluation process.
6. Future plans: the home health agency or community nursing service is by its nature a goal-oriented entity. It bears responsibility for relating agency planning to sound policy decision making and remaining responsive to the constituency it serves.

For each group the criteria and standards and practical implementation are defined.

11
BENJAMIN, A.E.
Determinants of state variations in home health utilization and expenditures under medicare.
Medical Care; 24, 1986, no. 6, p. 535-47, 23 ref.
nivel

Of the key federal programs that finance in-home services to the elderly, the Medicare program represents the largest and fastest growing. Although Medicare is a federal program, utilization and expenditures for home care vary widely across the states. Building on the work of Feldstein, Scanlon, and others, theory and data are presented that attempt to illuminate reasons why such variations exist. Using program data by state for 1982, nearly three fourths of the variation in home health utilization is explained by seven state characteristics. About three fifths of the variation in expenditures is accounted for by six state factors. Of most explanatory importance are home health agency (HHA) supply, need levels, presence of alternative sources of care, sources of referrals, and state resources. The results suggest the need to give more analytic attention to the impact of the market share of proprietary HHA's in explaining expenditure variations and the effects of total supply on utilization and spending.

12
BANNING, J.
Community nursing in Québec.
The Canadian Nurse; 77, 1981, no.4, p. 23-30, 2 lit.opgn.
rul nivel (C1963)

'Centres Locaux de Services Communitaires (CLSC) were introduced in the province Québec (Canada) in 1975. Under the Department of Social Affairs (in Québec) 12 Regional Councils are responsible for distribution of services and finances among hospitals, community clinics, chronic care facilities and all other service agencies. Within each Regional Council there are Departments of Community

Health (DSC's) which coordinate existing services and develop programmes to fill gaps. Closest to the people are the CLSC's which provide integrated primary services.
The work of one DSC and one CLSC is discussed. The facilities of CLSC Metro contain: Guy Metro Clinic, Youth and Women's Clinic, Home Care Programme and Family Life Education. With the exception of the last programme, nurses have an important task in these services. The Home Care Programme, eight nurses, fifteen homemakers and some social workers provide integrated care to elderly and handicapped people in particular. Primary goal of the service is to assist individuals to remain at home as long as possible by supporting them in their activities of daily living and by teaching them about safety, nutrition etc.

13
BENNET, M.J.
An alternative staffing pattern for domiciliary care: registered nurses and substitute relatives, part 2. Quality of care given by home health aide.
The Australian Nurses Journal; 12, 1983, no. 6, 12 ref.
kb nivel (C 1967)

A non-professional worker, a Home Health Aide, was introduced into a domiciliary nursing team in the role of a substitute relative for a six month demonstration period. Under nursing supervision, the aides performed those activities that would have been delegated to a relative (had a suitable one been available), namely personal care and some incidental household tasks for the elderly who were under a medical/nursing care plan. Part I of this article demonstrated that their introduction into the team enabled the nurse to spend significantly less time on basic hygiene and maintenance activities, and more on support and socialization activities and care of a more technical and complex nature. The sponsoring agency was able to provide longer and/or more frequent visits to those requiring intensive nursing as well as to those who needed the care of a substitute relative.
Part II will address other issues and will show that the care given by the aides was of high quality and relevant to the needs of the community. Four measures of quality were used, namely assessment of clinical performance, interviews with current and discharged pa-

tients, a questionnaire to referring local medical staff and a retrospective outcome audit. The alternative staffing pattern was also found to be cost effective.

14

BUHLER-WILKINSON, K., S. REVERBY.
Can a time-honored model solve the dilemma of public health nursing?
American Journal of Public Health; 74, 1984, no. 10, p. 1081-83, 9 ref.
nivel

A reflection on public health nursing in reply to an article by Dreher (see no. 16). Despite complex medical, social and economic problems, which create a contemporary need for Drehers model, it remains an ideal obtainable only in the rarest circumstances. Historical evidence is considered in understanding why this model has not been implemented nationally, despite numerous well funded attempts to do so throughout the 20th century.

15

CUMBERLEGE, J., A. CARR, P. FARMER, E. GILLESPIE.
Neighbourhood nursing: a focus for care, report of the Community Nursing Review.
London: Department of Health and Social Security, 1986. 110 p.
nivel (R3140)

This report is built up in two parts. Experience in the field is reported in the first part. The second contains a programme for action following the recommendations presented. In the first few chapters, categories of patients are distinguished who need community nursing, such as chronically ill, elderly and handicapped. Many patients prefer to be nursed at home; some patients need professional help 24 hours a day. Accordingly, one of the aims is to substitute intramural by extramural help; this demands an increase in the work of district nurses. The management should also involve auxiliaries and professional help in their planning and evaluation of services.
The number of professional workers in district nursing has increased one third and the number of auxiliaries has doubled since 1974. The

policy statements lack an effective coordination of services: there is too much overlapping in practice. A district nurse is normally added to a primary health team. This presents problems when the practice does not concentrate on a geographical area, while the district nurse does.
In chapter four, the authors recommend a definition of neighbourhoods in each district for the planning, organization and provision of nursing and related primary health care. A neighbourhood consists of ten to fifteen thousand people. A profile of trends in morbidity and mortality rates and social characteristics of inhabitants has to be compiled for each neighbourhood. And health visitors, district nurses and school nurses should work together in 'Neighbourhood health services' (not yet institutionalized).
In the remaining chapters of the first part, the organization of services, the role of other nurses and the functioning of primary health care are discussed. Recommendations on the education of nurses inter alia are presented.

16
DREHER, M.
District nursing: the cost benefits of a population-based practice.
American Journal of Public Health; 74, 1984, no. 10, p. 1107-1111, 6 ref.

This paper presents some serendipitous findings from an ethnohistorical study of public health nursing in rural New England. A birds-eye-view of the development of the decentralized distribution system of community nursing services is recorded. The trend in the last few years shows an centralization of health care. The data collected were both qualitative and quantitative in nature and derived from direct observations, public records dating back to 1900, census records, and open-ended interviews with town residents, public officials, medical care providers, and retired and active public health nurses. Hamilty County, which served as the site for this study, consists of 26 townships. A centrally based visiting nurse and home health agency covers a service area of 19 of the 26 towns. In keeping with the criteria used to evaluate primary health care, the model is examined for the extent to which it is accessible, available, accountable, acceptable, comprehensive, coordinated, and cost-effective. The author ends with recommendations

for quality assurance by means of education facilities, staff-centralizing and organization of conferences to reduce the isolation of the district nurses.

17
EMERY, G.M.
General practitioners and the community health nursing service.
New Zealand Medical Journal; 95, 1982, no. 710, p. 428-30, 1 ref.

A small study was carried out to determine if it would be feasible to match nursing zones with practices. On one day 590 patients of 48 practitioners were visited by district nurses. On average one nurse visited 18 patients, while the majority of practitioners did not have more than 14 patients. With allocation, two general practitioners would have needed three nurses (one part-time), two nurses to two practitioners. At the other end of the scale if a nurse had been allocated to each of the 34 doctors who had fewer than 15 patients visited she would have been under utilized. Another finding was that the number of streets where patients of practitioner live varies from 3 to 191. Apart from technical skill, cost effectiveness of the community health nursing service is governed by two major factors, a maximum amount of time spent in direct patient contact and a minimum amount of the time spent in travelling and other areas of non-direct patient contact. In conclusion; allocation is not cost-effective because the increased travelling time would require more nurses for the same number of visits.

18
GALLAGHER, B.M.
Nursing role in home health care.
In: Community health nursing: keeping the public healthy. L.L. Jarvis (ed.). Philadelphia: F.A. Davis Company, 1981. p.199-218, 23 ref.
rul nivel (C1985)

This chapter considers nursing care provided by home health agencies, which the National League for Nursing defines as agencies which provide multidisciplinary health care to the sick, the disabled, and the injured in their place of residence. Some of the common types of home health agency are visiting associations, home

care units of hospitals, private home health agency, and home health units of official health departments or combination agencies. Clients who receive nursing care in the home are usually either homebound or have nursing needs which can best be met in this setting. A review of the historical development of home care in Europe follows: the provision of nursing care in the home is apparently not a new type of service.

The author stresses the importance of the educational preparation of community health nurses, because they have a much closer contact with the public than other members of the health team. Furthermore they must be able to take decisions autonomously. Prevention, recovery and patient education are central tenets in education. Education in humanities is also demanded, because the nurses will work with people of different ages, and from different socio-economic and cultural groups.

Since 1937, the United States Public Health Service and the Department of Public Health in each state have cooperatively compiled periodic data regarding the educational preparation of public health nurses. The most recent educational survey was in 1972 in which the educational level of a projected number of 57.000 registered community health nurses (for whom home health care is a primary function) was surveyed. By comparing the results with the recommendations of the NLN, it is clear that 66% of the nurses did not meet this standard.

There has been a steady increase in the number of agencies which offer nursing services in the home. In 1963, only 56% of the American population had access to these services; by 1972, the comparable figures were 92% of the population. The availability of these services varies greatly among different geographic areas. Urban residents have access to a greater variety of services than rural residents.

Four types of agencies which provide home health services are distinguished and discussed.

- voluntary agencies: non-commercial and unofficial;
- official agencies: non-commercial and financed by tax funds and official monies;
- combination agencies: not commercial and financed by taxes, fees, endowments, third party payments, and perhaps federal grants;
- proprietary agencies: commercial.

The article ends with considerations of the processes of licensing,

certification and accreditation, which affect the service characteristics of home health agencies.

19
HARRIS, M.D.
The changing scene in community health nursing.
The Nursing Clinic of North America, 23(3), 1988, p. 559-68, 14 ref.
nzi

Diagnosis Related Group based reimbursement created multiple new problems for patients families, home health administrators, and the staff who provides direct patient care in the home. The author examines these myriad problems. Some of the problem-solving techniques that innovative home health professionals have initiated to provide continued quality health care services to homebound individuals of all ages are also discussed.

20
HERNANDEZ, S.R., A.D. KALUZNY, B. PARKER, Y.M. CHAE, J.R. BREWINGTON.
Enhancing nursing productivity: a social psychological perspective.
Public Health Nursing, 5(1), 1988, p.52-63, 51 ref.
knaw

A major determinant of organizational productivity is the design of structures and processes within a functioning organization. Research has focused on structures that contribute to productivity, but has given much less attention to the processes that occur particularly in health service organizations. We examined the relationships of organizational process and productivity in 20 nursing work groups in a sample of local health departments in North Carolina. Analysis focused on level of organizational climate (communication flow, decision-making practices, motivational conditions, concern for human resources), leadership behaviors, and quality of group interactions. The relationships of these processes to productivity (number of services produced per unit of staff time available) across a series of major departmental services were evaluated, together with implications of findings for strategies to improve the functioning of nursing work groups.

21
HOWDEN, C.L.
Family Practice; 4, 1987, no. 1, p. 1-2, 7 ref.
nivel

The author discusses two recently published reports on future directions in nursing: 'Project 2000, A New Preparation for Practice' and 'Neighbourhood Nursing, A Focus for Care'(see no. 15). While in traditional nursing the relation patient-nurse is stressed, these reports focus on the relation between care and community.

22
HUGHES, J., P. STOCKTON, J.A. ROBERTS, R.F.L. LOGAN.
Nurse in the community: a manpower study.
Journal of Epidemiology and Community Health; 33, 1979, no. 4, p.262-269, 16 ref.
bijl nivel (C1983)

High priority at present is given to the expansion of health visiting and home nursing services a part of the change of emphasis from institutional to community care. The aim of this study was to provide nurse managers in two regional health authorities with basic information about community nurses which could be used for service planning and development. 5,033 community nurses and auxiliary staff working in North-east and North-west were questioned. The data required for the study included among others the grade, date of birth, sex, marital status, appointment date, qualifications, hours worked, place of residence, and working base. The results of the study emphasize the particular problems of staffing the community nursing service in inner London, where home nurse and health visitors were younger, more recently appointed, and relatively less experienced than staff in other parts of regions. High turnover rates and chronic recruitment difficulties in inner London prevent nurse managers from maintaining both the level and the quality of the services they aim to provide.

23
JUERGEN, J., P. POTTHOFF.
Cost containment in a statutory health insurance scheme by substitution of outpatient for inpatient care? The case of the Bavarian Contract.
Health Policy, 8, 1988, p. 153-169.
nivel

Among manifold attempts at containing the rapid growth of health care expenditure, one which attracted considerable attention was the 1979 agreement between Bavarian health-funds and office-based physicians of Bavaria that, in some ways, reshaped the remuneration scheme for ambulatory medical treatment. This so called 'Bavarian Contract' tried to approach cost containment by initiating trans-sectoral substitution processes in favour of outpatient medical care and to the disfavour of, above all, the hospital sector of the health care system. This paper deals with the question of whether in Bavaria (between 1979 and 1983/84) the structure of services and prescriptions was modified in a way that indicates the occurrence of substitution processes as intended by the 'Bavarian Contract'; also, whether there is any evidence of cost containment effects brought about by intensifying the ambulatory services of office-based physicians. The study results provide some weak hints at substitution processes in favour of ambulatory services; but there is no evidence that expending ambulatory medical services may help to contain the growth of health care expenditure.

24
KIVELÄ, S.L., K. PAHKALA, R.R. TERVO.
Factors explaining the referral of the elderly to home nursing or home help.
Health Policy; 6, 1986, no. 1, p. 73-85, 32 ref.
nivel

Factors explaining the referral of the elderly to home nursing or home help or both were studied in a population (n=1358) aged 60 years or over and living in the commune of Ähtäri, a semi-industrialized community in middle-western Finland, using social and health care registers and questionnaires in collecting data. The clients of home nursing and of combined home nursing and home help were predominantly women, whereas men were in the majority among

those referred to home help. A stepwise regression analysis showed old age, living alone, low self-perceived health, low education and few visiting contacts to explain home nursing or home help in the regression model were old age, low self-perceived health, low standard of housing, high amount of symptoms and lowered functional capacity. The poor availability of social support is more important a factor explaining the referral to home care among elderly men then among women. On the other hand, low health status and poor functional capacity, as well as poor availability of physical support are more important factors among women than men.

25
MATTNER, K.M.
Public health nursing and productivity measurements: are home visit numbers the right focus?
Nursing Management, 1988, 19(3), p. 99-104. 18 ref.
knaw nivel (C2335)

The rising cost of healthcare, competition and subsequent pressures for cost containment have been the driving factors behind public health nursing's attention to productivity. The focus on home visit counts has raised at least three issues or concerns: (1) potential for compromise of quality of service, (2) question about the validity of home visit numbers as a measurement of productivity, and (3) potential for a negative impact on morale by focussing on numbers.

26
MCINTOSH, J.B.
District nursing: a case of political marginality.
In: Political issues in nursing: past, present and future. R. White (ed.). Chicester, etc.: John Wiley & Sons, 1985, vol. 1, p. 45-66, 62 ref.
nivel (B1813)

Contemporary studies of the organization of health-care, and the professional groups who deliver it are drawing increasingly upon analytical frameworks. Three of these concepts are used to present the theme of this chapter, which is that district nurses as a professional body remains unjustifiable marginal in health policy-

making. The firsts of these concepts is based on the premiss that health policy is determined as much by interest groups outside parliament as by the elected members themselves. A second focus is an examination of the ways in which district nursing has suffered from 'policy drift', where changes are introduced without reference to any precise long-term objectives. The third concept is 'symbolic policy making', a situation characterized by statements of intent followed by failure to effect any significant change.
These three concepts are used to explore the ways in which certain aspects of the district nursing service have developed. In particular the author examines its organization and management, the district nurse's role in the primary health team, professional education, and problems of manpower planning.
Finally it is concluded that at a time when the government's aim was to increase resources for community care, district nurses have not been able to exert influence over budget allocation. They are marginal to the policy-making process that most affects their own service. However, they are a vital source of information about the effectiveness of community care provision. Their exclusion from the policy community means that patient interests are not adequately represented.

27

MCILMOYLE, E.L., M.F. KERR, Z.M. MATHEWSON, J.H. ELWOOD, A.E. EVANS.
Myocardial infarction: hospital and home management in Northern Ireland.
Journal of the Royal College of General Practitioners; 35, 1985, no. 35, p. 280-83, 21 ref.
nivel

Some 262 general practitioners in the Belfast area were asked to complete a questionnaire about their attitudes and practice regarding the management of myocardial infarction at home. A final response of 211 (80%) was achieved. Responders indicated the frequency with wich they could consider home management of myocardial infarction patients above and below 65 years of age. In addition general practitioners were asked how many patients with myocardial infarction they had treated at home in the preceding year. Another question invited comment on which myocardial infarction patients under 65 years of age were suitable for management at home.

Results : of the 211 responders, only nine percent would sometimes consider home care for patients under 65 years of age, although 55 percent would sometimes consider home care for those over 65 years and three per cent preferred home management for this group. In the year preceding this study, seven per cent of these general practitioners treated only 22 myocardial infarction patients under 65 years of age at home (two per cent of all cases in the area). Home care for myocardial infarction patients appears to be less popular in Belfast than in other parts of the United Kingdom. The views of the general practitioners concerning home care are discussed. While it may be acceptable to treat at home the small group of patients who have survived myocardial infarction for several hours the hypothesis that home care in general is as good as hospital care, has yet to be proved.

28
ROBERTS, J.A.
Staffing community nursing services in London.
Nursing Times; 76, 1980, 4 december, p.2164-66, 7 ref.
nzi nivel (C2007)

In november 1977 and February 1978 surveys were undertaken to collect data about community nurses employed in the North East Thames and North West Thames regional health authorities (London). Information was collected on age, marital status, date of qualification and length of service. Differences between district nurses and health visitors for inner London, outer London and the counties in the two regions are discussed. Inner London staff were younger, less likely to be married and more recently appointed than those working elsewhere. In designing a policy to recruit and retain community nurses, the factors affecting the willingness of nurses to work in the community are studies. Some recommendations are done to remove the shortage of district nurses and especially health visitors, and to develop an efficient staff policy.

29
ROBERTSON, R.
The nursing process in community nursing.
Nursing Times; 77, 1981, 22 july, p. 1299-1304, 7 ref.
nzi nivel (C2008)

This article describes how one group of district nurses implemented the nursing process. The basic steps of the process - assessment, planning, implementation, and evaluation - apply equally to nursing in hospital and nursing in the community. An attempt was made to see how the approach to nursing care could be adapted to the needs of community nursing. The objectives of the study were:

- To orient the staff towards this change in approach to nursing care through practical involvement using the basic steps of the process.
- To explore the level of knowledge among the staff and to offer further guidance where necessary.
- To introduce and test a system of recording.
- To look at the benefits to the patient of this more systematised approach.

72 patients were evaluated. The following points emerged among others: the paper work increased and the care plan presented problems with planning and recording. However, it was felt that the basic concept of the nursing process was valuable and should be pursued.

The conclusion is that this approach to nursing care is more organized and from a professional and legal point of view more acceptable than that was done in the past. A clear picture of the patient emerges which includes his life-style, health problems and individual needs. From there a pattern of care develops which insures a quality of care that meets the needs of the individual patient safely.

30
SCHULZ, P.R., MAGILVY, J.K.
Assessing community health needs of elderly populations: comparison of three strategies.
Journal of Advanced Nursing, 13(2), 1988, p. 193-202.
nzi

Three research strategies for assessing the community health needs of the elderly population of an urban neighbourhood are described. Two primary research strategies, survey and ethnography, are contrasted with the types of health-related information available from the 'Census of Population and Housing'. Different types of data emerged from each research strategy with census and survey data providing a global portrait of the community, and ethnographic data yielding more detail about the place of health in the living experience of older residents.

31
TEHAN, J., S.L. COLEGROVE.
Risk management and home health care: the time is now.
Quality Review Bulletin; 12, 1986, no. 5, p. 179-86, 9 ref.
rul nivel (C2016)

This article examines the major areas of risk exposure for Medicare-certified home health agencies, with particular emphasis on patient care issues. A workable structure for a risk management programme is proposed.
Over the last five years, the number of Medicare-certified home health agencies has more than doubled. Although payments to home health agencies make up only about 2% of Medicare expenditure. In the home health care industry, increasingly complex patient care procedures have increased risk exposure, causing an increase in premiums. All Medicare-certified home health agencies must continuously meet Medicare's conditions of participation. Still, there are only minimum standards, and no incentives currently exist to implement higher operating standards.
Agencies must care for sicker patients, under increasing guidelines, for essentially the same amount of money, that was made available prior to the introduction of prospective payment. Home health agencies face three areas of risk: patient care services, the role

of primary care-giver and employee health and safety. Three prevention measures must be used: selection, orientation, and in-service training of staff; documentation that clinical practice and administrative functions are carried out in accordance with established policies and procedures; and a centralized reporting system that identifies, evaluates, and resolves patient care problems in a timely fashion. Home health agencies must evaluate whether a nurse with hospital experience will adapt successfully to the demands of home health care. The registered nurse new to home health care must become familiar with agency policies and procedures and documentation standards, and he or she must obtain certification to perform specialized procedures such as chemotherapy or intravenous medication; increasingly becoming standard practice. Furthermore, the nurse must be taught to recognize situations that indicate alternative interventions, as well as when he or she should notify the attending physician.

An effective training lowers the change of failures. Manuals specific to the patient can be also valuable in assisting motivated care-givers (partner, family or neighbours). Finally, the development of a comprehensive, practical risk management programme to minimize mentioned risk is discussed.

32

WILSON, A.A., L.T. RINKE.

DRG's and the measurement of quality in home care.

The Nursing Clinic of North America, 3, 1988, p. 569-578.

nzi

The home health industry needs evidence to quantify effects on patient's health status as a result of the home care services provided, or the services not provided because of inadequate reimbursement. According to the authors, a challenge lies with nurses in the community to measure the effects, or patients outcomes, as a result of home care service delivery in realistic terms and within the framework of nursing practices. They discuss 'client-centered programme objectives', which provide a structure for evaluating the quality of home care services.

33

WORRALL, J., L. A. GOLDSTONE.
A general study of district nursing in Wigan.
Nursing Times; 76, 1980, no. 6, p.21-26, 5 ref.
nzi nivel (C2019)

Report of an research into the use of a new management information system (in Wigan), as a basis for planning of services, and the variations in district nurses' work. The demographic facts, social backgrounds and health care facilities of the Wigan Area Health Authority are described. Since 1974, more district nurses have been located with a practitioner instead of being located in a geographical area. All surveyed nurses kept records of procedural registration and diaries. The first contains information about the physical, mental and social background of the patient. The second contains the amount of time spent on different tasks. All data are differentiated as to State Registered Nurses (SRN's), State Enrolled Nurses (SEN's) and nursing auxiliaries. The average patient is female, ambulatory or semi-ambulatory, frail or handicapped, continent and mostly considered for long-term care.

Some conclusions from the diary records:

- The differences between Wigan times and national times are minimal.
- The mean minutes taken by SRN's and SEN's in Wigan in the major categories are strikingly similar.
- Comparison of the mean minutes taken for various activities on a centre by centre or nurse day by nurse day basis shows wide variations.

3. Tasks and work

3.1. General

34
BONNEFIL, C.W., P.L. WHEELER.
Nursing audit: measure the care, not just the chart.
Military Medicine, 1988, 153 (3), p. 155-157, 3 ref.
knaw

Four community health nurses determined that typical criteria used in nursing audits govern the quality of the format of documenation, but did not measure the quality of care itself. The response to this problem was to develop minimum discharge criteria of nursing care for each of the recognized nursing diagnoses. Several positive results have been noted, including: streamlining of documentation, clarification for the individual nurse of minimum standards against which his/her care will be measured, and clarification of the point at which a nursing problem can or should be closed.

35
BATTLE, S., J. MORAN-ELLIS, B. SALTER.
Defining a role.
Community Outlook; 1985, october, p. 11-14, 12 ref.
nzi nivel (C1965)

The principal findings briefly presented of an investigation into the work of district nurses and the gap between theory and practice in district nurse training curriculum started in 1981. The research had four main objectives:

- to examine the nature of the district nurse's role, and its relationship to the roles of other members of the primary health care teams;
- to identify the major factors which influence changes in the district nurse's role;
- to relate the implications of the first two aims to the current curriculum and make necessary recommendations on how it could be changed;
- to identify ways in which individual teaching centres can become

responsive to changes in the role of the district nurse in their own locality.

Information was collected from structured interviews and diaries of district nurses. The students felt the curriculum gave them more confidence in their work.

36

BATTLE, S., J. MORAN-ELLIS, B. SALTER.
Spreading the load.
Community Outlook; 1985, december, p.22-23, 2 ref.
nzi nivel (C1966)

This article is the third in a series of the Department of Health and Social Security, considering the work of district nurses in rural and urban districts. Three questions were central in interviews with 59 nurses:

- how do they view their general workload?
- how do they perceive their patient groups?
- what is their attitude towards decisions in nursing care?

All but one of the district nurses in each district were 'attached' to general practitioners. The urban spread with 44% of the district nurses working with four or fewer doctors, a further 35% working with between five and eight doctors and the remainder working with larger numbers of doctors (10-19) based at, or associated with the health centres from which the district nurses worked. 39% of the rural and 34% of the urban district nurses said there were regular practice meetings involving general practitioners and others connected with the practice. The frequency of contact with other personnel is split up in terms of district-type and nurse-function. The general impression is that the workload is increased: 42% said they had more patients on their caseload; 31% went to more meetings; 47% had more paperwork and 39% said the time they were able to spend with patients had decreased over the last year. Other research data concern kind of patient, function of nursing auxiliaries and attitude of the practitioner towards the district nurse.

37
BOWLING, A.
District Health Authority policy and the 'extended clinical role of the nurse' in primary health care.
Journal of Advanced Nursing; 10, 1985, no. 5, p. 443-454, 16 ref.
rul nivel (C1969)

In this article historical trends encouraging an extended role for the nurse in general practice are described, the Department of Health and Social Security (DHSS) policy regarding this and the legal position of the nurse is discussed. The results of a postal questionnaire to all 192 Directors of Nursing Services (DNS's) in England are presented. The study aimed to document the extent to which nursing policies at district level had been developed to meet DHSS recommendations. Although 71% of the DNS's questioned said a policy on the extended role of the nurse had been drawn up in their districts, only 13% clearly specified the type of grade of nurse who was permitted to undertake specified tasks. The last is one of the criteria of the DHSS. The final criterion to be met before 'delegated' or 'extended role' tasks are undertaken by nurses, according to the DHSS, is the specification of 'what safeguards must accompany the delegation of particular tasks in order that the safety of the patients is not jeopardized'. As the DHSS did not further define this requirement, the evaluation of district policies in terms of this item is difficult. If all the districts issued uniform, detailed guidelines, the confusion over this 'extended role' might be further reduced and certainly the legal implications clarified for the nurses for whom it is relevant. For this to be satisfactorily achieved, it is essential for the DHSS to give guidance and support.

38
BOYLE, J.S., M.M. COUNTS.
Toward healthy aging: a theory for community health nursing in an Appalachian community.
Public Health Nursing, 5(1), 1988, p.45-51, 14 ref.
knaw

In this research project we explored beliefs about healthy aging in a Appalachian community. A major goal was to develop theory for community health nursing interventions that promote and maintain

health during the aging process. A convenience sample of 105 community informants responded to an open-ended interview schedule that elicited beliefs and values of health and aging. The data were analyzed for the purpose of producing grounded theory; a major category that emerged portrayed the aging process as a collection of attitudes about oneself. Health was described as feeling good and being able to enjoy life. The informants reported that health is maintained by good nutrition, exercise, and an environment that is safe and promotes individual growth and development. A beginning theory of independence through self-care and client involvement emerged from the data analysis. A second component of the theory suggested that in promoting healthy aging, populations, nursing interventions that are grounded in the understanding of cultural beliefs and practices are likely to be more beneficial to clients than those that ignore or displace such beliefs and practices. This theory has the potential of being extended to a variety of settings.

39
CAMERON, E., F. BADGER, H. EVERS.
Old, needy and black.
Nursing Times, 84(32), 1988, p. 38-40.

The authors discuss the findings of a survey in Birmingham which shows that those who are elderly and black are not getting the home nursing they need. It is the opinion of the authors that: many of the factors which contribute to the low take-up off district nursing by this black client group stems from service ethnocentrism; 'black issues' on the district nursing agenda continue to be ignored; and district nurses tend to hold stereotypical views of black people and their situations like dominant views of society. On the other side, black elderly tend to know less about the nursing services than white elderly. A plethora of voluntary black groups have developed as part of self-help or other supportive movements within black communities.

40
CARR, A.J.
The state enrolled nurse in the community.
Journal of Community Nursing; 3, 1980, no. 12, p. 14-15.
nivel (C1970)

Article with reference to the 'Report of the Working Party on the Education and Training in District Nursing for State Enrolled Nurse. The State Enrolled Nurse (SEN) is member of the district nursing team. She is accountable to the district nurse for carrying out part or all of the nursing care programme for individual patients and their families, recording her findings and reporting back to the district nurse. The emphasis on basic nursing skills show that in the working party's view the SEN is qualified by training and good-basic experience to undertake many of the nursing procedures in the community. The party proposed that only two other staff be attached to the district nurse, that is, district enrolled nurses and/or nursing auxiliaries.

41
CHAVIGNY, K.H., M. KROSKE.
Public health nursing in crisis.
Nursing Outlook; 31, 1983, no. 6, p. 312-16, 14 ref.
nzi nivel (C2025)

In this article, three factors which contributed to problems in public health nursing in the U.S.are distinguished: fragmentation of services, problems in educational preparation and confusion about the role of public health nurses. In the proposed solution, which provides a method for change, delivery of services will focus on public health needs; provider outreach to meet community needs will supersede primary care; the health professions will share resources rather than responsibilities; public health nursing will focus on disease prevention and control rather than on treatment; and nurse practitioners in other specialties will refer clients to public health nurses when their particular skills are needed.

42
CLARKE,L.
District nurse: coordinator.
Journal of District Nursing; 3, 1985, no. 9, p. 9-10, 14 ref.
nivel (C1972)

Community nurses are expressing increasing concern about the development of their role as member of a primary care team, and their relationship with other agencies. The author presents a historical perspective of home care until the introduction of auxiliary nurses in 1977. A second part deals with the present tasks of community nurses. The last part considers future developments.
Several studies of the tasks of community nurses are mentioned; The district nursing service today is essentially a support service to elderly (43% of the clients). The amount of time spent in direct patient contact has decreased: in 1965, the district nurse spent 60% of her time in direct contact with patients, but by 1982 this had fallen to below 50%.
In the future, the district nurse as leader of the nursing team must focus attention upon the community as a target for intervention rather than upon the individual patient, and become an enabler, supporting and encouraging her staff. She will have then have more time to assess patient's social and nursing needs, draw up treatment programmes, delegate responsibilities, monitor and review treatment plans and also become an innovator and coordinator of services in the community on behalf of clients.

43
DUNNEL, K., J. DOBBS
Nurses working in the community: a survey carried out on behalf of the Department of Health and Social Security in England and Wales in 1980.
London: Her Majesty's Stationary Office, 1982, 94 p., appendices, tables, 7 references.

This survey has three aims:
- To sketch a profile of nurses working in the community, with special attention to their tasks, training, experience, qualifications, and the organization of the work.
- To produce an overview of activities of the different types of nurses. Different activities are compared with different clients.

- To identify the structures of labour within health districts, and relate these structures with district characteristics.

Data were collected by means of interviews with the different types of nurses: 33% district nurses, 8% obstetric nurses, 20% health visitors, 11% nursing auxiliaries, 8% school nurses, 6% practitioner attached nurses, and 14% other nurses, of a total of 4528 respondents. 95% of the respondents kept a diary of daily activities.

A part of the interview deals with the relation of the nurses with the general practitioner's practice. About half of the district nurses, obstetric nurses and health visitors were attached to one practitioner's practice. 20% of the district nurses work at four or more practices. A correlation appeared between number of contacts with practices and positive judgments of nurses. Other subjects of the interview were several patient related activities (like the possibility of getting to know patients personally and the continuity of care), travelling time and visiting time.

The analysis of the diaries showed that a third of all nurses worked for 41 hours or more per week. District nurses spend respectively 24%, 26%, and 50% of their time to travelling, non-clinic activities and visits. Health visitors respectively 16%, 46% and 38%. The time of visit is divided in: technical testing, technical procedures (e.g. injections), other nursing help (personal care), and advising activities.

The time of visit is specified per type of nurse in a table. 90% of the 'patient-time' is spent at the patient's home. Health visitors spend only 56% of their time to home visits.

Some striking differences were found among the 24 districts. Especially, great differences existed in numbers of other nurses than district nurses and health visitors. For instance, 62% of the geriatric nurses work in two districts. The time spent on different age and sex categories were analysed by means of the diaries. The differences among districts arise from specific organizations for basic care and less from social and economic variables.

44
ELKINS, C.P.
Providing service in a client's home.
In: Community health nursing: skills and strategies. C.P. Elkins.
Maryland: R.J. Brady Co., 1984. p. 231-255, 36 ref.
rul nivel (C1975)

Although the roots of community health nursing are in home visiting, this is now only one of a number of modalities for delivering community health nursing services. The first paragraph describes the differences between care at home and care in a hospital setting. Several keys to successful home visiting are discussed. The range of services provided in the home are divided into: teaching, supervision, monitoring and observation, and direct nursing care. These are discussed.

Clients suitable for home care vary with regard to problems and services needs:

- short-term, intermittent needs; for chronic disease supervision, direct care provision and teaching
- extended hours needs; as support for terminally ill and as respite for care-givers
- short-term, daily needs, for care following recent hospital discharge and acute illness
- long-term, intermittent needs; for rehabilitation and chronic disease management.

The next paragraph is devoted to hospice care for terminally ill persons nursed in the home setting.

Whatever the type of home care programme, a team approach is essential to its success, according to the author. Minimally the team consists of the client, the community health nurse, and the physician who orders the home care.

The author stresses an effective discharge planning. Hospital liaison nurses can accomplish the continuity of care from the hospital into the home.

Home care is becoming bigger business as the availability of third party reimbursement monies increases. Home health agencies provide care on a fee-for-care basis. The majority of payment for services comes from Medicare, Medicaid, and private insurers.

45
GILHOOLY, M.L.M.
The impact of care-giving on care-givers: factors associated with the psychological well-being of people supporting a demented relative in the community.
British Journal of Medical Psychology; 57, 1984, no. 1, p. 35-44, 25 ref.

The aim of this paper is to present findings concerning a variety of factors expected to influence, either directly or indirectly as mediators, the psychological well-being of persons caring for a demented relative in the community. The sample included both co-resident and non-resident supporters and the data were collected via a semi-structured interview. Only the sex of dependant, sex of supporter, satisfaction from help of relatives, blood/role relationship, duration of care, frequency of visits from a home help and community nurse were significantly correlated with supporters' morale and mental health. The directions of these correlations were, however, not always as expected, e.g. the longer the duration of care giving the higher the supporters' morale and the better the supporters' mental health.

46
HICKS, D.
Home nursing and home nurses.
In: Primary health care: a review. Department of Health and Social Security, D. Hicks. London: Her Majesty Stationary Office. 1976, p. 299-359, ± 40 ref.
nivel (B225)

The author follows the discrimination of the Sub-Committee on the Organization of Group Practice in: health visitor, home nurse, domiciliary midwife, practice nurse or clinic nurse and enrolled nurse. Definition and organization of tasks in primary health care, described in the report of mentioned Sub-Committee, are often cited. Schedules contain data like number of home nurses, attached or not, spreading of community nurses, the total number of patients cared in and outside their homes (specified to age). What strikes in the last schedule is the high frequency of home cared elderly over 65.
A study of Hockey (1965) shows that, in case of attachment of home nurses, collaboration and communication is minimal. The education of

home nurses, training by the Royal Institute of District Nursing, does not appear to be a necessary qualification.
An analysis of 352 diaries, kept by one researcher during his work in 1970/71, shows that community nurses spend most of their on travelling (43%) and on contacts with patients (40%). Most patients are female (74%), rather mobile, and 33% are 75 years and over. Most patients (40%) need care longer than 12 weeks. During this study, 39% of the state registered nurses and 31% of the state enrolled nurses were attached to a practitioner.
Several regional studies about the role of community nurses are presented. Cartwright, Hockey and Anderson's study (1973) of care for 703 terminally ill shows that 33% of the patients had contact with community nurses. The biggest part (23%) were visited between 50 and 300 times by a home nurse. The sort of care included the whole range of nursing basic practices and a few technical practices.
The chapter ends with several studies of the work of nurses in primary clinical services in primary health care teams.

47
KOHLER, P.
Model of shared control.
Journal of gerontological nursing, 1988, 14(7), p. 21-25. 8 ref.
knaw nivel (C2334)

The purpose of this article is to describe a concept of shared control between the nurse as health-care provider and the client and demonstrate its potential, positive effects in terms of client morale, satisfaction, and compliance with health maintainance regimens. The nurse working with elderly in community health settings is in an advantageous position to function as client advocate and share decision-making power with clients. The model consists of a process in which the nurse and client interact through six progressive modules. In each module, specific activities and responsibilities of both nurse and client interplay to arrive at specific outcomes. The author describes the model's use in modifying noncompliant behavior of an 80-year old man.

48
LUKER, K.
Do models work?.
Nursing Times, 84(5), Feb 3-9, 1988, p. 26-9, 9 ref.

Nursing models can be divided in everyday working models, conscious or unconscious used by community nurses, and formal research models, such as those of Henderson, Roper and Orem. Can the formal models help to improve the quality of care? The author discusses the shortcomings of formal models, like their focus on ill individuals and minimum attention to environmental factors; their sometimes unrealistic assumptions; and their political one-sidedness. Formal models have, however usefully served as catalysts in clarifying the educators and researchers' thoughts on nursing; they assist the nurse in identifying problems.
To improve the quality of care (by formal models), nurse researchers need to work together with practitioners. Through this co-operative effort new interventions may emerge and informal models of nursing may be modified and extended.

49
MILLS, R.
Community nurse: professional or provocateur?
Journal of Community Nursing; 5, 1982, no. 8, p. 7-8.
nivel (C1997)

The recent edict on the role and function of the district nurse has created a new dimension in the servicing of community divisions. The new extended curriculum for district nurse training is another milestone. The author discusses the financial, functional, professional en educational aspects in relation with community nurse management.

50
PHILLIPS, E.K., M.E. FISHER, D. MACMILLAN-SCATTERGOOD, A.J. BAGLIONI, J.C. TORNER.
Home Health Care: who's where?
American Journal of Public Health; 77, 1987, no. 6, p. 733-34, 10 ref.
nivel

The growth and privatization of home care is a relatively recent phenomenon, but is expected to continue at a rate of between 12 and 20 per cent at least through 1990. This situation has prompted questions regarding competition for clients, comparability of care, and stability of financial bases between the public and private agencies. These questions led to the design of an exploratory study of differences in care and sources of payment between public and private home health agency clients.
Referrals to two home health agencies, one public and one private, were examined over a one-year period (n=290). Clients in the public agency required greater frequency of visits, more nursing services, and care for a longer period of time than did those in the private agency. The public agency served a larger proportion of indigent and Medicaid clients. Increased service delivery with a decreased financial base may forebode an unhealthy future for traditional public home health agencies.

51
REEDY, B.L.E.C., A.V. METCALFE, M. DE ROMAINE, D.J. NEWELL.
A comparison of the activities and opinions of attached and employed nurse in general practice.
Journal of the Royal College of General Practitioners; 30, 1980, no. 217, p. 483-489, tables, 22 ref.
nivel

The authors compared the nursing and medical activities and the opinions of nurses employed by general practitioners by interviewing a random sample of 153 nurses in 113 practices, situated in four rural and five urban area health authorities in England. Some results: between 1972 and 1976, the number of first treatments given by health authority employed nurses decreased from 59,5% to 44,8%. In 1976, 55,2% of the first treatments were located at practitioner's surgery or health centre. Other tables show that attached

nurses were more involved than employed nurses with 'caring' activities whereas in 'technical' activities the employed nurses predominate. However, there was much less difference between them in 'intermediate' activities. In the remaining tables, nurses' opinions about location of their work and about their professional relationships are shown. 85% of the nurses think that in the future not be confined to district work alone: she will combine it with work in health centres and doctors' surgeries.

52
ROSS, F.
A challenging district.
Nursing Mirror; 160, 1985, no. 8, p. 35-37, 16 ref.
nzi nivel (C2330)

Article on the future role of the district nurse in caring for the elderly in the community. By the end of this century the numbers of those aged between 65 and 74 will decrease by about 13 %, while those aged 75 years and more will increase about the same. The very old will constitute 45% of all old people. Especially in cities, very little has been invested in the primary care services, resulting in chronic under-provision, difficulties of patient access and a lack of innovation and development in the service. The cuts in social services imposes serious strains on primary health care in general, and on district nursing in particular, according to the author. The national average is one district nurse to 3.377 population. The author mentions several causes for the fact that district nurses spend less time to social work.

53
SALTER, B., S. BATTLE, J. MORAN-ELLIS.
Where the buck stops.
Community Outlook; 1986, Jan., p. 19-20, 3 ref.
nzi nivel (C2009)

The fourth in a series describing a DHSS-sponsored study of district nursing in an urban and a rural district health authority, the article looks at the nurse's managerial role. Information is based on telephone interviews with planning and social services depart-

ments, health authority reports and semi-structured interviews with nurse managers. Limitations on the availability and format of data meant that direct comparisons between the two districts were not always possible.

Much of the district nurse's work is with the elderly, and changing trends in this population group in both districts are analyzed. Other sources of pressure are the rapid development of private residential homes for which the district nurses have a statutory duty to provide care and reductions in the numbers of hospital beds and length of stay, leading to an increase in patients needing care and the supply of district nurses. In the urban district there was variation in opinions on the effects of early discharge and rapid turnover on hospital-community liaison. The introduction of the mandatory community option in nurse training had helped and in the rural district ward sisters worked for two days in the community where possible.

54

SCHMELE, A.

A method for evaluating nursing practice in a community setting.

Quality Review Bulletin; 1, 1985, no. 4, p. 115-22, tables, 18 ref.

nzi nivel (C2010)

The dramatic changes in the health care system, including increased consumer participation, accrediting measures, regulatory controls and the nearly prohibitive costs of health care, have increased the concern of professional practitioners for quality assurance programmes (QA). The author, a consultant, began an evaluation of the nursing practice in a community nursing service agency. Collaboration with community health nurses and a survey of nursing literature made it apparent that QA in the community health setting has received less attention from nursing than it has in the acute care setting.

The ANA standard-Nursing Practice was developed by the Congress for Nursing Practice in 1973. These generic standards encompass the essential elements of the nursing process. During the research, the nursing process was divided in the elements assessment, planning, implementation and evaluation of nursing care, and included the following assumptions the standards are valid and acceptable for professional nurses; the use of the nursing process affects the outcome of client care, and the practice of community health nursing

is based on the nursing process. The nurse-client interaction among 28 clients and 14 nurses were analyzed. Further, the data of the client records are registered and 28 clients were interviewed. Generalization of the results is not possible due to method and population.

55
SCOTT, R.S., M. MOUNTIER, L. BROWN, D.W. BEAVEN.
Utilization of health services by diabetic patients. 1: The district nursing service.
New Zealand Medical Journal; 96, 1983, no. 739, p. 679-80, 2 ref.
eu

In 1981 the district nursing service in Christchurch was making 590 home visits, on a weekly basis, to 73 patients for the purpose of insulin treatment. This was 13,9% of their total workload. Through a programme of education many were able to manage the injection technique themselves. In other cases the provision of pre-loaded syringes permitted less frequent attendance by the district nurse. At survey, one year later, the patient numbers visited had fallen to 46, and the number of weekly visits had been reduced by half. These results show the benefits of research programmes, aimed at evaluation of health delivery, with a view to improving efficiency and reducing costs.

56
TORNYAY, R. DE
Public Health nursing: the nurse's role in community-based practice.
In: Annual review of public health. vol. 1., 1980. p. 83-94, 30 ref.
nivel (B629)

Review of types of nurses in primary health care and their roles in different community based practices. The term 'public health nursing' has been replaced by 'community health nursing' because many are not working for the government. Changes in health care needs of society have resulted in the expansion of the nurse's role. Practice tends to focus on community groups that are at risk because of specific problems, such as disadvantaged preschool children, high

risk pregnant women, or people suffering from specific long-term health problems. The community health nurse's responsibilities include: administering personal health services, supervising other nursing personnel in providing such services, teaching people and providing information about health, recording and analyzing health data for individuals and groups, coordinating activities and resources activities and resources in the community, helping to maintain a healthful environment, and assessing the health needs of the community. Further, several areas for training are mentioned.

Although traditionally the emphasis of community health nursing has been on the maintenance of health, today the emphasis is shifting to the provision of primary care to individuals and or groups of people. This is happening in part because health insurance carriers recognize diagnostic and treatment procedures but not health maintenance activities. In the past, public health nurses were distinct from other nurses because of the settings in which they practiced, but during the last two decades nurses in other types of practice also have been moving into the community.

Archer & Fleshman have developed a classification system to describe the major functions of community nurse practitioners. Four functions are the responsibility of community health nurse in:

- long-term care; which is increasing because of the emphasis on cost containment by health agencies and because the desire for improved quality of life.
- primary care. The definition of the American Academy of Nursing explicates two dimensions: the person's initial contact with the health delivery system, and the added responsibility for the continuum of care.
- in working with specific population groups. For a long time community health nurses have had their attention focused on high risk people: the young, the elderly and the pregnant. Preschool children are a high risk group that has benefited from increased health services. As a further specialization stemming from the successes of pediatric nurse practitioners, school nurse practitioners have been providing a broad range of health services to school-age children since 1970.
- in providing services for persons living in a specific area; health care in geographically isolated areas has always been a problem. The importance of self care is discussed.

57
WORRALL, J., L.A. GOLDSTONE.
The problems of variations in work patterns of district nurses.
Nursing Times; 76, 1976, April 24, p. 45-51, 5 ref.
nzi nivel (C2019)

Historically, the management of district nursing service was informal in that those responsible for it had little or no formal management training. With the emphasis moving towards community care, with the amalgamation of management regimes after reorganization and with the advent of professional styles of management, it became necessary for district nursing to be provided with a reliable management information system to use in the examination of resources as a basis for service planning. This paper describes the method now operating in Wigan and the results obtained from its application. Tables give information on travelling time, patient visits, technical procedures etc.
Some results: the average time for patient contact 226 minutes, but varies from 183 to 320 minutes. Finally some recommendations are proposed to admit a patient independence-classification to the patient records.

58
ZIRING,, P.R., T. KASTNER, D.L. FRIEDMAN, W.S. POND, M.L. BARNETT, E.M. SONNENBERG, K. STRASSBURGER.
Provision of health care for persons with developmental disabilities living in the community.
JAMA, sep. 9, 1988, vol 260(10), p. 1439-44.
nivel

Persons with developmental disabilities living in the community have a greater number and variety of health care needs than the average population of the same age and sex. The erroneous assumption that the generic health care system would be able to provide all necessary services to the large number of individuals recently transferred from state residential facilities to the community has proved to be an unexpected disappointment to human service policy makers. In an effort to remedy this situation, a programme of health care services was established by the New Jersey Department of Human Services at a community teaching hospital to supplement the existing generic system of medical care. Within four years, the programme had

rapidly grown to provide care for 729 patients who had come to rely on the center for primary care, specialty medical and dental services, and medical case management. The demographic characteristics of this programme are described as well data on morbidity, service utilization, and special problems encountered when care was provided to this complex and medically underserved population.

3.2 Prevention.

59
PHILLIPSON, C., P. STRANG.
Health education and older people: the role of paid carers.
Health Education Council / Department of Adult Education, University of Keele, 1984. 173 p., appendice, ref.
nivel (R3560)

Report of an investigation into health education and paid carers during 15 months. The authors identify deficiencies in health education in four areas: knowledge about the elderly population, organizational barriers, negative attitudes, deficiencies in training. A structured questionnaire was given to health visitors, district nurses, social workers, wardens of sheltered housing schemes and home helps. With exception of the home helps, all groups are interviewed. The data are presented under the headings: visiting elderly people (tasks and priorities), coordination, role of health education, strategies for health care, and training.
In chapter four, the findings of questionnaires and interviews with 57 district nurses in one district are discussed. The majority (67%) work in a geographical limited area. 90% of the nurses said they spent at least 60% of their time on the elderly. Most nurses wish for more variety. Collaboration between practitioners and health visitors is evaluated positively; the contacts with social workers are less positive.
Attitudes towards older people are discussed in chapter eight. Chapter ten deals with a strategy for health education. The authors argue that it may be important for the morale of district nurses, that they become involved in work with the 'young elderly'. Now, they are spending large amounts of time dealing with people in the final stages of a chronic illness, which means their potential role as an agent of prevention and health education can be neglected.

60
SLATER, J.
Data on health education.
Journal of District Nursing; 6, 1987, no. 5, p.5,7,8,10.

This article, following on 'Health for all' (see no. 61) discusses the results of a questionnaire in the fields of health beliefs, perceptions of health education, ad hoc programmes and concepts of health and health education. Finally, learning styles, like 'In-service Education and Training' for district nurses are discussed.

61
SLATER, J.
Health for all.
Journal of District Nursing; 6, 1987, no. 4, p. 18-20, 22. 9 ref.
nivel (C2013)

This is the first of three articles investigating ways of helping district nurses to contribute to health education. Recent developments in nursing, such as the nursing process, demand that all nurses are concerned with promoting health, and therefore with health care as medical care. This will go some way toward responding to the World Health Organization's 'Challenge to all primary health workers, to achieve health for all by the year 2000'. The author describes a study of health promotion tasks in Central Nottinghamshire Health Authority (CHNA). All 135 district nurses were sent a questionnaire with four aims:

- To discover the degree of difficulty experienced by district nurses in using skills identified as necessary to health education.
- To discover the health issues about which the target group felt they needed further education.
- To find out how far the district nurses' ideas of health education reflect current trends.
- To discover the most common learning style of the target group, as effective learning can only occur if learning needs have been identified properly.

The different sections of the questionnaire are discussed. The recorded data will be used for development of in-service education and training (INSET) activities.

62
SUTTON, A., P. WILKINSON.
You the teacher.
Journal of District Nursing; 5, 1986, no. 6, p. 21-22,24, 10 ref.
nivel (C2015)

This article discusses the role of the district nurse as health educator. As a result of the increase of behaviourally related diseases more health information. However, nurses are still focused on practical procedures. The concept of preventive health care is not emphasized enough in basic education, while recently qualified nurses consider it as an attractive aspect of their work. District nurses should play a more interactive role with information as an important component. It should be possible for district nurse and health visitor to work together in elaborating health information and education.

63
WINDEGUTH, B. VON, M.T. URBANO, J.S. HAYES, K.K. MARTYN.
Analysis of infant risk factors documented by public health nurses.
Public Health Nursing, 5(3), 1988, p. 165-9, 11 ref.
knaw

Public health nurses' assessment of infants for established, biological, and environmental risk was examined in a retrospective analyses of records. Findings indicated that nurses assessed infants for selected risk factors and growth and development, but did not comprehensively assess for environmental risk. This led to recommendations for improved documentation and future continuing education.

3.3. Care for terminal patients

64
EDWARDSON, S.R.
Physician acceptance of home care for terminally ill children.
Health Services Research; 20, 1985, no. 1, p. 83-101, 36 ref.
nivel

The study reported here explored the factors associated with the implementation of Martinson's model of home care and treatment for children in the terminal stages of illness with cancer. The model is described as an example of a health care strategy that was dramatically different from the prevalent model of care and may have conflicted with existing values. The means called for two important changes in prevailing practices. First, this was a nurse-directed rather than a physician-directed care program. Second, parents assumed the role of primary care-givers with health care professionals serving as consultants and assistants upon the request of the parents.
Data for the study were gathered from the hospital records of the children and from a survey of their oncologists.
The findings suggest that physicians viewed the model of care as desirable and made their referral decisions on the basis of their judgement about whether the family in question was technically and emotionally capable of providing the care.

65
FLASKERUD, J.H.
Community health nurses' AIDS information needs.
Journal of Community Health Nursing, 5(3), 1988, p.149-57, 10 ref.

Community health nurses (CHNs) provide direct nursing care to acquired immune-deficiency syndrome (AIDS) clients in their homes and in community settings such as clinics, long-term care facilities, and hospice facilities. Direct-care needs are exemplified in the case management of the client in the community. The case management of the AIDS client in the community can include direct care to prevent and control infections, to maintain nutrition and fluid

status, to manage pain, to manage alterations in bowel and bladder elimination, to treat circulatory impairment, to treat the consequences of decreased activity and immobility, and to provide psychosocial and bereavement support and counseling. In addition, CHNs provide indirect care to clients and their families through such services as education, referral, and counseling. As part of case management, they provide education on the disease; financial, housing, and health resources; and referral to community AIDS services, centers, and support groups. CHNs are involved in AIDS prevention through public health education, counseling the public about sexual practices, counseling persons who have human immunodeficiency virus (HIV) infections, and AIDS-related complex (ARC), and making referrals to community resources for education, testing, and support. Prevention and education activities take place in health settings, social settings, and occupational or work settings.

66

JOHNSON, I.S., M. COCKBURN, J. PEGLER.

The Marie Curie/ St. Luke's Relative Support Schemes: a home care service for relatives of terminally ill.

Journal of Advanced Nursing, 1988, 13(5), 565-570.

nzi

A hospice-based scheme for the support of relatives of dying patients is described. The majority of carers were females and almost a third of them elderly. Most patients were suffering from malignancy. Relatives reported a high level of satisfaction with the help they received from the scheme, but late referral was a common source dissatisfaction. A larger proportion of patients subsequently died at home but it is suggested that the intervention of the relative support scheme was not the only contributory factor. The perceptions of nurses working for the scheme and the susceptibility of volunteers to stress are highlighted.

68
KIRSHNER, B, M.C. HALL, A. GILPIN, N. DAY.
Assessing symptom control in palliative home care.
Canadian Family Physician; 30, 1984, p. 2274-80, 8 ref.
nivel

The home care programme in the Region of Peel provides home services to selected patients, as an alternative to hospitalization. The home care staff coordinates nursing, physiotherapy, occupational and speech therapy and other support services to patients when services are ordered by the referring physician. Control of symptoms in cancer patients on this home care programme was studied, to identify problems related to caring for these patients at home. The patients were admitted for acute or palliative care. The average length of stay for the 79 patients receiving acute care was 29,5 days, compared to an average of 28,7 days for the 125 patients receiving palliative care. The study was based on independent physician assessments of patients' medical charts, as well as interviews with the home care providers. A table shows that there was little difference between criterion services requested and those provided. Major problems in coping with the burden of disease at home were reported in 16 cases (8%). These problems included:

- inability of the patient or family members to cope with the physical and emotional demands of patient care,
- a strong preference on the part of some family members for the patient to die in hospital, despite the patient's wish to die at home.

The results showed problems in control of pain, nausea and constipation; the causes were less than optimal care and non-compliance. Another table shows that 79 patients (38%) were discharged to hospital, some of them as a result of treatment problems mentioned above.

There is an urgent need to improve palliative care to home care patients and to provide better, more frequent reassessment of patients with uncontrolled symptoms.

69
LAUER, M.E., B.M. CAMITTA.
Home care for dying children: a nursing model.
Journal of Pediatrics; 97, 1980, no. 6, p. 1032-35, 8 ref.
wkz nivel (C2024)

A model is presented for providing home care services for children dying from cancer and for their families. Forty-two families whose children were patients at the Midwest Children's Cancer Center received home care during the first two years of this programme. Variations in patient age, diagnosis, or family structure did not preclude successful participation in home care. In all families, the medical and nonmedical financial burdens of inpatient and outpatient hospital care were reduced when the child died at home. Since this programme was initiated, terminal care has shifted from hospital-based medical management to nursing support in home for the majority of children at the cancer center.

70
LUNT, B., R. HILLIER.
Terminal care: present services and future priorities.
British Medical Journal; 283, 1981, no. 6291, p. 595-598, 15 ref.
nivel

Since 1975 hospices and other specialist services for terminal cancer have expanded rapidly. In December 1980 this survey found 72 such services in Britain providing 58 patient units, 32 home care-teams, and eight hospital support teams. Many were outside the National Health Service. Inpatient units provided 1297 beds (modal size 21-25 beds) and dealt with under 7% of deaths from cancer. Home care teams provided 76-5 full-time equivalent nurses (modal size two nurses). Regional variations were considerable: from 10-9 beds/million population in Trent to 48.5 beds/million in South-west Thames; no home care nurses in Mersey and Wales, and 5.1 nurses/million in Wessex. Of 58 more services being planned, the 17 starting in 1981 will not substantially alter these regional imbalances. Respondents' opinions suggest a target of 40-50 inpatient unit beds/million population. This might be reduced if hospitals were better equipped to deal with these patients.

Suggested priorities are to redress regional inequalities, develop home care and hospital support teams rather inpatient units, and improve teaching and training. Co-ordination of plans between the National Health Service and the voluntary sector is needed.

71

MARTINSON, I.M., D.G. MOLDOW, G.D. ARMSTRONG, W.F. HENRY, M.E. NESBIT, J.H. KERSEY.
Home care for children dying of cancer.
Research in Nursing & Health; 9, 1986, p. 11-16, 25 ref.
rul nivel (C1994)

The feasibility of home care as an alternative to hospitalization for children dying of cancer was studied. The authors attempted to examine:

- The ability of the family to provide good care at home and to keep the child until death.
- The willingness of the family to provide such care.
- The degree of nurse and physician involvement in such care.
- The nurse and family abilities to procure adequate medication, medical equipment, and supplies.

The home care system was defined as nurse-directed with a consultant physician and did not entail extensive participation by other health professionals. Of 58 children cared for at home during the 2-year project, 79% died at home and 21% died in the hospital or en route to it. The findings, as shown by interview data, suggest that home care at the end stage of life is a viable alternative for children dying of cancer and for their families.

72

MARTINSON, I.M., W.F. HENRY.
Home care for dying children.
Hastings Center Report; 10, 1980, no. 2, p.5-7.
lb nivel (C1993)

Report of the project Home Care for the Dying Child, developed at the University of Minnesota. The model of care was used in 58 families. Above, the model was used in organizations to assist primary health care. Each family is assigned a particular nurse who

visits the home when she is needed and is available to the family on a 24 hour basis. Although home care is substantially less costly than comparable care provided in the hospital (preliminary data suggest 50% less), several factors affect the impact of this cost on the family. First, home care is covered rarely over 80% by private health insurances. A second factor was the degree to which the family's financial resources had been depleted by previous efforts to treat the child's cancer. A third factor was the degree to which the child's illness and concomitant care impeded the parent's ability to work. The article ends with remarks on the control of the home care. It appeared the nurse spend much time to precise concepts of home care.

73

NORMAN, R., BENNET, M.J.

Care of the dying child at home: a unique cooperative relationship.

Australian Journal of Advanced nursing; 3, 1986, no. 4, p. 3-16, 4 ref.

kb nivel (C2003)

As a alternative place for a child to die home has recently become reality. This paper describes the development of a project which provided continuous care for children dying of cancer whose parents wished to assume responsibility for their total care at home. The project involved a unique cooperative relationship between a hospital Haematology/Oncology Unit and a District Nursing Service. A small study examining the role of the district nurse was also undertaken and is reported on. An education programme for district nurses was developed collectively. The major purposes of the study were to describe the type of people requiring such care and to explore the extent and patterns of care provided for them by the district nurses. Data were collected over a 15 month period. A total of 21 children was included in the Paediatric Palliative Care Project, of whom 17 died at home. The patients are classified to age, sex, diagnosis, family etc.

The average number of home visits was 20.9, on the average 34,5 hours. Of the total number of visits, 80.7 % were before the death of the patient and 9.7% in the hospital. The main task of the district nurse was to support the family emotionally (67.1%), while 10.3% of the time was spent on physical care.

It was concluded that home is a suitable place for a child to die, provided that adequate support is given to the parents and nursing staff involved.

74

BLANK, J.J., B.J. McELMURRY.

A paradigm for baccalaureate public health nursing education.

Public Health Nursing, 5(3), 1988, p.153-9, 22 ref.

A national study was conducted to determine what constitutes baccalaureate public health nursing education. The primary focus of this article is the essential concepts in the education of public health nursing. The assumption was that an ideal curriculum represents a knowledge base that is acceptable to members of the profession based on an accepted paradigm. Data were collected using a mailed questionnaire distributed to all National League for nursing-accredited baccalaureate programmes and completed by the person responsible for the public health nursing curriculum. The questionnaire obtained information related to theory and practice objectives. A response rate of 82 percent (N = 275) was obtained after follow-up mailings and telephone calls. Content analysis of responses allowed the authors to identify 11 concept areas considered essential and receiving great or some emphasis by more than 90 percent of the respondents. There seems to be consensus that the concepts of family-centered care, health maintenance/promotion, community, levels of prevention, holism, continuity of care, epidemiology, self-care, population-based care, and home health care constitute the theoretical base of public health nursing education. These results were compared with results offered by the Consensus Conference report. Public health nursing educators are encouraged to continue to define what constitutes baccalaureate preparation for public health nursing.

75
District Nursing.
Nursing Mirror; 151, 1980, no. 11 (supplement), p. i-xxviii.
rul

While district nursing is still based on the principle of caring for the patient at his own house, the way in which this is put into practice has changed considerably in recent years. A new curriculum for education and training of district nurses will be introduced the next years. Several authors discuss the education of district nurses in this supplement.

P. Miller reports the recommendations of the Panel of Assessors for District Nursing Training for a new curriculum. This must be attuned to the present role of the district nurse wthin the health care team. Changes in curriculum are connected with changing morbidity rates, early discharge from hospital, increasing number of elderly, especially 75 years and over, and changes in management of health care services.

J. Spiller discusses the nursing process and how it is taught at the West London Institute of Higher Education. In succesion; assessment, planning and implementation of the nursing process are in discussed in relation with the education of students. The planning is divided into short-term and long-term goals. Priorities of care can be determined by means of Maslow's hierarchy of needs.

The practice-oriented contributions of S. Marshall, T. Lake and N. Marzella deal respectively with the benefits of the nursing process in practice, patients with emotional problems, and the treatment of varicose ulsers.

H. Ruddick-Bracken makes some personal observations on the new national district nurse course. The current course will change in a training which equals the level of the course of health visitors. Attention will be paid to the fact that the district nurse is involved with patients from all social-economic groupings. An understanding of the social and psychological factors are important when the nurse is acting in an instructing or supervisory capacity.

76
FLYNN, B.C.
Community health nursing education.
Annual Review of Nursing Research, 1988, 6, p. 167-90. 66 ref.
knaw nivel (C2332)

The research included in this review was focused on education for community health nursing (CHN). The content of this chapter includes several areas: criteria and procedures for conducting the review, methodological issues, research on basic education, research on graduate education, trends, and recommendations for future research. In spite of methodological and substantive dificiencies in the research, recognizable patterns were found. The research related to the selection of students in CHN programs indicated that there were international differences in nursing education. In the United Sates baccalaureate education has included basic preparation in CHN, whereas this has not been the case in most other countries.

The majority of research related to classroom coursework has been focused on concepts and competencies in basic CHN education. Over the years content and experiences in CHN appeared to be reintegrated into the curricula rather than found in a single or separate CHN course.

The greatest proportion of investigators focused on students' clinical experiences, indicating the complexities and difficulties in providing appropriate experiences for students. There were conflicting reports on the usefulness of community nursing centers as clinical sites. Some of the researches gave evidence that students who traveled in teams for home visits were more likely to report abusive incidents.

Recommendations for future research include conceptual, methodological, and substantive considerations. According to the author, future research in CHN education needs to be related to a conceptual base. Investigators could apply and modify conceptual frame works that have been found useful in health services or educational research. Such application would enhance the organization of knowledge in research on CHN education and encourage appropriate generalizations across studies.

77
JARVIS, P., GIBSON, S.J.
An investigation into the validity of specifying 5 "O" levels in the General Certificate of Education as an entry requirement for the education and training of district nurses.
Journal of Advanced Nursing; 6, 1981, no. 6, p. 471-82.
nzi nivel (C 1984)

District nursing, like many other professionalising occupations, has stipulated that possession of five ordinary level GCE passes might constitute one criterion of entry. This paper reports a longitudinal study over four intakes of district nurse students in one teaching centre and examines the relationship between selection criteria, in particular educational achievement prior to entry to the course, and the students' achievement during this. The research explored the relationship between educational achievement prior to commencing their course of study and the level of academic and practical performance during it. Additionally other factors, including the results of aptitude and personality tests, were examined to see if they would provide indication of the level of the students' grades during training. No factors were discovered that might provide an adequate basis for selection, which raises questions about trying to specify any pre-requisite for selection other than state registration and appropriate professional experience until further research has been undertaken.

78
LOPEZ, M.J., N.H. RADFORD.
District nurse training: a pilot survey of demand, provision and students.
Journal of Advanced Nursing; 10, 1985, p. 361-67, 5 ref.
nzi nivel (C1989)

A pilot survey of district nurse training provision for the period April 1982 - March 1983 was carried out to provide a profile of training institutions; their resources (human and physical), courses and students. Information was collected by means of postal questionnaire sent to the 50 UK training institutions. The survey highlighted differences between district nurse and district enrolled nurse training: variations in entry requirements, size and length of

courses, and staffing. It also gave an overview of the students' characteristics and provision of training for other professional groups. It proved the feasibility and value of collecting such information, and also provided the basis for a current study (Baseline Data Project), which will produce a package of survey material, and software for analysis to enable the subsequent collection of information.

79
MILNE, M.A.
Community nursing: community enquiry techniques.
Midwife, Health Visitor and Community Nurse; 17, 1981, no. 6, p. 237-41, 11 ref.
kb nivel (C1999)

The aim of this paper is to highlight differences in the approach to patient care by the members of the primary health care team (i.e. general practitioner trainees, health visitors, district nurses and social work students). The students were given a patient management questionnaire consisting of a stem case history of a family problem. It became apparent that different professions acted in an unlike manner. The main variables were in the extent: underlying causes were probed in an attempt to ease a problem, clients were involved in the decision process, questions were structured. Social work students and general practitioner trainees tended to use a logic-constructive questioning approach. Health visitors and district nurse students on the other and tended to be haphazard in their questioning. These and other differences resulting from different types of education are supposed to be partly responsible for problems in the functioning of health care teams.

80
OWEN, G.M.
For better, for worse: nursing in higher education.
Journal of Advanced Nursing 1, 1988, p. 3-13, 31 ref.
nzi

In this paper the recently proposed developments in nursing education within the United Kingdom are discussed within a historical

context. Since a number of nursing departments already exist within the higher education sector (comprising universities, polytechnics and colleges of technology), it is suggested that use should be made of the experience already gained by nurses working within higher education. The pros and cons of nurse education being provided in or associated with higher education are discussed. Theoretical perspectives from change theory are applied. The importance of educating the practitioner for a holistic and community-based role is stressed.

81
OWEN, J.
Learning from each other.
Community Outlook; 1987, feb., p. 15, 18, 12 ref.
nzi nivel (C 2004)

This study by a senior trainer in general practice looked at interprofessional education in the 151 GP teaching practices in Wales to see if their facilities could be used to train other members of the team. Questionnaires were sent to 14 course organizers in Wales, to the nine chief administrative nursing officers for completion by community nursing officers, to district nurse and health visitor tutors, and to directors of social services. An experimental questionnaire was sent to 20 practice nurses and discussions took place with midwifery teachers and school nurses. Interdisciplinary education was not common and was more likely to take place in larger practices in urban areas. The responses of different categories of staff are analyzed and a lack of active interest in training is seen among GPs. It is suggested that the newly formed Centre for the Advancement of Interprofessional Education could co-ordinate these activities.

82
PITTMAN, K.S., R.H. STEVENS, E.M. FULP, R.M. HOUSE.
Addressing continuing education needs of public health nurses in North Carolina.
The Journal of Continuing Education in Nursing, 1988, 19 (4), p. 158-65.
knaw nivel (C2333)

A year-long project was designed to assess continuing education needs and plan appropriate programs for public health nurses. All public health nurses in North Carolina, including 1,625 registered nurses and licensed practical nurses, were surveyed. Overall, the top five needs identified by public health nurses were: (1) legal aspect/risk management, (2) obtaining continued compliance, (3) counseling skills, (4) sexual abuse of children, and (5) leadership skills.

83
SANKAR, A., S.L. BECKER.
The home as a site for teaching gerontology and chronic illness.
Journal of Medical Education; 60, 1985, no. 4, p. 308-13, 15 lit. opgn.
nivel

The care for the chronically ill elderly is a major national health problem. Considerable concern and attention have been focused on the shortcomings of medical education in this area of care. Research findings have demonstrated the relevance of a home care experience for teaching the interactions of the social, psychological, environmental, and biological factors which characterize chronic illness. The value of such an experience has taken on added significance in light of the federal government's prospective payment system for reimbursing health care costs under the Medicare program, a system that encourages early discharge of patients from the hospital. To manage these patients successfully, physicians need to understand and appreciate the influence of social, psychological, and environmental factors in the course of a disease. The home setting is an appropriate place for teaching about these factors, just as the hospital ward is appropriate for the understanding required of acute illness.

84
TANSEY, E.M., LENTZ, J.R.
Generalists in a specialized profession.
Nursing Outlook, 36(4), 1988, p. 174-8, 2 ref.
nzi

Community nursing stresses the ability in knowing and caring for people rather than the precise performance of technical skills. Curriculum committees, however, replace community content and experiences with more acute care experiences that guarantee practice in and perfection of life-sustaining skills. A look at the educational background of the majority of nurse educators today reveals that community nursing is not an equal and integral component of the preparation of educators. At the other end of academia, baccalaureate education is influenced by increasing specialization in education at the master's level. The authors argue in favour of a larger part of community nursing in education. Because, community nursing provides the educational opportunity for students to integrate their specialty knowledge and develop a holistic practice. Another reason is that the community health nursing experience is currently the only practical in which the students must learn to adapt functional skills to the realities of each patient's sociocultural environment.

5. Collaboration

85
BOND, J., A.M. CARTLIDGE, B.A. GREGSON, A.G. BARTON, P.R. PHILIPS, P. ARMITAGE, A.M. BROWN, B.L.E.C. REEDY.
Interprofessional collaboration in primary health care.
Journal of the Royal College of General Practitioners; 37, 1987, no. 297, p. 158-61, 11 ref.
nivel

A study of interprofessional collaboration involving 148 general practitioner and district nurse pairs and 161 general practitioner and health visitor pairs was undertaken in 20 health districts throughout England in 1982-83. Data were collected using personal interviews and a prospective record of referrals and consultations. The ratings of collaboration recorded showed that only 27% of general practitioner-district nurse pairs and 11% of general practitioner-health visitor pairs were working in partial or full collaboration. Structural arrangements such as attachment, the number of general practitioners that community nurses work with, and working from the same building were found to be strongly associated with collaboration.

86
EJLERTSSON, G., A-K. JANSSON.
The district nurse and the district physician in health care teams: an analysis of the content of primary health care.
Scandinavian Journal of Primary Health Care; 5, 1987, no. 2, p. 73-78, 12 ref.
nivel

An assessment of community nursing in relation to physician care has been made in a Swedish primary care district. The staff was organized in health care teams. A totally integrated, comprehensive care service for everyone in the geographically defined district was made possible, as all members of the team used the same medical records. Visits in district care (district nurse, practical nurse) amounted to more than 50% of the visits of the team. The visiting

pattern in district care was dominated by the young and the old, the ages below 5 years of age making 3,7 visits per year, and the ages above 75 years making 10 visits. Health care was an important task among the children, while chronic ulcer of skin, senile dementia and diabetes were the most common diagnoses among the elderly. Every third visit in district care was a home visit. In almost 50% of the visits no appointment had been made in advance, which demonstrates a high accessibility to the district nurse. The distribution of diagnosis presented several social problems. Diagnoses like neuroses, alcoholism, and senile dementia produced many visits by few patients. Compared to the physician's visits, the district nurse made more home visits, made more visits among the young and the old, and had a different distribution of diagnosis. Regardless of, or despite, their different ways of working, the district nurse and the district physician complemented each other in the team co-operation. In addition to her role as a health professional concerned about health care and medical treatment, the district nurse is an important social contact for many individuals living in her district.

87

McCLURE, L.M.

Teamwork, myth or reality?: community nurses' experience with general practice attachment.

Journal of Epidemiology and Community Health; 38, 1984, no. 1, p.68-74, 8 ref.

bijl nivel (C1996)

A survey of 93 community nurses, 48 health visitors, and 45 district nurses was carried out in one area health authority where nurses had been attached to general practice schemes for up to 10 years. The purpose of the study was to determine the nurses' impression of teamwork within their attachment arrangements. Half the group surveyed had either a geographical area or other area health authority responsibilities, or both, in addition to their primary attachment commitment. No structured plan for preparing or evaluating attachment groups had been carried out by the area health authority. Only one third of attached nurses were working from premises shared with other members of the attachment group, and often facilities were poorly designed for teamwork. Health visitors were generally less enthusiastic about attachment and identified more obstacles in

developing teamwork than did district nurses. Health visitors also tended to stay with individual attachment groups for shorter periods than did district nurses. Most nurses communicated frequently with attachment group members, but these opportunities were unplanned and usually limited to immediate problems of patient care. In a few attachments patterns of communication and collaboration appeared to be non-existent. Despite the problems identified in this study, most respondents prefer attachment to working alone in a geographical area and value their links with the area health authority. Evaluation and positive direction is needed if the primary care team is to develop.

88

STRANG, J.R., N. CAINE, R.M. ACHESON.
Team care of elderly patients in general practice.
British Medical Journal; 286, 1983, no. 6368, p. 851-54, 14 ref.
nivel

The aims of this investigation on primary health care teams were:

- to develop a simple encounter form to record workload which could be used by all team members,
- to quantify the interaction between members of the primary health care team by studying patterns and numbers of cross referrals.

Doctors (46) and their nursing colleagues from 17 practices collected data for a 14 day period between April 1978 and February 1980. Each time medical care or advice was given to an elderly person an encounter form was completed. During the study 6.744 encounter forms were completed.

Analysis of the workload shows that doctors dealt with 55% of the patients, community nurses with 35%, practice nurses 7%, health visitors 1% and social workers 0,3%. Doctors referred about 30% of the encounters to nurses and social workers whilst only 2% of encounters were referred from the nurses to doctors. The health visitor was seen as being the most independent nurse member of the team.

89
WOODS, J.O., M.P. PATTEN, P.M. REILLY.
Primary care teams and the elderly in Northern Ireland.
Journal of the Royal College of General Practitioners; 33, 1983, no. 256, p. 693-94, 696-97, 4 ref.
nivel

The results of a questionnaire were used to examine how primary care workers set about the management and surveillance of their elderly patients. The majority of practices had attached visitors (76 per cent) and attached district nurses (59 per cent), while 61 per cent of general practitioners worked in health centres. Over half of the responding practices had age-sex registers. Few of the practices (14 per cent) had screened their elderly patients in the last five years and maintained an 'at-risk' register. Twenty per cent of practices held a regular meeting on their elderly patients but only half of these reviews involved the available health visitors and district nurses.
At least half of the general practitioners and district nurses plus three quarters of the health visitors felt dissatisfied with the care of the elderly.
A single and systematic review of elderly patients conducted jointly by general practitioners, health visitors and district nurses would do much to improve the care of this group of patients and the morale of these workers.

90
ZIMMER, J.G., A. GROTH-JUNCKER, J. MCCUSKER.
A randomized controlled study of a home health care team.
American Journal of Public Health; 75, 1985, no. 2, p. 134-41, 25 ref.
nivel

This report describes the findings of a randomized study of a new team approach to home care for homebound chronically or terminally ill elderly. The team includes a physician, nurse practitioner and social worker delivering primary health care in the patient's home, including physician's house calls. Weekly team conferences assure coordination of patient care. The team is available for emergency consultation through a 24-hour telephone service. The team physician attends to the patient during necessary hospitalizations. This

approach was evaluated in a randomized experimental design study measuring its impact on health care utilization, functional changes in patients, and patient and caretaker satisfaction.

The team patients had fewer hospitalizations, nursing admissions, and outpatient visits than the controls. They were more often able to die at home, if this was their wish. As expected, they used more in-home services, measured in weight cost figures; their overall cost was lower than their controls, but the difference was not statistically significant. Their functional abilities did not change differently from the controls, but they, and especially their informal caretakers in the home, expressed significantly higher satisfaction with the care received.

6. Substitution of home care for intramural care

91
BIRNBAUM, H., R. BURKE, C. SWEARINGEN, B. DUNLOP.
Implementing community-based long term care: experience of New York's Long Term Health Care Programme.
The Gerontologist; 24, 1984, no. 4, p. 380-86, 9 ref.
nzi nivel (C1968)

Description of the process of implementing the New York State Long Term Home Health Care Programme (LTHHCP) during its initial three years of operation. Over half the states are currently establishing community-based long-term care programmes. The intent of the LTHHCP is to provide nursing home level care for chronically ill patients who need institutional care but live in the community. The goal is to reduce the human as well as the fiscal costs involved in institutionalizing chronically ill persons.
The LTHHCP differs from previous home care programmes in several aspects:
- broad range of services
- admission only of persons who are medically eligible for institutionalization
- ceiling on annual costs at 75% of the costs of caring in a skilled nursing or intermediate care facility
- coordination of patient services by one person

These four aspects are discussed extensively.
Some operational findings during the implementation are that: Clients and their families appear satisfied with the programme, especially by the increased independence. Not all the LTHCP services offered are equally used; use of medical social services and home health aides is widespread. Although statements about the aggregate impact of the LTHCP on Medicaid expenditures are premature, it is known that expenditures for the care of persons in the LTHHCP have averaged less than 75% of the expenditures for their appropriate level of residential health care. The LTHHCP appears to have led to increase informal support by some client families. As a result of the LTHHCP's, several traditional home care providers expanded their target populations and service offerings.

Apparently no unique factors about New York State environments would prevent LTHHCP replications elsewhere, according to the authors. However, it took the LTHHCP two and an half years to progress from a concept to an operational programme.

92

BRICKNER, P.W.

Home health care for the aged: how to help older people stay in their own homes and out of institutions.

New York: Appleton Century Crofts, 1978. 306 p. 663 ref. appendices.

rul

This book discusses methods of finding and assessing old, home-bound people through the development and implementation of home health care programs for the aged. Section one defines goals for the program, discusses methods of organization, and analyses a working project, the Chelsea-Village Program of St. Vincent's Hospital, in operation since 1973 on the Lower West Side of Manhattan. Case reports and material from conferences of this program are used illustratively throughout the book.

Section two discusses the functions of the nurse, physician, and social worker; their combination in teams; how to make health teams working; and the importance of the medical chart in organization and in patient care. Nurses working in these programs are concerned with patient screening and case evaluation, independent nursing practice, traditional nursing duties, team membership, and teaching of peers and students.

Section three provides information about life support services, like foood and nutrition, housing, transportation, homemaking services and relief fom social isloation.

section four considers the financial aspects of home health care: how much it costs, and a comparison with institutions.

93
CLARK, F.
Hospital at home: the alternative to general hospital admission.
London, Basingstoke: MacMillan Publishers LTD, 1984, 205 p., 71 ref.
nivel (B1496)

Experiences with home care nursing in England and other countries are described and analyzed. The changes in organization of the National Health Service needed for home care to become an effective alternative for general hospitalization are the central theme of the book.

The history of health care in England is discussed in the chapters one to three, with special attention to the functioning of the National Health Service. There appears an impasse in the relation between hospital services and community services and between specialists and practitioners. One of the reasons for this impasse is the fact that a part of the hospital beds are occupied unnecessarily, while other people are put on long waiting lists. The author discusses the introduction of home care services, especially for those patients who are in need of much general care and mental support. These patients can be of all ages and all diagnostic categories. The author distinguishes three conditions for successful home care:

- the physical as well the emotional and psychological needs of the patient have to be met.
- consequently the patient has to be approached in the correct way
- it must be clear to the authorities that in the case of home care the costs are lower.

In chapter four experiments with home care outside of England are discussed. In the United States, the initiatives of Dr. E.M. Bluestone in New York are very important. Many experiments in the US and elsewhere are based on his ideas on home care nursing.

In chapter five the experiences of the author with the French organization 'Hospitalisation à Domicile'. Their experiments, started in 1957, contain the possibilities of home care for patients who are not placed under basic health care. In 1970 the home care alternative was officially recognized and the number of projects increased to over twenty in the seventies. Every HAD-unit is divided in one sector under management of a medical social worker who cares for the social and financial interests of the patient; and one sector under management of a nurse who is responsible for the treatment from day to day. When necessary, 'aides-soignantes' are

asked to look after the domestic and mental needs of the patients. The practitioner visits the patient, twice a week apart from emergencies. The duration of HAD-nursing varies from one week to many months, sometimes years. From the results of an survey among 515 HAD-patients in 1978, it appeared that 16,3% of them came in contact with HAD via a practitioner.

In comparison with the French experiments the English experiments (chapter six) are more limited. From 1976/77 more attention is directed to elderly and terminal patients. In several places collaboration emerged between practitioners and specialists of the hospital department of geriatrics. Later on limited forms of home care programmes for children started too. Sometimes, these forms of home care met resistance from district nurses; they said their equipment was not adequate.

Chapter seven is devoted to the 'Hospital at Home' project in the Peterborough Health District. It is remarkable that the average costs are not lower than in the case of hospitalization.

In chapters eight, nine and ten the functions of different home care disciplines are discussed.

In chapter eleven, the authors discusses the conditions for initiating a local home care programme in greater depth.

In her conclusion (chapter twelve) the author writes that reorganization of the National Health Service is necessary for optimal patient care. The original advantages of the NHS over health care systems in other countries threaten to disappear. The author sees dangers among others things in the position of the practitioner, who is not supervised by health authorities; the gap between hospital and basic health services and the confidence of authorities in local social work.

The Ministry of Health and Social Services has to create more provisions for home nursing and organize the finances. A new type of nurse is needed for Hospital at Home: oriented towards general patient care at home and appropriate for non-nursing aspects when the family is not able to.

94

CURRIE, C.T., L.E. BURLEY, CHR. DOULL, CHR. RAVETZ, R.G. SMITH, J. WILLIAMSON.

A scheme of augmented home care for acutely and sub-acutely ill elderly patients: report on pilot study.

Age and Ageing; 9, 1980, p. 173-80, 2 ref.

ru nivel (C1974)

A pilot study for a scheme of augmented home care for elderly patients with acute or sub-acute illness is described. General practitioner care was supplemented by the services of a geriatrician. Home Help and District Nursing Services were involved where appropriate. Their task include general nursing, supervision, giving injections etc. Not all patients needed home help or district nursing help; sometimes simple medical interventions were enough. Functional recovery was assessed using an index based on the individual patient's pre-morbid function. Of 37 patients treated at home, six required admission to hospital and three died. The remainder made satisfactory functional recovery. Preliminary evidence suggests that in patients with comparable illness, recovery of function in terms of Everyday activities is more rapid at home than in hospital. This augmented home-care scheme proved practicable and acceptable to patients and participants. The authors suggest that further controlled studies should be carried out.

95

HEDRICK, S.C., T.S. INUI.

The effectiveness and cost of home care: an information synthesis.

Health Services Research; 20, 1986, no. 6, p. 851-880, 44 ref.

nivel

The effect of home care on patient outcomes and costs of care has been controversial. This information synthesis summarizes results from studies of home care using experimental or quasi-experimental designs, explicitly including judgments of methodological soundness in weighing the results. In 12 studies of programmes targeted at chronically ill populations, home care services appear to have no impact on mortality, patient functioning, or nursing home placements. Across studies, these services either have no effect on hospitalization or tend to increase the number of hospital of

hospital days; ambulatory care utilization may be increased by 40 percent. The cost of care either is not effected or is actually increased by 15 percent. The critical need at present is for better-designed studies to test the effects of different types of home care, targeted at various types of patients, on the outcomes assessed in the existing studies, as well as on other important outcomes such as family finances, quality of life, and quality of care.

96

HENDRIKSEN, C., E. LUND, E. STRØMGARD.

Consequences of assessment and intervention among elderly people: a three year randomized controlled trial.

British Medical Journal; 289, 1984, no. 6457, p. 1522-24, 11 lit.

nivel

Over three years 285 randomly selected subjects aged 75 years or over and living in a suburb of Copenhagen were visited every three months in their own homes (the intervention group) to assess whether scheduled medically and socially preventive intervention would influence the number of admissions to hospitals or nursing homes, the number of contacts with general practice, or mortality. A randomly selected group of 287 people of the same age and sex were visited during the final three months of the study (the control group). Two hundred and nineteen admissions to hospitals (4884 bed days) were registered for the intervention group compared with 271 (6442 bed days) for the control group. Especially during the second half of the study, a significant reduction in the number of admissions to hospitals was seen in the intervention group. Twenty people in the intervention group and 29 in the control group moved into nursing homes ($p>0,05$). The corresponding numbers of deaths were 56 and 75 ($p<0,05$). No difference was seen in the number of contacts with general practice. Significantly fewer emergency medical calls, however, were registered for the intervention group.

Subjects in the intervention group benefited from the regular visits and the increased distribution of aids and modifications to their homes to which these led. The regular visits probably also produced an important increase in confidence.

97
HUGHES, S.L., L.M. MANHEIM, P.L. EDELMAN, K.J. CONRAD.
Impact of long-term home care on hospital and nursing home use cost.
Health Services and Research; 22, 1987, no. 1, p. 19-47, 2 ref.
nivel

This article reports the long-range impact of a long-term home care programme in Chicago on hospital and nursing home use and on overall health care costs over four client-years of observation. The evaluation utilized a quasi-experimental design with a comparison group composed of clients who received home-delivered meals. The health services utilization experience of consecutively accepted treatment (n=157) and comparison group (n=156) subjects was monitored for 48 client-months following acceptance to care. Imputed costs were then assigned of each type of care measured. Findings include a significantly lower risk of permanent admission to sheltered and intermediate-level nursing home care in the treatment group but no difference in risk of permanent admission to skilled-level nursing home care. Despite savings in low-intensity nursing home days, preliminary findings indicate that total costs of care were 25 percent higher in the treatment group. However, these costs are accompanied by significant quality-of-life benefits in the treatment group.

98
HUGHES, S.L., D.S. CORDRAY, V.A. SPIKER.
Evaluation of a long-term home care programme.
Medical Care; 22, 1984, no. 5, p. 460-75, 31 ref.
nivel

This article reports the outcomes of a 9-month evaluation of the Five Hospital Homebound Elderly Programme (FHHEP), a model long-term, comprehensive, coordinated home care programme in Chicago. Outcomes assessed include the mortality, comprehensive functional status, and rates of hospitalization and of institutionalization of the elderly (mean age, 80,4 years), chronically impaired population served by the FHHEP. The evaluation utilized a quasi-experimental, pre-post-test design with a non-equivalent control group consisting of similarly elderly and impaired subjects who received OAA Title III-c home-delivered meals. Consecutively accepted experimental

(n=122) and control group clients (n=123) were interviewed using the Duke/OARS Multidimensional Functional Assessment Questionnaire at the time of acceptance to service and 9 months later. Service utilization data were also obtained for both groups to correlate client outcomes and characteristics with level and type of services used. Data collection took place over a 31-month period. Post-test functional status measures were obtained for 83% of experimental and 81% of control subjects. Multivariate analysis was used to control pretest differences. Major findings include a significant reduction in the nursing home admissions (16 vs. 28) and nursing home days (including sheltered care) of experimental group clients. The reported analyses also show an increase in experimental clients' sense of physical health well-being and a decrease in their number of previously unmet needs for community services. Somewhat paradoxically, the experimental sample also demonstrated a decrease in physical activities of daily living (PADL) functioning. The mortality and hospitalization rate were equal for both groups. Despite savings in nursing home days of care, average per-capita costs for experimental group clients were 19% higher than for controls. However, additional cost was accompanied by an increase in quality of life. Longer-range cost and outcomes are being assessed through a 4-year follow-up study currently in progress.

99
HUGHES, S.L.
Apples and oranges?: a review of evaluations of community-based long-term care.
Health Services Research; 20, 1985, no. 4, p. 461-488, 33 ref.
nivel

This article synthesizes the contradictory findings of the community-based long-term care evaluation literature by grouping 13 studies into three models of care tested. All studies are reviewed according to the tenets of internal and external/construct validity to ascertain what is 'known' and 'not known' about the effectiveness of this new type of care, and to specify areas needing further research. The evaluations are grouped in three programmes:
- Traditional 'skilled' home care programmes which provide skilled nursing care to patients following hospitalization for an acute

episode of illness. The intent is to reduce hospital use without compromising the health status of patients.

- Expanded home care programmes which provide a more practical and flexible package of services, like speech or physical therapy.
- Case management demonstration programmes which integrate different types of help to stop fragmentation.

Findings suggest that increased pre-operational specification of underlying theory, increased sophistication in targeting services to high risk groups, use of multivariate analysis, and the development of more relevant outcome measures will improve the quality of the future study findings, thereby contributing to theory and model building in this field.

100

MACLENNAN, W.J., F.E. ISLES, S. MCDOUGALL, E. KEDDIE.
Medical and social factors influencing admission to residential care.
British Medical Journal; 288, 1984, no. 6418, p. 701-03, 14 ref.
nivel

The increasing number of people aged over 75 in Britain makes heavy demands on health and social services. To obtain accurate information for rational allocation of resources to domiciliary and residential services, a group of 98 house-bound women over 75 were compared with a group of 99 women of the same age in residential care. They had a similar range of physical disorders with the exception that deafness was more common among women in residential care. A much higher proportion in residential care were demented. Though in many respects women in residential care had less physical incapacity, a higher proportion needed help at times of crises. Important social factors were that women at home were more likely to be living with others, and that the principal helper was more likely to be a husband or relative than a neighbour. Both groups received the same amount of support from home helps and community nurses.
Any reduction in the number of residential care places for elderly women whose relatives are not available or are unable to cope would require the establishment of an effective community psycho-geriatric service and a system for providing appropriate subjects with 24 hour care and supervision.

101
MOWAT, I.G., R.T.T. MORGAN.
Peterborough Hospital at Home Scheme.
British Medical Journal; 284, 1982, no. 6316, p. 641-43.
nivel

The Peterborough Hospital at Home Scheme has explored the possibilities of treating at home patients who, if it were not for the scheme, would be in hospital. The scheme has been enthusiastically received by patients, consultants, general practitioners, nurses, and other health care workers. A full report of the resultant data is in preparation, but several key findings are presented in this article.

More than 200 cases have now been admitted to the scheme. When a patient is admitted to the scheme the attached district nurse is primarily concerned. If necessary 24 hours cover can be given to a patient, but in practice the average daily cover is, for each patient, sister in charge (0,84 hours), a bank of State Registered Nurses (1,36),a bank of State Enrolled Nurses (1,86) and patient's aide (5,00). Questionnaires were completed by general practitioners for each patient in the series, and three interviewers conducted evaluative structured interviews with the district nurse and the most concerned patient aide, relative and (where possible) with the patient. Respondents were asked to identify the tasks undertaken by project staff and to rank these in order of perceived importance to the care of the patient. The most common tasks undertaken by the district nurse were: supervision of patient's aides (55% of cases), nursing procedures (47%), support/supervision of the patient (43%), supporting relatives (37%), monitoring the patient's condition (33%), assessment of patient (25%) and mobilization of the patient (12%).

Care must be exercised when attempting to compare costs of the Hospital at Home with those of a conventional hospital owing to many variable factors. Hospital at Home costs a day are, for instance, lower than in an acute hospital, but the duration of care is longer. Possibly, the average patient treated by the Hospital at Home requires more nursing time because many are terminally ill.

7. Continuity of care

102
AUERBACH, M.
Changes in home health care delivery: another perspective on the effects of DRGs.
Nursing Outlook; 33, 1985, no. 6, p. 290-91, 4 ref.
nzi

The Taylor hypothesis suggests that the effect of DRGs is an episodic increase in referrals to home health care agencies of both chronically ill and acutely ill patients. These patients will need to recuperate from the acute illness that caused their hospitalization in the first place. The New Jersey experience indicates that the tightening reimbursement system will permit a shorter episode of home care services than in the past few years. Agencies will have to provide seven-day, twenty-four-hour service. At the same time, they will have more difficulty justifying seven-day intervention to the Medicare programme. Understanding the full effects of the change in health care delivery reimbursement on patient care and nursing care will require research and investigation.

103
GAUMER, G.L., BIRNBAUM, H., F. PRATTER, R. BURKE, S. FRANKLIN, K. ELLINGTON-OTTO.
Impact of the New York Long-Term Home Health Care Programme.
Medical Care; 24, 1986, no. 7, p. 641-653, 4 ref.
nivel

The Long-Term Home Health Care Programme (LTHHCP), also known as the Nursing Homes Without Walls, is an innovative, comprehensive Medicaid programme in New York State that provides nursing home level of care to patients at home. This paper evaluates the performance of the first nine LTHHCP sites over the first two years of operation. Across all sites there is clear evidence that the programme has been extremely successful in reducing levels of nursing home utilization. In the five upstate sites, considerable cost savings have also been achieved while improving patient survival. In

the four New York City sites, patient outcomes have also been favorable, but health care costs for clients have been higher than would have been the case had clients not enrolled in the LTHHCP. Across the entire state, results could have been better if enrollment had been targeted to subsets of the eligible patient groups for whom the LTHHCP is most cost effective.

104
KING, F.E., J. FIGGE, P. HARMAN.
The elderly coping at home: a study of continuity of nursing care.
Journal of Advanced Nursing; 11, 1986, no. 1, p. 41-46, 16 ref.
rul nzi nivel (C1987)

Thirty-three elderly clients who had been hospitalized and required continued care at home were studied for 3 months, with 836 visits made. Coping at home was studied in relationship to the certainty-uncertainty scores, perceived level of health, and perceived satisfaction with nursing care services. The relationship between coping and certainty/uncertainty was significant; the relationship between coping and perception of care was not significant. This study presents data to contribute to nursing knowledge in the care of elderly people at home. The paper concludes with recommendations for future research continuing on these data.

105
VETTER, N.J., D.A. JONES, C.R. VICTOR.
Projected use in two general practices of services by the elderly at home.
British Medical Journal; 289, 1984, no. 6453, p. 1193-95, 3 ref.
nivel

The proportion of people aged over 70 years in the community will, it is estimated, rise appreciably over the next 10 to 15 years. The impact, however, on different areas and different services will vary greatly. Using county based population projections this paper estimates the likely future demand by elderly people for home services in two contrasting general practices. The study population consisted of 1342 persons born in or before 1909, who lived at home and were randomly selected from the age-sex registers of two general

practices. To maintain services to meet the present demand, increases ranging from 11% to 15%, depending on the area and the service, will be required. In tables the demand for general practitioner contact, for home visits from practitioners, for domiciliary nurse; and use of home help, and meals on wheels are distinguished.

106
VICTOR, C.R., N.J. VETTER.
DN's and the elderly after hospital discharge.
Nursing Times; 80, 1984, no. 15, p. 61-62, 1 ref.
nzi nivel (C2017)

A 4% random sample of elderly patients (aged 65 years and over) discharged from NHS non-psychiatric hospitals in Wales were interviewed three months post-discharge using a postal questionnaire. Data were collected about the social characteristics of the patients, their morbidity and contact with the district nursing service. Compared with before admission, contact with the district nursing service increased threefold after discharge, indicating that any attempts to increase the discharge rate of elderly from hospital will impose very substantial demands upon the district nursing service.

8. Use of home care

107

BRANCH, L.G., T.T. WETLE, P.A. SCHERR, N.R. COOK, D.E. EVANS, L.E. HEBERT, E.N. MASLAND, M.E. KEOUGH, J.O. TAYLOR.
A prospective study of incident comprehensive medical home care use among the elderly.
American Journal of Public Health; 78, 1988, no. 3, p. 255-59, 25 ref.
nivel

This prospective study directly examines, in a defined community population, the extent to which a wide array of characteristics predict utilization of an important long term care (LTC) service over a two-year interval among the cohort of 3.706 people aged 65 or older. The overall age-sex adjusted rate of two-year incident home care use was 3.2 per cent. For both men and women, the rates among the aged 85 or older group were approximately 12 times the rates of those aged 65 to 74. The multivariate predictors of incident home care, adjusted for age and sex, were five: receiving help with at least one activity of daily living, being dependent in Rosow-Breslau functional health areas, being homebound, more errors in mental status items, and no involvement with social groups. The dominance of indicators of frailty in physical function and cognitive function are consistent with the predictors of another group of LTC clients, those who subsequently enter nursing homes. However, in the present study the ratios of medical home care use were similar for those living alone and for those living with others in the multivariate model, suggesting the possibility of differences between home care and institutional LTC clients.

108

FORTINSKY, R.H., C.V. GRANGER, G.B. SELTZER.
The use of functional assessment in understanding home care needs.
Medical Care; 19, 1981, no. 5, p. 489-97, 16 ref.
nivel

This study explored the use of functional assessment as a means for understanding individuals' needs for long-term care in the home

setting. A primary focus of the study was to test the usefulness of a modified Barthel Index as the functional assessment instrument that measured personal care need. Data were derived from 89 chronically ill and/or disabled people who were receiving home health care from the Visiting Nurse Association of metropolitan Providence, Rhode Island (VNA). The VNA-programme defined basic care as the provision of home health aide services 3 to 4 days per week plus surveillance visits by a registered nurse once every two weeks, to elderly and chronically ill patients who do not have acute medical conditions, but who presumably could not be supported in the home without such care. The position taken is that personal care need for home-based services is not defined diagnostically but rather in functional terms. In addition to personal care need, the study explored psychological, socio-economic and demographic characteristics of these individuals, as well as the specific services delivered by the VNA.

Results indicate that the modified Barthel Index may be used to obtain detailed information regarding ability to perform activities of daily living in the home. The data also suggest that psychological functioning must be carefully assessed when personal care need is found to exist, particularly in elderly persons. The findings of the study indicate that individual need for long-term care might be measured by functional assessment in order to most effectively direct services into the home.

109

GINZBERG, E., W. BALINSKY, M. OSTOW.

Home health care: it's role in the changing health services market. Totowa, New Jersey: Rowman & Allanheld Publishers, 1984, 186 p., 126 references, tables, appendices.

A survey was performed in the seventeen southern counties of state New York. The responses of a patient sample, restricted to individuals who were receiving home care services, were analyzed in terms of basic demographic characteristics, clinical diagnosis, types and intensity of services provided etc. Further, the costs of home care are discussed, and an overview is given of the main policies of home health care in the eighties.

Chapter one presents a historical review and the global lines of the study. An historical milestone was the recognition of home care

programmes by Medicare and Medicaid in 1965. In 1978 they financed 80% of all home health care.
By means of literature research (in chapter two) the authors show several causes for the tardy growth of home care within the total expenses for individual health care, like: the relative unfamiliarity with home care, the complex administrative organization, fewer guarantees for quality of care etc.
In chapter three the patient survey is reported. The elderly especially appear to need general care, covered only by Medicaid, while most of the elderly are assigned to Medicare.
Chapter four shifts the focus to the provide agencies. Normally these organizations concentrate on a limited number of aims. Hospital bound organizations are restricted by the institutional aims of the hospital or the county department. Most patients are served by the first type of organization. In the community the nurses play a central role; they visit the patients and work at recruiting, training and supervision. In a hospital the role of nurses is limited to coordination of care.
In chapter five an effort is made to asses, in light of past experience and present practice, the potential and limits for future growth of home health care.
The concluding chapter six extrapolates from all of the foregoing the particular characteristics of southern New York State and presents a set of recommendations for public policy-makers.

110
HINDS, C.
The needs of families who care for patients with cancer at home: are we meeting them?
Journal of Advanced Nursing; 10, 1985, no. 5, p. 575-81, 8 ref.
nivel (C 1982)

A diagnosis of cancer in a family member has a impact on the entire unit. A study was conducted to determine needs perceived by families as they met the care requirements of such patients, to assess how families coped with these needs and to determine the resources they utilized. Families were selected from a stratified random sampling of patients who were receiving treatment at a local cancer clinic. Classification was by sex and site of disease. Families were interviewed in their homes. Descriptive statistics were used to summarize

the data. Chi-square test of independence was conducted on selective on selective qualitative variables.
Eighty-three family members consisting of 43 males and 40 females with average ages 53 and 54 years respectively participated in the investigation. Families needed assistance with the physical care of patients. As many as 31% of them were coping poorly with this area of care. There were also several unmet needs in the psycho-social domain. The need most frequently expressed by families was for a place where they could turn to discuss their fears. Nineteen (23%) of the families knew of community services they could call on for assistance. Only seven (8%) of the families had utilized these services. These results suggest that fresh approaches might be needed in order to achieve our goal of family-focused care.

111
KRAMER, A.M., P.W. SHAUGHNESSY, M.L. PETTIGREW.
Cost-effectiveness implications based on a comparison of nursing home and home health case mix.
Health Services Research; 20, 1985, no. 4, p. 387-405, 15 ref.
nivel

Case-mix differences between 653 home health care patients and 650 nursing home patients, and between 455 Medicare home health patients and 447 Medicare nursing home patients were assessed using random samples selected from 20 home health agencies and 46 nursing homes in 12 states in 1982 and 1983. Home health patients were younger, had shorter lengths of stay, and were less functionally disabled than nursing home patients. Traditional long-term care problems requiring personal care were more common among nursing home patients, whereas problems requiring skilled nursing services were more prevalent among home health patients. Considering Medicare patients only, nursing home patients were much more likely to be dependent in activities of daily living than home health patients. Medicare nursing home and home health patients were relatively similar in terms of long-term care problems, and differences in medical problems were less pronounced than between all nursing home and all home health patients. From the standpoint of cost-effectiveness, it would appear that home health care might provide a substitute for acute care hospital use at the end of a hospital stay, and appears to be a more viable option in the care of patients who

are not severely disabled and do not have profound functional problems. The Medicare skilled nursing facility, however, is likely to continue to have a crucial role in post-hospital care as the treatment modality of choice for individuals who require both highly skilled care and functional assistance.

112
MALCOLM, L.A., C.S. HIGGINS.
A study of the recipients of district nursing services in Christchurch.
New Zealand Medical Journal; 96, 1983, no. 741, p. 762-65, 18 ref.
er nivel (C 1991)

This paper reports on a study of the patients and the services provided by the Nurse Maude District Nursing Association in Christchurch. The 1149 recipients were predominantly elderly, 80,8% being over 65, 68,8% female and long term patients with musculoskeletal disorders comprising more than one-third of the principal diagnoses. Services were provided to 26 per 1.000 of the elderly population, which is close to suggested guidelines. This rate increased markedly with age. Ten percent of patients utilised 40% of the nursing time. They may be considered as borderline cases for whom community care with community services was an acceptable and efficient alternative to long term hospital care.

113
SIENKIEWICZ, J.L.
Patient classification in community health nursing.
Nursing Outlook; 32, 1984, no. 6, p. 319-321, 4 ref.
nzi nivel (C2011)

Patient classification systems are playing an increasingly important role in the delivery of health care services. But little research has been done on their application to community health nursing. This research examines the effects of a weighted patient classification system on the quality of care rendered by community health nurses as indicated by the nursing documentation for the admission visit. In a quasi-experimental study the quality of care given a control and a experimental group of patients are compared. The experimental group was classified by required level of care to allow time for accurate documentation; the control group was not classified. Findings show the greatest differences in the assessment phase.

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