EXPERTISE OF COMMUNITY HEALTH NURSES

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PREFACE

This study was concerned with the expertise of community health nurses as evident in self-reported, personal examples of care which were rated by three expert judges. The study partially replicated research conducted among hospital nurses which identified expertise as the highest level of performance and also identified domains of nursing practice in that practice setting. One objective of the study was to determine whether expertise was identifiable in the narrative examples submitted by the community health nurses. A second objective was to determine whether all the domains of practice identifiable in the institutional setting could also be identified in community health nursing practice. A third objective was to examine potential relationships between the expert level of community health nursing practice, as identified by the judges in this study, and various demographic variables. In addition, the results of the two studies were compared.

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CHAPTER I

INTRODUCTION

Many authors have pointed to the need for an accurate description and documentation of nursing. The questions of what nursing is and what nursing does to effect specific client outcomes have not been addressed carefully or thoroughly by nurses (Guilino & LaMonica, 1986, p. 81). Benner (1984) has described what nurses do by identifying five levels of competency in clinical nursing practice. She reported that the expert nurse, the highest of the five levels, may get a gestalt of the situation and make decisions based on perception. The work of Benner, which was done in the acute care setting, needed to be replicated in the community health setting. While it was not possible to replicate Benner's study methodology, this study focused on expert nursing practice among community health nurses and provided examples of community health nursing expertise.

The Problem

The purpose of the study was to describe expert nursing as practiced by community health nurses. Because systematic documentation of expert clinical performance may be a first step in clinical knowledge development, Benner (1984) has stated that clinicians can benefit from systematically recording and describing critical incidents from their practice that illustrate either

expertise or a breakdown in performance. She contended that as expert clinicians document their performance, new areas of clinical knowledge are made available for further study and development.

While pursuing documented examples of expert community health nursing, responses were sought to the following research questions:

1. Are the seven domains of nursing practice identified by Benner (1984) in the acute-care setting also identifiable from clinical practice examples reported by community health nurses?

2. Can self-reported incidents of expert nursing care be used to discern an expert level of community health nursing practice?

3. Is there a relationship between the level of skill performance reported by community health nurses and nurses' ages, educational backgrounds, national certification statuses, marital statuses, lengths of experience in nursing, lengths of experience in community health nursing practice, agency sizes, or sizes of the population served?

4. How do the results of this study of nurses in the community setting compare with Benner's study which included the expert nurse in the hospital setting?

Background and Significance

Excellence in nursing practice is an elusive quality. Yet the need to define and measure expert nursing practice is an inescapable task. Many previous studies of nursing practice have attempted a description from the sociological perspective. Others have used approaches such as task analysis, competency lists, and the application of abstract scientific concepts to describe nursing

practice. However, there has been a paucity of descriptive studies which permit identification of the knowledge embedded in clinical practice and permit identifying the behaviors of the expert nurse.

Clinical knowledge is gained over time. Because nursing is an applied discipline, it has been described as both an art and a science. Nurses who are in the front line of practice know intuitively which problems are important (Dick, 1983, p. 44). What nurse clinicians learn from clinical practice enables them to make clinical judgments which vary according to the level of in-depth skill acquired. Benner (1984) has described what expert nurses do in specific patient care situations and has identified how beginners perform differently from experts. She also proposed that as nurses develop their careers, they change their intellectual orientation and refocus their decision-making on a different basis than the process-oriented one they were taught.

Benner used the Dreyfus Model of Skill Acquisition as a tool for examining and understanding the differences between the experienced nurse and the novice. The model was inductively derived by two University of California, Berkeley, professors who brought together their expertise as mathematician/systems analyst and philosopher (as cited in Benner, 1982a, p. 402). Although the model was developed from studies of chess players and pilots, Benner found that, when it was generalized to nursing, it took into account increments in skilled performance based upon experience as well as education.

Benner (1982a, p. 402) used interviews and participant observations to confirm the generalizability of the Dreyfus Model of Skill Acquisition to nursing. The model asserted that in the

acquisition and development of a skill, one passes through five levels of proficiency: 1) novice, 2) advanced beginner, 3) competent, 4) proficient, 5) expert. In her research, Benner was able to differentiate the characteristics of each of the five levels of skilled nursing practice.

While identifying levels of nursing skill, Benner (1982a) demonstrated that experience was not merely the passage of time or the accumulation of longevity. She clarified the definition of experience as it was understood and used in the acquisition of expertise.

> Experience is the refinement of preconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theory (p. 407).

Changes which Benner (1982a, pp. 403-6) discerned between levels of skilled performance, as nurses were observed at various levels, were of two general types. One was a movement from dependence on abstract principles to the use of past experience as paradigms. The other was a change in the perception and understanding of a situation so that it was seen less as a compilation of equally relevant pieces and more as a complete whole in which only certain parts were relevant (p. 402). Benner identified the following seven domains of nursing practice from critical incidents of expert nursing practice in acute care settings:

1. The helping role of the nurse
2. The teaching-coaching function of the nurse
3. The diagnostic and patient monitoring function of the nurse
4. Effective management of rapidly changing situations
5. Administering and monitoring therapeutic interventions and regimens

6. Monitoring and ensuring the quality of health care practices

7. Organizational and work-role competencies

In the Dreyfus Model of Skill Acquisition the expert's performance was considered to be holistic. Therefore, in Benner's (1982a, p. 406) work, the expert nurse's performance was also considered to be holistic rather than fractionated, procedural, and based upon incremental steps. By viewing performance in this way, it was possible for Benner to capture the intentions, expectations, meanings, and outcomes of expert nursing practice in acute care settings (1984, p. 4).

While Benner viewed the expert nurse's performance as holistic, the notion of holism was not new in the nursing literature. Current nursing literature had numerous examples of holism. The holistic approach to nursing care has included the physical, mental, and spiritual aspects of care. Holism was the unity of mind and body wherein the individual is viewed as a unified biopsychosocial being. Alterations in one part affected the whole (Krauss, 1984, p. 372). Whitmore and Utz (1985, p. 147) stated that the doctrine of holism is in opposition to mechanism, reductionism, and dualism which have pervaded twentieth-century western medicine. Therefore, the doctrine of holism pertained both to aspects of patient care as well as to the process used to view nursing performance.

Martin (1986, p. 133) has stated that holistic nursing practice is a term deeply rooted in nursing's past. She made reference to the holistic approach in the professional origins of nursing stating that Florence Nightingale might be called the first holistic nurse because she stressed the importance of primary prevention and health

maintenance. Martin also stated that the community health nurse has the opportunity to practice more holistically than his/her counterpart in the hospital. Therefore, it is assumed that the expert level of skill acquisition may be identified among nurses in the community health nursing setting just as it was in the acute care setting.

Community health nursing practice has not received the attention for study that hospital nursing has received. Historically the term "public health" was used more often than the term "community health" to describe this subspecialty of nursing practice. In early accounts of home visiting, health teaching, and drawing on epidemiological concepts to determine the focus of actions, nurses were considered public health nurses (Stanhope & Lancaster, 1984, p. 123). While attempting to distinguish between community health nursing and public health nursing, Smith (1984, p. 179) stated that the practice of public health nursing is to some extent subsumed under the broad classification of community health nursing. However, she stated that the practice of public health nursing has traditionally focused on the health of populations by using programmatic planning techniques. Nevertheless, she stated that the goal of both those nurses considering themselves community health nurses and those who consider themselves public health nurses is the promotion of the health of populations.

Gulino and LaMonica's (1986, p. 80) findings regarding the role of the public health nurse were consistent with Smith's statement that health promotion is the goal of those nurses who work in the community. They reported that seventy-nine percent of the nursing interventions in their sample of public health nursing home visits

were for health counseling and education. These activities were, without doubt, for the purpose of promoting health. Hall and Allan (1986, p. 316) pointed out that despite medicine's dominance, nursing has maintained an interest in health. This interest has enabled the profession to focus on the integrity of an individual as a whole, as well as on the interrelationships among the individual, his or her family, and the environment.

Because community health nursing has been a senior-level course in the baccalaureate curriculum, the results of this study have implications for nursing education and nurse educators. It also may be useful to nurse administrators and those educators of community health nursing administration. Information gleaned from this study may be used in developing job descriptions, establishing standards of practice, and in employee evaluations. Educators may identify changes which need to be made in curricula at both the undergraduate and graduate levels. In attempting to validate that the findings of Benner (1984) related to expert nursing in the acute-care setting can also be found in the community setting, a clearer description of the complexity of expert practice of community health nurses was evident. In addition, the examples obtained in this study may be used to enable learners to more successfully progress from the novice level of skill acquisition toward the expert level of practice. The expertise may also enlighten the public which nursing serves regarding what community health nurses do, and thereby garner more support for the use of public funds in expanding this humanitarian type of nursing practice.

Basic Assumptions

The following assumptions were made in designing this study:

1. Descriptive information about expert community health nursing practice can be gathered by requesting that nurses relate, in writing, their personal experiences which made a difference for the client.

2. Community health nurses who respond to the request for examples will be able to identify those examples which are expert and report them with honesty, objectivity, and fluency.

3. Anonymity of respondents will increase the potential for obtaining valid responses.

4. Community health nurses in local health departments which operate outside metropolitan areas in the state will have similar experiences and similar ranges of educational backgrounds and other demographic characteristics.

Scope and Limitations

In the study of expert nursing practice of community health nurses, the sample was self-selected from the population of community health nurses who were employed by three governmental agencies. Therefore, the sample was a limitation of the study as it did not include community health nurses employed in other settings. Because the study was limited to a relatively rural, south-central state, the findings are not generalizable to any other state or to a more urban population.

Another limitation of the study was the lack of a structured instrument which might have guided the subjects in their responses and encouraged more detail and completeness of the examples. The

inability of the investigator to talk with the subjects to clarify and amplify examples was also a limitation.

The influence of unconscious processes and selective recall of experience when producing examples cannot be estimated and was therefore a limitation. Also, because the study data consisted of self-reported data, it was possible that deliberate distortion may have occurred.

Another limitation was that individuals with associate degree or diploma preparation in nursing participated in the study. This made it impossible to generalize these results to those areas where only nurses with baccalaureate or higher degree preparation are employed as community health nurses.

The scope of the study was limited to perceptions of a limited number of nurses and to certain specific roles performed by those nurses who chose to participate. This was not representative of all nurses and all roles of community health nurses. The subjects were limited to those nurses who provide direct care to clients. The influence of some uncontrolled variables may be minimized in this way.

Definition of Terms

For the purpose of the study, the following definitions were used:

Basic Professional Education - The education which prepares the nurse to take the licensure examination to become a registered nurse. This education may be the baccalaureate program in higher education, the associate degree program at a community college, or the diploma program at a hospital school of nursing.

Client Assessment - A step in the nursing process in which the nurse employs skill in differentiating normal from abnormal in the physical, psychosocial, and spiritual realms. From this assessment the nurse develops a plan of care indicating the interventions to be used and the criteria for evaluating the client's progress.

Community Health Nurse - A person who has completed a state-accredited basic nursing program, is currently licensed as a registered nurse in the state, and is working for the state health department or one of the two city-county health departments that exist in the state. The term public health nurse was used synonymously with the term community health nurse for the purpose of this study. (Note: a baccalaureate degree is not required.)

Community Health Nursing - "A synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations. Health promotion, health maintenance, health education and management, coordination, and continuity of care are used in a holistic approach to the management of the health care of individuals, families, and groups in a community." (Standards of Community Health Nursing Practice, 1986, p. 17).

Expert Nurse - A registered nurse who no longer relies on rules, guidelines, or maxims to connect understanding of the situation to an appropriate action. This person has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of multiple alternative solutions. An expert nurse may provide consultation for other nurses, but most importantly, he/she can describe clinical situations where the interventions made a difference in client outcome.

Expertise - A special skill which develops when the clinician tests and refines theoretical and practical knowledge by challenging expectations in actual clinical situations. Experience is a requisite which promotes perception of the clinical situation as a whole.

Health Promotion - The prevention of illness by educating, counseling, and motivating the client toward the highest level of wellness that is achievable for the individual and his/her family.

Holistic Health - The unity of mind and body in a biopsychosocial being in which alterations in one part will affect the whole.

Holism - A doctrine which opposes mechanism, reductionism, and dualism. The assumption is that it is not possible to understand an individual by looking at the component physical or chemical units that make up the body. The focus is on the individual's culture, environment, and physical, spiritual, and mental health.

Organization of the Study

This research study is presented in five chapters. Chapter I introduces the study, explains the problem, discusses the significance of the study, assumptions, limitations, and defines terms. Chapter II presents a review of the literature related to excellence in nursing, commitment and creativity in nursing, expertise and the expert nurse, and expertise in community health nursing practice. Chapter III presents the methodology of the study including subjects, instrumentation, and collection and treatment of the data. Chapter IV describes the findings of the study. Chapter V includes a summary, conclusions, and recommendations for further research and for nursing education.

CHAPTER II

REVIEW OF SELECTED LITERATURE

Introduction

The movement of higher education away from the classical curriculum heralded offerings in the applied areas of study. Although the Yale Report of 1828 attempted to perpetuate the old course of study, the curriculum was reshaped, and the concept of the mind was also altered (Rudolph, 1962, p. 132-3). The mind was no longer viewed as a receptacle and a muscle with various potentialities waiting to be trained. Lindsley, an academic reformer of the nineteenth century, recognized the need for a broadly practical education, yet he was also committed to intellectual excellence (p. 116).

Lindsley's ideas for a great educational institution made it possible for John Dewey, a later reformer, to expand the potential for excellence using a method of education based on the principles of problem solving (Levine, 1979, p. 258). The wholeness of experience, rather than compartmentalization of knowledge, represented the epitome of Dewey's vision (p. 260). By ascribing the virtue chiefly to the process rather than to the subject itself, experience-based education came into being. Dewey also focused on the continuity of the educational process, according to Ratner (1939, p. 627), by stating, "Education is a constant reorganizing and reconstructing of experience." This concept of education was compatible with the

discipline of nursing. The goal of education has been to prepare capable practitioners who were also concerned with the process of their practice. Consequently, it was possible to recognize excellence in practice as well as in education.

The review of the literature on nursing excellence and expertise and on the characteristics and behaviors of expert nurses revealed that the subject has only recently been addressed. Concerns have been more in the realm of competent rather than the expert level of practice in many professions, including nursing (Stedman, 1985, p. 207, Benner, 1982b, p. 303). The review of literature was divided into four areas: (1) excellence in nursing; (2) commitment and creativity in nursing; (3) expertise and the expert nurse; and (4) expertise in community health nursing practice.

Excellence in Nursing

Prior to the literature on expertise in nursing, numerous authors were concerned about excellence in nursing. Hodgman (1979, p. 22) stated that excellence was not simply excelling in scholarship or grade point averages. Rather, for her, there was no essential difference between excellence in academia and excellence in service. She stated that excellent nurses are thinkers, feelers, and doers (p. 25). To be excellent meant to stand out and to conduct oneself in such a way as to be readily noticed as being good.

Prior to Hodgman's definition of excellence, the American Nurses' Association (ANA) began a specialty certification program (News, 1974, p. 190). The endeavor drew from the multiple areas of excellence which Hodgman described. A candidate for certification was required

to submit an application which assured educational attainment along with a description of clinical experience. At least three years of licensure was necessary before qualifying to take a specialty examination. After passing the examination, it was necessary for the candidate to have reference vouchers submitted by peers as well as evidence of excellence in practice in the form of personal case studies and reports of innovative projects. All the evidence was evaluated by one of the five ANA divisions on practice. A program of recertification was planned with a five year cycle.

By the end of 1976, 1263 nurses had been certified by ANA in seven areas of nursing. Programs to certify specialists in additional areas were being developed (News, 1977, p. 1393). However, ANA decided to expand its certification program to two levels which would include credentialing for competence as well as for excellence. The revised program was developed because of the belief, stated by the Interdivisional Council on Certification, that recognition for excellence served only a select group. The earlier program did not directly serve the large majority who did not yet qualify for the distinction of excellence, but nonetheless provided fully adequate care. Under the new program, excellence in practice was intended to be recognized through the awarding of diplomate status in the American College of Nursing Practice (News, 1976, p. 869). However, the new program met with hostility because the master's degree was required to be certified for excellence, and many of those already certified did not have a degree. Consequently, implementation of the diplomate category was held in abeyance (Kelly, 1977, p. 567).

The original ANA certification of excellence went through several

transitions and changed dramatically. Mauksch (News, 1978, p. 534), chairperson of the Interdivisional Council on Certification during a critical change, enumerated several purposes for the certification process. She emphasized accountability and quality assurance to the public, beyond that required for basic licensure, as a major purpose. Other stated purposes were the recognition of individual achievement and quality of practice, and the identification of nurses whose services might be individually reimbursable by federal or state funds.

In the changes which occurred in the certification process, there was a deliberate movement away from the concepts of excellence and competence. Mauksch (News, 1978, p. 551) recognized problems with the terms as she stated that either term was inherently intractable. She further explained that excellence was extremely difficult to define and permitted certification of only a few. The problem Mauksch viewed with the term competence was the suggestion that a nurse who was not certified was incompetent. Therefore, the definition of certification became quite general in an attempt to reach the large majority. Consequently, the concept of excellence appeared to be lost from the credentialing process at that time.

Kelly (1977, p. 562), in a review of the history of credentialing of health care personnel, recognized credentialing as primarily intended to provide the public with at least safe and effective care. She pointed to this as the hallmark of professional accountability. Nevertheless, she quoted Selden, an expert in the accreditation field, who had a different perspective.

> It is true that any professional society or group, no matter how socially oriented, will tend to develop barriers to protect itself... Among the contemporary protective mechanisms for the health professionals are accreditation,

> certification, licensure, and registration. All four of these mechanisms medicine has employed with excellent results, if not always for the benefit of society, at least for the benefit of most members of that profession. And now many of the numerous other health professions wish to adopt, if they have not already done so, the same steps which medicine has fashioned to meet the needs of society and its own protection (as cited in Kelly, 1977, p. 563).

Kelly (1977, p. 563) questioned whether - with the health care costs of today, with the fragmentation of services, and with the poor utilization and maldistribution of manpower - the consumer of health care should also be concerned about competence of the multitude of health practitioners who provide care. Nevertheless, she contended that the public was concerned, and she cited various searches, by educators and government, for answers to appropriate credentialing mechanisms. She concluded that licensure was an ineffective means of guaranteeing even safe practice (p. 564). Furthermore, she claimed that the ANA added to the confusion with the certification of practitioners into specialty areas, not at the entry level of practice but for excellence in practice. Kelly admonished nursing and other health disciplines to fuse health manpower credentialing with the public interest (p. 569).

Apparently the concept of excellence may not have been totally lost from the credentialing process, because at a later date, Fickeissen (1985, p. 265) reviewed the number of nurses who had been certified according to specialty. While recognizing that each specialty group has set its own objectives for certification, she listed the general goals of the process. Included among those goals was demonstration of excellence in practice. However, no evidence of excellence was required beyond testing. The certification process in place did not adhere to the concept of excellence as Hodgeman had

defined it.

Since the initiation of the credentialing endeavors, Diers and Evans (1980, p. 29-30) examined characteristics of the excellent nurse. Two characteristics which they considered essential were perseverance and passion. An example of perseverance, cited by the authors, suggested that perseverance in nursing has been necessary as changes in medical practice have occurred. These changes required nursing adaptation and professional growth. The characteristic of passion was referred to as a hungering and thirsting for nursing. This pursuit was viewed as the essence of excellence.

Henderson (1969, p. 2134) also addressed excellence in nursing. As an educator, she was concerned about a curriculum design which would produce an excellent nurse. Therefore, she identified measures to evaluate the nurse's clinical worth. Each of the measures was expressed in terms of concrete results which favorably impacted patients. Furthermore, Henderson stressed the importance of the nurse thoroughly mastering technical skills, yet remaining compassionate and sensitive to patients. She stated that emotional and technical responses may be used in a unique way that meet the peculiar needs of the person being served. Henderson cautioned against rigidity in evaluating the excellent nurse. She described a rationale which was related to the intangible quality of creativity that influenced the way the nurse meets the needs of the patient.

Dick (1983, p. 44), a nursing administrator, had a different perspective on excellence. She recognized excellence in nursing practice as a subject that created some discomfort, when it was discussed. She suggested that this may be because nurse-theorists,

laying claim to the topic, have attempted to create precise and reliable criteria to evaluate excellence without considering that nursing is so complex that it requires a broad overview approach. The complexity of nursing was emphasized as Dick pointed to the many roles of the nurse. Because she was interested in promoting excellence, she described things which she looked for in a nurse. Four elements of excellence which Dick described were:

> Practice should be based on a well-defined model and an internalized value system that respects the dignity of each individual.
>
> Commitment to scholarship and research is necessary to create new knowledge and validate practice.
>
> Each nurse functions simultaneously as expert clinical practitioner, educator, researcher and clinical practice manager.
>
> Nurses must continue to learn in order to maintain their skills and prevent professional obsolescence.

Although Dick did not mention economic reasons for seeking excellence in nurses, changes in the health care industry may now impact nursing and make excellence important for additional reasons. Mallison (1985, p. 635) recently wrote an editorial in a nursing journal which implicated nursing excellence as a competitive advantage for hospitals striving to attract patients. She referred to the work of Peters and Austin (1985), authors of books on excellence in business. Mallison made the point that the excellence in business, of which Peters and Austin wrote, may be applied to nursing and nurses. Because hospital employers of nurses are in greater competition than ever before, they are seeking career nurses who are serious, committed professionals. She suggested that just as Peters and Austin stated that "winners compete by delivering a product that supplies superior

value to customers, rather than one that costs less," the winning nurse will enable the employer to deliver superior nursing care. According to Mallison, this serious, committed nurse is passionate about excellence.

Further evidence of the continuing interest in the concept of excellence may be seen in the initiation of a new series in the old and prestigious nursing journal, The American Journal of Nursing (Mallison, 1987, p. 1127). Entitling the series "A Dialogue with Excellence," the editor has stated plans to display the eloquence and elegance of the work of expert staff nurses and to solicit examples for publication.

While the degree of visibility given to the concept of excellence has varied over time, a renewed zeal was apparent. Authors who wrote concerning excellence, although they represented different areas of nursing practice, used similar descriptive terms in discussing the concept. Throughout their writings, a recurring notion was that excellence went far beyond competence. Although excellence in nursing was an elusive concept, as evidenced by the ANA movement away from credentialing at that level of practice, enthusiasm for unveiling such practice has been increasing.

Commitment and Creativity in Nursing

While the previously cited nursing authors have written primarily concerning the subject of excellence, others have focused on creativity and commitment as important elements of expert nursing practice. Peplau (1974, p. 13), a nursing scholar, was one of these authors. When addressing an audience at the initiation ceremony of

Sigma Theta Tau, Nursing's Honor Society, she stated that creativity and commitment were two characteristics of individuals selected as leaders in nursing and for membership in the prestigious organization.

Suggesting that creativity and commitment herald excellence in nursing, Peplau attempted to describe commitment (1974, p. 13). She stated that it was a voluntary act that involved deliberate pursuit with directional aim (p. 15). Commitment, according to Peplau, always included competence, as a minimum. Sometimes, creativity was a part of commitment. She viewed the committed individual as one who recognized the need always to know more, continually striving to sharpen competence.

Vaillot (1962, p. 11), in a philosophical investigation of commitment to nursing, differentiated the committed nurse from the utilizer. She described the committed nurse as one for whom nursing was a creative act, a means of self-expression (p. 13). The utilizer was viewed as one who does not let herself/himself get involved in nursing. Vaillot stated that the goal of educators in professional schools should be the preparation of persons committed to their profession rather than the preparation of utilizers. She then attempted to examine the conditions which may favor or hinder the student nurse's commitment to nursing (p. 45).

Smith (1969, p. 15-16) reviewed Vaillot's work related to commitment to the nursing profession and further questioned to what the practicing nurse was committed. She submitted that the answer was a commitment to caring. Smith cited Vaillot's description of the committed nurse as one who places herself/himself at the disposal of another human being. Smith further stated that the caring orientation

included assisting a person under stress or illness or the threat of illness, providing comfort, reducing tension, nurturing, and ministering to patients in relation to perceived needs.

> The tasks, functions, or activities which constitute caring are personal, physical, or psychological in nature and are carried out in direct contact with and in behalf of the patient (p. 16).

Although Smith recognized that caring was a feeling, she considered it more than an emotion. She stressed that committed caring was based upon knowledge as well as an understanding of human behavior. Bemoaning the fact that so much nursing time has been spent meeting the physician's need for treatment assistance, she felt that providing nurturant caring should be the primary focus of the nurse's activities (p. 18). Smith, in addition to Vaillot, believed that commitment to caring was the anticipated outcome of nursing education.

Peplau drew commitment and creativity together. She did this when stating that commitment supplies the aim, focus or mission while creativity adds the particular way that energy is used, the discipline, and the scope of content (1974, p. 15). She felt that artists and nurses who are creative share particular facets of the process in their work. One of the major elements identified was energy, produced by anxiety, to heighten perceptual awareness and perfect a performance. A second element mentioned was discipline. The work produced, according to Peplau, required self-controlled efforts. She described a thought process with mastery of technique which resulted from repeated practice. This persistent striving with commitment and determination to perform well was viewed as essential for the perfecting of the artist's skills as well as the nurse's

skills (1974, p. 13).

In addition to energy and discipline, Peplau (1974, p. 13-14) stressed that a creative act rests upon concrete content. Just as a pianist knows circumstances of the musical composer when writing, in addition to knowing the score, the creative nurse investigates and fully informs herself\himself about a client, as well as becoming knowledgeable regarding similar cases by reading reports. Peplau believed that various theoretical explanations will be pursued for the phenomena observed. Thus, all the three elements, energy, discipline, and content converge in the act of performance called nursing practice. While Peplau recognized that these elements of creativity did not constitute the entire substance of creativity, she held that the essential part was the convergence of the elements in relation to something, with creativity identifiable in the product.

Peplau (1974, p. 14) stated that creativity may stem from internal motivation, just for the sake of doing it, or it may evolve to incorporate a need for approval and reward also. When creativity and commitment were operating together, Peplau felt that, most often, it was a combination of self-propelled creative performance and a degree of interest in public acclaim for the performance. Nevertheless, she characterized commitment as a voluntary act involving a motivating focus and a propelling aim. Creative nurses were described by Peplau as those committing their energies to the advancement of the nursing profession in the public interest.

In addition to Peplau, Levine (1973, p. 15) believed that creativity in nursing had artistic qualities. She described a difference between creativity in art and in science. An example given

to demonstrate this difference was that the poet creates for his/her own sake, and when the intensity of his/her commitment is satisfied, everything else is secondary. However, because the nurse begins with a human commitment the consequences of creativity for her/him will always involve the patient.

Steele and Maraviglea (1981, p. 65) in their writings on the subject of creativity in nursing, refrained from presenting one definition of creativity. However, they provided a general guideline or framework. The prevailing idea was that creativity was the ability to view problems with new insights and to generate new solutions for resolving problems. Also, they pointed out that creativity was cumulative. Because the satisfaction generated from creative expression created a desire to continue to create, the triggered positive feelings became self-perpetuating.

Torrance (1966, p. 6) had a view of creativity somewhat similar to the view of Steele. However, he offered a definition of creativity.

> ...process of becoming sensitive to problems, deficiencies, gaps in knowledge, missing elements, disharmonies, and so on; identifying the difficult; searching for solution, making guesses, or formulating hypothesis about the deficiencies; testing and retesting these hypotheses and possibly modifying and retesting them; and finally communicating the results (as cited in Harty, 1973, p. 7.).

Howell's (1973, p. 5) definition of creativity had components similar to those of the other authors.

> ...a rearrangement of knowledge already acquired; a different combination of an element from one subject with an element from another in a new relationship.

Pesut (1985, p. 5), a nursing educator interested in stimulating creativity in students, believed that creative thinking was the

foundation for scholarship in nursing. He suggested what he considered to be a new definition of creativity:

> Creativity can be defined as a metacognitive process that: (1) generates novel and useful associations, attributes, elements, images, abstract relations, or sets of operations, and (2) better solves a problem, produces a plan, or results in a pattern, structure, or product not clearly present before.

Although Pesut's definition of creativity was not entirely new, his views, plus those of the other authors consulted, were in agreement that commitment and creativity were elements of excellence in nursing practice. A commitment to caring for the patient and advancing the profession in the public interest was the mission of the excellent nurse. The creative process was viewed as an individualized method of problem solving limited only by the nurse's persistence in seeking novel approaches.

Expertise and the Expert Nurse

From the previous authors cited, it was assumed that excellence in nursing required expertise. Expertise had to be present for excellence to prevail. However, until recently, the term expertise was rarely evident in the literature in association with excellence. More has been written concerning the caring and nurturing elements rather than the expertise and knowledge base of nursing. Kellams (1977, p. 30) believed that two basic ideals defined the essence of the profession of nursing. One of these ideals was social service while the other was expertise. He described the basis for expertise as the possession of a depth of unique knowledge. Kellams noted that society has valued expertise highly, and consequently, the professional nurse should exercise professional judgment even in

seemingly routine cases or routine procedures.

Rosenfeld (1986, p. 485) also stressed knowledge as the basis of expertise. He described expertise as emanating from prolonged specialized training in a body of abstract knowledge. He contended that acquiring expertise through extended education was dependent upon formulating theoretical knowledge based on empirical research. He stated that nursing has only begun to develop a body of abstract knowledge, and consequently, the profession lacks a source for scientific expertise.

One of the earliest uses of the term "expert" in relation to nursing was when a nurse served as an expert witness in legal testimony. Clark (1985, p. 53) has stated that an expert was generally accepted as a professional person with a higher degree of skill, care and learning than that of the average practitioner. However, she recognized that whether one was a specialist or not appeared to be a matter of one's own determination.

Perry described an expert witness as one who, by education or experience, possessed knowledge that the ordinary layman did not have (1977, p. 460). Although this suggested that such a witness would be an excellent practitioner, Perry stated that, in most cases, minimal qualifications have been sufficient. Litman (1987), a nurse who has become a lawyer specializing in medical-legal cases, agreed with this practice. She stated that, in her experience, educational credentials of nurses serving as expert witnesses have been more impressive to the legal system than clinical expertise. Consequently, an acceptable expert witness in a court of law may not be the most knowledgeable nurse in the practice area. Such a person may be a professional

expert witness although not at all familiar with the realities of clinical nursing practice in the specific case being tried.

While the legal use of the terms "expert" and "expertise" were not clearly defined, Pichert and Elam (1985, p. 10) reviewed literature in search of explicit standards for experts. They recognized that the ANA standards for practice for various clinical areas were broadly stated and required expert testimony to delineate specifics of the standards. Nevertheless, these authors described experts as people who have demonstrated that they have acquired expertise or a body of operative knowledge within a given domain. They proposed that all who pursue, capture, and master the body of operative knowledge may be considered experts. Recognizing the possession of knowledge as the requirement for being considered an expert, they attempted to differentiate novices from experts. It was pointed out that the decisions of experts were better, and their decisions were made more rapidly than the decisions of novices. Experts were better able to recognize relationships among elements of problem situations.

Pichert and Elam (1985, p. 10) acknowledged that there were more differences than similarities between experts and novices. Nevertheless, the problem-solving strategies used by both novices and experts were similar according to these authors. Both novices and experts used one of two approaches to hypotheses generation. Either several hypotheses were considered simultaneously, or new hypotheses were generated serially, each one only after its predecessor had been ruled out. The authors concluded that the basic form of reasoning behavior was similar regardless of level of expertise.

Pichert and Elam (1985, p. 10) also made an attempt to determine the reason for the superiority of experts. They hypothesized that experts have an ability to organize information into "chunks" more quickly and to move information through the system, grouping it into larger, better organized and interrelated "chunks." It was even suggested that experts' superiority may result from doing some of the cognitive processes of problem solving "automatically." In summary, the authors stated that experts were found to conceptualize a problem more quickly which allowed them more cognitive energy to form an approach and consider the alternatives.

Hord and Huling-Austin (1985, p. 13) studied the process of change and the facilitators in the change from novice to expert. These educators were especially interested in the process of diabetes educators becoming experts and facilitating their diabetic client's acquisition of expertise in managing their own diabetes. The Concerns-Based Adoption Model was developed to provide guidance in acquiring expertise. It was interesting to note the active presence of a facilitator, with access to a variety of resources, in this model. It was assumed that experts had help from others in perfecting their skills.

Benner and Wrubel (1982a, p. 11) approached expertise in a different manner. Giving greater credibility to areas of expertise other than knowledge, they stated that in every knowledge-intensive field with an applied, clinical component, there is disagreement between practitioners and theoreticians. They believed that this stems from Western cultural roots which have traditionally placed a premium on abstract reasoning. The result, according to Benner and

Wrubel, was a better understanding of theoretical knowledge with a higher value being placed on it than on knowledge gained through practice and experience.

When explaining the clinical skill involved in expertise, Benner and Wrubel (1982a, p. 11) referred to the ideas of Polanyi and Kuhn (1962), two philosophers of science. They pointed to the difference between knowing "that" (theoretical knowledge) and knowing "how" (practical knowledge learned through skilled practice). The kind of practical know-how, in which the principles or rules are not known, was likened to the skill of learning to swim or ride a bicycle. This knowledge, acquired without theoretical understanding, is called the unspecifiable knowledge of a skill. These skills are almost wholly irreducible to objective measurement strategies.

Benner and Wrubel agreed with Polanyi and Kuhn (1962) that objective and replicable measurements are preferable when they are attainable. Nevertheless, they felt that it was best to acknowledge the clinical judgments which are not quantifiable and objectifiable. Consequently, they held that it was best to plan for the acquisition of clinical judgment in training the clinician and in advancing clinical knowledge. In describing individuals who posses skills that are irreducible to objective measurement strategies, Polanyi (1962) called them "connoisseurs." He said that these individuals possess the ability to make qualitative, discriminating judgments which fall in the realm of expert human judgment.

Benner (1984) enlarged upon the work of Polanyi and applied the definition of expertise specifically to nursing. She also described the process of developing expertise.

> Expertise is developed only when the clinician tests and refines theoretical and practical knowledge in actual clinical situations. Expertise develops through a process of comparing whole similar and dissimilar clinical situations with one another, so an expert has a deep background understanding of clinical situations based upon many past paradigm cases. Expertise is a hybrid of practical and theoretical knowledge (p. 294).

Benner (1984, p. 37) explained the problem-solving approach used when expertise is present. In explaining this, she referred to the work of the Dreyfuses (1980). They described that with expertise, the process of reading the whole situation permits movement to the accurate region of the problem without wasteful consideration of a large number of irrelevant options. Benner stated that expertise in complex human decision making, such as nursing demands, makes it possible to read clinical situations, and that there is knowledge imbedded in clinical practice when expertise prevails.

Benner and Wrubel (1982c, p. 30) recognized that the expert's valuable clinical knowledge was taken for granted. They believed that only by systematically describing and documenting areas of clinical knowledge will it be possible to recognize and communicate the knowledge embedded in the skilled practices of the expert nurse (p. 33). The use of paradigm cases are believed to be an excellent way of presenting clinical knowledge that is often difficult both to teach and to learn in other ways.

Benner (1984) proceeded to validate her ideas by studying experts in clinical practice in considerable depth using a naturalistic methodology. She described differences between the experienced nurse and the novice. The tool which she used in her descriptions was the Dreyfus Model of Skill Acquisition (1980). Stuart Dreyfus, a

mathematician and system analyst, and Hubert Dreyfus, a philosopher, developed a model of skill acquisition based upon their studies of chess players and airline pilots (1980). The Dreyfus Model postulated that in the acquisition and development of a skill, a student passed through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert.

The five-level continuum of the Dreyfus Model (1980) described changes in three general aspects of skilled performance. One was a movement from dependence on abstract principles to the use of previous experience as paradigms. The second was a change in learner perception so that the situation was seen less as equally relevant pieces and more as a complete whole in which only certain parts were relevant. The third major change was a departure from the role of detached observer to one of involved performer. These changes were evident as Benner reported the results of her systematic study of the applicability of the Dreyfus Model to nursing.

Benner (1984, p. 14-15) used twenty-one paired descriptions of the same clinical incidents in her study. These were obtained by separately interviewing beginning nurses and nurses recognized for their expertise by peers and supervisors. Also, interviews and/or participant observations were conducted with fifty-one additional experienced nurse clinicians, eleven newly graduated nurses, and five senior nursing students. All the observations and interviews, both individual and small group, were conducted in six hospitals. Although educational background was not a criterion, the majority of nurses had a baccalaureate degree, and seven had master's degrees.

The intent of Benner's (1984, p. 16) study was to identify

meanings and content. Through analysis of incidents, following the Dreyfus Model, Benner was able to describe the performance characteristics at each of the five levels of development in general terms as well as the teaching/learning needs at each level. The model was considered a situational model rather than a trait or talent model. The five levels of proficiency identified by Benner (p. 291-298) were as follows:

Stage 1: Novice

That stage in the Dreyfus model of skill acquisition where no background understanding of the situation exists, so that context-free rules and attributes are required for safe entry and performance in the situation. It is unusual for a graduate nurse to be a novice, but it is possible. For example, an expert nurse in gerontology would be a novice in a neonatal intensive care unit. Many first-year nursing students will begin at the novice stage; however, students who have had experience as nurse's assistants will not be novice in basic nursing skills. According to Benner, the term novice should not be attributed to the newly graduated nurse because, in most cases, the nurse will perform at the advanced-beginner level.

Stage 2: Advanced Beginner

One who can demonstrate marginally acceptable performance; one who has coped with enough real situations to note, or to have pointed out by a mentor, recurring meaningful situational components. The advanced beginner has enough background experience to recognize aspects of a situation.

Stage 3: Competent

A stage in the Dreyfus model of skill acquisition typified by considerable conscious, deliberate planning. The plan dictates which attributes and aspects of the current and contemplated future situation are to be considered most important and which can be ignored. The competent stage is evidenced by an increased level of efficiency.

Stage 4: Proficient

The proficient performer perceives situations as wholes rather than in terms of aspects, and performance is guided by maxims. There is a qualitative leap or discontinuity in problem approach between the proficient and the competent level of performance. The proficient performer recognizes a situation in terms of the overall picture. This person recognizes which aspects of the situation are most salient. The proficient performer has an intuitive grasp of the situation based upon a deep background understanding.

Stage 5: Expert

Rules, guidelines and maxims are not depended upon to connect understanding of the situation to an appropriate action. An intuitive grasp of each situation enables the nurse to zero in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. Performance is fluid and flexible and highly proficient. Analytic problem solving may still be done when events and behaviors are not occurring as

expected (pp. 31-4).

Reexamining the work of Hubert and Stuart Dreyfus, Benner (1984, p. 37) pointed out that in the studies of pilots, it was only by dropping the rules that one was able to become really proficient. While if there were insistence that expert pilots paid attention to the rules and guidelines they were taught as beginners, their performance actually deteriorated. Because some levels of skill acquisition, described by Benner, had approximate periods specified for achievement of that level, experience was defined precisely.

> Experience does not refer to the mere passage of time or longevity. Rather, it is the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory (1984, p. 36).

Benner (p. 36) suggested that experts generate theory and research from the practical world. Experience is referred to as a clinical dialogue with theory making refinements accessible or possible for the experienced nurse.

According to Benner (1984, p. 34) expert clinicians are not difficult to recognize. However, it was not possible to capture the steps in the process of highly skilled human performance. Therefore, the usual criteria for performance evaluation could not be used in identifying expert performance. Benner recommended an interpretive approach with qualitative evaluation strategies added to the usual quantitative measures. Because the context and meanings inherent in the clinical situation strongly influenced the performance of the expert nurse, context-free principles and elements did not capture the knowledge embedded in the expert's actual practice (p. 35). Benner and Wrubel (1982b, p. 13) suggested that a qualitative leap occurred

from acquiring the recognition ability of the expert clinician, to functioning as an expert after acquiring the recognition ability.

Because Benner (1984, p. 39) valued the context of clinical practice, she used an interpretative approach in her research. She referred to the work of Heidegger (1962), Taylor (1971), and Rabinow and Sullivan (1979) (as cited in Benner, 1984, p. 39) as earlier scholars who had used the interpretive strategy. It was believed that the advantage of this method was that it allowed synthesis rather than analysis, and it permitted a manageable yet rich description of actual nursing practice. Especially in the study of practical knowledge at the expert level, Benner held that the topic must be studied holistically.

The example used by Benner (1984, pp. 39-40) to illustrate use of the interpretive approach was the bed bath, a procedure with different meanings dependent upon the context. Initially, the bed bath was viewed as essentially a comfort measure during the early portion of a patient's illness. As recovery occurred, the same procedure might mean excessive fostering of dependence. Therefore, as the interpretive approach was used, the timing, meanings and intentions of the nurse were clearer. Thus, the whole could be seen and the significance of the nurse's contributions appreciated (p. 41).

Benner's (1984, p. 45) research methodology included the presentation of examples of expert nursing performance to a research team for consensual validation. Sometimes one patient-nurse episode yielded more than one competency. Multiple examples of each competency allowed confidence in the interpretation. By this method, actual performance demands, resources, and constraints were described

rather than hypothetical ones. Also, a rich description of nursing practice was provided. An adequate description of the competency was dependent on the examples with the focus on the whole situation rather than on dividing it into specific tasks as is done in teaching the beginner.

Thirty-one competencies emerged from Benner's (1984) analysis. These were classified into seven domains which were derived inductively from the competencies. The seven domains with the competencies within each domain follow:

I The Helping Role (p. 50)

The Healing Relationship: Creating a Climate for and Establishing a Commitment to Healing

Providing Comfort Measures and Preserving Personhood in the Face of Pain and Extreme Breakdown

Presencing: Being with a Patient

Maximizing the Patient's Participation and Control in His or Her Own Recovery

Interpreting Kinds of Pain and Selecting Appropriate Strategies for Pain Management and Control

Providing Comfort and Communication Through Touch

Providing Emotional and Informational Support to Patients' Families

Guiding Patients Through Emotional and Developmental Change: Providing New Options, Closing Off Old Ones: Channeling, Teaching, Mediating

Acting as a psychological and cultural mediator

Using goals therapeutically

Working to build and maintain a therapeutic community

II The Teaching-Coaching Function (p. 79)

Timing: Capturing a Patient's Readiness to Learn

Assisting Patients to Integrate the Implications of Illness and Recovery into Their Lifestyles

Eliciting and Understanding the Patient's Interpretation of His or Her Illness

Providing an Interpretation of the Patient's Condition and Giving a Rationale for Procedures

The Coaching Function: Making Culturally Avoided Aspects of an Illness Approachable and Understandable

III The Diagnostic and Monitoring Function (p. 97)

Detection and Documentation of Significant Changes in a Patient's Condition

Providing an Early Warning Signal: Anticipating Breakdown and Deterioration Prior to Explicit Confirming Diagnostic Signs

Anticipating Problems: Future Think

Understanding the Particular Demands and Experiences of an Illness: Anticipating Patient Care Needs

Assessing the Patient's Potential for Wellness and for Responding to Various Treatment Strategies

IV Effective Management of Rapidly Changing Situations (p. 111)

Skilled Performance in Extreme Life-Threatening Emergencies: Rapid Grasp of a Problem

Contingency Management: Rapid Matching of Demands and Resources in Emergency Situations

Identifying and Managing a Patient Crisis Until Physician Assistance Is Available

V Administering and Monitoring Therapeutic Interventions and Regimens (p. 123)

Starting and Maintaining Intravenous Therapy with Minimal Risks and Complications

Administering Medications Accurately and Safely: Monitoring Untoward Effects, Reactions, Therapeutic Responses, Toxicity, and Incompatibilities

Combating the Hazards of Immobility: Preventing and Intervening with Skin Breakdown, Ambulating and Exercising Patients to Maximize Mobility and

Rehabilitation, Preventing Respiratory Complications

Creating a Wound Management Strategy that Fosters Healing, Comfort, and Appropriate Drainage

VI Monitoring and Ensuring the Quality of Health Care Practices (p. 137)

Providing a Backup System to Ensure Safe Medical and Nursing Care

Assessing What Can Be Safely Omitted from or Added to Medical Orders

Getting Appropriate and Timely Responses from Physicians

VII Organizational and Work-Role Competencies (p. 147)

Coordinating, Ordering, and Meeting Multiple Patient Needs and Requests: Setting Priorities

Building and Maintaining a Therapeutic Team to Provide Optimum Therapy

Coping with Staff Shortages and High Turnover:

Contingency planning

Anticipating and preventing periods of extreme work overload within a shift

Using and maintaining team spirit; gaining social support from other nurses

Maintaining a caring attitude toward patients even in absence of close and frequent contact

Maintaining a flexible stance toward patients, technology, and bureaucracy

Although Benner has published more extensively than others on the topic of the expert nurse, a limited number of other sources were found. Some concepts described by Benner were further explained by Gordon (1986, p. 953-5) in a study which she conducted on models of clinical expertise. Job descriptions composing a career ladder were analyzed. The goal of the study was to restructure nursing services, within a hospital, enabling the promotion of clinically competent

nurses in an advancing career in patient care. This was a departure from the traditional pattern for upward mobility which had previously led the nurse away from patient care and into administration. The job descriptions, with a list of quantifiable behaviors, were central in evaluating nursing behavior in the setting where the study was conducted.

Gordon also based her work on the Dreyfus model of skill acquisition. She identified three dominant images of the nurse at each of four existing job levels. The images, present in varying degrees were the nurse as problem-solver, as teacher, and as scientist. A criticism of the job descriptions, as Gordon viewed them, was that behaviors were evaluated without a context. As an example, the situation of evaluating the nurse's teaching without concern for the patient's readiness to learn, was given. Without evaluating the relationship between the nursing behavior and the situation in which it took place, the appropriateness and timing of the behavior could seldom be assessed. In addition, a nurse's practice had been repeatedly judged on the basis of written work such as nursing histories, nursing care plans, and charting rather than on practice.

According to Gordon's (1986, p. 957) analysis, job descriptions were deduced primarily from beliefs and theories about what constituted optimal nursing practice. A preferable method, suggested by Gordon, was the development of job descriptions from studies of actual effective nursing practice which helped the outcomes for patients. An example was given of evaluation inconsistency with the position levels in use. The nurse, in the example cited by Gordon,

was at the highest level position in the career ladder and was referred to as the "clinical expert." This nurse held a master's degree and was knowledgeable in current literature and theory. However, she had worked only one and one half years in her specialty area. Although she was expert in theory and science, she was not considered an expert in practical skill by those with whom she worked.

After observing the practice of many nurses, Gordon (1986, p. 957) stated that experience was not adequately appreciated. Furthermore, she contended that unusual intelligence and education did not provide understanding and enable nurses to respond intuitively. For Gordon this intuitive response was the outstanding characteristic of practical expertise.

While the Dreyfus (1986) model suggested that the foremost characteristic of expert practice was replacing analytic reasoning with intuitive responses based on vast experience, Gordon (1986, p. 957) felt that the job descriptions she analyzed placed theoretical knowledge at the apex. Nevertheless, she felt that the lack of situational understanding and background concrete experience explained the strong dependence on formal models such as the job descriptions. As she pointed out, when formalism and analytic rationality became the ideal, the intuitive and holistic traits of expertise became obscured (p. 960). Although formal models were essential in moving the novice along toward the development of expertise, Gordon insisted they were not appropriate for developing, rewarding, and recognizing the higher levels of clinical expertise.

Another researcher interested in studying nursing expertise was Fenton (1984, p. 262). She studied the skilled performance in

clinical settings of nurses who had the master's degree. A composite picture of successful nurses emerged from the data collected. The purpose of the study, done with other graduate faculty, was to design instruments to evaluate curriculum. Benner's (1984) research methodology was used in collecting critical incidents, which also provided case studies for students to analyze as part of their clinical and core courses. While this research was ongoing, it was reported that many advantages were found in the use of this approach to curriculum planning and evaluation. An especially important advantage was that the faculty perceived that the gap between practice and education was narrowed (p. 274).

Another research report was that of Steele (1986, p. 109). The purpose of her naturalistic study was to evaluate a specific graduate nursing curriculum for its effectiveness in preparing advanced practitioners. Also, it was intended that the practice of nurses prepared with the master's degree would be more clearly defined. The goal was to understand the actual practice of the nurses being studied without manipulating variables.

Although the curriculum evaluation study included thirty nurses, Steele presented data from only four child health nurses whom she had personally studied. The nurses were engaged in different types of practice. The variety of specialization included roles in administration, oncological problems in children, working with children with cleft lips and palates, and children with congenital or acquired disabilities receiving rehabilitation services. Seven vignettes were reported along with the domain of skilled nursing practice which the vignette demonstrated. One vignette was identified

as an example of the helping role of the nurse, another demonstrated the teaching-coaching function of the nurse, two were examples of the diagnostic and patient monitoring function, and two were the domain of monitoring and insuring therapeutic interventions and regimens. In addition, another domain was identified beyond those which Benner identified. This was the consultative role of the nurse (1986, p. 109-16). At the conclusion of the ethnographic study, four areas were identified in which curriculum strengthening was indicated (p. 117).

1. Development of collegial relationships with physicians and other health care providers
2. Development of successful strategies for influencing bureaucracies to respond to patient's and families needs
3. Articulation and validation of the value of the role of the advanced nursing practitioner in the health care system
4. Development of the formal and informal consulting role of the advanced nurse practitioner

All the researchers cited, who studied expertise and the expert nurse, have emphasized the initial step in the development of clinical knowledge as systematic documentation of expert clinical performance. Benner (1984, p. 35-6) has proven that there is value in developing a consensus among expert nurses about descriptive language and comparable observations. It has permitted others to expand upon her research and has the potential for further enhancing performance. Benner has suggested that the study of proficient and expert performance may also make it possible to describe the patient outcomes which result from this performance. Identification of the knowledge embedded in clinical practice can further develop the scope of nursing practice of nurses who wish to and are capable of achieving excellence. When experts can describe clinical situations where their

interventions made a difference, performance may gain visibility and the recognition of expertise.

Excellence and expertise in nursing have been studied by a few scholars. Expert nursing practice has been systematically described in some situations. There was a lack of agreement among authors regarding whether possession of a body of specialized knowledge, as is required of an expert witness in a court of law, is the critical piece of expertise, and what role intuition plays in expertise. Several authors agreed that a study of the topic requires analysis of the situation in which the expert behavior occurred. This was found to be necessary in order to determine the appropriateness of the nurse's actions within the context. Therefore, a naturalistic methodology, as initiated by Benner, appears to be desirable for continuing study.

Expertise in Community Health Nursing Practice

Confusion has existed regarding the focus of community health nursing practice (Williams, 1977, p. 250). Williams recognized that nurses in both education and service have been "...in a conceptual and semantic muddle about the nature of community nursing practice." Even community health nurses themselves have had trouble with the concept.

The roots of public health practice may be found in the work of Florence Nightingale (Winslow, 1946, p. 330). In 1854, when she and 38 selected nurses responded to the unsanitary conditions of the Crimean hospitals, the death rate decreased from 420 per 1,000 to 22 deaths per 1,000 in just a few months. The vision of the nurse held by Nightingale was not one merely of an attendant to the sick, but as a teacher of hygiene (p. 331). She conceived the nurse as one who

cared for the patient and also cared for the house and home, teaching how to render it more healthful (p. 332).

In 19th century England, the government began to take steps to protect the public health (Heinrich, 1983, p. 318). This effort in the public health movement has constituted one of the major elements of social action (Kark, 1981, p. 3). It was aimed at modifying the environment and people's behavior in order to promote the health and welfare of society. The main objectives of public health practice were to promote health, prevent disease, and ensure the best possible distribution of health and medical care facilities.

Although the origins of public health lie deep in the traditions of all societies, the scientific development, which was linked with the technologic and industrial revolution, has been comparatively recent (Kark, 1981. p. 3). In the United States, the public health movement became firmly established just before the turn of the century (Monteiro, 1987, p. 65). As a humanitarian ideal, it grew into a substantial force which effectively attacked human suffering and need (Kalisch & Kalisch, 1978. p. 256). This was evidenced by a noticeable decline in tuberculosis, diarrheal diseases of children, and typhoid fever. Furthermore, the decline in the death rate between 1900 and 1914 was attributed to improved water and sanitation conditions, new medical discoveries, and the work of public health nurses (p. 258).

The title public health nursing, used to characterize the humanitarian work done by nurses, has been largely replaced by the term community health nursing. According to de Tornyay (1980, p. 83), the nursing profession itself promoted this change as the term public health referred to the activities of those who work for government

bodies in the delivery of health care to various populations. She contended that today many nongovernmental groups are involved in delivering health care, and community health nurses work in a wide variety of governmental and community settings from migrant agricultural workers' camps to ambulatory clinics located in all types of hospitals. Consequently, de Tornyay stated that the term community health was more descriptive for nurses than public health.

While the accomplishments of public health nursing may be cited, Williams (1977, p. 250) recognized a need to diminish the confusion regarding the scope of practice of the community health nurse. According to Williams, there is a major difference in the way that community health nursing is defined. She stated that many nurses have tended to consider any care setting other than the inpatient, hospital setting as a community setting. These same individuals considered any nursing care taking place in these alternate settings as community health nursing.

In an effort to learn more about the practice of community nurses, Archer and Fleshman (1975, p. 359) administered a questionnaire to a group of nurses who identified themselves as community nurse practitioners. Results of the study indicated considerable diversity with regard to the characteristics and functional categories the nurses described regarding their work. They worked in a variety of settings and focused their attention on a range of problems which included the individual, a diagnostic specialty, planning for widely defined health issues, and management of systems. Settings where the nurses were employed ranged from clinics, private health agencies, physician's offices, schools, and any number of

places including government health care agencies.

de Tornyay (1980, p. 83-4) held the concept that the setting in which nursing care is provided is the element which differentiated community health nursing from other areas of nursing practice. She stated that for much of its history, community health nursing has focused on case finding and health maintenance, as well as on health teaching and counseling activities. The responsibilities of the community health nurse listed by de Tornyay are: 1) administering personal health services, 2) supervising other nursing personnel in providing such services, 3) teaching people and providing information about health, 4) recording and analyzing health data for individuals and groups, 5) coordinating activities and resources in the community, 6) helping to maintain a healthful environment, 7) assessing the health needs of the community (Miller and Albers, 1975, p. 535).

Williams (1984, p. 251) contended that the distinction regarding the setting where nursing care was provided does not reflect the essence of public health practice. In contrast to de Tornyay's concept of community health nursing, Williams (1977, p. 251) stressed the difference between the focus of clinical nursing and medicine on the one hand, and that of public health practice on the other. She described the unit of care of clinical nursing or medicine as the individual patient or family, while the unit of care of public health practice was the community. Williams preferred Kark's (1981, p. 3) concept of public health which placed greater emphasis on the promotive and preventive objectives rather than on curative care. He stressed the importance of modifying the environment, health-related behavior, and health action by the community.

The patient-community concept is elusive and difficult to operationalize. While community health concepts are integrated into basic nursing education programs, Williams (1977, p. 251) felt that the teaching frequently emphasized individualistic approaches. Rather than accenting methods of defining problems and assessing impact at aggregate levels, students are taught to make decisions at the patient-provider level, according to Williams. Consequently, the lack of clarity continues about what community health nursing really is.

Because Williams (1977, p. 251) was concerned with the aggregate dimension of community health, she proceeded to distinguish between aggregates and groups. She stated that a group, when used in the public health sense, is not limited to an interacting entity as it is when it was used as a sociological term. In the context of public health, a group referred to individuals with one or more personal or environmental characteristics in common. These characteristics may mean that a group is at risk for developing specific health problems. The example given to describe a group, in the manner in which it is used in public health, is that of black males. These individuals, as an aggregate/group, have a higher prevalence rate of hypertension than white males. Williams stated that although individual or even family-oriented clinical services may be necessary for dealing with the personal health service needs of populations, they are not enough. She asserted that clinical and community dimensions should be appropriately merged.

Williams (1977, p. 252) stated that the dimensions of clinical and community may be brought together by use of the epidemiological

approach in public health nursing practice. This included anticipating and estimating the extent of personal health problems at the community level without limiting the problem definition to only those seeking care. Therefore, an aggregate approach involves estimating the relationship between those who need a service and those who are already receiving the service. In this way, it is possible to determine the size of the aggregate and what percentage was currently being served. All the while, the focus of nursing remains on the promotion of health-related behaviors and the provision of personal health services to members of populations or communities.

An example of Williams' dimensions of community health nursing, including the epidemiological approach to community focusing on the aggregate, is apparent in the writings of Anderson, McFarlane, and Helton (1986, p. 222). They adapted a model for practice from the Neuman Health Care Systems model (as cited in Anderson et. al., 1986, p. 220). Using eight subsystems for assessment, the authors analyzed data of an actual community. They sought to determine community health needs and strengths, as well as to identify patterns of health responses and trends in the use of health care services. Safety emerged as the primary health-related concern of community residents. Personal safety concerns had increased in the assessed community. These concerns resulted from an increase in episodes of burglary, robbery, and assault according to police records. Further analysis revealed that assault, or battering of women by husbands, ex-husbands, boyfriends, or lovers was the specific area with the greatest increase in incidence. The model was intended to guide practice, education and research in nursing and was entitled the Community-as-Client model.

Anderson, McFarlane, and Helton (1986, p. 222) made use of the model to put into practice the definition of public health nursing as a synthesis of public health and nursing. As application of the Community-as-Client model proceeded, the community nursing diagnosis was developed. The diagnosis was: Increased battering of women related to low self-esteem, substance abuse, high dependency needs, a history of exposure to violence as a child, and community acceptance of violence. Next, the authors went to the literature, where they found reports of a national increase in domestic violence with frequent mutilation and violence inflicted during pregnancy.

Planning and intervention phases were the next steps in the Community-as-Client model (Anderson et al., 1986, p. 223). Nursing interventions were intended to promote health and to contribute toward regulating and controlling the community's response to stressors. To plan a community-focused program, more information was needed on the prevalence of battering in the specific community under investigation. Because frequent contacts with nurses were anticipated during pregnancy and because the literature documented that pregnant women were at risk of battering, a relatively small prevalence study of battering during pregnancy was completed. Women at highest risk of battering during pregnancy were identified.

With the above information, a prevention program focusing on pregnant women was proposed with primary, secondary, and tertiary levels of prevention (Anderson et al., 1986, p. 224). An implementation schedule was suggested over a three-year period. This ultimately resulted in an educational program directed toward both professionals and the general public. The authors of this project,

successfully completed, suggested that the model may be applied in public health nursing practice to a wide variety of problems that affect the well-being of a specific population.

McKay and Segall (1983, p. 328) stated that the public health model emphasized the complexity of interactional factors existing in practice. Decision making for the aggregate, they believed, required more extensive knowledge and skills than those necessary when dealing with individuals. These authors viewed primary care by the community health nurse, directed toward the individual, as complementary practice. They suggested that this type of practice is expected by the nurse prepared with the initial professional degree, while true community health nursing, directed toward the aggregate, is considered a competency of the nurse with graduate education (p. 333).

While there has been confusion about the nature of community health nursing, many leaders agreed that it is a synthesis of public health and nursing (Williams, 1984, p. 807). Basic preparation for the practice of community health has been education at the baccalaureate degree level. These ideas were evident in the definition of community health nursing developed by the American Nurses' Association.

> A synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations. Health promotion, health maintenance, health education and management, coordination, and continuity of care are used in a holistic approach to the management of the health care of individuals, families, and groups in a community (Standards of Community Health Nursing Practice, 1986, p. 18).

Perhaps because of confusion regarding the definition and focus of community health nursing, examples of expert practice were not

readily found in the literature. However, in the exemplars cited by Benner (1984), there were two incidents reported by the nurses employed in the hospital, which occurred at an earlier time in the nurses' practice when they were employed in the community setting. When the concept of community health nursing described previously by de Tornyay, and the definition of community health nursing of the American Nurses' Association were considered, the examples from Benner's work appeared to be expert examples of community health nursing practice. Both examples were in the domain of the teaching-coaching function. In addition, they were the only examples given for the competency entitled "Assisting patients to integrate the implications of illness and recovery into their lifestyles."

The first example of expert public health nursing practice collected by Benner (1984) was that of a nurse relating the role she played with a severely handicapped woman. It demonstrated the situation-based, interpretive approach to describing nursing practice. The expert example as related by the nurse follows:

> When I was very young, I worked for the Visiting Nurses Association. One woman I went to see on consultation hadn't been out of her bedroom for five years and was just dying of depression. She'd had a stroke and had not had much physical therapy. She had one completely frozen arm and very little mobility with her right leg. At the time, I knew very little about her chances for recovery. There were no orders for physical therapy. "Her heart is bad, the exercises might kill her," I was told. (Now you have to remember, that this was many years ago). And I said, "She's dying anyway, she is dying because her whole world is just the four walls." And I wanted the opportunity to help, and I asked the doctor to give me the opportunity, by giving an order for physical therapy. And I promised to talk to the husband and to her about the fact that it is taking a big chance and that she may die. The doctor reluctantly gave me an order, and I exercised that woman, and got her out of bed. I got a book out of the library and read up on CVA physical therapy because I knew very little about physical therapy. She never regained the use of the hand

> and arm, of course, but she did get to the point that she could walk with help. And the first day she walked out of her bedroom, she just burst into tears. She died five years later while cooking dinner. She had learned to peel potatoes with her one hand, wedging them against her paralyzed arm. She was a marvelous lady who was dying because she was being treated like an invalid, and she felt useless and hopeless (p. 81).

The above example demonstrates a nursing activity in which only a nurse practicing outside the institutional setting might have been involved. Because the setting was the home, and the intervention extended over a period of time, as opposed to episodic services, the example is consistent with the concept of community health nursing practice which de Tornyay (1980) described. The nurse helped the severely handicapped woman to integrate her physical limitations into her activities of daily living and to reestablish a meaningful life. The actions of the expert nurse demonstrated both commitment and creativity.

The second example of expert community health nursing reported to Benner (1984, pp. 81-4) concerned a school child not attending classes in the classroom. The public health nurse identified the case by looking through cards maintained in the clinic for all the health problems in the school. The student was a senior in high school who was being tutored at home because he was confined to a wheelchair. The expert nurse questioned why the child did not go to school and learned that the boy's father was unable to carry him into the station wagon and take him into school. Upon making a home visit, the nurse learned that the boy's physical condition was deteriorating due to a rare kind of progressive muscular dystrophy along with nutritional deficiencies. He was socially isolated, and his family had no devices to assist with his care. There was no supportive person to whom the

family could relate while trying to provide the best care they were able to provide. The nurse coordinated medical care which had been fragmented due to multiple providers who had told the family that the boy's condition was hopeless. She arranged for the Muscular Dystrophy Association to renovate the home to make caring for the boy easier. The association also provided transportation for him whenever he wanted to go. In addition, probably the most meaningful intervention was enabling him to resume attendance at spectator sports and to resume announcing at football games. The expert nurse's evaluation of the difference these interventions made in the life of this boy was that he smiled much more, really blossomed, and appeared to become stronger.

Another example of expert community health nursing practice was described by Schwartz (1986, p. 175). The example was related as part of the job of a psychiatric public health nurse, a specialist working with chronically ill psychiatric patients in a half-way house. Because many of these clients were unprepared to live in the community, the nurse attempted to assist them in learning to shop, communicate their needs, and manage their finances. This example concerned a woman who spent approximately thirty years in a state mental hospital and was discharged to live in the half-way house. The description of her clothing was truly bizarre. She accumulated $700 over the Social Security allowable limit, and her checks were going to be stopped as well as a $3000 penalty levied. The nurse went to Legal Aid, and the appeal was denied. She then went to Federal Court on behalf of the client. The judge hearing the case was shocked by the defendant's appearance, behavior, and lack of coherence. However, he

was impressed with the nurse's qualifications as an expert witness. Her explanation of the circumstances led him to waive repayment of the money saved in excess of the amount allowable. He also permitted the client to keep her checks when the nurse assured him that the same situation would not happen again.

In the above example the nurse served as an advocate for the client. Her commitment is evident in her persistence when the appeal to Legal Aid was denied. In addition, while she was providing nursing services to the individual, this client and her situation represented a group of individuals who lived in a sheltered environment for many years and no longer had the skills to function in society outside the institution. This group of individuals is considered an aggregate in the public health sense of the term.

Still another example of expertise in services to the aggregate was evident when a child psychiatric nurse reached out to her community during the aftermath of the Challenger explosion of January, 1986 (Lee, 1987, p. 87). Both as a mother and as a professional, she recognized the importance of offering children an opportunity to express their feelings about the disaster. She referred to books and papers about how children react to death and loss. While examining the tragedy with her own children, the expert nurse decided to prepare a letter to other parents as a way to enable them to foster discussion about the disaster with their children. The letter, widely distributed through the school, summarized some of the television programs thought to be helpful in encouraging openness and questions. It also pointed out anticipated thinking patterns of young children and parental mourning behaviors helpful to children in working through

grief.

The above example more clearly adheres to the concept of Williams who viewed community health nursing as assessment and intervention reaching the aggregate rather than merely the individual and family. With the confusion regarding the concept of community health nursing, and the unclear focus and scope of practice, the need was suggested for collection of a number of examples of expert practice in this area. Anderson (1983, p. 48) has stated that public health nursing has a rich legacy which should continue. She further suggested that survival is dependent upon the ability to articulate what the nurse does and the difference that expertise in this area of practice makes.

As Benner (1984, p. 35) stated, an initial step in the development of clinical knowledge is the systematic documentation of expert clinical performance. She felt that experts may benefit from systematically recording and describing critical incidents from their practice which illustrate expertise or even a breakdown in performance. Benner's contention was that this documented performance may open new areas of clinical knowledge for further study and development. It is evident that clinical knowledge of community health nursing has the potential to serve this purpose. However, in any study describing expert clinical performance, both concepts of community health nursing, the view of any nursing care delivered outside the hospital, as well as the view focusing on the community as the client, may be anticipated .

Benner (1984, p. 35) further stated that developing a consensus among expert nurses about descriptive language and comparable observations has the potential for further enhancing performance. The

study of proficient and expert performance may make it possible to also describe the patient outcomes which result from this performance. Identification of the knowledge embedded in clinical practice has the potential to further develop the scope of nursing practice of nurses who wish to and are capable of achieving excellence. The nursing educator can make use of this knowledge in teaching the novice. In this way the student/novice may become aware of the expert nurse's skill, which they will attempt to emulate.

Benner and Wrubel (1982a, p. 14) recognized that areas ripe for clinical knowledge development may be found in every field of nursing practice. They suggested the collection of paradigm cases in which the clinical lesson stands out. This serves to heighten perceptual awareness as well as conceptual clarity (p. 15). These authors proposed that paradigm cases represent clinical knowledge that is easiest both to teach and to learn because learning is by example rather than by precept (Benner and Wrubel, 1982c, p. 31). They pointed out that proficient and expert nurses develop clusters of paradigm cases around different patient care issues, and they use past concrete examples much as a researcher uses a paradigm to guide research (Benner, 1984, p. 193). Based on the uses of paradigms of expert nursing suggested by these authors, perhaps it is possible to use paradigms of expert community health nursing in nursing education to enable the student to grapple with the complexity of expert practice of community health nursing.

Summary

A review of the literature led to several understandings.

Expertise in nursing was found to be an illusive concept which has recently gained increased visibility in the literature. The qualities of creativity in practice and commitment to the client were found to be inherent in the concept. Expertise was found to be of increasing value because of technology and the changing health care scene. Research done to date on expertise has been of the naturalistic type. This has permitted familiarity with the context and has enhanced understanding. Most research of expert nursing practice has been done with nurses in the institutional setting of the hospital. Few examples of expert community health nursing, labeled as such, may be found. Community health nursing was found to be a complex and ill-defined area of nursing practice with much disagreement regarding its focus and scope. Because the expertise of community health nurses has not been researched, this area of practice deserves attention to enable nursing educators to define more clearly the scope and focus of practice for students who are seeking to understand this curriculum content. This research provides paradigm cases for teaching the expertise of community health nursing and for assisting the student/novice to begin progress through the steps toward becoming an expert in community health nursing.

CHAPTER III

METHODOLOGY

Introduction

The purpose of the study was to describe expert nursing as practiced by community health nurses. The methodology selected followed a pattern similar to that of a study conducted by Case (1986). In the earlier study, community health nurses were asked to provide narrative, qualitative descriptions of their stressful experiences. The major difference in this study was the topic and content of the nurses' experiences. Recommendations for maximizing responses to questionnaires were followed according to Baker (1985, pp. 118-21).

Population and Sample

The population for the study consisted of 286 community health nurses employed in three separate health department systems in one Midwestern state. The largest of the three systems was the state health department. It governed local county health departments in 66 counties which employed approximately 240 nurses at the time of the study. The other two systems were the large metropolitan city-county health departments in the state's two largest cities. These two independent systems employed a total of approximately 65 nurses under

administrations separate from the state system.

From the population described, subjects were registered nurses whose chief responsibility was the provision of direct patient care. There were no restrictions on educational requirements of the subjects, as nurses from all types of registered-nurse programs were employed by the health departments. Subjects with advanced degrees or credentials, i.e., nurse practitioners and those holding national certification in a specialty area, were also included in the study. The data-producing sample were those nurses who chose to participate. Demonstration of each subject's willingness to cooperate in the study was indicated by returning the completed instruments.

Instruments

Two instruments were used to obtain information from the nurses. The first was a biographical questionnaire, and the second was an instrument used to explore the nature of expert practice as perceived by community health nurses. The instruments were accompanied by a cover letter to the potential participants (Appendix A). In preparing the cover letter, recommendations made by Gay (1981, pp. 162) and Baker (1985, p. 119) were followed. Specifically, their advice was attended related to building rapport with the subjects and conveying that success of the project depended on their participation. While Gay suggested addressing the cover letter to the potential responder, this was not possible because the investigator did not have individual names of the staff nurses. However, each letter was personalized by the signature of the investigator.

Biographical Questionnaire

The questionnaire (Appendix B) was designed to describe the study group and secure necessary information for analysis of study question three, "Is there a relationship between the level of skill performance reported by community health nurses and nurses' ages, educational backgrounds, national certification statuses, marital statuses, lengths of experience in nursing, lengths of experience in community health nursing practice, agency sizes or sizes of the population served?" The subjects were informed that both tools together could be completed in 45-60 minutes. The investigator's phone number and address were given to the subjects in the event that they had questions. A stamped envelope addressed to the investigator was also provided for returning the instruments.

Examples of Expert Community Health Nursing Practice

The instrument used to explore the nature of community health nurses' expert practice was titled, "Examples of Expert Community Health Nurses' Practice" (Appendix C). It was attached to three blank sheets of paper for the convenience of the responding nurses in describing examples. Subjects were asked to describe three situations in their nursing practice during the previous three years in which they considered their performance to be expert/excellent and which they also considered to be the essence of nursing and made them glad to be a nurse. While Case (1986), who patterned her research after Fox and Diamond (1964) as well as Jacobson (1976), used the term "incident" for the examples of stress which she was seeking, the term

"example" was used in this study. This term was chosen to avoid a negative connotation. The term was defined for the subjects as a complete narrative or summary including the conditions, events, personnel, and feelings involved in the example. "Expert clinical practice" was defined as events when the nurse had an intuitive, holistic grasp of the situation and zeroed in on the accurate region of the problem without wasteful consideration of multiple alternative solutions.

Subjects were told that an expert nurse may provide consultation to other nurses, but most importantly, he/she should be able to describe clinical situations in which committed/creative interventions made a difference in the outcome for a client, family, or group of clients. The nurses were also told that any aspect of their work situation, which included direct patient care, bureaucratic changes implemented, and influencing legislation, were suitable sources for examples. In accordance with Case (1986), Fox and Diamond (1964), and Jacobson (1976), an explanation of the difference between an example and a generalization was included in the directions. An example of a generalization , which would not be helpful to the study, was provided to aid validity by increasing the likelihood that the data collected would be the desired kind of data. In addition, possible examples of expert practice involving groups of clients were offered. Subjects were instructed not to identify participants by name in their examples. Confidentiality was assured. However, nurses were advised to provide their name and address if they wished to receive a copy of the abstract of the study when it was completed.

Reliability and Validity

The expectation of reliability was supported by basing the tool on the work of Case (1986), Fox and Diamond (1964), and Jacobson (1976). The method of requesting written narratives from practicing nurses, as reported by the above researchers, was known to have resulted in clear, comprehensive, qualitative descriptions of stresses experienced in clinical roles in hospital settings and also in the community health setting (Case, 1986). Therefore, it was assumed that, in a similar fashion, nurses would be clear and reliable when describing expert clinical nursing performance.

The instrument was pretested to establish validity. Pretest subjects were queried to assist in the identification of deficiencies in the instruments. A panel of three expert judges was used to review and classify the reported incidents into one of four categories: not an expert example, good example, better example, best example. This was a further aid in establishing content validity.

Reliability of the experts was initially planned as part of the study. Redistribution of ten percent of the randomly-selected examples to each of the three judges, after a period of two weeks, was intended to establish each rater's reliability in the way the examples were rated in a second review. However, due to a tragedy in the personal life of one of the judges, she became inaccessible for reliability testing, and this segment of the research was abandoned.

Data Collection

Ethical Safeguards

A written request for permission to conduct the research,

accompanied by a copy of the abstract, was sent to each of the three health department systems in the state where the study was conducted. Approval of the research as "exempt" by the Institutional Review Board of the state health department was received. The chief executive officer of each of the city-county health departments gave approval for their staff nurses to participate in the study.

Distribution of Instruments

Research instruments were personally distributed to the seventeen regional nursing supervisors of the state health department system at their regularly scheduled group meeting. In addition, a representative from each of the two city-county health departments was in attendance. An abstract of the study was provided prior to the meeting, and the research topic was listed on the agenda for the meeting. The researcher attended the meeting to describe the research. This provided the supervisors with an opportunity to question the investigator regarding the study and to request clarification of the procedure. Also, the opportunity was available to explain which nurses should be given research instruments and to enlist the help of the supervisors in distribution. Supervisors were asked for their assistance in gaining the cooperation of their staff. The supervisors then distributed the forms to all registered nurses providing direct patient care in their areas of the state. Research instruments were later provided to the two chiefs of nursing at the city-county health departments for distribution to the appropriate nurses in their systems.

Maximizing Return of the Instruments

After distribution of the instruments to the supervisors, six weeks were allowed for completion and return of the materials from the nurses in the county health departments. This time span was planned to allow three weeks for the supervisors to visit their counties and three weeks for the nurses to reply. Because the city-county health departments did not have a travel problem, less time was allowed for nurses in those systems to return their instruments.

Five weeks after the investigator's initial meeting with the state health department supervisors, a follow-up letter (Appendix D) was sent to the supervisors and the chiefs of nursing at the city-county health departments. The letter asked for assistance in urging the return of the research instruments. Also, an extension of the date for return of the instruments was given. Enclosed in the letter to the supervisors was a self-addressed, stamped postcard. It was requested that the postcard be returned to the investigator stating the number of nurses to whom instruments had been distributed. This was done in order to determine the rate of return of the instruments.

The Expert Panel

A panel of three expert judges was selected. The experts were chosen for their experience in community health nursing, nursing administration in community health nursing, and nursing education. All three held master's degrees. In addition, all were familiar with the context of nursing in the state.

Prior to submitting the examples to the expert panel, examples

submitted by each nurse were separated and mixed among the other examples. This was done to assure individual consideration of each example and to avoid potential bias on the part of the experts. The examples were then numbered, and identical copies were given to each of the three experts. Copies of the cover letter and research instruments which had been given to the subjects were also given to the experts in order to familiarize them with the specific request to which the nurses had responded.

In addition to providing copies of the materials sent to the subjects, a copy of the seven domains of nursing practice and the thirty-one competencies identified within the domains, according to Benner (1984), was provided for the experts. Also, after telephone consultation with Dr. Patricia Benner (June, 1987), three additional domains were identified which were anticipated in community health nursing practice. The three domains were:

VIII The Identification of Aggregate Needs and Actions Taken to Meet the Needs

IX Guarding the Community Against Communicable Disease by Tracing Carriers and Contacts

X Reintegrating the Isolated/Alienated Individual or Family into the Community

One further domain was suggested to the experts for use in classifying the examples. It was based on the research of Steele (1986, p. 115):

XI The Consultative Role

The experts were asked to identify within which of the Domains of Nursing Practice identified by Benner, or the additional four domains, the example fell.

The experts were also asked to rate each example. Four ratings were possible. The choices were good, better, and best example, or not an example of expert community health nursing. Ratings were then scored based on a weighted point system as follows:

Not expert example	0
Good expert example	1
Better expert example	2
Best expert example	3

Data Analysis

The following research questions were considered in analyzing the results of the research instruments:

I. Are the seven domains of nursing practice identified by Benner (1984) in the acute-care setting also identifiable from clinical practice examples reported by community health nurses?

II. Can self-reported incidents of expert nursing care be used to discern an expert level of community health nursing practice?

III. Is there a relationship between the level of skill performance reported by community health nurses and nurses' ages, educational backgrounds, national certification statuses, marital statuses, lengths of experience in nursing, lengths of experience in community health nursing practice, agency sizes, or sizes of the population served?

IV. How do the results of this study of nurses in the community setting compare with Benner's study which included the expert nurse in the hospital setting?

Three of the four research questions addressed in the study were

qualitative and did not lend themselves to statistical analyses. Analyses of data returned by the expert panel made it possible to respond to questions one and two. However, study question three required the application of statistical methods. The scoring system, as described, made it possible to develop a percentage score for each example. This was derived by adding the total number of points awarded by the three experts and dividing it by the maximum number of points possible. In each case the highest number of points possible was 9. This occurred when each expert rated a given example as "best" which resulted in a score of 3 X 3 = 9. The highest percentage score was 100%. The formula used and an example of the scoring system are as follows:

$$\frac{\text{Total number of points awarded}}{\text{Total number of points possible}} = \text{Percent of Perfect Score}$$

For example:

$$\frac{\text{8 points awarded}}{\text{9 points possible}} = 89\%$$

It was then decided by the investigator, in an arbitrary fashion, that only those examples receiving a score of greater than 60% would be accepted as expert examples of community health nursing. This required that an example had to receive a minimum of six points to be considered an expert example.

In order to determine a cumulative score for each nurse, the total number of points awarded for all examples provided by the same nurse was divided by the maximum possible points. Therefore, the maximum number of points for nurses who submitted three examples was 27. This score was acquired by a nurse who submitted three examples

which were all rated as "best" examples, or 3 (examples) X 9 (points for each example) = 27. The maximum number of points possible for a nurse who submitted two examples was 18. A nurse who submitted only one example was able to accumulate a maximum score of 9. By rating nurses with a cumulative score, each nurse's contribution was more equitably considered.

The formula used to determine a nurse's expertise score, and an example of the scoring system are as follows:

$$\frac{\text{Total number of points awarded for all examples submitted by one nurse}}{\text{Total number of points possible for the nurse}} = \text{Percent of perfect expert score}$$

For example:

$$\frac{\text{23 points awarded}}{\text{27 points possible (from 3 examples)}} = 85\%$$

Using the scoring system described above, it was decided by the investigator, also in an arbitrary fashion, that those nurses who received a score greater than 60% would be accepted as part of the expert group of nurses for the purpose of this study. To achieve this, a nurse submitting three examples had to acquire at least 17 of a possible 27 points. For a nurse submitting two examples, at least 11 points were required to be considered part of the expert group. A nurse submitting only one example was required to acquire at least six points to be assigned to the expert group.

The Fisher exact probability test, a nonparametric statistical technique described by Siegel (1956, p. 96-104), was selected for initial data analyses. It was appropriate because scores computed for

each nurse's level of expertise, in this study, permitted assignment of a dichotomous outcome, to either the expert or the non-expert group. The qualitative nature of the independent variables and the small sample sizes also were appropriate for this technique.

When it was not possible to collapse independent variables logically into two categories, chi-square analyses were performed (Gay, 1981, p. 325). All continuous independent variables utilized the t-test to compare means among expert and non-expert nursing groups (p. 319 and 327). Because the nature of the study was descriptive, statistical significance was accepted to be $p = 0.10$.

In order to evaluate the relative importance of the independent variables as predictors of nursing expertise, logistic regression analysis was performed. This method was described by Kahn (1983, p. 111). Importance was denoted as the absolute magnitude of the standardized coefficient (coefficient/standard error).

Summary

The methods described in this chapter afforded a description of the nursing practice of community health nurses. It also permitted a comparison of the domains of practice which had been identified in hospital nursing with those in community health nursing. Based on ratings of an expert panel, examples of nursing practice in the area of community health were grouped. One group of examples was accepted, for this study, as expert practice. The other group was accepted as not being expert practice. Also, two qualitative levels of community health nursing practice were accepted. One level of practice was considered expert, and the other was considered not expert, only for

the purpose of this study. In addition, some demographic characteristics of the nurses were examined for a relationship to the level of expert practice which the expert panel identified.

CHAPTER IV

ANALYSIS AND DISCUSSION

Introduction

This chapter contains an analysis of the data collected in the study as well as a discussion of the results. Following a review of the literature related to expertise in nursing, research instruments were distributed to 286 public health nurses in order to collect self-reported examples of expert community health nursing practice. Biographical data and personal examples were mailed by the subjects directly to the investigator. This method yielded a rich description of community health practice as reported by a group of nurses in one Midwestern state.

Examples were given to a panel of three experts who rated them for the quality of community health nursing practice exhibited. They also identified the domains of practice which they found to be evident. Ratings of each individual example were assigned weighted scores, and the scores of the examples submitted by each individual nurse were totaled. Scores of individuals were then examined in relation to the biographical data submitted.

Four research questions were posed in the study. Data collected to respond to three of the questions were of a qualitative nature and did not involve analysis utilizing statistical methods. One question,

testing biographical data for a relationship to the quality of community health nursing expertise, required statistical analyses.

Response Rate and Respondents

Research instruments were distributed by nursing supervisors and the chiefs of nursing in the two city-county health departments to 286 nurses. Responses were received from 65 nurses (23%). There were 13 (20%) nurses who submitted only biographical information. Four of the 13 reported that they had been employed as community health nurses only recently and did not have examples to contribute. The 9 nurses who returned biographical information without an explanation may not have read the written communication from the investigator. Cases in which data were missing may have been the result of having distributed the research instruments through the supervisors rather than directly to the potential subjects. However, it was the only method of distribution permissible by the agencies.

Of the 65 nurses who responded, 52 (80%) submitted examples for the study. This resulted in an effective response rate of 18%. A total of 128 self-reported examples of expert community health practice was submitted by the 52 nurses. There were 33 nurses who submitted three examples. Ten nurses submitted two examples, and nine nurses submitted only one example. One nurse did not submit biographical information with examples.

The respondents were categorized into expert and non-expert groups, as will be explained on pp. 73-4 below. Following this categorization, current educational levels of the 51 subjects, as indicated on the biographical instrument (Appendix B), were examined.

This is displayed in Table I.

TABLE I

EXPERTISE BY CURRENT LEVEL OF EDUCATION

Current Education	MS N (%)	MSN N (%)	BA/BS N (%)	BSN N (%)	Assoc. Degree	Diploma N (%)	Total N (%)
Expert Nurse	1 (2)	2 (4)	2 (4)	9 (18)	9 (18)	6 (12)	29 (57)
Non-Expert Nurse	0	0	2 (4)	10 (20)	4 (8)	6 (12)	22 (43)
Total	1 (2)	2 (4)	4 (8)	19 (37)	13 (26)	12 (24)	51 (100)

The diversity of the educational levels of the nurse/subjects was obvious. Twenty-five of them, or 49%, did not have a degree in higher education. Twenty-six percent had an associate degree education, and 24% were diploma-educated nurses. Yet the Chief of Nursing Service (Swink, 1987), speaking for the largest of the three health department systems, reported that 80% of the nurses employed in that system were educated at the associate degree or diploma level. Nevertheless, twenty-six (51%) of the subjects in the study had some type of degree. Three subjects had a master's degree, 2 in nursing and 1 in another area, four had a bachelors degree that was not in nursing, and 19 were educated with the bachelors degree in nursing.

The sample of nurses who submitted examples of expert community health nursing was not representative of the educational level of the

community health nurses employed in the Midwestern state where the research was conducted. This skewed sample resulted in a bias of the study. There were two potential explanations for the fact that a greater representation of the subjects was from those who were educated with degrees in higher education. One possibility was that nurses educated at the technical level may have felt that they were not experts and did not have examples of expertise to contribute. Another possibility was that the same, non-participating nurses, without degrees, may have had less interest in research and were less motivated to participate in research of any type. Nevertheless, the sample bias is acknowledged.

While recognizing the limitations imposed by the bias, a system of assigning points to examples was devised. It was based on the ratings given the examples by the three judges. Initially, the judges rated the examples from four possible choices which were: not an expert example, good example, better example, and best example of expert community health nursing. Then the investigator assigned 0 points to an example rated as "not expert," 1 point to an example rated as a "good example," 2 points to an example rated as a "better example," and 3 points to an example rated as a "best example" of community health nursing. Consequently, it was possible for an example to acquire a maximum of 9 possible points when all three judges agreed that the example was a best example of expert community health nursing. The point score was then reported as a percentage score. Total scores for the examples, using this weighted scoring system, ranged from 0% to 100%.

Percentage scores for the nurses were then derived by adding the

total number of points assigned to the examples submitted by one nurse and dividing this number by the total number of points possible for that nurse. The number of points possible was dependent upon the number of expert examples submitted by the nurse. Therefore, a nurse submitting three examples had the potential for receiving 27 points. Total scores for the nurse/subjects ranged from 0% to 100%.

The investigator made the arbitrary decision to accept examples as expert when they received a score higher than 60%. In the same fashion, a nurse who received a score higher than 60% was considered part of the expert group of nurses for the purpose of the study. These decisions, made with regard to the criteria for acceptance of expert examples and expert nurses, resulted in the following division of the sample:

Expert Examples	82
Non-Expert Examples	46
Total Examples	128
Expert Nurse Group	30
Non-Expert Group	22
Total Nurses	52

One nurse who submitted three examples failed to return biographical data. This subject was part of the expert group of nurses according to the criteria described.

Examination of Research Questions

Each of the four research questions was analyzed in the order in which it was posed. The following section identifies each question and reports the results of analyses of the data.

Domains of Nursing Practice in Community Health

Research Question I. Are the seven domains of nursing practice identified by Benner (1984) in the acute-care setting also identifiable from clinical practice examples reported by community health nurses?

Each of the three expert panelists was given a list of the seven domains of nursing practice identified by Benner (1984) in her research done with nurses employed in the hospital setting. In addition, the thirty-one competencies listed under the seven domains were provided for a clearer description of what Benner had included under each domain (see pages 35-7 for Benner's domains and competencies). The panelists were also given the three additional domains which were agreed upon by Benner and the investigator (June, 1987). An additional eleventh domain was suggested to the panelists from the research done by Steele (1986). The additional four domains were suggested to the judges because both Benner and the investigator agreed that community health nursing included domains beyond those identified in the institutional setting.

Panelists were asked to list the domains they were able to identify in each example. Because the investigator did not limit the number of domains that might be identified in an example, the range of domains identified for one example varied from one to seven. Frequent agreement occurred among the panelists regarding the domains identified. Often all three experts identified the same domain for an example. However, in some instances, additional domains were identified by one panelist which were not listed by the others.

In the analysis of the domains identified, no attempt was made to

determine whether the domains were assigned to expert examples or non-expert examples. Because the intent of this research was to describe the practice of community health nurses, it was determined that it was significant simply to ascertain whether all of Benner's (1984) domains were evident in the research sample. Table II lists the domains and the number of times each was identified in the 128 examples by the expert panelists.

TABLE II

DOMAINS IDENTIFIED IN EXAMPLES

Domain		Evident in Examples N
I	The Helping Role	146
II	The Teaching-Coaching Function	118
III	The Diagnostic and Monitoring Function	143
IV	Effective Management of Rapidly Changing Situations	71
V	Administering and Monitoring Therapeutic Interventions and Regimens	33
VI	Monitoring and Ensuring the Quality of Health Care Practices	48
VII	Organizational and Work-Role Competencies	18
VIII	The Identification of Aggregate Needs and Actions Taken to Meet the Needs	63
IX	Guarding the Community Against Communicable Disease by Tracing Carriers and Contacts	25
X	Reintegrating the Isolated/Alienated Individual or Family into the Community	13
XI	The Consultative Role	26

The result of analysis of domains of nursing practice clearly demonstrated that all seven domains identified by Benner (1984) among nurses employed in the institutional, acute-care setting were also identified among the community health nurses of this study sample. In addition, four other domains suggested to the judges were identified among the 128 examples of nursing practice in this study. It was evident that nurses in this study functioned most frequently in the

Helping Role, the Diagnostic and Monitoring Function, and the Teaching-Coaching Function.

It was noteworthy that the four additional domains suggested to the expert panelists, beyond the seven identified by Benner (1984), were all evident in the examples in this study. Benner (1987) and the experts, in their comments, confirmed that Domains VIII, IX, and X were important parts of public health nursing. Although Domains IX and X were identified least commonly, they were thought to be unique to public health.

Discriminating an Expert Level of Nursing Practice

Research Question II. Can self-reported incidents of expert nursing care be used to discern an expert level of community health nursing practice?

This qualitative question can only be answered based on the ratings of the expert panelists and by comparing their ratings. Of the 128 examples, there was complete agreement on only 12 of them. The judges agreed that 7 of the examples were best examples of expert community health nursing. They also agreed that one example was a good example, which was the weakest of the three possible ratings within the expert category. Furthermore, there was agreement by all three panelists that four examples were not expert. This level of complete agreement was approximately 9%. Table III displays the ratings of the examples by the expert panelists, the points assigned using the weighted scoring system, and designates which examples were accepted as expert examples according to the criteria for the study.

TABLE III

EXPERTS' RATING OF ALL EXAMPLES

Points Awarded	Number of Examples (N)	Percent of Perfect Score	Expert=+ Non-Expert=-
9	7	100	+
8	17	89	+
7	29	78	+
6	29	67	+
5	15	56	-
4	14	44	-
3	3	33	-
2	7	22	-
1	3	11	-
0	4	0	-
	128 Total N		
		82 Expert Examples	
		46 Non-Expert Examples	

After a determination was made regarding the points awarded to each example and regarding which examples would be accepted as "expert" in the study, the process of examining the total number of points accumulated by each nurse was calculated. Table IV displays the scores achieved by the nurses, the number of nurses achieving each score, and which scores placed nurses in the expert group and which were part of the non-expert group.

TABLE IV

SCORES OF EXPERT AND NON-EXPERT GROUPS

Number of Nurses (N)	Individual Points/ Points Possible	Score (%)	Expert = + Non-Expert = -
1	9/9	100	+
1	25/27	93	+
2	24/27, 24/27	89	+
2	23/27, 23/27	85	+
1	15/18	83	+
8	14/18, 14/18, 14/18, 14/18, 14/18, 14/18, 21/27, 7/9	78	+
4	20/27, 20/27, 20/27, 20/27	74	+
1	19/27	70	+
6	12/18, 12/18, 18/27, 18/27, 6/9, 6/9	67	+
4	17/27, 17/27, 17/27, 17/27	63	+
4	16/27, 16/27, 16/27, 16/27	59	-
4	15/27, 15/27, 15/27, 5/9	56	-
3	14/27, 14/27, 14/27	52	-
1	9/18	50	-
5	12/27, 12/27, 4/9, 4/9, 4/9	44	-
2	11/27, 11/27	41	-
1	8/27	30	-
1	1/9	11	-
1	0/18	0	-
52 Total Nurses		30 Expert Nurses 22 Non-Expert Nurses	

Due to the many differences among the raters, without communication among them, consensus was not possible. Therefore, an expert level of community health nursing practice was not clearly discriminated. A complete set of the examples accepted as "expert," according to the criteria of this study, along with the percentage

score assigned, and the domains of practice identified in the example may be found in Appendix E. In addition, selected "non-expert" examples may be found in Appendix F.

Potential Relationship Between Skill Level and Biographical Variables

Research Question III. Is there a relationship between the level of skill performance reported by community health nurses and nurses' ages, educational backgrounds, national certification statuses, marital statuses, lengths of experience in nursing, lengths of experience in community health nursing practice, agency sizes, or sizes of the population served?

Data from 51 nurses were available for analyses. One subject who submitted examples of expert practice failed to return biographical information. Concerning age of the subjects, the specific age of each nurse was not asked. Rather, a choice of age groups was suggested in order that the subject might indicate the one which represented that particular individual's age (Appendix B). Eight groupings were available. These were in five-year intervals, beginning with 21 through 25 and ending with the 56 and older age group. All age groups were represented among the subjects with the exception of the 21-25 age group which was not indicated by any subject. Table V reports the ages of the subjects.

TABLE V

AGES OF SUBJECTS

Age	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56+
Expert N=	0	6	4	7	5	3	3	1
Non- Expert N=	0	4	3	3	2	6	2	2
Total	0	10	7	10	7	9	5	3

For statistical analysis, the age groups were collapsed into four groups. This permitted each cell to be larger. Table VI displays the ages of subjects in four groups.

TABLE VI

EXPERTISE BY AGE GROUPS

Age in years	<31 N (%)	31-40 N (%)	41-50 N (%)	>50 N (%)	Total N (%)
Expert Nurse	6 (11.8)	11 (21.6)	8 (15.7)	4 (7.8)	29 (56.9)
Non-Expert Nurse	4 (7.8)	6 (11.8)	8 (15.7)	4 (7.8)	22 (43.1)
Total	10 (19.6)	17 (33.3)	16 (31.4)	8 (15.7)	51 (100)

Chi-square = 0.927, df = 3, p = 0.819

Analysis of the data according to the age of the subjects who were expert and those who were not expert was not significant at the 0.10 level. Although the age groups were reduced from eight to four, N was still less than 5 in 37% of the cells. Therefore, chi-square may not have been a valid test. A larger number of subjects in each cell may have indicated a relationship between age and expertise in community health nursing practice. It would seem likely that expertise accompanied by some degree of experience might be present with increased age. However, this study did not indicate that such a relationship existed.

The educational background of the 51 subjects was analyzed according to the type of basic nursing education program each had completed. There were subjects who had completed each of the three types of programs: 1) baccalaureate degree, 2) associate degree, and 3) diploma program. See Table VII below:

TABLE VII

SUBJECTS BY BASIC PROFESSIONAL PROGRAM

Professional Nursing Program	BSN N (%)	Associate Degree N (%)	Diploma N (%)	Total N (%)
Expert Nurse	11 (21)	10 (20)	8 (16)	29 (57)
Non-Expert Nurse	10 (20)	4 (8)	8 (16)	22 (43)
Total	21 (41)	14 (27)	16 (31)	51 (100)

All three programs prepare nurses to take the registered nurse licensure examination. More nurses had completed the baccalaureate degree than either of the other two types of programs. Because the numbers were small in each cell, the associate degree and diploma-educated nurses were grouped together for analysis. This was logical because graduates from those two programs did not have community health nursing courses as part of their curriculum, while graduates with the bachelor's degree in nursing did have such preparation. See Table VIII below:

TABLE VIII

EXPERTISE BY BASIC NURSING EDUCATION

Type of Basic Nursing Education	Bachelors in Nursing N (%)	Associate Degree or Diploma N (%)	Total N (%)
Expert Nurse	11 (21.6)	18 (35.3)	29 (56.9)
Non-Expert Nurse	10 (19.6)	12 (25.1)	22 (43.1)
Total	21 (42)	30 (58)	51 (100)

Chi-square = 0.292, df = 1, p = 1.589
Fisher's Exact Test (2-tail) = 0.774

The relationship between the nurse's basic nursing education and

the quality of the expert examples provided by that nurse was not significant at the 0.10 level. While the curricula of the programs were different, and while only the nurses completing the baccalaureate program had community health nursing courses as part of the educational process, there was no significant difference in the quality of expert examples provided by the nurses from the various programs in this study.

In addition to considering a relationship between expertise and the nurse's basic nursing education, additional earned college credits beyond the basic professional education was examined for a relationship. This information was collected for 50 subjects. There were 36 of the 50 nurses who had earned further college credits. See Table IX below:

TABLE IX

EXPERTISE BY ADDITIONAL COLLEGE CREDITS EARNED

Credits Beyond Basic Professional Education	No N (%)	Yes N (%)	Total N (%)
Expert Nurse	6 (12)	22 (44)	28 (56)
Non-Expert Nurse	8 (16)	14 (28)	22 (44)
Total	14 (28)	36(72)	50 (100)

Chi-square = 1.363, df = 1, p = 0.243
Fisher's Exact Test (2-tail) = 0.343

Testing the data revealed that there was no significant difference at the 0.10 level between the expert group of nurses and the non-expert group related to whether they had earned additional college credits beyond their basic professional education. Although not significant at the level accepted for this study, it was interesting to note that a considerably higher percentage of the expert nurses than the group of non-expert nurses had earned further college credits. Perhaps the expert nurses were more motivated to expand their knowledge and gain further education than were the non-expert nurses. Only with a larger sample of nurses could this relationship be tested adequately.

Another area of education was tested for a relationship with expertise. This area was that of earning a degree other than the initial professional education. In some cases the degree was the bachelor's degree, either in nursing or some other field, if the original nursing education had been the associate degree. In the case of the nurse whose basic professional education was the bachelor's degree, the additional degree may have been a master's degree either in nursing or in a related field. In the case of a subject earning a degree, motivation for expanded learning and achieving a goal, rather than merely earning credits, was probably demonstrated. This was anticipated to have a potential impact on expertise. Table X displays the data for this variable.

TABLE X

EXPERTISE BY HIGHER DEGREE

Higher Degree	Yes N (%)	No N (%)	Total N (%)
Expert Nurse	5 (9.8)	24 (47.1)	29 (56.9)
Non-Expert Nurse	2 (3.9)	20 (39.2)	22 (43.1)
Total	7 (13.7)	44 (86.3)	51 (100)

Chi-square = 0.702, df = 1, p = 0.402
Fisher's Exact test (2-tail) = 0.684

Statistical analysis indicated that there was no significant relationship between expertise and earning a higher degree, in this study. The Fisher's exact test (2-tail) yielded a level higher than the 0.10 level of significance determined for the study. However, the number of nurses who had earned a degree beyond the professional education was small. Only 7 nurses of the 51 in the sample had earned some type of degree following professional education. These numbers were too small to demonstrate a relationship. A further study with a larger sample may identify a significant relationship.

Another factor examined in relation to expertise was whether the nurses had earned certification. There were a variety of responses to the question concerning certification. One subject reported holding certification in cardio-pulmonary resuscitation. Another responded that certification as a registered emergency medical technician was held. Still another reported certification in the area of sexually transmitted diseases. For the purpose of this study, only those

nurses reporting that they held national certification as a nurse practitioner or as a certified community health nurse were considered to be certified. There were 20 subjects who reported holding certification of the type described. See Table XI below:

TABLE XI

EXPERTISE BY CERTIFICATION

National Certification	No N (%)	Yes N (%)	Total N (%)
Expert Nurse	17 (33.3)	12 (23.5)	29 (43.1)
Non-Expert Nurse	14 (27.5)	8 (15.7)	22 (56.9)
Total	31 (60.8)	20 (39.2)	51 (100)

Chi-square = 0.132, df = 1, p = 0.716
Fisher's Exact Test (2-tail) = 0.778

There was no significant difference at the 0.10 level between the group of expert nurses and the group of non-expert nurses regarding whether they held national certification as nurse practitioners or certified community health nurses. This was a rather surprising finding, because one would expect that nurses who had specialized in an area of practice would have expertise recognizable by the expert panel. Nevertheless, it was apparent that a larger proportion of the certified nurses were expert than was true for the non certified nurses.

Another variable examined for its relationship to expertise was

marital status. Although marital status was asked on the biographical instrument with a choice of possibilities offered (see Appendix B), because there was a preponderance of married nurses, the groups were collapsed into two categories. All nurses were grouped into either a married group or one called "other," which included nurses who were divorced, separated, widowed or never married. The results of this analysis are displayed in Table XII below:

TABLE XII

EXPERTISE BY MARITAL STATUS

Marital Status	Married N (%)	Other N(%)	Total N (%)
Expert Nurse	23 (46)	6 (12)	29 (58)
Non-Expert Nurse	16 (32)	5 (10)	21 (42)
Total	39 (78)	11 (22)	50 (100)

Chi-square = 0.069, df = 1, p = 0.793
Fisher's Exact Test (2-tail) = 1.000

The Fisher's exact test did not demonstrate a relationship at the 0.10 level between marital status of the nurses and whether they were in the expert group or the non-expert group. A larger sample would be necessary in order to test this concept.

A potential relationship between a number of additional variables and their relationship with the group of expert nurses and with the

group of non-expert nurses was then analyzed using a t-test for independent variables. This information is displayed in Table XIII below:

TABLE XIII

SUMMARY OF T-TEST COMPARISONS BETWEEN EXPERT AND NON-EXPERT NURSING GROUPS

Variable		Expert	Non-Expert
Years of RN Experience	Mean	14.1	13.6
	SD	9.20	10.39
	N	29	22
Years of PHN Experience	Mean	7.9	6.4
	SD	5.55	5.00
	N	29	21
Number of PHNs in Agency	Mean	7.4	8.4
	SD	5.65	8.50
	N	29	22
Population Served	Mean	98,380	122,893
	SD	187,027.4	178,634.5
	N	29	20
Population Served per PHN	Mean	12,056	9,434
	SD	11,139.4	8,450.2
	N	29	20

Application of the t-test to the case of whether years of experience as a registered nurse was significantly different between the expert group and the non-expert group revealed a value for t of - 0.1873, df = 49, p = 0. 8522. Therefore, the data from this study

suggested that there was no significant difference between the two groups with regard to the independent variable, years of experience as a registered nurse. Because the sample size was small, testing of this variable in a larger study may result in a significant difference.

When the t-test was applied to the independent variable, years experience as a public health nurse, the value for t was - 0.9844, df = 48, p = 0.3299. These data suggested that the years of experience spent as a public health were not significantly related to whether a nurse was part of the expert group of nurses or the non-expert group, in this study. With the small sample size of the study, this was the only conclusion which could be reached. However, a larger sample may show a significant relationship.

The independent variable, number of public health nurses who work in the agency, was examined for a potential relationship. It was anticipated that employment in a setting with a larger number of nurses would result in sharing, peer interaction, learning from one another, and consequently also result in a greater degree of expertise. Analysis of the data resulted in a value for t of 0.5422, df = 49, p = 0.5901. This suggested that there was no significant relationship between the number of nurses who worked in the agency and whether a nurse was part of the expert group of nurses or the non-expert group, in this study.

Still another variable examined for a relationship to expertise of community health nursing was the size of the population served. When the t-test was applied to the data, a value for t was -0.4632, df = 47, p = 0.6454. This suggested that the independent variable,

size of the population served, was not significantly related to whether a nurse was part of the expert group of nurses or the non-expert group.

The last variable examined was related to the population served per public health nurse (PHN). This figure for the expert and the non-expert groups was derived by dividing the population served by the number of PHNs. When the t-test was applied to these data, a value for t was - 0.8898, df = 47, p = 0.3781. This suggested that there was no relationship between expertise and the population served per PHN. A larger sample has the potential for yielding different results.

Analyses of all the additional variables suggested that, in the entire study, there were no significant differences between the expert group and the non-expert group for any of the independent variables. It was then decided to submit the data to the stepwise logistic regression procedure. Because the sample was small and none of the variables indicated a relationship with expertise, this method was indicated to demonstrate a logistic prediction of nurse expertise. Table XIV lists the variables in the order in which they were related to expertise in this study.

TABLE XIV

SUMMARY OF THE LOGISTIC MODEL PREDICTING PUBLIC HEALTH NURSING EXPERTISE

Parameter	Coefficient	Standard error	Coefficient Standard Error
PHN Nursing Experience	-112.06	1,054,000	-0.000106
RN Experience	22.785	249,100	0.000091
PHNs/Unit Population	0.010	11.29	0.000086
Marital Status	15.298	549,200	0.000028
Initial RN Education	-8.602	405,800	-0.000021
Age	-0.144	12,710	-0.000011
Higher Degree	-5.198	0.0	0.0
Certification	0.0	0.0	0.0
Constant	-5.836	0.0	0.0

Neither earning a higher degree beyond the basic professional nursing education nor earning certification was predictive of expertise, in this study. However, the six other variables suggested some degree of predictability. The predictability of each variable was not related to whether the coefficient standard error was a positive or a negative number. The strongest predictor of expertise was the number of years experience in public health nursing.

Comparing the Expert Nurse in Two Settings

Research Question IV. How do the results of this study of nurses in the community setting compare with Benner's study which included the expert nurse in the hospital setting?

This study differs in a variety of ways from the study of Benner (1984). Because the examples in this study were written anonymously, there was no opportunity to discuss the examples with the nurse. Benner had the opportunity to do this in her study, and the process of discussion clarified misunderstandings and enabled the researcher to identify the problem-solving process used by the nurse. Consequently, the results of Benner's study methodology was a richer description of expertise of nurses employed in the hospital setting than was possible in this study of expertise among community health nurses.

Another difference in the results of the two studies was that Benner's (1984) study was purely qualitative. She was able to identify five levels of practice which ranged from novice to expert. This was not possible in the present study. However, one of the results was a measure of the type of community health nursing activities, according to the domains identified by the expert panelists. Nevertheless, the sample was small and may have influenced the frequency of nursing activities in the various domains.

A further difference in the present study was that four additional domains of nursing practice were evident in community health nursing that were not evident in the practice of the nurses whom Benner studied. This result was significant because Domains VIII, IX, and X were thought to be unique to community health nursing. The examples of expert community health nursing, according to the

criteria established for this study, may be found in Appendix E.

Summary

This chapter has presented the findings of the current descriptive study. The research answered four questions related to community health nursing and the expertise of this area of nursing practice which has been studied relatively little. Research findings suggested that the critical elements of caring, commitment, and empowerment leading to action by expert nurses were evident in examples from both this study and the earlier study conducted by Benner (1984). Nevertheless, a greater degree of complexity was evident in public health nursing with a larger number of domains of practice evident. The final chapter will summarize the research findings, draw conclusions, and make recommendations emanating from this study.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary of the Study

The purposes of the study were: 1) to describe expert nursing as practiced by community health nurses; 2) to identify the domains of nursing practice evident in self-reported examples of expert community health nursing; 3) to attempt to discern an expert level of community health nursing practice; and 4) to examine potential relationships among the group of expert nurses, identified in this study, and specific biographical variables.

Nurses in three health department systems in one Midwestern state submitted written, personal examples of expert community health nursing practice. The examples were rated by a panel of three expert judges, and domains of practice were identified. Ratings were assigned from four possible choices. The possibilities along with the weighted points assigned by the investigator were as follows: not an expert example = 0, a good example = 1, better example = 2, or best example of expert practice = 3. When an example was considered a best expert example by all three judges, the highest possible score of nine, or 100%, was given to that example. Only those examples receiving a score above 60% were considered expert for the study.

A total of 128 examples were submitted by 52 nurses. There were 82 examples in the expert group according to the criteria of the

study.

The total number of points awarded the examples provided by one nurse were divided by the number of points possible for that nurse. This produced a percentage score for each of the subjects. Only those nurses who received a score above 60% were considered expert nurses for the study. There were 30 nurses in the expert group and 22 in the non-expert group. Biographical variables were examined for a relationship with the nurse's level of expertise.

The statistical treatment utilized with discrete data was the two-tailed Fisher exact probability test. The 0.10 level of confidence was selected as sufficient evidence to accept a relationship between expertise and any of the biographical variables. When data could not be reduced into two categories, chi-square analyses were performed. The t-test was used to compare means when data were in the form of continuous independent variables. In order to evaluate the relative importance of the independent variables as predictors of nursing expertise, the logistic regression analysis was performed.

Findings, Implications, and Conclusions

The results of the study and a discussion of the findings, implications, and conclusions are included here. Each research question was addressed individually.

Research Question I. Are the seven domains of nursing practice identified by Benner (1984) in the acute-care setting also identifiable from clinical practice examples reported by community health nurses?

Analysis of the domains identified by the expert panelists revealed that all of the seven domains identified by Benner were also identified in the 128 examples of community health nursing. Because it was intended merely to describe the practice of this area of nursing, all examples were considered in answering the question. Therefore, it was not important to differentiate whether the domains were identified in the expert or the non-expert group of examples. In addition to the seven domains which Benner identified, the expert panelists also identified four additional domains. This finding suggested the complexity of community health nursing. The finding and suggested conclusion were compatible with a quotation from the writings of Florence Nightingale (1867). Referring to the qualifications of the community health nurse, she wrote:

> On the whole, it would seem to require a higher class of women to be District Nurse than even to be Hospital Nurse. If the District Nurse is merely an ordinary sort of woman, she does not find enough to do, except in epidemic times, when she is overwhelmed. There is not enough to do in healthy times to occupy an inferior class of woman; but how much too much to do in teaching the poor cleanliness, care of children, how to obtain fresh air, how to prevent disease, etc., to occupy the higher sort of woman?

It was clear that nurses in this study functioned most frequently in the domains of the Helping Role, the Diagnostic and Monitoring Function, and the Teaching-Coaching Function. Although this finding implied that public health nursing activities are less frequent in the other domains, the small size of the study sample may have affected the frequency distribution. Nevertheless, the findings were compatible with a study of role implementation conducted by Gulino and LaMonica (1986, p. 87). They reported that by auditing client records representing home visits made by public health nurses, seventy-nine

percent of the nursing interventions were for health counseling and education. They also reported that the most frequent activities of public health nurses were client assessment. While the terms for nursing functions used by Gulino and LaMonica were different than those used in this study, they equated to the diagnostic and monitoring function and to the teaching and counseling functions described by Benner (1984). Although the study of Gulino and LaMonica represented only home visiting activities, which may not accurately represent all public health nursing activities, it was of interest in relation to the findings of this study. Frequency comparisons of types of nursing functions were not part of Benner's study. However, it appeared to be noteworthy in the present study.

While some domains were identified less frequently than others by the expert judges, the fact that eleven domains were identified, as compared with only seven domains in the acute-care setting, a greater degree of complexity of this nursing subspecialty was implied. Therefore, the conclusion was drawn that community health nursing requires a broader level of skills than is required for institutional nursing.

Research Question II. Can self-reported incidents of expert nursing care be used to discern an expert level of community health nursing practice?

The 128 examples of expert nursing submitted by the nurses represented a wide range of expertise, according to the judgment of the expert panelists. While a range of choices within the expert category was offered the raters, this method had both positive and negative effects on the results. It permitted less-stringent, forced

decision-making than would have been required if ratings had been only expert or non-expert. Thus, by assigning scores to each example based on weighted values for the various ratings given by the judges, the investigator was able to accept examples as expert when they were above the chosen level of 60%. This was probably wise due to the subjective nature of the ratings. However, the negative effect of the rating method was that the degree of complete agreement was diminished.

When evaluating the results of the study, the decision to not require complete agreement among the judges may have been wise for additional reasons. Because the criterion for acceptance of an example as expert was a score above 60%, this meant that an example being assigned 6 of a possible 9 points was accepted as an expert example, for this study. Thus, it was possible to accept examples as expert which one panelist rated as "not expert," while the other two panelists rated them "best" examples. This did, in fact, occur with 21 examples. These results were due, in part, to a difference in philosophy among the experts regarding the concept of community health nursing.

The decision to accept examples as expert when two judges agreed and the third judge rated the example at the opposite extreme appeared to be justified because the panelists represented the differences which exist within the nursing profession regarding the concept of community health nursing. Two of the experts appeared to prefer the concept that any nursing care provided outside the institutional setting was community health nursing, while the other expert held a more restrictive view regarding the substance of community health

nursing. Consequently, when two experts agreed that an example was a best expert example, it was accepted. The reality of the differences in philosophy between the expert panelists did not, therefore, exclude examples from the expert group.

While the expert panelists serving as judges for this research were different in their philosophy, with one holding the restrictive view of community health nursing, the results may have been very different had the judges been in philosophical agreement. It may have resulted in even more examples being accepted as expert even at the same level of 60% agreement. If the judges had been split in the other direction, with two of them holding the more restrictive view of community health nursing and one judge more accepting of what constitutes community health nursing, fewer examples may have been accepted as expert.

Based on the wide range of differences among the expert panelists and the manner in which they rated the examples, it was concluded that an absolute differentiation between expert and non-expert examples and between expert and non-expert groups of nurses, which was dependent upon the rating of the individual examples, was not possible in this study. Although a distinct differentiation was not achieved, many expert examples were generated which may be utilized in nursing education to characterize the activities of this area of practice. With a larger number of nurses, randomly selected among those with different professional educations providing examples, and a larger panel of judges, employing a Delphi technique, the potential exists for developing a clearer delineation of expertise in community health nursing.

While the study did not permit discrimination between expert nurses and non-expert nurses, the results have potential value for nurse educators as they attempt to describe, for the novice/student, the role of community health nurses. The study also has implications for curriculum development in nursing education. As Benner (1984, p. 41) pointed out, clinical judgments become more refined and astute over time. Knowledge is far too complicated to be presented in instructions and cautionary statements to the learner. Much of the clinical know-how can only be demonstrated as the particular situation arises.

Due to the role complexity of community health nursing and to the need for demonstrating the skill in situations as they arise, there were implications that a guided work experience might serve the purpose of strengthening clinical judgments of new community health nurses. Ackerman and Baisel (1975, p. 374) described such a program. It was a nine-month, work-study program initiated by the Boston Visiting Nurse Association. Realizing the need to bridge the gap from student to professional, an internship in community health nursing was developed. When evaluating the program, the authors recognized considerable benefit to the agency by nurturing professional confidence, expertise, and satisfaction. Consequently, the conclusion reached was that a preceptorship or internship in this area of nursing has the potential for increasing the amount of expert nursing practiced by community health nurses.

Research Question III. Is there a relationship between the level of skill performance reported by community health nurses and nurses' ages, educational backgrounds, national certification statuses,

marital statuses, lengths of experience in nursing, lengths of experience in community health nursing practice, agency sizes, or sizes of the population served?

Results of data analyses indicated no significant relationship between community health nursing expertise and any of the variables examined. It was expected that nurses who were educated at the baccalaureate level, who had the theory and clinical experience of community health nursing in the curriculum of their professional education, would demonstrate a greater level of expertise when compared with nurses whose education was at the associate degree or the diploma level. However, the quality of expert examples, as rated by the judges, was not significantly different between the two groups. Perhaps a larger random sample of nurses, representing the various levels of professional education, may indicate a significant relationship between expertise and this variable as well as some of the others.

When the data were submitted to the stepwise logistic regression procedure, the most predictive variable for expertise was the number of years experience as a public health nurse. This implied that a greater degree of the essential components for the development of expertise was acquired after graduation and during the employment period. It further implied that expertise developed through repeated opportunities to practice the skill rather than by means of educational preparation. The notion was compatible with a quotation from the work of Benner (1984) as she studied expertise among nurses in the hospital setting.

> Expertise is developed only when the clinician tests and refines theoretical and practical knowledge in actual

> clinical situations. Expertise develops through a process of comparing whole similar and dissimilar clinical situations with one another, so an expert has a deep background understanding of clinical situations based upon many past paradigm cases. Expertise is a hybrid of practical and theoretical knowledge (p. 294).

The second strongest variable predictive of expertise was the number of years experience as a registered nurse. This was not surprising because it may be assumed that many of the experiences from one practice setting may be transferred to another practice setting. Nevertheless, Nightingale (1867) recognized that a higher level of knowledge and qualifications was required for public health nursing than was necessary for hospital nursing.

The predictive value of the other variables was less strong. Two of the variables had no predictive value. Neither earning a higher degree beyond the basic professional nursing education nor earning certification was predictive of expertise, in this study. Results of the stepwise logistic regression were not conclusive, but merely suggestive. A larger study may provide more convincing results upon which to base conclusions.

Implications from the statistical analyses were that there is no significant relationship between any of the independent variables and expertise of community health nurses. However, due to the small sample size, the conclusion reached was that further study with a larger random sample is indicated before acceptance of these implications.

Research Question IV. How do the results of this study of nurses in the community setting compare with Benner's study which included the expert nurse in the hospital setting?

A number of different results emerged in this study when compared

with Benner's (1984) study. Due to the self-reporting of the examples, in writing, with no opportunity to question the nurse who submitted the example, as Benner (1984) had done, insufficient information was a frequent occurrence. The expert panelists wrote comments related to this along with their ratings. The result was a lack of clarity in some examples. Consequently, the quality of the examples was diminished somewhat, thereby limiting the descriptiveness of this type of nursing expertise. A further difference was the inability to delineate levels of practice from novice to expert in community health nursing practice in this study as Benner had done in her study of nurses in the hospital setting.

In the present study it was not possible to identify the problem-solving approach used when expertise was present. However, the manner in which expert community health nurses read the whole situation, without dependence on abstract principles, was evident in the examples collected in this study as it was in Benner's examples. In addition, expertise made a difference in patient outcome in both studies.

Benner's (1984) study was purely qualitative, and she made no attempt to identify the extent to which the nurses she studied functioned in each of the domains she had identified. In the present study, it was possible to quantify this element of the subjects' activities. This was valuable in that it demonstrated the areas where the nurses were concentrating efforts which they considered expert.

In a specific way the research of Benner (1984, p. 170-1) and the present study are extremely similar. In both studies the central role of committed, involved nurses who used the holistic approach was

evident. As Benner has stated, caring is underestimated and undervalued. However, caring motivates problem-solving and creativity and empowers the nurse. This is true, according to Benner, although the nurse exerts power from a position of low status in the hierarchy (p. 216). Examples of this caring, commitment, creativity and power were previously cited in the review of the literature. In the present study, numerous examples of the same elements of excellence may be seen in the group of expert examples which have been reproduced in Appendix E along with the percentage score of each example and the domains which were evident.

Another result of the present study, when compared to Benner's work, was that it demonstrated the complexity of the role of the community health nurse. This was evident because there were more domains in which the nurses functioned in this study than did the hospital nurses whom Benner studied. Most importantly, the expert examples generated provided the initial step in documenting expert clinical performance in community health nursing practice. This descriptive study implied that community health nursing expertise was an evolution of nursing expertise beyond that which is practiced in the institutional setting. The conclusion was drawn that there were differences between the two studies, but significant similarities were evident.

Recommendations

Based on the findings of this study, the following recommendations for further research and for nursing education are made:

Research

1. A naturalistic study of community health nursing should be done to accurately describe the scope of this area of practice.

2. In order to describe the expertise of community health nursing more accurately, examples from a larger sample of nurses should be rated, using a Delphi technique to insure that the different philosophies of community health nursing are represented in rating the examples.

3. A study which clearly delineates the levels of expert practice from novice to expert, similar to the study conducted by Benner (1984), including interviews of nurses which may identify the problem-solving process and the knowledge embedded in clinical practice should be done with community health nurses.

4. In light of the fact that, according to this study, levels of education and experience made no significant difference in community health nurses' concepts of expertise, further study needs to be done with a random sample representative of the three basic professional educational levels, as well as from those who have continued their education beyond the basic professional program, in order to determine variables which make a difference and whether specific curricula and/or experience modify perception of expertise and expert behaviors.

Nursing Education

1. Due to the complexity of community health nursing and the larger number of domains of practice exhibited by nurses in this

nursing subspecialty, a level of professional education which provides a greater degree of experiential learning is indicated for those practicing in this area.

2. Because community health nursing is more complex than some areas of practice and requires considerable autonomy, a period of internship should be considered as part of the educational preparation for those entering this area of practice.

3. Paradigm examples of community health nursing expertise should be used in teaching courses in community health nursing to increase the student's understanding of the scope of practice.

4. The concept of mentoring and developing mentoring relationships should be taught in nursing education to enable novices and advanced beginners in the profession to identify those from whom they may learn to become expert community health nurses themselves.

5. Nursing education and public health service providers should collaborate to revise baccalaureate nursing curricula in order to strengthen the theory and practicum experience of this component of professional education and provide a more consistent view of its philosophy to the student .

The purpose of this study was accomplished in that it described the expertise of community health nurses as it currently exists in one Midwestern state. It also emphasized the lack of clarity, within the nursing profession, regarding the philosophy of community health nursing and the complexity of interactional factors. It is anticipated that this study may stimulate further study of the skills of community health nurses which may not be quantifiable. However, such research has the potential for enabling educators to teach

community health nursing more successfully within nursing education programs. It is also anticipated that this descriptive study characterized expertise as holistic, committed caring which made a difference in the outcome for patients, families and communities, and that it may be helpful to those aspiring to become expert community health nurses.

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APPENDIXES

APPENDIX A

LETTER TO PARTICIPANTS

March 10, 1987

Community Health Nurses
County Health Departments
State of Oklahoma

I would like to invite you to join me in identifying the nature of expert clinical practice of community health nurses. Undoubtedly, there have been situations when you "grabbed the bull by the horns" and took decisive action. You felt satisfaction and pride in the nursing care provided. Your commitment made a difference.

Only the nurse at the "front line" can describe events of the type needed for this study. You are important to the results, and by sharing personal examples from your practice, a valid representation will be possible.

Participation is voluntary and involves the completion of the Nurses' Biographical Questionnaire and "Examples of Community Health Nurses' Expertise." It is estimated that both together will take 45-60 minutes to be completed.

Responses will be anonymous, because the forms are not numbered or marked in any way. No co-worker, supervisor, or administrator will know how you have responded.

Please participate by completing the questionnaire, writing up your three incidents, and returning both to me by April 20, 1987. I have enclosed a postpaid envelope for your convenience.

Thank you for your consideration of this research effort.

Sincerely yours,

Donna J. Eckhart
220 South Ridge Road
Stillwater, OK 74074
(405) 372-3163

APPENDIX B

BIOGRAPHICAL QUESTIONNAIRE

Nurses' Biographical Questionnaire

Your response to the personal information requested below is important to this study. It will be important to determine whether certain background characteristics are related to what community health nurses perceive as expert nursing practice. Answers are confidential. The information which you provide here will not be identified personally.

Directions: Please put a check mark on the appropriate line or fill in the blank if needed.

1. How long have you been employed as a registered nurse? _____ years and/or _____ months
2. How long have you worked in community health nursing? _____ years and/or _____ months

3. From what type of basic nursing program did you graduate?
   _____ (1) associate degree
   _____ (2) diploma
   _____ (3) baccalaureate (B.S.N.)

4. If you have earned certification, what type? _____

5. Have you earned college credits beyond your basic nursing program?
   ____ No ____ Yes ____ Number of credits

6. What is the highest degree you have earned? _____

7. What is your highest nursing degree? _____

8. What was your age at your last birthday?
   _____21-25 _____31-35 _____41-45 _____51-55
   _____26-30 _____36-40 _____46-50 _____56+

9. What is your marital status?
   _____ (1) single, never married
   _____ (2) currently married
   _____ (3) widowed
   _____ (4) divorced/separated

10. How many community health nurses (R.N.s only) work in your agency? _____

11. What is the approximate population of the region served by your agency? _____

Only complete if you would like a copy of the abstract with results of the completed study.

NAME _____
ADDRESS _____

APPENDIX C

INSTRUCTIONS TO SUBJECTS

Examples of Community Health Nurses' Expert Practice

This method of enquiry is designed to explore the nature of expert clinical practice of the community health nurse. Please respond by sharing some of the experiences which make you glad to be a nurse and which you consider to be the essence of nursing. In order to maintain anonymity, do not identify the agency for which you work, or refer to anyone by his or her real name in describing examples.

Please describe three situations in your nursing practice in which you considered your performance to be expert/excellent community health nursing. Each event should be a complete narrative as distinguished from a generalization. For example, "identifying and managing a client with a dangerously high blood pressure reading" is a generalization and will not contribute helpful information to this study. Your description of the situation should portray the conditions, events, personnel, and feelings involved. "Expert clinical practice' means events when the nurse had an intuitive, holistic grasp of the situation and zeroed in on the accurate region of the problem without wasteful consideration of multiple alternative solutions. An expert nurse may provide consultation to other nurses, but most importantly, he/she can describe clinical situations in which committed/creative interventions made a difference in the outcome for a client, family, or group of clients. Possible examples of expert practice which involve groups of clients may include influencing local rules or laws by mean of speaking to groups, writing letters, etc., on health issues. Any aspect of your work situation (direct patient care; bureaucratic changes implemented; and influencing legislation) is a suitable source for examples. Experiences described should have occurred during the past three years.

Thank you very much for your participation.

APPENDIX D

FOLLOW-UP LETTER TO SUPERVISORS

April 13, 1987

District Nursing Supervisors
Oklahoma State Department of Health

Dear :

Last month I requested that you distribute research tools to the nurses under your supervision. I appreciate your cooperation in the effort to identify the expertise of community health nurses. I feel confident that the information in the completed study will be of value to you.

Unfortunately, the response of staff has been disappointing. Perhaps my request for information has been put aside during this busy spring season. Regretfully, unless more examples are sent to me, the project will have to be abandoned. This would be unfortunate. Because I personally know of many examples of expert practice which truly made a difference in the outcome for a client, I would like to let others know by means of this research effort.

To date, only 13 examples have been mailed to me. Some of the information has documented remarkable commitment and enormous effort. I believe that you, as a nursing manager, can take pride in the nursing care being delivered.

I would like to ask you to please remind and urge your nurses to write up their examples and mail them to me. Also, please inform them that I have extended the deadline to April 27, 1987.

A self-addressed, stamped postcard is enclosed. It is provided for the purpose of stating the number of tools you distributed. Because the number of forms given to you may not have been entirely accurate, the returned postcard will enable me to determine the rate of return.

Thank you so much for your assistance and also for your previous efforts.

Sincerely,

Donna Eckhart
220 South Ridge Road
Stillwater, OK 74074
(405) 372-3163

APPENDIX E

EXAMPLES OF EXPERT COMMUNITY HEALTH NURSING

APPENDIX E

EXAMPLES OF EXPERT COMMUNITY HEALTH NURSING SCORING 100%

DEVELOPING A COUNTY HEALTH DEPARTMENT, 100%
DOMAIN VIII.

A neighboring county does not have a county health department. Our county clients had to wait a long time for appointments because we were booked with "out of county" folks. I first had the clerks keep a record of all out of county clients and what clinic they had attended so we could see the volume of out of county clients. I gave these stats to my administrator who presented them to the county commissioners of the "other county." After many meetings and much work on his part, they agreed to fund a satellite clinic in their county. I am now a member of the task force trying to get a bond issue passed for a full service health department in this county. With a lot of luck and a lot of work still ahead, maybe we can get a health department! This has been a sometimes frustrating and sometimes rewarding experience! I dislike dealing with the bureaucracy of upper middle class commissioners who have no understanding of the plight of the lower class and their lack of ability to get health care! It's a good feeling, now that the ball is rolling, to see some of the people respond to this problem. We have all kinds of people from all different backgrounds working together to get health care for their county.

MEDICATING A NON-COMPLIANT TB PATIENT, 100%
DOMAINS I, II, III, V.

Trying to get medication to, and then swallowed by a new T. B. patient was a challenge. He was past middle age, American Indian, and also stayed drunk most of the time. It was not possible to find him every day to give his medication as he might go home or he might not. He received a Social Security check, and his case worker had arrangements made for him to eat one meal each day at a boarding house. He did come in daily, at some time, to eat. I made arrangements for the owner of the boarding house to give his medicine daily. I had it put up in daily doses to be given. This worked, and I was able to keep him on treatment until it was completed.

IDENTIFICATION OF A SEIZURE DISORDER, 100%
DOMAINS I, II, III, IV, VI, VII, VIII.

A 6 year old client and his parents presented in my clinic discouraged with the response they were receiving from local physicians concerning a behavior problem of their child. They were being told nothing was wrong. On interview, it was reported that the child was not passing at school, and the parents and teachers were

unsure of the problem. The child had a positive history of emotional abuse, and in the past 3 years, since moving in with his father and stepmother, they had noted the child to be quieter than other children his age and to exhibit episodes of loss of memory. Teachers at school reported that the child was unable to follow instructions, often needing the teacher to repeat the directions 4-5 times.

I worked with the parents in developing a plan of care that led to having the child evaluated through the Well Child and Guidance clinics in the health department. I coordinated the scheduling and follow-through of the appointments for a complete physical exam, developmental screening, and audiology evaluation. Upon completion, each professional wrote up their reports. My final assessment, based on all the findings, was that the child had a seizure disorder with thought processing defect. We (myself, the child development specialist, and the audiologist) met with the parents presenting our findings and initiated further follow-up with the Child Study Center. I again coordinated the scheduling and follow-up of this appointment. Child Study supported our findings and placed the child on Tegretol. Now, it is 2 years later. The child, who when I first saw him sat in his chair with a vacant look, now greets me quickly when I see him in clinic for well child care. And, as for school, he is an A and B student.

ASSESSING A CONGENITAL HEART DEFECT, 100%
DOMAINS I, II, III, IV, VI.

I recently saw an infant for a routine, 2-month, well- baby check-up. This particular infant had been seen 1 week previously by a private physician for cold symptoms. I discovered the infant had clubbing of the fingernails, a significant systolic (Grade III/VI) heart murmur, and weight gain of only 1 pound during the past month. The mother listed the health department (not the private physician) as the primary source of health care, when completing initial forms, stating that she only went to the doctor because she couldn't get an appointment to be seen here.

I felt the infant needed a cardiologist's care ASAP, so I made an appointment for Children's Hospital Cardiology Clinic. The infant was seen 1 week later. The diagnosis was ventricular septal defect.

TEACHING MENTALLY RETARDED PARENTS, 100%
DOMAINS I, II, III, IV, VI.

One of my experiences involved a couple who were not married, but lived together. They initially came in for venereal disease clinic. They were very limited mentally as well as financially. They had to depend on his family for most everything, and she resented this very much.

Initially this woman had an intrauterine device as a means of birth control, but she talked some doctor into removing it. Therefore, she became pregnant, was certified for WIC, and our challenge started. She had heart problems, but did well during pregnancy.

Home visits were made as well as the couple coming into the office for WIC, family planning, and immunizations for the baby. On one home visit, the parents were not sure they were mixing the formula correctly. They asked what they would do if the baby became sick,

choked or had pain. I felt like at that visit I taught many parenting skills plus nutrition and emergency care.

I developed a good rapport with the family. They lived in the country several miles from town and could not always make their appointments. They knew where to go for help (health department) when problems or questions arose. Teaching was not limited to the one visit. I've spent several hours with this family both at the clinic and in their home.

I felt good that the parents were willing to open up and share with me their lack of knowledge. This permitted them to accept the teaching. Other disciplines involved were the child development specialist, nurse practitioner, and the nutritionist.

CONTROLLING AN EPIDEMIC, 100%
DOMAIN IX.

In the spring of last year, a family planning patient told another public health nurse about a friend at the college who had measles. After the second patient reported the same thing, we contacted the Immunization Division and contacted the "measles case." Through this effort and the measles outbreak control, a mass clinic, and a lot of investigation, 2 cases of measles were identified on a rodeo team. We were able to institute measles controls in all contact areas where the teams had been and were able to immunize a lot of people who were at risk for the disease. This was made possible through several counties working together. All the staff members worked together at home and also on the front lines. The Immunization Division gave me direction as to which way to go next.

CONTROLLING AN EPIDEMIC, 100%
DOMAINS I, IV, VIII, IX.

In April of 1986, after being trained only a few months in communicable disease nursing, I received a call from the Oklahoma State Department of Health informing me that our local college rodeo club had been exposed to rubeola. To complicate matters, our rodeo club's collegiate rodeo was scheduled in two weeks. I notified all physician's and hospital infection control people to increase their awareness of rash illnesses.

All highly suspicious cases were referred to our health department for measles serological testing. A time line was obtained from these cases to identify contacts. After serological confirmation and/or exposure to a confirmed case, the surveillance system was increased notifying all physicians, hospital emergency rooms, the college, schools, and day cares in the area along with all sheltered workshops and treatment centers. Contacts were notified of exposure and advised to check their immunization history and age. Those who didn't find this information or who were not appropriately covered, were encouraged to receive vaccine. I set up a clinic in the evening on the campus during the rodeo club meeting and vaccinated all members that had not previously been vaccinated or had no documentation of vaccination. Most were cooperative and those who hesitated were convinced by peer pressure. We also devised a letter to be given to all students on campus alerting them to suspected and confirmed measles cases on campus, symptoms of disease, and encouraging them to review their immunization status. The letter also informed them of

free immunization clinics to be held on campus.

I organized and set up clinics and approximately 250 students were screened and immunized. We had five cases of rubeola during this epidemic, but I feel the number would have been much higher if I had not been trained in communicable disease, had not given it top priority, and spent those extra hours during the acute phase.

EXAMPLES OF EXPERT COMMUNITY HEALTH NURSING SCORING 89%

DEVELOPMENT OF A PATIENT INFORMATION SHEET FOR BREASTFEEDING MOTHERS AND A SUPPORT SYSTEM AFTER DISCHARGE, 89%
DOMAINS II, VIII, XI.

For several months the nutritionist and I discussed the misinformation our new breastfeeding mothers were armed with prior to and upon discharge from hospitalization. By the time they came in for their WIC postpartum appointments, they were already having difficulty with breastfeeding or had begun supplementation at the encouragement of their less than supportive pediatrician. It became apparent that we must reach these mothers while still in the hospital if we were to impact their breastfeeding experience. We also felt we had to reach the nurses who were passing on some of this misinformation.

In order to get the cooperation of the staff, we chose to first contact the head nurse of labor and delivery. She seemed receptive to our idea for an information sheet.

The nutritionist and I then set out to find the most comprehensive material we could use to develop our information sheet. After much review of material, we adapted a pamphlet to be given to the new breastfeeding patient. We included both our names as well as one other PHN who was as committed to the success of breastfeeding mothers. I have received very encouraging feedback regarding our efforts and have found great reward in assisting these young parents.

CURRICULUM DEVELOPMENT: AN INTER-AGENCY TEEN BABY-SITTING CLASS INVOLVING THE LOCAL HEALTH DEPARTMENT, POLICE, FIRE DEPARTMENT, AND EXCHANGE GROUP, 89%
DOMAINS VIII, XI.

For years the health department had been involved in presenting baby-sitting classes to interested teens within the community. As incidents of child abuse become more publicized, parents were seeking assurance regarding the safety of their children. With this in mind, the local exchange group and I met several times to develop a 6 week course for teens which was expanded to include more safety information as well as growth and development information, crafts, etc.

We also saw a need within our community to increase the involvement of the police department with local teens and hopefully enhance communication between them.

Major changes were implemented in this first inter-agency effort:

1. Classes were held at the police department
2. Police and fire department personnel were given more class time
3. Situations and crisis role-playing were used to raise awareness
4. A new public information file was created at the police department with the name, address etc. of the graduated participants.

Parents were able to identify themselves to the police and obtain sitter information prior to hiring them. The students were also given an identification card, signed by the police chief, with their picture on it.

Extra press coverage was given this new concept in baby-sitting

classes and it was so well received we had to limit the number of participants in future classes.

Our expectations for this class were exceeded. We gave talks at local clubs, and I was able to raise public awareness regarding this and other health department programs.

The curriculum is now being used in the local Vocational Technical School and other baby-sitting classes held within our community.

A FAMILY IN CRISIS, 89%
DOMAINS I, II, III, IV, VI, VII, X.

I first met Tammy on a hot afternoon in mid-summer. This was my last home visit of the day, and I was glad. It had been a long afternoon, and I anticipated a brief visit with a young mother of three referred to me by an Indian hospital after the birth of her third child.

As I approached the residence, I saw an old farm house with a small wading pool and an old swing in the front yard. A large, scruffy dog met me at the car, and I decided to announce my arrival with my horn. Soon an attractive young woman with a big smile and a fat baby in her arms came out to greet me. I introduced myself to her and she invited me in. She had two small sons, whom she introduced as Jay and Brian, sitting in the middle of the living room floor. The baby, Chad, was nursing vigorously at the breast. I asked the usual questions regarding her health, birth control etc. She talked almost non-stop once the strain of new introductions wore off. I became aware of how desperate she was for a "friendly ear." I just let her talk on until I felt I had to leave. She followed me all the way to the car hardly stopping her constant flow of conversation long enough to draw a breath. I promised to return the following week.

On the next visit, I found the young mother out in the yard, her head under the hood of an old truck. She had been crying. As I questioned her, I learned that her husband, Bob, had removed the battery from the car in order to keep her from leaving. They had had a very difficult marriage. She was 16 when she became pregnant with her first child. Abused by her stepfather since age 13, she ran away over and over until a school counselor had forced her to confide her reasons for running. Once revealed, her mother blamed her. The mother & father received help but Tammy bitterly recounted, "No one helped me." Finally, she became pregnant by a man who refused to marry her once he learned she was frequently used by her stepfather. Tammy's husband, Bob, married her at age 18 and became father and husband. Two years later they had another son and now a third. Bob was displeased with another pregnancy but accepted their "fate." He was from a very hard background and felt he had to keep a "tight rein" on Tammy. Prior to her first pregnancy, Tammy confided she did "15 hits of speed a day." She said once she found she was pregnant, she stopped because she didn't want to hurt the baby. She was a loving mother, but I saw in her the "quick fuse" personality when the children stressed her.

As Tammy and I developed a more trusting relationship, I suggested counseling. She said Bob would not consider this. I suggested maybe a visit by our social worker in her home would be less threatening. She agreed and our MSW made several visits to the home.

Several months later, Bob and Tammy bought 10 acres of land 6 miles farther out in the country. Bob tolerated my visits, and I felt a need to keep close ties with Tammy. He kept her isolated from most people and did not allow her to have a phone. For 1 year they lived in a camping trailer on their 10 acres of land. Tammy cooked on a bárrel. I helped her vent and devise a cooking surface. When I visited, I checked the children, helped her haul water from a nearby well across the highway, and just listened.

Most of all, Tammy needed to be heard and understood. She needed to feel accepted as she was. She was terrified she would be turned into welfare because they had no running water. Though they had no running water, the children were always clean. They bathed in a nearby pond in the warm weather. At other times Tammy hauled water in a small wagon across the highway and heated it in a coffee maker. They devised an outdoor "john" which I felt was acceptable as a temporary solution. Bob came to accept me as no threat to them, and Tammy said I was the only person he liked among her few friends.

Each time I visited I tried to bring clothes for the boys or food which sometimes found its way into my car in unmarked sacks prior to my visits. Bob worked hard in construction but work was scarce during the winter. Once I arrived to find Tammy and the boys huddled together around a space heater with noxious fumes filling the small trailer. I told her this was dangerous and that the trailer was not vented for that type of heating. They finally got propane heat and the winter was mercifully mild.

Tammy once confided she felt uncomfortable about bathing the boys once they were 4 or 5 years old. When I questioned her about why she felt this way, she said "because I heard abused children grow up and abuse their kids." I talked at length with her regarding this and many related subjects through months to come.

I used to drive along the highway on my way to another town and see Tammy and the boys walking along the road picking up cans to sell for "fun money." She was always very resourceful.

I helped Tammy get a tubal ligation through Indian Health Service. She (and I) feared another unwanted pregnancy.

Transportation was always a problem. They only had one car. This was another excuse to keep Tammy isolated. Bob loved Tammy, and she loved him, but their rather stormy relationship always left me puzzled and uncomfortable. Tammy once told me that Bob said if she left him he would go to the judge and tell him about her stepfather and her past drug history. This, he told her, would ensure that he would get custody of the children. Though I suggested marriage counseling to them, it was flatly rejected.

Perhaps the most dramatic recollection I have regarding their many crises was the time I was returning home from work one evening. It was dusk, and I pulled into the service station off the highway. As I pulled to a stop, I saw Bob fly out of his truck carrying all three boys. He ran to my car, tossed all three boys in and shouted "Tammy's been in a bad wreck. Could you take the boys?" Three days later he came back for them. She had been life-flighted to another city with head trauma. A car pulling a flat-bed trailer had lost one of the trailer wheels. It bounced through the windshield and she lost control of the car. She had a rather mild injury considering what might have been. I checked on her frequently following her hospital

discharge. She and Bob were unable to locate the driver of the car and they were sued for her medical expenses.

They seem to always live from crisis to crisis. At present, they do live in a much larger trailer with all the comforts we take for granted. One day, I hope Tammy writes a book. Her experiences are so very unique. She has told me over and over how grateful she is for my visits and for my help.

ADDRESSING ADOLESCENT NEEDS, 89%
DOMAINS II, VIII, XI.

Parents and educators in my area tend to "look the other way" and deny that we have a problem with teen pregnancy. One high school principal even stated, "I know we've had 3 or 4 high school girls get pregnant but, they've all had abortions or gotten married, so that doesn't count!" Because this issue concerned me greatly, I went first to the newspaper. I wrote a series of 6 articles on teen sexuality and pregnancy. The letters to the editor were quite interesting for the next few months! --- (many pros and cons!). I had many parents and teenagers contact me. Our number of adolescents in family planning clinics increased, many with parents "in tow." The parents at one high school organized a task force, and along with the superintendent, teachers, and "experts" from the health field have planned a one week "life skills" seminar covering sexuality, drugs, self esteem, date rape, decision-making, etc. It has been a lot of work putting this program together for them, but I have really seen the "fruits of my labor."

INITIATING PRENATAL/PREPARED CHILDBIRTH CLASSES, 89%
DOMAINS I, II, VI, VIII, X.

Although there are many prenatal classes given in this county, they all cost $25-$35. Health department clients are unable to pay these fees , so the "people who need the service the most" were unable to attend. Many health department clients are adolescents and primigravidas. They lacked knowledge of their bodies, child care, bonding, nutrition, etc. We (I) now give prenatal classes every other month. 2 sessions of 2 hours each are given. The client can come alone or bring a coach. We go over general information about pregnancy, anatomy and physiology, labor and delivery, nutrition, child care, breathing, relaxation techniques, and show a film on normal delivery. Our patients feel closer to each other, and many have developed friendships with others in the class. It gives them a chance to ask questions and gives them a feeling of group support! Many times during class someone will say, "I thought I was the only one who had that problem, or felt that way." One of the local physicians who delivers many of our patients told me recently that he has seen a tremendous difference in the attitude of our patients in labor and delivery. He said that there was less "screaming" in labor and delivery and a more "confident" feeling in our patients. He asked if he could refer his patients to my class! This is working well, and he is now more cooperative with the health department. I have gone all through their pregnancy with them and feel closer to them. They also tend to be more open and "tell it like it is ." Another county health department has also started prenatal classes using my outline.

HOME CARE FOR A TUBERCULOSIS PATIENT, 89%
DOMAINS I, II, III, IV, V, VI, VII, X.

A 74 year old male with TB and pneumonia was started on oral TB medications and Streptomycin injections. He lived 20 miles from town. Home visits were made religiously to give daily injections 5 days per week for 2 weeks, then 3 times per week for awhile, then weekly for a year. The patient's condition improved so much over the year that he now goes anywhere he wants. I believe his recovery was the result of meticulous follow-up, as he could never have gotten adequate treatment if home visits were not made.

AN INFANT WITH RAPIDLY INCREASING HEAD MEASUREMENT, 89%
DOMAINS I, III, IV, VI.

A small infant was being certified for the WIC program. The infant's head seemed unusually large for her body size. She also had "sunset eyes." The client was referred to a private physician. She then returned to the clinic a month later for WIC voucher pick-up. The infant's head size was growing too fast compared to the body size. The infant was referred back to the private physician with a copy of the head-growth graph. The mother returned stating that the infant was sent to the hospital and had a shunt placed. Mom also stated that the infant had been born with a "cyst" in her brain.

SEXUALLY TRANSMITTED DISEASE FOLLOW-UP, 89%
DOMAINS I, II, III, V, VI, IX.

A regular health department client came in and asked to see the "VD" nurse. I recognized Mr. A. as a WIC client. He had received a call from a woman he had sex with. She told him that she had gonorrhea. After examining Mr. A., I confirmed that he did indeed have symptoms of Gonorrhea. I treated him according to protocol. Also, I interviewed him regarding contacts, and he named his wife who was pregnant with twins. After I explained the possible consequences to the babies he agreed to inform his wife of her need for treatment, although he expressed fear to do so.

Mr. A. returned for his "test of cure" and stated he had informed his wife and she was "on the same medicine as me." He was on Tetracycline, which is contraindicated during pregnancy. I tried to determine who his wife's obstetrician was, but he did not know or would not say. The family did not have a telephone. However, I remembered seeing the A's in the Guidance waiting area recently. After checking with the Guidance secretary, I found that Mrs. A. was scheduled for counseling in 3 days.

On the day of the counseling appointment, I waited until after the counseling session, and I advised Mrs. A. that she had been named as a contact to Gonorrhea. She did not know this fact and had not been treated. I gave information regarding how the disease is transmitted and asked how many sex partners she'd had in the past 60 days. She replied, "Only my husband." I did treat her, advised that she send all her partners in for treatment, and Mr. A. presented the next day. He was retreated (had resumed sex with his wife prior to her treatment) and strongly advised them to abstain until both had taken all their medications. He was not angry or upset at my intervention.

FOLLOW-UP FOR A PAP TEST ABNORMALITY, 89%
DOMAINS I, II, III, VI.

No other nursing professional, in my opinion, has the option to go that last mile as public health nurses do. In this story, one patient was helped because I continually let the patient know that I cared about what happened to her. She had moderate-severe dysplasia on a pap smear. Our agency does follow-up for dysplasia to be sure the patient realizes the risk involved as to the potential for developing cancer. This patient had been given several appointments to our Dysplasia Clinic which she had not kept. She had no telephone listed on her record, and the contact phone number she had given was disconnected. A home visit was the only way it seemed possible to locate her. My first visit to her home was discouraging as she wasn't at home. On the second home visit, although she wasn't at home, her neighbor told me that she had started working. I was able to find her at work. She gave me one or two reason's why she hadn't kept her appointments, but when she realized I was interested in her and had gone to the trouble to locate her, she realized this was a serious matter. The next appointment to clinic she kept, and biopsies done showed probable carcinoma in situ. The patient subsequently underwent surgery and a hysterectomy was performed. In "blowing my own horn," I probably saved her life.

A CHAOTIC FAMILY, 89%
DOMAINS I, II, III, IV, IX.

The client was a 30 year old mother who had two children out-of-wedlock and a newborn infant. They older children were 8 and 10 years old. The 10 year old had a history of seizures, and the mother had quit his medication without physician consultation. The newborn had hypothyroidism and was placed on Synthroid daily. The reason for referral to the PHN was that the physician was concerned that the mother would discontinue the infant's medication, which was essential, as she had done with the older child.

Home visits were made and the home was assessed to be unstable with an unstable marriage, husband using drugs and alcohol, transportation undependable, and I was not sure that the infant's follow-up appointments for care would be kept. Weekly home visits were made to make ongoing assessment of the home and the infant. During a 3-week period, the infant gained 0-2 ounces per week. Mother stated, "Dr. said when he gets worried about the weight he will let the nurse know." I took formula to the baby on each visit, but there was no improvement. I sent the clinic Dr. written information about the infant's lack of weight gain, home assessment, and apparent failure-to-thrive. It took the clinic 2 months to decide that the child was failure-to-thrive.

During the home visits, I discovered that the "father" in the home had sexually molested the 8 year old. He is now in jail, and Child Welfare is involved with the family. I notified CPU of Child Welfare's involvement and of the failure-to-thrive status of the infant.

Mother is now beginning to cooperate with the public health nurse. She has been getting the infant in for clinic visits and therapy and continuing the medications. She has the 8 year old in sexual abuse therapy and has scheduled the child with the history of

seizures for a complete medical exam.

A CHILD WITH TUBERCULOSIS, 89%
DOMAINS I, II, III, V, IX, XI.

I had a TB client, age 11. The health department had been attempting to see that this client was treated since 1978. In 1983, I took over the responsibility as TB nurse. At that time, the child was still being managed. Due to non-compliance of the mother and the child, it had been extremely difficult to get the child into the health department in the past. In 1984, I devised a plan with the child's school teacher and principal to assure that the child was at least taking his medication five times a day. I would then go to the school monthly to monitor the child and refill the medication. I also devised a back-up system in case the teacher was gone to assure that the client continued getting his medication. I utilized the school counselor for this. With the help of the school and the nurse, the child was able to complete his treatment. This may seem like nothing to someone on the outside, but you have to understand that the nursing staff was very apathetic to helping this child complete his TB meds due to the fact that they had past difficulty in getting this child to the health department for medication refills. One other thing--an authorization for surrogate was signed by the mother to authorize the health department to take the TB meds to the school and to allow the teacher/counselor to issue the TB medications.

INITIATING HEALTH EDUCATION IN THE SCHOOL, 89%
DOMAINS II, VIII, XI.

I have been a public health nurse for almost ten years now and have tried yearly to get a teen educational program in our school system. A letter was sent to every school in our county informing them of this educational opportunity during a specific month (so I could order films and schedule clinic around). The program consisted of any or all of the following information: AIDS, venereal disease, adolescent sexuality development, decision-making, teen pregnancy, and methods of contraception with emphasis on "Saying No." In years past, I sent the letters to counselors and principals. This year I sent the letter to the superintendents with a pre-empt statement regarding Oklahoma ranking 4th in the nation for teen pregnancy and one in eight Oklahoma girls give birth before their nineteenth birthday. Also, I stated that Oklahoma now has 101 confirmed cases of AIDS with an estimated 50 carriers per diagnosed case. My day was made when I got a call from our junior high wanting an assembly on the above topics! We scheduled it and presented the program, and now they want us to do the 7th grade twice a year! We are elated and are developing our curriculum for this request.

ASSESSMENT OF A MALIGNANT BREAST TUMOR, 89%
DOMAINS II, III, VI.

During an examination at a chronic disease screening in an outlying clinic in a small community about thirty miles from the health department, a suspicious lump was found in a seventy year old female's breast. When I stressed the importance of seeing a physician very soon, she requested that I contact a particular surgeon for her.

I called the office and was able to get an appointment for her in a few days. She did have a mastectomy soon after for a malignant tumor which had not metastasized.

Since that time, the client encourages the people of the community to come to the clinic and especially encourages the breast examination. She helps in the clinic as a volunteer and tells everyone that the nurse found the lump early enough and saved her life.

EARLY IDENTIFICATION OF BOTH A CHRONIC AND ACUTE HEALTH PROBLEM IN THE SAME CLIENT, 89%
DOMAINS I, III, V, VI.

A woman in a small community had not been in to the chronic disease screening clinic for quite awhile as she was caring for her husband who had cancer. After his death, she came to the clinic. On screening, she was found to have a low hematocrit and an elevated blood sugar.

I encouraged her to see her doctor very soon, stressing the importance of it and telling her it was time for her to take care of herself. She did see her physician, tests were done, and she was found to be bleeding from a tumor of the colon. She was also diagnosed as having adult onset diabetes. Surgery was done shortly after, and the tumor was found to be malignant. I went by to see her later, and she told me that if I had not insisted, she would not have seen the doctor as early as she did and, it might have been too late when she did go.

ASSISTING BREASTFEEDING MOTHERS TO SUCCEED, 89%
DOMAINS II, VIII, XI.

I developed one program that was successful while it lasted. During WIC and Well Child Clinics it was noted that breastfeeding mothers had often discontinued breastfeeding and switched to bottle feeding before coming to clinic. It appeared that they did this within a few days after going home. The reason for doing so, in almost every case was, "I did not have enough milk" or "my milk didn't satisfy him." On investigation, I learned they received no teaching at the hospital, and in fact, the OB nurses at the hospital knew very little about breastfeeding. The nurses felt they were too short-staffed and did not have enough time to spend on teaching. This is a rural hospital where nurses have many responsibilities. I met with the nursing director and ultimately received permission from administration and medical staff to make rounds for the purpose of teaching breast feeding techniques, what to expect, and care of newborn in the home. I also took the opportunity to introduce the other services of the health department. The doctors in the community are not jealous of the health department. I did this for approximately one year, but due to changes at the health department and time problems, the hospital visits were discontinued. I hope to do it again or perhaps find another nurse who would be willing and able to help these breastfeeding mothers.

SUSPECTED CHILD ABUSE, 89%
DOMAINS I, II, III, IV, VI, IX, X.

S. P. was a 15 month old female who came to the clinic with her

mom for a routine check-up. During the history, mom described a rash around the anus which seemed to be spreading. She believed the rash was a fungus, although no other family members had the same kind of rash.

On examination, the child had mild rales and decreased breath sounds; a large cluster of venereal warts which were protruding from the rectum involving the anal area.

Upon questioning the mom, the home situation was discussed. The father was in the home, and the grandmother was caring for the child. I sent the child to an emergency medical center (mom's choice) for treatment of the pneumonia and informed mom that the rash was warts and could be contacted sexually. She denied any knowledge of sexual contacts with the child, seemed upset and shocked at my explanation. I told her that I would follow-up with the doctor at the medical center and that I was obliged to report the case to child abuse authorities. She seemed relieved that I would make a report, as she had questions concerning any sexual encounter. The child was seen by the physician at the emergency center, and sent home. The doctor did not report the abuse as he felt the venereal warts could have been transferred to the child during birth, being dormant until now. I followed up with the Department of Human Services, Child Protective Agency, a few days later. They had required physicals for each family member and found no venereal warts present. The abuser was believed to have been someone who had been living with the family several months ago. His whereabouts were unknown to the family. I felt relieved to know that the close family was not to blame. However, I flagged the chart as high risk for future abusive situations due to the family's tendency to move frequently and the history of friends living in the home. In the case of a second incident, this record would be valuable in the investigation. DHS did recommend regular health visits for the child and provided social work services to the family.

ASSISTING A MOTHER TO BREASTFEED SUCCESSFULLY, 89%
DOMAINS I, II, III, VI.

I received a postnatal referral on Terri. Normal newborn, breastfeeding mother was about all it said. When I called to set up the home visit, her mother answered the phone. She stated that they had been to the clinic the day before. The baby was weighed and the physicians' s assistant was not satisfied with the infant's weight gain. Terri had really wanted to nurse but was having feelings of insecurity and had given the baby the formula as instructed at the clinic. The baby was up most of the night crying, and Terri was most uncomfortable. I made a home visit the same day.

Terri was cordial but guarded when I met her. Her self-esteem was shaky. I brought with me a breastfeeding chart and several booklets on the subject. We talked about the pregnancy and labor and delivery. I worked slowly toward the subject of breastfeeding. Terri had prepared her nipples and had all she needed to keep them in good shape. We discussed newborn care, and she was comfortable with bathing, cord, and circumcision care. After I had encouraged her to continue all that she was doing, I tackled the weight issue. We found average weight gains of breastfeeding babies, looked at the baby's birth weight, and weight at the baby clinic. She didn't know that

newborns lost weight after birth. She felt she may have told the PA the birth weight instead of the discharge weight. I could see her relaxing as she nursed the baby. We plotted his expected weight gain, and I said I would return in two days to weigh him again. She had my name and number to call me if she encountered any problems. We discussed the Basic 4 Diet, fluid intake, her vitamins and iron supplements, and most important her rest.

Terri had felt the need to treat her mother as a house guest and was now going to let her mother take over. Since the father of the baby was not involved, we will have to formulate a plan later that will involve the mother going back to work, breastfeeding around that, and day care for the baby.

When I returned to weigh the baby, he had gained 6 ounces in two days. He was better but still colicky. We discussed ways to help. Terri was more at ease with the baby. She stated for a while she felt she could do nothing right for him. I will continue to see Terri and son until they are both doing well with their schedule. I felt very knowledgeable in dealing with the breastfeeding difficulty since I breastfed all four of my children. I have also been fortunate to attend some excellent workshops on the subject. I like to see mothers who really want to breastfeed succeed.

EXAMPLES OF EXPERT COMMUNITY HEALTH NURSING SCORING 78%

TEACHING THE FAMILY OF A CHILD WITH TETRALOGY OF FALLOT, 78%
DOMAINS I, II, III, V, VII.

My first encounter with the family was when the child was in for a WIC clinic and was being scheduled for a Well Child Clinic appointment. Her appearance was pale with little activity as she sat in her mother's lap. When she was later seen for a physical at the scheduled clinic appointment, she was again pale with cyanotic lips and nails and a grade V heart murmur. The child was then 18 months old, and although surgical repair for Tetralogy of Fallot had been scheduled, the parents were very reluctant to follow through. The child had missed the appointment date for the surgery and had no follow-up appointment. A great deal of time was spent with the parents that day and in the following weeks establishing and initiating a plan of care that would result in the repair of the heart defect.

The initial teaching began with educating the parents about the normal heart and then the defects and repair that was needed. The parents had not had anyone explain the procedure to them. They had been told the child had a "bad" heart and needed surgery. They had been reluctant to follow through as they felt the child would die with or without the surgery--so why have the child exposed to the trauma. With the information given the parents during our interaction, they came to understand that the surgery could possibly enable the child to live through adulthood and lead a very near-normal life. When they decided, the child was rescheduled through Cardiology Clinic and then surgery was scheduled. I worked closely with the parents throughout the process assisting them in obtaining payment through DHS, with living arrangements while the child was in the hospital for surgery, and with support and education. Phone calls and letters were mailed to DHS, the hospital, and the physician. After the surgery and while the child was still hospitalized, phone calls were made to the hospital to keep in touch with the parents and inquire about the progress of the child.

After the child was released from the hospital, the cardiologist referred the child back to my clinic where she continues to receive well child services and follow-up of her heart condition. She returns to the cardiologist as scheduled. The child is now a 3-year-old active, laughing preschooler, and the parents report that her growth and development is comparable to others her age. I still keep in touch with the cardiologist and sit down with the parents after each of their visits to him to answer and explain any questions the parents might have.

ADVOCATING FOR IMMEDIATE PATIENT CARE, 78%
DOMAINS I, III, IV.

One day a patient called the office complaining of a headache and requested a blood pressure check at home. I went to her house and found that she could hardly walk and also complained of extreme dizziness. I called her doctor, and the receptionist said she could come into the office in 2 weeks for an appointment. After demanding several times to talk to the nurse or doctor, I got the patient in to

the doctor immediately. Consequently, the patient was hospitalized for 4 days and her blood pressure changed.

AN INFANT FEEDING PROBLEM, 78%
DOMAINS, I, III, IV.

The situation involved a 4 month old female, her mother, and myself. The child was scheduled into the clinic due to the mother reporting that the child was a poor feeder. On history, the mother reported that the child had been seen the past week by a physician who had told her everything was OK and that the infant's feeding would pick up. On exam the infant was found to be a very slow weight gainer, to have a grade II-III murmur, and to tire easily while feeding. Based on this information, I told the mother my concern regarding the feeding problem and poor weight gain being related to the murmur. With the mother's consent, an appointment was scheduled for a cardiology evaluation. On evaluation, the infant was found to have a large ventricular septal defect that will need to be repaired when she is older. The cardiologist referred the parent back to my clinic where the mother and I reviewed the cardiologist's findings. The infant is now 10-11 months old and attends well child clinic regularly. Her weight is within normal limits with feeding greatly improved. The mother has on numerous occasions expressed her gratitude for my listening to her concerns and caring enough to have the child further evaluated.

GETTING MEDICAL CARE FOR A NEWBORN WHOSE FAMILY HAD NO MONEY, 78%
DOMAINS I, III, IV, VI.

I was called in to consult with a public health nurse, who was doing general clinic one day, concerning a jaundiced newborn. The infant was so yellow, he was an orange color from head-to-toe. The father said the infant had been discharged from the Children's Hospital 3 days before, and the "jaundice level" was OK. I felt that this was not acceptable, so I called the hospital, received a report that the bilirubin level had been 11 when the infant was discharged. I then contacted my medical back-up physician and received orders for a bilirubin level to be drawn at the local hospital. With the help of my administrator, charges were deferred for this baby's blood test and results were called to me that afternoon. The level was 15, so I referred this family back to Children's Hospital where the infant was still treated on an outpatient basis, but at least was under the doctor's supervision, having regular blood levels drawn. With the help of the public health nurse, this family was successfully re-entered into the medical system, receiving proper supervision of the infant's problem.

GUIDING A FAMILY TO AN ACCEPTABLE CARE PROVIDER, 78%
DOMAINS I, II, III, VII, VIII, XI.

During a routine 6 month well baby exam, I discovered an infant who had clonus, spasticity, hyperreflexive movements, and scissoring. The mother had no idea her infant was not developing normally. She had acknowledged that her infant was somewhat 'slow' in learning to roll over. I explained to the mother the physical findings, possible methods of determining the etiology etc. A referral was made to the Child Study Center.

On subsequent follow-up visits, the mother expressed dissatisfaction with the resources where she had been referred and requested referral to the Shriner's Hospital in LA. This was facilitated with the assistance of the Child Development Specialist and Social Worker, both becoming involved with this case at my request. The infant, 1 and 1/2 years later, is doing well developmentally, can sit up, roll over, and is continuing to receive care through Shriner's, the local health department, and the Guidance Center.

MANAGING CARE FOR A HOPELESS AND HELPLESS ELDERLY MAN, 78%
DOMAINS I, II, III, V, VII.

Managing a client who had open abdominal wound complicated with kidney failure--and who was very difficult to work with due to non-compliance. On discharge from the hospital, he was followed by a home health agency (out of town) --then referred to the local health department for services. The client lived in a very substandard dwelling (no running water and limited heating services). He had no other family member or other responsive party and was no longer receiving services from the Department of Human Services. Arrangements were made to see the client through the office setting 3 times weekly. Eldercare also became involved since environmental needs were identified. Probably in all my nursing career, this man stands out as far as being difficult to work with because of the frustrations and the anger especially when he shifted responsibility for his health care to us. On every visit he would mention the $213 per month that he got asking, "how can you live on that," and requesting "could you do something about it." But with the patience of Job, and the tenacity to do the best for him, we managed to get his wound completely healed. The patient moved into a comfortable, low-rental apartment with adequate plumbing/heating, and the man is still living today. He was seen by out department for about 5 months. I feel we made a difference.

A PREGNANT WOMAN AT TERM WITHOUT PRENATAL CARE, 78%
DOMAINS I, II, III, IV, VI.

A client who was 9 months pregnant and had no prenatal care dropped into the health department. She was concerned about "sores" in the genital region and had experienced labor pains off-and-on during the day. I examined the "sores" and assessed that she probably had an active outbreak of genital herpes. Several calls were made, and I got her into the OB-Gyn Clinic in Tulsa the same day. They assessed her to be in active labor and did a C-section because of the outbreak of genital herpes.

REFERRING A CRITICALLY ILL INFANT, 78%
DOMAINS I, III, IV, VII.

A 3 month old infant came in with the parents for WIC evaluation. Upon examining the infant, it was assessed that the child was underweight with a severe cough and sternal retractions. The parents reported the infant had been ill for 2 weeks. The infant was immediately referred to the emergency room and transported to Tulsa to the intensive care nursery. The diagnosis was Pertussis.

MANAGEMENT OF A NON-COMPLIANT PREGNANT WOMAN AND HER BABY, 78%
DOMAINS I, II, III, IV, V.

An experience which comes to mind involved a family with 3 children and another on the way. The mother was very obese and began to have hypertension. She was enrolled in our maternity clinic and was well into the 7th month gestation with no prenatal care up to that point. The family did not have reliable transportation and just getting into clinic was a major accomplishment. Through group effort we did establish a special rapport with the family and compliance improved. The baby was delivered and did have significant problems at birth. The primary problem was intestinal and involved emergency surgery at Children's Hospital. Other complications also developed.

When the baby was discharged to go home from the hospital there was an open wound on the abdomen which required dressing changes and close supervision. With teaching and positive reinforcement this baby thrived and did quite well. The reward for me was being able to help a family learn and grow and cope with the baby's special needs. This baby was followed closely until the family moved out of the county, but we did succeed in getting the mother on family planning and of course WIC services for the baby and the other children.

HOME CARE OF A TERMINALLY-ILL CANCER PATIENT, 78%
DOMAINS I, II, III, V.

Most public health nurses have taken care of a terminally-ill patient, but my experience with a 46 year old woman was most traumatic for me as well as for the patient and her family. This patient suffered from carcinoma of the pancreas and liver, and she survived for two months. The reason this patient seemed closer to me than others was the fact that she was my age. She had arrived in our town after flying via airplane from a town in Texas. She knew she was seriously ill and wanted to be with her family living here. Her physician referred her to our agency. Other home care agencies do not accept "free" patients for home care when they have no Medicare or means to pay for home nursing. This woman, though poor, had much pride and showed tremendous courage through her ordeal, especially when her abdomen became enlarged and the appearance was like that of a woman eight or nine months pregnant. Her lower extremities were also very edematous. I was able to help her with fairly adequate nutrition until the last few days. We managed her pain fairly well through communicating with her physician to increase the pain medication dosage. I obtained sick-room supplies via the cancer society, and they helped to pay for her pain medication. Her inability to urinate later in her illness necessitated the insertion of an indwelling catheter, and I performed this task painlessly. Her family relied on me to help them understand what was happening to the patient, and we "all" were able to come to terms with the patient's eventual demise. There were many other small things I was able to do for the patient and family. I felt that in no other aspect of nursing is there more satisfaction than in this type of patient care. I felt confident that one nurse, alone, could do so much. My patient expired sometime during her sleep early one Saturday morning. Thankfully, I had prepared the family, and they knew exactly what to do. I still remain friends with the patient's sisters. A little anecdote to this story is that the patient's physician took the time to write a letter to me

thanking me for my assistance with the patient's care. I will never forget what it really means to be a community health nurse.

ADVOCATING FOR ADEQUATE CARE FOR AN INDIGENT CLIENT, 78%
DOMAINS III and IV.

I received a referral from a nearby hospital for home health care. I drove 20 miles to the neighboring town to find a 62 year old female with terminal cancer lying alone in a wet hospital bed. The woman had been transported via ambulance from her local hospital to the large city hospital for chemotherapy. Upon completion of the chemo, she was put back in the ambulance and sent home. The woman was suffering extreme pain, a mere touch brought tears to her eyes. She was married, but the husband was an alcoholic. He came in while I was there and said he wasn't staying around to take care of her. She was unable to even turn over in bed. Her only child refused to get involved because of a past history of alcohol abuse. Following my assessment, which proved to me the woman could not be left alone, I made numerous phone calls to get the woman back in the local hospital. She had no insurance and no money. After talking with 6 different people and making a personal visit to the Nursing Director of the hospital, they finally readmitted this woman. She died 2 days later. At least, I know she wasn't alone at home in a wet bed unable to even turn over.

IDENTIFYING ANEMIA IN A CHILD AND REFERRING, 78%
DOMAINS I, II, III.

We were just beginning our WIC program when one of our staff (public health community worker) noticed a little Spanish boy appeared pale during an immunization clinic. We gave the mother an appointment for WIC that week. The little boy was grossly anemic and was referred to a private physician. The physician sent him to a specialist suspecting possible leukemia. The child was found to be grossly anemic due to poor nutrition. The specialist's report showed the child would have died in a few months had this not been detected. The mother was Spanish-speaking and very isolated. She was very loving but ignorant about nutrition for her child. She was given all the information she needed to reverse the problem through an interpreter at our health department. The child is a strong healthy boy now and the mother returns to the health department occasionally to "thank us for her son's life." She even brought us his picture last time they came.

SUDDEN INFANT DEATH SYNDROME FOLLOW-UP IDENTIFIES ABUSE, 78%
DOMAINS I, II, III, X.

The case involves a referral from the state SIDS Foundation. It was the second child for a young couple. The mother was protected by her parents who rebuffed the services of a public health nurse and stated they would support their daughter--the marriage relationship was noted to be unstable. Numerous attempts at visits were futile. However, the mother contacted the state SIDS office 6 months after the infant's death. The Department of Human Services Child Welfare was involved because of an accusation by the father of sexual molestation of a sibling to the SIDS victim. He believed some homosexual friends of his wife had molested his daughter. The mother was seeking help

that had been directed by the courts. Many visits were made to help resolve the death of the child and counsel regarding the issue of sexual abuse. A joint collaboration of like counsel was made by the PHN, Parents Anonymous and a Child Welfare Worker. The mother and daughter are establishing a successful relationship. This duo has recently dealt with an intrauterine death of a third child. The mother has revealed that she has no acceptable support (emotionally) from her family. She is maturing and caring for her daughter. She still needs grief support, positive image support and information on appropriate age expectations for the child. The couple is isolated in a trailer quite removed from a social life. The father is not welcomed at all. The PHN has remained the one constant support and liaison. The mother has a negative view of DHS and a distant attachment to Parents Anonymous. The PHN has led the mother in searching her own emotional needs, her views and knowledge of what did take place at the time of sexual abuse and what can be done to prevent this from recurring.

Presently, the mother is seeking employment and plans to place her daughter in day care.

CONTROLLING AN EPIDEMIC, 78%
DOMAINS II, IX.

During a shigellosis outbreak, a symptomatic food handler was identified, tested and removed from work (in a senior citizen nutrition site). Lots of patient education took place and proved beneficial in control of the outbreak.

LONG TERM FOLLOW-UP OF A MULTI-PROBLEM FAMILY, 78%
DOMAINS I, II, III, VIII, X, XI.

Mom 36 years old
Dad 45 years old
Children
Female 3 years old
Male 15 months old

The family transferred from another county. There had been no medical supervision for the children. The father was being followed by the Veterans' Hospital for hepatitis and cirrhosis of the liver. The mom was being followed by a local general-practice physician for seizures. She was being medicated with Phenobarb and Dilantin but no blood levels had been done in the past year; only prescription refills had been ordered by the physician.

The mom presented with the children to clinic. The 3 year old female was quiet and had an anxious gaze. The 15 month male sat on the floor rocking and whining with no attempts to stand or walk. The 3 year old explored the room cautiously while the mom talked to the PHN. As she attempted to touch items in the room, the mom spanked and yelled at her. She stopped momentarily then proceeded till the mom again spanked or yelled at her. No attempt was made by the mom to cuddle the children.

The children were placed on the WIC program. The PHN made follow-up plans with concerns as follows:

1) Home visit to assess home environment--? drug or alcohol abuse leading to cirrhosis
2) Questionable developmental delay in the 15 month old

Refer to local pediatrician for neurological work up
3) Inappropriate parenting skills of the mom
Refer to child developmental specialist and Guidance
4) Mom needs follow-up for seizures & medication monitoring
Phone Mental Health to get mom into continuity of care
5) PHN support to mom & family as role model -- supportive personnel
6) Well child visits routinely for assistance with high risk situation

6 Years later

The family continues to be followed in the clinic. The children now are 9 and 6 years old. Both children and the mom have weekly guidance visits, and the speech therapist is working with the 6 year old boy on speech and letter development. The pediatric nurse practitioner visits the home as necessary and sees the children in clinic. The children were placed in Head Start when they were 5 years old due to a recommendation by the health department. The father died about 5 years ago from cirrhosis. The mom admitted to being alcoholic also. The public health nurse worked with the mom supportively to help her get involved in Alanon and with Mental Health to decrease her drinking. The mother applied and received AFDC and supportive social services to help with the family income since loss of the father. Since both children are in school now and receiving special education, mom intends to go to VoTech and provide herself with training to work part time. Parenting skills have increased through intervention of Guidance and Well Child Services.

On the mother's 42nd birthday, the PHN and the mom went out to lunch to celebrate. After lunch the mom gave the PHN a big hug and said thanks for everything you have done for me and my family. I could not have made it this far without you.

MANAGING AN UNDIAGNOSED DIABETIC PRIOR TO MEDICAL SUPERVISION, 78% DOMAINS I, II, III, IV.

The patient came into the health department stating that she had an aunt in the hospital with diabetes. The aunt had checked the client's blood sugar, and it was 500. She had no money and no job so could not see a physician.

About 4 hours later at the health department, the blood sugar check was over 200. It was recommended that the client see a physician. The client stated that she would have to go to the Oklahoma Memorial Hospital. She was given the number to call. However, when she called, they said she needed a referral from the clinic. The client was asked to return to the clinic for a fasting blood sugar. It was 249, so she was not given the glucose loading dose. I called OMH and made an appointment for her with the Medicine Clinic. They were not able to make the appointment for about a month. I phoned the local medical director and received permission to have the nutritionist figure out the diet requirements and counsel the client on it. Also, I stressed the need for daily exercise, discussed diabetes and how diet and exercise are the most important parts of treatment. The seriousness of any possible illness with diabetes was also discussed. I will be monitoring the client's blood sugar periodically, fasting and 2 hour post prandial, and watching the diet and exercise till she gets in to see the doctor at OMH.

ASSURING DIAGNOSIS AND TREATMENT OF CYSTIC FIBROSIS, 78%
DOMAINS I, II, III, IV, VI.

A mother came in with a 13 day old child for WIC certification. The birth weight of the infant had been 7 pounds and 10 ounces. Today's weight was 7 pounds and 9 ounces. The mother reported that the child had been taking three 24 oz cans of formula by 9 days of age and still appeared hungry. Therefore, she started adding cereal to the formula, and now the baby only was taking 48 oz per 24 hours. I counseled with the mother that this was real unusual for a child to take this much formula without having weight gain. The child just did not appear well. I stressed the need to have the child seen by a physician. The mother stated that she had an appointment the next week for a check up. She was advised that the child really needed to be seen that day. I asked her if I could call her doctor and talk with her about the child's condition and see if she would see the child that day. With permission, I called her doctor and was told to send the mother and child right over to the office and a sweat chloride test would be done. The test was abnormal, so the child was referred to Children's Hospital. The mother was supposed to call the physician back to find out the appointment time to take the baby, but she had not phoned.

There was a High Risk Infant CARE group meeting that day. We discussed the child with the Department of Human Services (DHS), and they knew the mother well. This was the mother's first child. They stated that she had no transportation and no phone. They intended to notify the mother of her appointment and provide transportation.

I checked back with DHS on the day after the appointment and learned that the mother had not been at home when DHS went to take them to the hospital. I made a home visit to the mother and asked her about not being available at the appointment time. She stated that she had to spend the weekend at the home of friends, and no one was at her house when she got home. I asked her how the child was doing, and she stated that the baby kept her awake all night, was not drinking as much formula now but was taking more water. Also, there was more spitting up of mucous. I asked her about the infant's stools, and she stated that there were white lumps in them. I asked if the stools were greasy, and she stated that they were. I told her these were symptoms of cystic fibrosis, so it was very important that she get the child seen as soon as possible. When asked whether she would take the child to Children's Hospital for diagnosis and treatment, she said she would.

I phoned the doctor and she arranged an appointment for the next day at 9:00 A.M. I then called DHS to ask if they could get transportation for the mother and baby. Things were uncertain for a while as the mother had failed to keep the first appointment. Finally, DHS did make arrangements to take the child to the hospital. I went by the house to tell the mother of the appointment and to be ready by 7:30 the next morning. I asked if she knew what cystic fibrosis was. She said no, she didn't. I explained to her what the disease was and again stressed the need for the infant to be examined and treated as soon as possible. I told her that the child might need to be hospitalized. The next afternoon I received a phone call from DHS stating that the child's weight was 7 pounds and 5 oz at the hospital with hospitalization for possible cystic fibrosis.

LONG TERM MANAGEMENT OF A MULTI-PROBLEM FAMILY, 78%
DOMAINS I, VII, VIII, IX, X.

I was called upon by a local elementary school principal to assist with a family infested with head lice. He said there was no mother in the home, and he didn't feel the father was capable of handling the problem. He impressed upon me that this was worse than the average problem. I made the home visit and found myself about 12 miles out in the country. The home consisted of a camper shell that would normally sit on the back of a truck, but this was on the ground. Needless to say, they lived in utter filth. My immediate problem, the first day, was to treat the children for lice. There was a nearby pond, so I washed their hair with pediculicide shampoo and pond water. Fortunately, it was a warm September evening. Then, I took them and their father to a neighbor's house, and the neighbor graciously let me bathe the children in his bath tub. The father had found some fairly clean clothes to put on the children. When we went back to the camper, I had a long talk with the father. He was 55 years old at the time and had stolen his children from his ex-wife. They had been roaming for 3 months but had settled so that his children could attend school. He earned money by scrounging through an illegal dump near which his camper was located. The neighbor with the bath tub was the owner and operator of the dump. He implored me not to notify welfare, because his wife might locate him. He then went on to describe how horrible she was as a mother. The children were ages 7 and 8, and they added their thoughts. They gave a convincing story that their life with mother was worse than the present one. Except for their lack of safe shelter, they gave the appearance of 3 happy vagabonds on a great adventure. From beginning to end, the whole ordeal took 2 years. In sequence the following events took place:

1) Notified welfare and a computer check determined that the children were better off with the father.

2) Volunteer women assisted in bathing the children and washing their clothes.

3) A local Sunday school class provided a used mobile home with free rent and utilities for 6 months, and after that, a local citizen allowed them to live rent-free in an old abandoned farm house not far from town. Food stamps were obtained also.

4) Illegal dump was closed down. The father lost his livelihood but got on social security disability.

5) Father became very seriously ill with congestive heart failure. The situation for the children deteriorated to the point where they were their father's caretaker. The boy was working at a nearby store to buy groceries.

6) A neighbor took the children in. Father was in the hospital much of the time now.

7) Legal custody of the children was given to the neighbor where they had been staying (questionable situation because the neighbor's parenting skills weren't good).

8) Father died. The boy and foster parents not getting along. Boy very personable and loved by everyone in the community.

9) Boy adopted by another family--good home.

10) Girl requested to return to her mother. DHS investigated and since the mother had remarried and was showing signs of stability, the girl was allowed to return to her mother. The girl still loves the

foster parents and calls them occasionally.

The welfare worker and I case-managed this together. Some of our efforts were failures, but the outcome was not as hopeless as it was in the beginning.

TREATMENT OF A SEVERE SKIN RASH, 78%
DOMAINS I, II, III, IV, VI.

Jenny was an 8 month old caucasian female who came to clinic because of a "terrible rash all over her body." The mother said Jenny had this rash since birth, and she had been seeing her family doctor and a dermatologist but did not have the money to go at this time. She said the rash had never really improved and was, in fact, worse than it had ever been. The baby was very fussy lately and scratched all the time.

Jenny was on Similac with Iron, approximately 1 can/day and 3 meals/day covering a variety of meat, vegetables and fruit juices. Growth and development was within normal limits. The mother bathed Jenny daily with baby soap (Baby Magic) and washed her clothes with Dreft. Immunizations were up to date. There were no pets or significant food or environmental changes recently.

Jenny presented as an 8 month old female, alert, active, well-nourished infant whose growth was within normal limits. The physical examination was essentially normal except for the following.

Head: Lopsided with frontal bossing on right side and fontanel soft & flat 2 cm by 1 cm in diameter with no crossing of sutures.

Ears: TMs red, landmarks not visible, bulging, poor light reflex.

Nose: Clear discharge but turbinates swollen & red.

Throat: Pharynx reddened.

Skin: Erythematous raised dry scaly confluent pruritic rash involving the entire skin surface sparing only the eyes, mouth, soles of feet and palms of hands. Some exudative crusted eruptions especially in the intertriginous areas of the arms and legs.

Development: Personal-social, fine motor, language development within normal limits. Gross motor: Unable to sit without support. Bears no weight on legs.

Assessment: 8 month old female whose growth is within normal limits with:

#1 Atopic Dermatitis
#2 Bilateral Acute Otitis Media
#3 Upper Respiratory Infection
#4 Motor Developmental Delay

Plan to address problems:

#1 Discontinue Similac with Iron & replace with Isomil.
Mother was counseled extensively on watching for causes of allergy such as foods, environmental factors that cause the rash to flair up.
a) Advised Dove for baths or Cetaphil Lotion. Decrease baths to every-other-day.
b) Humidify the house.
c) Keep fingernails cut short.
d) Use Eurecin Cream mixed with Hydrocortisone Ointment 1% on skin 2x daily to keep skin moist and discontinue as soon as redness noted.

#2 Treat with Amoxicillin for 10 days
#3 Dimetapp and vaporizer. Increase fluids, especially water.
#4 Give written motor development exercises to practice at home.

Consult with Pediatrician and mother referred to Diagnostic and Evaluation Clinic in Oklahoma City for further study and diagnosis due to developmental delay and lopsided head etc. Return appointment to clinic in 2 weeks.

The mother returned to clinic in 2 weeks. She was ecstatically happy because of the dramatic improvement. The infant looked like a different child. The skin was practically completely clear, the baby was happy, cheerful, and playful. The mother was diligently working on doing the motor stimulation exercises given to her. However, she had missed her appointment with the D & E clinic because she had returned to her family doctor who had said we would just watch the baby until she was 12 months old. Further delving uncovered that the mother did not drive. They had only 1 car, her husband was working at a job he had just received, and she had no transportation to Oklahoma City. We were able to arrange for transportation through her church, and since the mother had developed rapport and trust in me, she agreed to keep the appointment. An appointment was rescheduled for her with the Child Study Unit which she has assured me she will keep. I saw the mother and baby back a week ago. The ear infection is now clear, the respiratory infection is resolved, the baby's skin looks wonderful, and the baby is now sitting without support and is bearing weight on his legs. He is not yet pulling up to stand but the improvement has been truly remarkable.

ENABLING A YOUNG MOTHER TO DEVELOP MOTHERING SKILLS, 78%
DOMAINS I, II, III, VI.

A newborn was brought to the well baby clinic at 10 days of age for a health check-up. The baby had been discharged from the hospital 1 week prior. The birth weight was 5 pounds and 13 ounces. The infant was now 5 pounds and 1 ounce. The mother was an 18 year old, married, attentive person, but this was her first baby. The history revealed the infant was taking 14-16 oz of formula with Iron/24 hours. The mother said it took forever for the infant to take 1 to 1 and 1/2 ounces. He slept all the time. By Dubowitz the infant seemed to be a 36 week gestation. When the mother was observed feeding the infant, she held the baby close, positioning the bottle correctly, but she did not know how to insure the proper tongue and mouth position and how to stimulate the infant to suck. I demonstrated to her how to feed the infant and watched a return demonstration. I instructed her that the infant must have a minimum of 20-23 oz/day, 2 and 1/2 to 3 oz every 3 hours and helped her to work out a schedule. The physician was notified, and the mother was scheduled to return to the doctor's clinic in 2 days. I telephoned the next morning and the infant had taken 22 oz in the last 24 hours. She returned to clinic 2 days later and the infant's weight was 5 pounds and 4 ounces. She returned 1 week later and the infant's weight was 5 pounds and 12 ounces. Another week later the weight was 6 pounds and 4 ounces. I saw the infant for the 2 month check-up recently. He is thriving physically and developmentally. He weighed almost 10 pounds (9# & 13 oz).

Mother has just blossomed in confidence. Mothering skills and mother and infant are thriving.

IDENTIFICATION, ASSESSMENT AND TREATMENT OF A BABY WITH DOWN'S SYNDROME, 78%
DOMAINS I, II, III, VI, VIII, XI.

R. T. was brought to the health clinic by his mother, L., age 23. His 2 year old brother was present at the clinic also. Although pregnancy and labor and delivery had been without defined problems, the parents of R. T. had been told shortly after his birth that he was a Downs Syndrome infant. L. talked freely during the visit. She related feelings of shock and disbelief early on and later feelings of anger and guilt that this should happen to her child. As she talked, I could clearly hear that she wished to parent R. T., as she had his sibling, with love and understanding just as any normal child. The physician had informed the family of specific developmental problems to be expected. He explained that R. T. would seem to be as normal as any other child at first and as normal developmental milestones became more delayed, his difference would be more noticeable. Medically, R. T.'s problems included a heart murmur and a moveable kneecap. The parents were told that the heart murmur would probably worsen and had been told to have the orthopedic problem checked by a specialist. The parents had no idea of the availability of services for handicapped infants. After the physical assessment and specific instructions for handling a problem of nasal congestion, feeding and general care, I made an appointment for R. T. to be seen by WIC and gave L. the phone number to call about a time to check out a car seat through the local loan program. I listed the programs that I believed R. T. would qualify for and informed L. that I would check on services at Children's Medical Center for orthopedics, genetics and infant stimulation. Also, I informed L. of supplemental income and services provided by Crippled Children's Service and DHS. Within the week the special education professional with the local school had been notified and a home program had been designed for R. T., and appointments were made at Genetics and Pediatric Outpatient Clinics at CMC. He was on WIC and had been seen by a specialist concerning his knee and heart. Both were benign problems at his early age, but he would be followed regularly. The parents kept regular appointments and found answers to questions and concerns for feelings of grief with the loss of a perfect child. They requested ongoing sessions to clarify issues of sibling rivalry, parenting and the acceptance of R. T. by others as he became more a part of the family. Just recently, I attended an Individual Educational Program session designed for R. T. and participated in a multi-disciplinary program to meet the needs of R. T. in the areas of physical, emotional, cognitive and social health.

INTERVENING WITH AN ELDERLY COUPLE INCAPABLE OF SELF-CARE, 78%
DOMAINS I, II, III, IV.

Mrs._____ reported to the Health Department that an elderly neighbor may have had a stroke in the last few days. She was in bed but had no medical attention.

I made a home visit to the four-room, rural home. Mr. J., the 87 year old husband, answered the door. When I asked about Mrs. J., he led me to the bedroom. An 85 year old woman lay in the bed covered to

her chin with quilts. She was awake but not oriented. I asked permission to assess her. Mr. J. signed consent. The patient was dressed in a dirty, greasy, flannel nightgown, bra, and panties. Vital signs were normal. She sat on the edge of the bed, moved all extremities on command, but was totally disoriented. Mr. J. said, "She's been that way two days and hasn't got out of bed." I asked about her eating and drinking. He said, "She drank water and some coffee, but she hasn't eaten because she is the one who does all the cooking, and I don't know how." She drank some water and went back to lying down.

The neighbor who called us arrived. I learned from the husband that Mrs. J. had no physician, and the closest relative was a granddaughter in a city 60 miles away whom they had stayed with for several weeks after Mr J. had cancer surgery. The only others in the support system were the neighbors who had called me. Mr. J. was willing for me to call their granddaughter, but he had not done so because he just figured Mrs. J. would get better and be up and around.

I called the granddaughter and explained the situation. She said she would be there in about an hour-and-a-half.

With Mr. J.'s permission, I went to the kitchen to check on something for Mrs. J. to eat. There was no running water in the house. The pipes had frozen in early winter and not been repaired. Mr. J. hauled water in the several 5 gallon cans that sat on the floor. The stove, sink, and cabinets were all filthy (about 1/8 inch grey to black coating on them). There were no clean dishes or pans. I found one large pan, washed it, and enough dishes etc. to cook. There were several boxes of oatmeal, sugar, flour, coffee, canned milk, bacon, some canned vegetables, and bread. I cooked oatmeal. Mr. J. ate some and some bread. I fed Mrs. J. a bowl of oatmeal, and she ate ravenously and tolerated it well. I waited until the granddaughter arrived. Mrs. J. remained disoriented.

When the granddaughter arrived, she said she would take them to her home and take Mrs. J. to the doctor. She said they would stay there until they could take care of themselves.

INTRODUCING SEX EDUCATION INTO THE SCHOOL, 78%
DOMAINS II, VIII, IX, XI.

Our city has refused to have any sex education. The community and thus the school administration had been adamantly against it. This year the guidance counselor at the junior high school called. She said, "There is now an openness to having a Sexuality Seminar." We talked, and I agreed to go to an evaluation/planning meeting with male and female guidance counselors and the principal. I was asked to make a one-hour presentation for a Sexuality Seminar with outline, content and any visuals for their consideration.

I prepared material, and overhead transparencies for:

Reproduction
STD's
Contraception
Legal Aspects of Sexual Expression

We met again, and all agreed to use the material. I was to present it six times---to each grade and each sex separately. The following week I was to return for questions from each of the groups. I was the only presenter for the whole seminar.

After the Sexuality-Responsibility seminars, the feedback was good from faculty, ministers, youth workers from local churches, and parents. The guidance counselor said there were no negative problems from parents, and she felt the door would be open for similar opportunities in the future.

PERSISTENT FOLLOW-UP OF A DYSFUNCTIONAL FAMILY, 78%
DOMAINS I, II, III, V, IX, XI.

In this county we have a high risk infant team that works closely with the Department of Human Services. On a 3rd or 4th home visit with a social worker from DHS, we found a father in his mid 30's caring for 4 small children--wife at work. All family members were severely unkempt--also the house. The father was unshaven, hair uncombed, clothes rumpled and dirty. He would not look us in the eye. We inquired regarding the health of the family as we had heard that one of the girls had impetigo on her face and that he had been bitten on the hand by a dog. The hand had small areas of infection in the wounds, and we found out that he was using a fungicide on the impetigo. I explained to the father that the infection would spread and possibly scar the child's face unless it was treated properly. Arrangements were then made with the social worker for transportation to a clinic where all medical needs for the family could be met.

We had visited this family previously and took a very large Thanksgiving box. This particular morning Mr. X met us at the door holding a sharpened sickle. We smiled, thinking nothing of the sickle at the moment, and asked if we could come in. He said, "Yes." The eight month baby girl lay on the soiled sofa in stained clothing and blankets, bottle propped. He suddenly gave us a bomb shell by asking us, "Are you going to keep coming here to bug and harass us?" I stated I was sorry that he thought of it in this manner and that we were genuinely concerned about all of them and wanted to help and thought he would appreciate it. He did appreciate the food box, he said. He then threatened that if anyone attempted to take his children that he'd put them in their grave. We assured him that this was not our intent. It then began to dawn on us that he was a very angry man, but we couldn't understand what his problem was. It was obvious that he had been a capable person at some time in the past as he had been in the army for some time.

The reward came a few days later when he called the social worker and stated he was an alcoholic and wanted to admit himself for treatment. When asked what made him want to change, he stated the social worker and nurse kept coming back and encouraged a better life.

COUNSELING A PREGNANT ADOLESCENT, 78%
DOMAINS I, II, III.

About 2 years ago a 15 year old girl came to the health department for a pregnancy test. Her mother also came and when she was told the girl was pregnant, she was adamant the girl was going to have an abortion. When counseling with the girl alone, she was encouraged to make her own decision with which she could live. She planned to marry the boy regardless, and he did not want her to have an abortion. She decided against an abortion, got married within the next few months and was placed on birth control pills. She had experienced a miscarriage at 3 months.

About a year later she became pregnant again and carried the baby to term. She is now a fairly successful young mother being followed by the WIC program. Even though she was still quite young (17 years), at the birth of her child, she was no doubt a much better mother by waiting awhile to become pregnant again. She appears to be happy in her marriage and is finishing high school.

COUNSELING A MOTHER REGARDING A GENETIC PROBLEM, 78%
DOMAINS I, II, III.

During the examination of a child with Sickle Cell Anemia, I was alerting the mother to the genetic factors involved with future pregnancies. She stated she knew this, and was now pregnant again. She also stated that she had been to a doctor who advised abortion, but she did not want this. Since she felt that he did, she was afraid to go for prenatal care or ask for WIC. I explained that she had a 3 out of 4 chance of a healthy child and asked if the knew whether the baby's father was the same as the father of the child with Sickle Cell Disease. He was not. Consequently, I was able to assure her that this child would probably be healthy. She needed to ask the father of this baby to be tested for Sickle Cell. I was also able to get her an appointment at OMH Prenatal Clinic and an appointment for WIC. Consequently, she received medical prenatal care, WIC, and was relieved to find out that the father of her baby did not have Sickle Cell Trait.

SUPPORTING A MOTHER EXPERIENCING LOSSES, 78%
DOMAINS I, II, III.

I received a referral for Stacy from the hospital where she had delivered a post-term stillborn baby girl. She was receptive to my home visit but asked few questions, and her responses to mine were limited. I focused on her 3 year old son. He had frequent ear infections and was behind in his immunizations. She brought him to my Well Baby Clinic where I did his height, weight, developmental assessment, and talked to her about his eating and sleeping habits. It was at that point that we were able to talk about the effect of the long-awaited baby's death on him. His father had left the family shortly after the death. Stacy felt she was doing well but worried about the effects of all the changes on her son. We talked during his physical (which I do in my nurse clinic since I'm a PNP), and she asked me to come back to the house with some material on death that she could use to help her son. I made the home visit the next day. We talked for a long time about her son and his father. She felt this would be the bigger loss. Stacy was angry, grieving and accepting all at different times. We discussed her continuing WIC until she was no longer eligible, looking for a job, having some of her son's day care paid for by the government, and counseling available to her. Because she followed through with most of our care-plan, slowly, as she was able, she now has a job she loves at a nursing home. Her son is in day care. His immunizations are up to date, and the family seems to be doing well. It took us nearly a year, and the going was frustrating due to problems like no car, three ear infections which kept her off work and home with a sick child. Also, her counseling sessions were difficult to get to due to babysitting problems.

ASSISTING A FAMILY TO COPE WITH DEATH AT HOME, 78%
DOMAINS I, III, IV, VI, XI.

The family was unable to discuss the patient's needs with him because they could not bring themselves to discuss his condition and thereby find what was important to him and what things he wanted done before or after his death. The family didn't think they could deal with the actual death at home. The family included 3 children, 3 daughters and son-in-laws, young grandchildren not in the home, and the patient's wife.

I was able to talk individually with each family member and then with them as a group about the need for being open and truthful with the patient-- not to just say, "You're dying," but to say "We're here and pulling for you, and we support you no matter what."

We all were able to sit with the patient, hold his hand, and talk openly. The patient admitted to being ready to die and was relieved to be able to say it. All cried and talked and healed old wounds. The patient died at 2 a. m. and all the electricity went out just as it happened. The family lit candles all around the patient and sat and talked and remembered and cried and laughed.

They were very grateful for the beauty of his passing.

TEACHING A NEW DIABETIC, 78%
DOMAINS I, II, V, VI.

I worked with a new diabetic patient to enable him to accept and handle a disease he was, up to then, unable to handle. The patient was a school teacher and had lost his job because he kept breaking down in front of his class and crying and shaking. He was tearful and shaking when he came to my first Diabetic Class. After class, I sat and talked with him, reassured him that he was not a freak or different, and he was able to take control of his body and life. I worked after class each time with him, made referrals to special classes for problem areas, and asked him to help others in the class who were having trouble in areas he was excelling in. At the end of the classes, he was in control. Four months later he was still learning new things about his disease and was making a friend of it--no longer at odds with himself.

EXAMPLES OF EXPERT COMMUNITY HEALTH NURSING SCORING 67%

TEACHING HOME CARE TO THE WIFE OF A TERMINALLY ILL MAN, 67%
DOMAINS I, II, III, V, VI.

A 56 year old male was sent home from the hospital with the diagnosis of metastatic cancer. His wife knew absolutely nothing about caring for an ill person. Home Health Care was started. Medical equipment was ordered, and instructions on its use were given. With time, the patient's condition deteriorated. A lift was used for transfers. The patient's wife was taught all aspects of care which included bathing, turning, feeding, suctioning, catheter care, and dressing changes when a decubitus developed after a short hospitalization. The patient's wife kept excellent nursing notes. Spiritual and emotional needs of the patient and his wife were met. They felt a special bond during this time, and at the time of his death, they could both let go. The wife, many times since the man's death, has expressed gratitude to the nurses for teaching her to care for her husband at home and making such a trying time special.

IMMEDIATE RESPONSE TO A CRITICALLY ILL PATIENT AT HOME, 67%
DOMAINS III, IV.

This happened while I worked for a private home health care agency. I made a visit to a patient who had fallen on a floor furnace and received second degree burns on her arms, left flank, and left thigh. When I arrived, her husband told me she had an awful cold. When I was walking down the halls (10 feet long) to her bedroom, I could heart her rattling respirations. The patient was unconscious, foaming around the mouth, and she had 4+ edema in her feet and legs. I turned her to her side, grabbed a nearby towel, and began getting copious amounts of tenacious clear mucus rolling out the patient's mouth. Her respirations began to get less labored. I called the doctor. He made a house call, gave the patient 80 mg Lasix, and drove her and her husband to the hospital. This happened late on a Friday afternoon in a small town with 1 doctor. The patient was hospitalized over the weekend with Congestive Heart Failure. The doctor commended me on quick action and saving the patient's life.

COUNSELING A PATIENT FEARING AIDS EXPOSURE, 67%
DOMAINS I, II, III, IV, IX.

2:00 p. m., Tuesday

I received a telephone call from a man who was very concerned that his persistent sore throat and sinus drainage was AIDS. Because I was in the midst of a WIC clinic (clients in my office), I gave him a brief definition of AIDS, AIDS risk factors, and asked him to please call me back after clinic. He did not call back.

2:00 p. m., Wednesday

I received another call from Mr. S. He apologized for not calling back yesterday and burst into hysterical sobbing. He was awaiting his HTLV-III antibody test results and was overcome with fear and guilt. He was married, a father, a respected, government mid-level manager, and he was bisexual (unknown to his boss and family). I talked with Mr. S. for almost an hour allowing him to tell his story and express his feelings and fears. I attempted to give

"Gene" factual information about the antibody test, signs and symptoms of AIDS, risky practices, and I encouraged him to stop donating blood as a precaution for others. Periodically during our talk, he would sob in genuine fear. I allowed him to tell me about his bisexual feelings and reinforced that this was not sinful or even unusual. After ascertaining his exact symptoms, last risky exposure, and that he had been thoroughly examined by his doctor, I reassured Mr. S that he was probably at low risk for AIDS and that his antibody test would probably be negative. I encouraged him to seek counseling for his guilt feelings, take two Tylenol with a large glass of ice water, and try to get some rest. He said he would call me the next day after he got his test results.

3:45 p.m., Thursday

Mr. S. called to say his antibody test was negative and to thank me for listening, sympathizing and giving him valuable information. I again encouraged him to seek counseling for his guilt feelings.

SECURING RESOURCES FOR A QUADRIPLEGIC ADOLESCENT, 67%
DOMAINS I, II, III, IV, V, X.

I will describe a situation involving a home health care patient. He was a 17 year old male quadriplegic injured by a gun shot wound which caused brain stem injury and caused permanent paralysis from the upper cervical vertebrae making him a quadriplegic.

This patient was released from the Oklahoma Rehabilitation Center, sent home with family only. The only equipment they had was an electric wheel chair. On my first visit, I found the mother attempting to lift him from a mattress on the floor to his chair. The father was unemployed, trying to go back to school. There was a 5 year old child still at home and a total of 5-6 other children plus 2 parents.

The patient was being totally cared for by the mother, sometimes the father and one older sister. He had to be catheterized periodically and fed by the family. He was totally dependent on care from the family. At the time this case was opened, it was close to Christmas. This family had very little food, no refrigerator, and minimal furniture.

To sum up why this case was important to me, we began to work with community resources to try and help this family. After the family was interviewed, the local people and T.V. station became involved, and we did get some very positive help from the community. For example, after my first visit, a refrigerator was delivered the following day, and within 1-2 weeks an electric hospital bed was given to the family. Food was also provided.

Another staff nurse and I worked very hard to help the family, and we did feel good that we were able to help make their lives a little more adaptable to this patient's extreme and straining medical needs.

The 5 year old got enrolled in kindergarten, and the bus came and picked up the 17 year old. He was able to go to high school. This helped the mother have some free time and also helped the children. I think the most rewarding part for me was to realize how fortunate I am to have a full life, health, career, and that as a nurse, I was able to provide a small amount of comfort to a very special family. This is why I enjoy being a nurse, because I care about people and have

compassion for my fellow man.

DELAYING IMMUNIZATIONS, 67%
DOMAINS I, II, III, VI.

The client was a nineteen year old mother of two. She had complications during the prenatal period which included a car accident, severe weight loss, and threatened abortion. When the infant was born the weight was 5 pounds and 3 ounces and apparently was in good health. The mother fell and broke her hip one week postpartum. The parents came in to clinic for a 6 week check-up for the baby.

The physician was briefed on the history of the pregnancy, and after the exam, he ordered the first immunizations to be given. Upon looking at the parents and knowing the mother was still not feeling well, the PHN felt immunizations should be delayed one month to give the mother time to heal and rest before initiating shots: "Nursing front line" vs "Doctor's orders." PHN recommended return appointment in one month for exam and shots, and the doctor agreed. On the next visit, the parents thanked the nurse for intervening and delaying the shots. The mother felt better physically, was more adjusted to the baby, and the baby weighed 10 pounds. The baby received the first immunizations and had no reactions to them.

ASSESSING TOTAL FAMILY CARE NEEDS, 67%
DOMAINS I, III, VI, VIII.

This case involved a 72 year old female with Parkinson's, Foley catheter, multiple decubitus ulcers, being cared for by her 73 year old husband.

The general condition of the patient seemed to deteriorate in a weeks time. She became dehydrated, and her skin condition became worse. Repeated instructions in patient care did not produce the desired improvement. While attempting to determine what was going on with the patient, I asked the husband for a 24 hour recall of what the patient had to eat. He was unable to do this. I began to check out the husband's state of health and found him to be somewhat confused---not to the point of disorientation, but to the extent that he wasn't able to follow through with his wife's care. He was hospitalized and found to be in electrolyte imbalance. Correcting his problem produced better care for the patient.

PERSISTENT FOLLOW-UP MAKES A DIFFERENCE, 67%
DOMAINS I, II, III, VIII, IX.

The client who came into the family planning program was 21 years old. Her pap smear came back moderate to severe dysplasia. An appointment was made for dysplasia clinic. The client did not keep this appointment. She was contacted and counseled extensively, and another appointment was made. The client did make this appointment, and cryotherapy was recommended. An appointment was made to have the procedure done. The client did not keep this appointment either. So, the client was again contacted, counseled, and the risks of not receiving treatment were discussed. Another appointment was made for cryotherapy, and the patient did attend the appointment and follow-up.

AN ALLERGIC REACTION IN THE CLINIC, 67%
DOMAINS III, IV, VI.

The client came into the health department to receive his weekly allergy injection. The client was a 74 year old gentleman who was receiving .55 cc antiallergen. After 10 minutes he came to the nurse and stated his arm was swelling at the site of the injection. He was also beginning to pull at the neck of his shirt. I sat the gentleman down and picked up the phone and called his doctor at Enid, OK. I stated who I was and that I needed to speak to his doctor immediately. The physician came to the phone, told me to give 1/2 cc Adrenalin, and repeat if necessary, and to also give 25 mg Benadryl. I was instructed to monitor his blood pressure, pulse, respirations, and if any further problems arose to call back. Vital signs were monitored for 45 minutes until stable, and then the patient was released to his own care. The patient is now monitored closely after receiving allergy medication.

SUPPORT FOR A MOTHER CARING FOR A DISABLED CHILD, 67%
DOMAINS I, II, III, IV.

When I began public health nursing, I was involved in home care with a boy who was 12 years old that has numerous birth defects. At the time I saw him, he weighed about 35 pounds and was fed with a gastrostomy tube. He spoke no words and was complete care. His mother required assistance with the gastrostomy tube changes and infections that frequently occurred around the opening. More so, she required assistance with maintaining a normal life style while caring for this boy. Frequently, I couldn't decide if I did more by nursing hands-on and decision making or being the person who counseled the mother on her care and sources for help emotionally and physically with this boy. Public health is such a broad area of jobs within a job. It can be trying, rewarding, fun, stressful and enlightening to life around us. It is truly a wonderful "job."

A NEGLECTFUL MOTHER, 67%
DOMAINS I, II, XI.

The PHN was requested to become involved with a mother who had three of her four children removed from her custody by the Child Welfare Division of the Department of Human Services. The charge of neglect was substantiated on the 3 older children. The mother was pregnant with the fourth. There had been DHS social work involvement for 15 months prior to a PHN being contacted. Since that time, I have performed developmental testing for the fourth child and testing to demonstrate the level of the mother's involvement with this child through an NCAT (Nursing Child Assessment Training) test. The mother is now aware of her lack of interaction and subsequent relinquishment of the parental role. The fourth child has increased her level of development through the mother's willingness to be involved. The three children who were out of the home are gradually being incorporated back into the home. The mother is aware of the role reversals and working to gain her control as parent. There had been a negative tension between the DHS social worker and the mother that has now relaxed. The mother had not admitted to any problems and blamed false reports of sexual abuse on the removal of the children. She has not yet admitted the probability of sexual abuse, but is willing to

admit her extreme neglect as a problem and is working on that problem. It has taken weekly visits with positive attitude, some confrontational manner, and visible proof to the mother of her ability to parent.

FAMILY VIOLENCE, 67%
DOMAIN VIII.

As a PHN working with victims of family violence, I have been able to incorporate that interest and demonstrated community problem to the lay and medical community. This has been accomplished through a "health systems committee" of the local Community Service Council. Agency individuals researched existing literature, and I edited such for publication into two manuals on family violence. Three workshops have been held to enlighten the medical community on the use of these manuals. In doing so, there has been an awareness stimulated as to the gravity of this problem in all ages of family members. The elder, incapacitated, spouse, and child victims are receiving a greater recognition. Laws have been passed to better protect each. The medical community is still lax in asking the question, "Has someone hurt you in your home or of your family?" The confidence to do so with a knowledge of what to do if the answer is yes is growing. The conferences to educate the community have spread this word. Yet needed is the time to go into each clinic and hospital with a program to provide opportunity to role play and ask questions of how to intervene.

ADVOCATING FOR AN ELDERLY WOMAN, 67%
DOMAINS I, III, VIII, X, XI.

While working in the SODA program, I came upon an elderly woman living in unsafe conditions:

1) the windows of the house were sealed shut and covered with plastic, and it was extremely hot that summer;

2) the house was not clean, and rotten food was all over the kitchen, in the refrigerator and on the counters and table;

3) the doors would not lock, and a rope was tied over the doorknob and hooked on a nail;

4) the electricity was disconnected with no hot water over a period of 2-3 days.

With the help of a homemaker and the DHS adult protective services, I was able to feed the woman, get her electricity turned on, windows open, and family notified that she needed care.

MANAGING AN EMERGENCY PRENATAL PROBLEM, 67%
DOMAINS III, IV, VI.

A prenatal patient came into the clinic to see me for a routine 2 week check-up. I noticed when I checked the fetal heart tones that there was too much fetal activity. The rate was too fast. I reviewed the patients fetal activity chart which I give all my prenatal patients at about 28 weeks gestation. I called my back-up physician, and he recommended transfer to a high risk center in Tulsa (my office is approximately 50 miles away). Therefore, I called Hillcrest Medical Center and talked to the OB doctor on call. He recommended that the patient go to Tulsa to Hillcrest Hospital immediately. I talked to the patient's spouse, gave them the address and referred

them immediately. The outcome was that the baby's cord was wrapped around the neck. This called for an emergency C-section. The baby was salvaged but stayed in intensive care several days and is doing OK today. This patient had no prenatal care prior to her visit with me.

MANAGING TOXEMIA OF PREGNANCY, 67%
DOMAINS III, IV, VI.

A 39 year old woman came into clinic for prenatal care. When I saw her, she appeared toxic. Her blood pressure was 160/110. Her urine dipstick was 3+ for protein, but she did not know her danger. I called Tulsa, Hillcrest Hospital and was told to transfer her immediately. I consulted my back-up physician and he called the emergency room here in our community. We took her to the E.R. where the life-flight helicopter came after her and transported her to Hillcrest Hospital High Risk Center. She had a C-section that same day, and the outcome was a good baby.

ABNORMAL REPRODUCTIVE ANATOMY IDENTIFIED, 67%
DOMAINS I, III, IV, VI.

Sherri came to the health department for her annual physical exam. Her only complaint was intermittent dyspareunia (painful intercourse) for which she had seen a gynecologist last year. Upon pelvic exam, I found two vaginal openings with a vaginal septum. The right side was smaller, and I could not palpate a well-formed cervix. Using a speculum, I could visualize a 1.5 cm rudimentary-appearing cervix but could not determine if there were one or a double cervix.

I then asked if she used tampons. She said, "Yes, but I was the only one in my gym class that still had blood in her panties." I immediately suspected that she indeed had two cervices. Next, I placed a cotton ball at the opening of the cervix on the left, put the speculum in the right side and could not find the cotton ball. Therefore, I surmised she had a complete vaginal septum and two cervices, even though rudimentary. Bimanual exam of the uterus and adnexa was unremarkable.

After talking with her, we decided her dyspareunia was probably occurring when the penis entered the right, smaller vagina. She was referred to a gynecologist who confirmed my findings. He recommended an IVP for kidney function, because often in embryonic development, if the reproductive system is abnormal the renal system is too. Her IVP was normal. Further testing of the reproductive system will not be done until after pregnancy. If pregnancy wastage occurs, then a complete work-up will be done.

I received a complimentary letter from the doctor on this finding. In follow-up with the patient, she said she just laughed and told her husband, "Guess we've got a spare!"

SUPPORTING THE WISH TO DIE AT HOME, 67%
DOMAIN I.

I received a phone call from a private physician requesting that I make a home visit to a terminally ill patient. He stated that the family was having problems accepting the patient's desire to die at home. The patient had cancer of the lung, stomach removed, abdominal aneurysm, without mention of rupture, and emphysema. He was 80 years old, and his wife was 81 and trying to take care of him. On my first

visit, the patient was up and able to walk with a little assistance, talking and sitting up. The patient was aware and alert to time and place. His vision and hearing were good for his age. Respirations were shallow and rapid, but in all ways, the patient was doing well.

On my second home visit 1 week later, the patient was completely bedfast. He had given up and refused to take medicine, eat or drink fluids, and having lots of trouble coughing up mucous from his lungs. I talked with the wife and daughter who was present. They stated that the previous time when I visited the patient he was unusually well, the only day that good. They needed assistance getting an electric bed, bedside commode, blue pads, and a suction machine. I discussed with them that I might be able to get the needed supplies from the American Cancer Society, and I would check when I got back to the office. I discussed with the wife and daughter that the patient appeared to be giving up. The daughter stated that twice he has almost died but they couldn't handle it so took him to the hospital. The patient was very angry about them prolonging his life. They stated that they are now willing to let him die at home. I offered to come and sit with the patient and family at the time of death if they wanted me to. I suggested they just give me a call. I assisted them in making arrangements to have the funeral home pick up the body and take it to the emergency room for the doctor to declare the patient dead. That way they would not have to go through resuscitation measures. I pointed out that since it appeared that the patient had given up, death was probably imminent.

The wife was going to the doctor that day, so I advised them to go by the health department on the way home, and I would give them information on when the bed, commode, and suction machine would be delivered. I informed them of arrangements made with the funeral home, also. When they stopped by the health department, I introduced them to other nurses and told them I planned to be out of town briefly. The next day, one of the other nurses went out to be with the family at the time of death and to assist with arrangements at that time.

Having someone around helped this family to allow the patient to die at home as he desired. Also, it relieved the family of a lot of emotional and financial stress.

PROMOTING PERINATAL CARE CHANGES IN THE LOCAL HOSPITAL, 67%
DOMAIN VIII.

I was very instrumental in starting prenatal classes in our community about 12 years ago and changing our hospital rules which forbade fathers in the Delivery Room. That was a very satisfying experience. And even now, after 12 years and after not doing the classes in 6 years, even though they do continue to be offered, I see people who come up to me and remember the classes and say, "Oh, I could have never had that baby without you." Even though I know that's not true, it's a great ego-booster. I see advancements now with sibling visiting hours and more modern delivery room settings etc. I feel I was instrumental in getting some of these things started.

EARLY DETECTION OF A MALIGNANT LUMP, 67%
DOMAINS I, III, IV, VI.

During a routine physical exam on a chronic disease patient, a lump was found in her breast. I referred her to a doctor regarding this lump. It was malignant and resulted in a mastectomy. The malignancy was detected early enough to prevent metastasis. This lady would not have received a breast exam if that service had not been available through the health department. I feel that my expertise in detecting the abnormality helped save her life.

MATERNAL NEGLECT OF ILLNESS, 67%
DOMAINS I, III, IV.

A home visit was requested by the maternal health clinic to monitor compliance with recommended medical care for the newborn of a 20 year old mother who had a chaotic life. The father of the newborn had recently been released from jail, but was not involved with the mother and baby. The mother also had a 2 year old child whose father was then in jail.

The woman had given birth 6 days previously and was seen at the WIC clinic when the baby was 3 days old. Although the baby had signs of illness at the time, the mother had not reported them. When the home visit was made, the newborn was ill with rapid respirations, a temperature elevation, irritability, and a slightly bulging anterior fontanel. In addition, there was desquamation on the trunk, dark red-purple discoloration on the back, and diarrhea was reported. The mother and her children were staying with the maternal grandmother of the children, temporarily. The MGM was supportive and concerned about the baby. When it was advised that the baby have immediate attention by a physician, the grandmother encouraged the mother of the baby to seek care.

I later phoned the physician to confirm that the baby was seen. I learned that she was admitted to the hospital. I will continue to follow this family until stabilized.

CONVINCING A CARE-GIVER THAT MORE CARE WAS NEEDED, 67%
DOMAINS III, IV, V, VIII.

In the home health care area of my practice, there was an incident when I felt a difference was made by the action taken by another nurse and myself. A patient was being cared for in the home of her sister, who was very attached to this patient. The patient had a condition resulting in deterioration of the brain, and she was totally bedfast, incoherent, incontinent, with Foley catheter, and being fed through a feeding tube. The sister was extremely proud of the fact that she was caring for the patient in her home and was, we later realized, in adamant denial of the need for care beyond what she could give (nor could our facility continue to follow her due to inadequate interim care, as we also later realized).

Very early in the course of our facility taking on this patient for skilled nursing care, we were called out one evening because of a non-functioning catheter. Indeed at first glance it appeared the patient was getting good care. The home was clean, upper middle class. The patient was clean, on clean sheets in a nicely appointed bedroom. However, she was found to be severely impacted and showing signs of early decubiti in several places. Her mouth and lips were

dry and parched. She also appeared to be in need of suctioning. Breath sounds were such that we suspected pneumonia. Her sister, who was also elderly, did not have the strength and stamina to manage this patient even if she could have been taught the basic nursing care.

As luck would have it, the sister happened to be entertaining visitors at the time of our visit. The visitor was a man who had been a former student of the sister. He was at that time a state representative. The sister held this man in high regard. After the patient's impaction was removed, she was recatheterized, cleaned up, and repositioned. We then called the sister in and frankly discussed with her the need for more attention to the patient's needs other than just bathing and tube feeding. She still did not seem convinced. With her permission, we called in her friend and pointed out these needs to him. Since round-the-clock nursing care in the home was not an option in this case, we asked the sister to consider a nursing home for ongoing care, and for the immediate situation, we recommended physician evaluation. The friend concurred with our recommendations and was able to convince the sister to comply. The patient was admitted to the hospital that evening, and she later went to the nursing home. Another upshot of this situation was that the friend was able to see another facet of public health nurse functions of which he was unaware. He commented on this and seemed awed by the nursing duties we had performed that evening, stating, "I had no idea what all you all did." When I met him a year or so later, he commented again on it. This and the fact that he was a state representative, I feel, had tremendous public relations value for all public health nurses.

IDENTIFYING THE CAUSE OF SCHOOL ILLNESS, 67%
DOMAINS I, II, III.

A tiny, Spanish-speaking, kindergarten student would cry each day about 10 a. m., and no one of the school personnel could understand why unless "school phobia (he was one of 8 sibs)." After several visits to the home, the mother finally could explain to me, the school nurse, that the child was "fine" after he'd had a bowel movement in the bathroom at home. We arranged for him to use the principal's private rest room at school, rather than the open stall commodes which were too high for him to keep his feet on the floor. That frightened him and prevented him from defecating in school and lead to severe abdominal discomfort. He was a happy, successful student the rest of the school year after we corrected the problem.

IDENTIFYING A CONGENITAL HEART DEFECT, 67%
DOMAINS I, II, III, IV, VI.

A three month old was in for her first DPT. She was very thin and the mother was concerned about her excessive hunger and long feeding time. The PHN referred her to me for a physical. The history revealed that the child had a heart murmur at birth, but on subsequent visits to the pediatrician, the mother was told that it was "normal." A harsh, loud, systolic murmur was heard, Grade IV. The consulting pediatrician started Digoxin immediately. Cardiology evaluation was arranged quickly. We were able to support the mom's anger at the misdiagnosis by the first physician, her fears (as a very young first-time mom, and the family's dire predictions as to outcomes of

open heart surgery), and many questions. She still returns to the regional Cardiology Clinic held at the health department, and the child is a healthy 4 year old.

PROMOTING INDEPENDENCE IN A PARAPLEGIC MAN, 67%
DOMAINS I, II, III, V, VIII, XI.

A woman called the health department from a nearby city and reported that her paralyzed brother lived in our community. She said his daughter "got him out of a nursing home to get his money, but she was not taking care of him. He was sick and was alone and could not get out of bed." She said he had called her, but she had no transportation.

I made a home visit and found a 47 year old man in bed, unable to get out of bed unassisted, unable to walk, fully mentally oriented. He had three large decubitus ulcers and an indwelling Foley catheter. He had Medicare but was unaware of Home Health Care and other resources available to him.

His story summarized:

He had been confined to a wheelchair for about three years as a teenager, due to a childhood injury. However, for over twenty years he walked, was self-supporting, married, and bought his home. About eight years before, he accidentally shot himself in the leg. His wife died suddenly and unexpectedly four years before. His daughter reported he then withdrew, used alcohol constantly, and "quit trying."

Mr. B.'s support system included a twenty-one year old son against whom he had a restraining order, an eighteen year old daughter living 60 miles away, and a twenty-one year old, unemployed daughter of the home. He also had a sister, 60 miles away, and a brother, 90 miles away, both without resources to help him. There were a couple of neighbors and a friend in the community who were willing to do small tasks when he asked.

Mr. B. lay on his left side with his knees drawn up on a water bed. He could not get out of bed unassisted. He said he had not been out of the bed in his wheel chair more than four or five times in the four months since his daughter got him out of the nursing home. He remained unbathed on the same linens for days to weeks. He was left alone eighteen to twenty-four hours per day and on occasion several days. He smoked one to two packs of cigarettes per day and took Valium daily. He had a telephone within reach, but not the light switch. His diet was poor. He stated that he decreased fluid and food intake to avoid bowel movements and over flowing the catheter drainage bag when he was left alone. He was incontinent of stool often.

Mr. B. agreed to Home Health Care. For five months I gave intermittent skilled nursing care. The care included medication and dressing changes for the decubitus ulcers, and foley catheter changes. I instructed him and his daughter on medication, diet, hydration, mobility, decubitus care and prevention, personal hygiene and safety. I got a window sticker from the fire department, and I made referrals to and worked with DHS rehabilitation services and the humane society. I made contact with his physician and got him admitted to the hospital once with a urinary tract infection and pneumonia.

Referral and coordination got him admitted to O' Donahue Rehabilitation Institute. Funding was appropriated to get his home

remodeled to be wheel chair functional after his program at O' Donahue.

PREMATURE HOSPITAL DISCHARGE, 67%
DOMAINS III, V, VI.

I can remember a married black lady last year who was approximately 89 years old. She was sent home from the hospital to her 92 year old husband with whom she lived in the country. She only had distant family. This woman had cellulitis of her leg and a low grade temperature. She was coherent but unable to dress her leg wound and too weak to stand. She was carried into the house by her distant relatives who were not planning to stay and care for her. She was referred to us for home health care but was in need of 24 hour nursing care. I called the doctor daily and reported her need for more close observation and managed the case in order to get a provider started as soon as possible. The provider and I worked closely in order to give the lady and elderly husband the best care. They had no car, and no family checked on them regularly. Eventually, the woman was readmitted within 2-3 weeks and placed in a nursing home. I feel the lady was sent home prematurely due to the DRG crunch. The doctor kept saying that the hospital nurses said she could stand and walk some. She definitely couldn' t though, and her spouse was too frail and feeble to help. It took much care and thought to get the right help in the home and to convince the doctor of her feebleness and illness. She died 2 months later of thyroid storm.

HOME HEALTH CARE OF A TERMINALLY ILL WOMAN, 67%
DOMAINS I, II, III, IV, V.

Another home care patient, a 79 year old white, widow, alone with no family, was sent home from the hospital after repair of a fractured femur. Her only relative, 1000 miles away, was a cousin, and he managed her money. She had a 24 hour provider that started that first day after she came home. There were little or no discharge instructions...another premature discharge situation. She had her Foley removed the day of discharge. The cousin left an hour after she came home, and she was total care. Her underlying diagnosis was cancer of the bladder with metastasis. The total care of the client was exhausting to the provider as she required 24 hour care. She was very demanding, confused, incontinent of bowel and bladder and had multiple health problems. The provider and I worked to keep her home as long as possible, and both the provider and patient needed much TLC. The patient lasted a year at home with many catheter infections, bladder infections, bowel problems, vaginal and urethral hemorrhages, decubiti, and dehydration. As she became gradually more confused and ill, she was placed in a nursing home. She died 1 month later.

IMPROVEMENT OF FAILURE-TO-THRIVE, 67%
DOMAINS I, II, III, VI.

I received a referral on Michael, a 2 year old, from his social worker. His parents were in the midst of a bitter custody suit. He had been labeled a failure-to-thrive and had been in foster care and was now in the custody of his paternal aunt. At my initial home visit, he was quiet, preferred to be alone, did not like to be held, had bouts of diarrhea, was pale and was suffering alopecia. Height was on the 25th percentile for age, and weight was at the 10th

percentile for age. His aunt had numerous questions about toddler care, feeding and nurturing. Her self-confidence as a new wife was good, but she had not cared for many small children. It was important that she do well with her nephew. We spent a great deal of time discussing normal toddler behavior and what she could expect from Michael who was neglected for so many of his 24 months. I weighed him every week and we made adjustments in his schedule and feeding as he improved. With each visit, Michael became more friendly, and his aunt became more confident. We went through weight loses, no change in head circumference or height, refusals to eat, problems with his mother's visits causing behavior problems, and the on-and-off diarrhea. I used my PNP skills, mothering knowledge and basic care-plan type problem-solving to help this family. The end result was the continuation of the teaching to the father who was given custody of his son. He is doing very well with Michael and is most receptive to any suggestions I make. Michael's hair is now thick and lovely. His height is normal for his age, and his weight is also coming up to near normal. I enjoyed this case as the end result was very satisfying. I was able to work with a responsive family, and the end result was more than I could have hoped for.

SUPPORTIVE CARE IN TERMINAL ILLNESS, 67%
DOMAINS I, II, VI.

One experience involved the husband of a home health care patient more than the patient. The patient was terminal with cancer and very near the end. The husband required much supportive care as well as a need for basic knowledge of total patient care. After performing the required assessment and care for the patient on each visit, time was allotted for the husband to vent his grief, concerns, and guilt feelings.

During one visit, while administering care, the husband stated to the nurse that she was very tender with the patient and acted as if she really cared and became involved. He was also full of questions and never could accept "why" this had happened to his wife. The woman did expire, and the husband has come into the health department two times since then expressing appreciation.

INVESTIGATING SYMPTOMS, 67%
DOMAINS III, IV.

A caucasian male client presented with no complaints other than "being tired." The man reported having seen a physician "last week," but he just said that the man was getting old. The physician had run no studies, but the client's color was pale, and his pulse was 112. I ran a hematocrit which showed 27%. The physician was promptly advised of the situation, and the client was seen the next day. The problem was diagnosed as cancer of the kidney.

MANAGING A LIFE-THREATENING INCIDENT IN THE CLINIC, 67%
DOMAINS III, IV.

A caucasian female client in the older age group presented to clinic wanting her blood pressure checked because she didn't feel well. The blood pressure reading was 0/0, and the client collapsed. Supportive measures were begun which included oxygen administration and positioning.

The ambulance was called, and the husband was advised of the client's critical condition. The woman was referred to the closest medical facility despite the fact that she wished to go to one 42 miles away. The client had suffered a heart attack but did survive the incident.

APPENDIX F

SELECTED EXAMPLES OF NON-EXPERT COMMUNITY HEALTH NURSING

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SELECTED EXAMPLES OF NON-EXPERT

COMMUNITY HEALTH NURSING

HEALTH TEACHING AT THE SENIOR CITIZENS' CENTER, 56%
Domains II and VIII.

In our agency, the public health nurses give programs at Senior Citizen's Centers. These programs are informative, especially for the elderly, but I have also spearheaded programs for Home Demonstration groups. The program I give is "Breast Self Exam." This group is a captive audience, because they are very interested in health issues. I only speak to the women in these groups. Recently, I added "Osteoporoses" to the "Breast Self Exam" program. The women are eager to listen, and a good discussion usually follows my program.

MANAGING COLOSTOMY CARE, 44%
DOMAINS I, II, VIII.

The family of a colostomy patient was reluctant to even watch the colostomy care given to the family member. The patient had an episode of confusion and took off the colostomy bag during the night. The frantic family called wanting me to come immediately. I calmed the caller down, talked him through the bag replacement on the phone. I was able to go later in the day and found that he had done the procedure well.

ORGANIZING VOLUNTEERS TO ASSIST IN NURSING HOMES, 33%
DOMAIN VIII.

The need was identified for more community involvement in the local nursing home by citizens. I talked to church groups and was able to organize a volunteer group to go into two nursing homes.

SEXUALLY TRANSMITTED DISEASE PHONE CALLS, 22%
DOMAINS I, II, IX.

I usually receive phone calls related to sexually transmitted diseases and feel the information we provide concerned citizens is an essential service. The AIDS scare has increased the number of calls considerably. These are usually anonymous and must be handled when they are received. It is not possible to mail out additional information, because the callers are unwilling to be identified. This health information service is one of the most important, unnoticed duties a PHN performs.

ADMINISTERING ALLERGY INJECTIONS TO A THREE YEAR OLD, 0%
DOMAIN I.

I enjoy working with children. One rewarding thing to me is that I have a little 3 year old who takes weekly allergy shots. She cried and was scared to death of the shot. With the nurse's patience and understanding, she now looks forward to coming in for her allergy shot.

VITA 2

Donna Johnson Eckhart

Candidate for the Degree of

Doctor of Education

Thesis: EXPERTISE OF COMMUNITY HEALTH NURSES

Major Field: Higher Education Administration

Biographical:

Personal Data: Born in Detroit, Michigan, January 17, 1931, the daughter of William P. and Martha I. Johnson. Married to Franklin F. Eckhart on April 3, 1954.

Education: Graduated from Highland Park High School, Highland Park, Michigan, in June, 1948; received Associate in Science degree from Highland Park Junior College, June, 1950; received Bachelor of Science in Nursing from The University of Michigan, September, 1953; received Master of Science in Nursing from The State University of New York at Buffalo, September, 1976; completed requirements for the Doctor of Education degree at Oklahoma State University in December, 1988.

Professional Experience: Staff Nurse at Children's Hospital of Michigan, Detroit, Michigan, 1953-54; Central Supply Supervisor at Escambia General Hospital, Pensacola, Florida, 1954; Private Duty Nurse (part-time) at Princeton General Hospital, Princeton, New Jersey, 1958-59 and Children's Hospital of Buffalo, Buffalo, New York, 1960-63; Staff Nurse at Veterans' Administration Hospital of Buffalo, Buffalo, New York, 1973-75; Instructor at State University of New York at Buffalo, 1976; Assistant Professor at Oklahoma Baptist University, Shawnee, Oklahoma, 1976-82; Associate Professor at Oklahoma Baptist University, 1982-83; Joint Appointment, Oklahoma Baptist University and Oklahoma State Department of Health, 1983-85; Maternal and Child Health Nurse Consultant at the Oklahoma State Department of Health, 1985 to present.

Professional Organizations: American Nurses' Association; Oklahoma Nurses' Association; District #12 Nurses' Association; National League for Nursing; Oklahoma League

for Nursing; Sigma Theta Tau; National Association of Pediatric Nurse Associates and Practitioners, Fellow; Oklahoma Chapter National Association of Pediatric Nurse Associates and Practitioners; Oklahoma Public Health Association; Oklahoma Perinatal Association; Oklahoma Chapter of International Lactation Consultants' Association.