Perceptions of community health nursing from community health nurses in southwestern rural Montana by Margaret Clare Riley Winninghoff

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University
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Abstract:
The specific purpose of this research was to study community health nurses' perception of what they do and what they perceive as optimal community health nursing care. Data are needed for planning, evaluation, and upgrading the community health nursing care given in the sparsely populated state of Montana.

The design of this study is descriptive. Its purpose is to obtain information by means of ethnographic interviews on what care the community health nurse delivers and her perception about providing optimal nursing care.

The sample for this research study consisted of seven community health nurses employed in counties that do not have a full-time health officer. The seven registered nurses, all female, are from rural southwestern Montana.

The group of community health nurses consisted of five registered nurses with diplomas from a diploma program in nursing and two registered nurses with generic baccalaureate degrees in nursing.

The instrument used in this study was semistructured interviews made up of open-ended ethnographic questions.

The interviews were taped and also recorded by hand.

The findings indicated the following deficits in the delivery of community health nursing care in the southwestern part of Montana: community health nurses lack power; community health nurses only view their practice in terms of day to day tasks rather than broad based community health nursing practice; and community health nurses are unable to implement or change program direction in their communities.

The major conclusions are that to provide up to date community health nursing in small rural communities there is a need to hire community health nurses who believe they have power, who deliver health care based on broad based concepts of community health nursing, and who have the knowledge and ability to implement or change program direction in their communities.
APPROVAL

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This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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Date  July 7, 1984
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ABSTRACT

The specific purpose of this research was to study community health nurses' perception of what they do and what they perceive as optimal community health nursing care. Data are needed for planning, evaluation, and upgrading the community health nursing care given in the sparsely populated state of Montana.

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The findings indicated the following deficits in the delivery of community health nursing care in the southwestern part of Montana: community health nurses lack power; community health nurses only view their practice in terms of day to day tasks rather than broad based community health nursing practice; and community health nurses are unable to implement or change program direction in their communities.

The major conclusions are that to provide up to date community health nursing in small rural communities there is a need to hire community health nurses who believe they have power, who deliver health care based on broad based concepts of community health nursing, and who have the knowledge and ability to implement or change program direction in their communities.
BACKGROUND AND RATIONALE FOR THE STUDY

Introduction

Community health nursing is an integral part of the health care system in Montana. In the United States, there are various ways in which community health is organized. Community health nursing may be organized under the jurisdiction of federal, state, county, or city government. In Montana, there are basically two ways in which community health nursing can be delivered: through organized health departments or through non official, community-based nursing services. Whereas the organized health departments are similarly operated and provide similar services, small nursing services may deviate considerably from standards set for larger organizations. At present, there is a lack of information about Montana rural community health nurses who do not work in organized health departments.

Nursing consultants are available to nurses serving rural communities in sparsely populated areas. How much need there is for direction and assistance in meeting local nursing needs, how effectively needs are being met, and whether assistance would be used by the community health nurses is not known. The writer's experience as a consultant indicates that some consultants are not used by
the community health nurses as much as would be expected and that local politics and attitudes play a role in how community health nursing services are used in a community.

Based on this experience, a need for studying community health nursing in small communities has been identified. A study of what community health nurses do and what they perceive as optimal nursing care would provide a basis for understanding the operation of community health nursing services in sparsely populated areas. This knowledge would provide a basis for evaluation of available nursing services in rural areas.

The goals of nursing relate to the provision of services to individuals, families, groups, and communities (Saperstein & Frazier, 1980). The American Nurses' Association's (1973) definition of community health practice is as follows:

Community health nursing is a synthesis of nursing practice and public health science applied to promoting and preserving the health of the population. The nature of this practice is general and comprehensive, is not limited to a particular age or diagnostic group, and is continuing, not episodic. The primary responsibility is to the population as a whole. Therefore, nursing directed to individuals, families or groups contributes to the health of the total population. Health promotion, health maintenance, health education, coordination, and continuity of care are utilized in a holistic approach to the family, group, and community. The nurses' actions acknowledge the need for comprehensive health planning, recognize the influences of social and ecological issues, give attention to population at risk, and utilize the dynamic forces which influence change. (American Nurses' Association, 1973).

The definition and role of community health nursing in
the delivery of health care according to the American Public Health Association (1980) is as follows:

Community health nursing synthesizes the body of knowledge from the public health sciences and professional nursing theories. The implicit overriding goal is to improve the health of the community by identifying subgroups (aggregates) within the community population which are at high risk of illness, disability, or premature death and directing resources toward these groups. This lies at the heart of primary prevention and health promotion. Community health nursing accomplishes its goal by working with groups, families, and individuals as well as by functioning in multi-disciplinary teams and programs. Success in the reduction of risks and improving the health of the community is dependent on a full range of consumer involvement, especially from those groups at risk as well as the community and its members, in health planning, in self help, and in individual responsibility for personal health habits which promote health and a safe environment (American Public Health Association, 1980).

Background of the Problem

At present, there are six organized health departments in Montana: Billings (Yellowstone County); Missoula (Missoula County); Great Falls (Cascade County); Helena (Lewis & Clark County); Bozeman (Gallatin County); and Kalispell (Flathead County). These six organized health departments have a health officer and director of community health nursing. The rest of the counties in Montana offer services by a community health nurse but are not attached to an organized health department. The services provided by community health nurses in these counties vary according to determined need and ability of the county to pay for services.
Purpose of the Study

The specific purpose of this research is to study community health nurses' perceptions of what they do and what they perceive as optimal community nursing care. Data are needed for planning, evaluating, and upgrading the community health nursing care given in the sparsely populated state of Montana.
Chapter 2

REVIEW OF LITERATURE

Historical Review of Community Health Nursing

Literature related to community health nursing in rural or sparsely populated areas is very limited. To understand the present state of community health nursing, it is necessary to view community health nursing in its historical context.

The evolution of community health nursing in the United States came out of a narrow view of both its purpose and what groups it served.

In the nineteenth century, the main responsibility of official health agencies was control of communicable diseases and sanitation. Between 1875 and 1900, district nursing services were developed in various cities. Lillian Wald, (1867-1940), who was both a nurse and social worker at the beginning of this century, was responsible for many developments in community health nursing (Jarvis, 1981). Miss Wald, in 1909, persuaded the Metropolitan Life Insurance Company to begin, on an experimental basis, a home nursing service for its policyholders through a working arrangement with the Henry Street Settlement. Twelve years later, a study and review of the project showed that the program had been highly successful and had been adopted by
Community health nursing agencies in many communities (Leahy, Cobb, & Jones, 1982).

With the assured income from the provision of nursing services to policyholders for which the insurance companies paid full cost, community health nursing agencies had a firm basis on which to build their overall budget. The remainder of the budget could then be raised in the community by charging full or partial fees for visits to non-policyholders who could afford to pay by gifts and by allotments from community funds (Leahy, Cobb, & Jones, 1982.).

The American Red Cross was a pioneer in rural community health nursing when, in 1912, it provided community health nursing care to people in the villages and on the farm. Much of the work was done by "itinerant nurses", who were sent to an area for several months at a time to demonstrate home care for the sick, to demonstrate school nursing, and to initiate and provide well-baby conferences. These nurses also conducted mothers' classes and home nursing classes. It was hoped that the communities would recognize the need to employ full-time community health nurses to carry on the program (Leahy, Cobb & Jones, 1982).

Although community health nursing arose from the private sector and originally was geared to provide home nursing services to the poor, it is now firmly established in the public domain and serves persons from every
socioeconomic level.

Originally, the community health nurse was considered to be a generalist, providing all types of service. One of the more important functions was bedside nursing, and according to one scholar, she endeavors to discover and remedy physical defects and habits as well as unsanitary conditions. She gives various members of the family definite instructions regarding the prevention of disease and the development of sound health. (Moore, 1923).

Community Health Nursing in the Eighties

Today, the concept of community health nursing as one that embraces a broad range of services is widely accepted. The majority of community health nurses operate within the context of an official health department or a combination agency. The major financial support for an official health department comes primarily from local taxation supplemented by state support; consequently, many professional activities of these departments are mandated by state law.

Generally, the official health department is directed by a health officer who often is a physician. Under the health officer's authority, there may be several divisions which are responsible for implementing various programs and activities. For example, the nursing department is responsible for maternal child health, tuberculosis, immunizations, sexually transmitted diseases, family planning, problem pregnancy programs, various clinics, home visiting, counseling, and referral and followup. The laboratory department is responsible for testing, reporting, and controlling the quality of programs. The environmental
Sanitation department is responsible for the inspection and evaluation of public establishments for sanitation and cleanliness, sampling of water from wells, investigation of septic tanks, and followup. All departments interact and coordinate their services to provide comprehensive community health programs. Because the health department is supported by tax monies, services are provided either free of charge or at a nominal fee.

The health of the community is the major goal in community health nursing. In community health practice, the nurse considers the individual within the context of the family unit and thereby offers a family-centered service. The community health nurse, through a unique relationship with families, is usually accepted by them as a supportive, helpful person to whom they can turn in times of stress and difficulty. The nurse acts as the liaison between the family and the community resources.

The community health nurse is called upon to exercise independent judgement and take independent action without the built-in network of supervision available to the hospital nurse. As a practitioner of nursing, the community health nurse must test and evaluate various concepts and theories drawn from nursing, such as behavioral sciences, microbiology, physics, chemistry, and economics, to devise a framework for action. Data must be collected and systematized to formulate the health and social profile of
the client. On the basis of this profile, family health problems are defined, priorities are set, and nursing care plan are developed. Implementation of these plans are based on (1) the nurse's ability to coordinate needed services through direct care and/or appropriate referral to community agencies, and (2) the family's ability to understand the need for the plan and their willingness to participate in achieving the health goals (Benson & McDevitt, 1980).

Community health nurses function in a variety of roles, and various skills are needed in these roles. Some important examples of these skills are communication, teaching and learning, interpersonal relationships, problem-solving, and decision-making. Community health nursing can no longer be defined by describing particular jobs because there are a number of recurrent roles that community health nurses function in at work. The roles that are especially important for community health nurses are as follows: advocate; collaborator and team member; community organizer; consultant; coordinator and facilitator; deliverer of services; educator; evaluator; information gatherer; researcher; manager; and referral director. All of these roles are enacted in different places but seldom all together.

There are other community health practice skills that community health nurses utilize in their daily work. Careful consideration is given to the health status of many
population aggregates. These aggregates may be defined in various ways, such as infants during their first year, expectant mothers, children of school age, the older population, or groups of people who have just experienced the death of a spouse. Community health nursing demands attention to multiple and sometimes overlapping aggregates.

Attention must be given to the influence of environmental factors (physical, biological, and sociocultural) and of the health of populations. Priority must be given as well to preventive and health maintenance strategies over curative strategies. Community health nursing is family-oriented care outside of the institutional setting, but it is also a matter of focus on group health problems, both present and projected (Williams, 1977.)

The essence of community health nursing is a concern for the health of population groups. The primary focus of community health nursing practice is defining problems (assessment) and proposing solutions (treatment) at the population (aggregate) level (Williams, 1983).

In population-focused community health nursing, the emphasis should be on the relationship between the health status of a given population, the determinants of its health status, and the care system's responses and effectiveness. Community health nurses should give priority to developing and maintaining structures for providing care to a defined target population, collaborating with the public to
identify needs and potential solutions, participating actively in system level decisions, and influencing other decision makers to enable such development.

The home visit is the classic and traditional preserve of the community health nurse. It remains an excellent way, and is very often the only way, for the nurse to observe home situations, family interactions, and various positive and negative forces that operate on the client. People usually behave different in their own homes than they do in public places. A sense of being "on one's own turf" can change modes of behavior and ways of relating to people and events. People behave more naturally in their own homes, and displaying a "put-on behavior" is absent. The nurse visiting in the home is a guest, often uninvited and sometimes perceived as a threat in spite of good intentions. This places an entirely different character on the nurse-client relationship than the relationship that occurs in a clinic or office situation, where it is the client who is in strange territory and who is the "guest" of the agency.

The nurse in the home can fill a variety of roles and functions and can provide direct nursing care that includes both physical and emotional aspects. This care may be on a short-term basis, as with a client who has recently been discharged from the hospital and who still needs dressing changes or injections, or on a long-term or permanent basis,
as in the case of the chronically ill or permanently disabled person.

The home visit can serve as a teaching situation or as a review of teaching done in the hospital or doctor's office. For example, a client may give every indication of having mastered the techniques involved in colostomy care, but in a different environment, self-confidence can erode, and lessons can be forgotten. The nurse can assess what is needed and can reinforce teaching already done. When the nurse enters the home, there is an opportunity to determine in what areas of teaching she can be of help. She can also determine what other agencies or health professionals might be needed and can make the appropriate referrals.

The most important function of the community nurse in the home might very well not be the laying on of hands or "doing" something; the client's greatest need may be to talk. It is only by making a home visit that the nurse can gain insight into the entire scope of the client's problem. Sometimes during a home visit, the nurse's most therapeutic act is simply listening. By making a home visit, she can often assess whether the client has the necessary resources, e.g., money, emotional stability, transportation, or living arrangements, to deal with the health problems at hand. Only by assessing the resources can the nurse assist the client to set up logical objectives to deal with whatever problems exist (Fromer, 1979).
As contracts are made between teachers and students for grades in a course, so are contracts made between nurses and clients to meet health goals. It is essential for the establishment of a workable contract that both the client and the nurse have a clear idea of what the health problem is, the purpose of the nurse's visits, what the desired objectives are, and what means are to be used to reach the goal. The client and the nurse must have the same goals; unless there is agreement, there is no point in developing a contract. Contracts are extremely effective in some situations, but each time she considers using the contract technique, the nurse must carefully evaluate whether it is appropriate.

The community health nurse's role as a change agent is an important function in community health nursing. Almost every nursing action taken results in change. Making a physical assessment almost always results in changes in the information the nurse has about a client. In the past, nurses had to request and wait for the results of a physical examination from the physician. Now, nurses can do their own examinations and can discuss their findings with the physician. There is also a change in the kinds of actions nurses can take on an independent basis, as well as a change in the rapidity with which the action can be taken. The information that nurses seek is immediately available when they obtain it themselves. Participation in community
health planning usually results in changes in the kinds of services offered to clients and often in the nurses' perceptions of themselves (Fromer, 1979).

A major component of community health nursing is involvement in policy formation at various organizational and governmental levels. Community health nurses should be active in the policy arena primarily because this is a crucial modality for influencing the health of defined populations (Williams, 1983).
Chapter 3

METHODOLOGY

Research Design

The design of this research study is descriptive. Its purpose is to obtain information by means of ethnographic interviews on what care the community health nurse delivers and her perceptions about providing optimal nursing care.

The ethnographic approach is a naturalistic, comparative method aimed at studying human behavior and attitudes through observations in the natural setting. A natural social setting reflects the society of which it is a part. A society's culture consists of whatever an individual had to know or believe to operate in a manner acceptable to its members. Culture is the form of things that people have in mind: their models for perceiving, relating, and otherwise interpreting them. Ethnographic description requires various methods of processing observed phenomena to inductively construct a theory of how informants have organized a common phenomenon. It is the theory, not the phenomenon alone, which ethnographic description aims to present (Goodenough, 1964).

The method of participant observations is synonymous with the ethnographic approach. The major instrument for the collection of data is the investigator. Thus, the
successful employment of the method of participant observation is predicated upon one's ability to establish rapport and relationships of mutual trust and respect with informants (Ragucci, 1972).

Key informant interviewing is used to its best advantage when it is closely integrated with participant observation (Pelto & Pelto, 1978). Every individual is a participant observer; if not of other cultures, then at least of his or her own. By structuring observations and systematically exploring relationships among different events through interviewing, meticulous, eyewitnessing participant observation can be converted to scientific use (Spradly, 1979).

**Definition of Terms**

For purposes of this study, definitions include the following:

**Perception**: All the processes by which individuals acquire information about the environment and about their own internal states.

**Ethnography**: The work of describing a culture and learning about it from the people. Ethnography is descriptive and comparative (Evaneshko & Kay, 1982). Statistical measurements for this kind of research are descriptive (Spradley, 1979).

**Community health nurses**: Registered nurses in a
sparsley populated area, i.e., the person who delivers the services in the diverse community settings in which they work.

Sample and Setting

The sample for this research study consisted of seven community health nurses employed in counties that do not have a full-time health office. The selected seven registered nurses are from rural southwestern Montana and are a convenient sample of the rural community health nurses that do not have a full-time health officer. The group consisted of five registered nurses with diplomas from a diploma program in nursing and two registered nurses with generic baccalaureate degrees in nursing.

Data Collection Methods

The instrument used in this study was semistructured interviews made up of open-ended ethnographic questions. (See samples of instruments in Appendix B.) The questions were developed to elicit specific information from individual community health nurses and were pretested with two community health nurse colleagues to determine that the interview was of proper length, that questions were clear, and that needed information was obtained. In addition, the questions were examined by experts in nursing and anthropology. The researcher asked the same sequence of
questions, with questions requesting elaboration and clarification as required. Each of the seven community health nurses, the key informants, were interviewed using the same words and phrases, with no change in the way the interview was conducted.

These key informants from selected communities were encouraged to speak in terms they generally use and were asked to respond to an ethnographic interview for the purpose of giving a detailed account of what they actually do and what they perceive as optimal community health nursing care.

The nurse's total self-system affects her perceptions. Value systems, ideals, life goals, experience, presets, expectations of self and others, and contexts all affect perception. What a person sees and hears and how he or she interprets this information is regulated by the self system. Perception is more than seeing and hearing; it also includes interpreting this information. Interpretations are functions of values, social conditioning, and life experiences and expectations. The nurse's perception of herself will affect her view of others (Douglass, & Bevis, 1974).

Validity

To ensure the validity of this study, the following were considered.
Face validity: "On the assumption that all members of a culture are carriers of the culture, any person who belongs to the group under study is a possible informant." The researcher as an community health nurse and observer also was assumed to have face validity (Spradley, 1979).

Construct validity: Validation of status and role was accomplished by questioning someone other than a close friend or relative of the informant (Spradley, 1979). This was accomplished by validation with community health nursing professors of Montana State University.

Content validity: Cross-checking informants' statements with and across groups will establish norms for one group and for the population as a whole (Spradley, 1979). This was accomplished by interviewing the five community health nurses with diplomas from a diploma program in nursing regarding their expertise in particular content areas and then interviewing the community health nurses with generic baccalaureate degrees in nursing as expert informants with each content area to establish validity.

Reliability

The same researcher gave the same questionnaire to all the registered nurse informants. The method of administering the questionnaire was uniform (using the same words and phrases), and no changes were made in the way the interviews were conducted. The ethnographic interview, that
is the questionnaire, was examined by experts in nursing and anthropology. These experts were Montana State University nursing professors with specialities in research, community health nursing, community mental health nursing, and anthropology.

Content Analysis

In ethnographic descriptive studies, the data are semistructured. The researcher recorded the interviews by hand and also taped the interviews. First, the researcher compiled all the information that was obtained from the community health nurses' perception of what they do, and the researcher then categorized their responses. Second, the researcher compiled all the information obtained from the community health nurses' perception of optimal nursing care and categorized these responses. The categories were compared to see if there were incongruities to determine key elements in the nursing role from a community health nurse's point of view.

Protection of Human Rights

Three major factors are involved in the protection of human rights: informed consent, confidentiality of data collected, and protection of the individuals from harm (Brink & Wood, 1978).

The researcher contacted each possible informant by
phone: a verbal explanation of the study was given, and approval was obtained. Appointments were made with each informant, an abstract of the study was given to each, and time was allowed for questions and further explanation. A form titled, "Participation in Thesis Regarding Community Health Nursing in Rural Montana" was given to each informant to sign. (See Appendix A.)

Pilot Study

A small pilot study was conducted with two community health nurse colleagues to determine that the interview was the proper length, that questions were clear, and that needed information was obtained. The two community health nurses were interviewed, and they pretested the open-ended ethnographic questions and offered helpful comments.
Chapter 4

DATA ANALYSIS

INITIAL ANALYSIS OF DATA

Introduction

Section I presents the characteristics of the sample, the interview procedure, the informant characteristics, and the domain and taxonomy analysis.

Characteristics of the Sample

The informants for this research study, seven selected registered nurses from rural southwestern Montana, were a convenient sample of the rural community health nurses who work in counties that do not have a full-time health officer. The seven informants lived and served different communities, and each was interviewed twice over a four-month period. The first interview was conducted in person at the work sites of each of the community health nurses, and the second interview was conducted by telephone.

Interview Process

The initial interview was conducted in person with the community health nurse, and the interview was recorded by hand and also tape recorded. Professional rapport was
easily established between the investigator and community health nurse because the researcher was also a community health nurse. After obtaining written consent from each informant, demographic data were collected.

To determine their perceptions of what they do, the informants were asked to respond to "grand tour" questions, such as "Describe what you do from day to day in your job" and "How much time do you spend in each one of these areas?" After all of the interviews were completed, tapes and notes were analyzed for domains, i.e., categories of meaning that include other smaller categories. After collecting data, listening to tapes, and working on a preliminary analysis, it was necessary to do a follow-up interview by telephone to clarify definitions of terms and restate the question about how nurses would envision their roles and job functions under ideal conditions. Domains were examined for related terms, and clarifying questions were formulated such as,

"Setting aside the real situation in your particular county, if you were able to fantasize on providing optimal community health nursing, explain to me how you would do it?"

"Who would you like to see make the final decision regarding community health nursing care in your county?"

"Now, fantasize on the type of organization you would like to have to determine community health nursing in your county?"

"You used the following terms in our first interview... Will you describe in detail or give me your definition of these in your own terms?"

Informant Characteristics

Table 1 illustrates the general characteristics of the
seven community health nurse (CHN) informants. Time of registered nurse licensure ranged from 1941 to 1975. The group of seven community health nurses consisted of five registered nurses who were graduates of a diploma program in nursing and two registered nurses with generic baccalaureate degrees in nursing. All of the community health nurses interviewed were women.

None of the seven community health nurses had ever worked as a community health nurse in states other than Montana. Length of time in their community health job ranged from seven months to thirteen years.

Demographic Data on the Community Health Nurse Informants

All the community health nurses are employed in rural communities. They all belong to at least one professional nursing organization and subscribe to one professional nursing magazine.

Community health nurse 1 is employed part-time in a small rural community with a population of approximately 1000. Since graduation in 1944, she had one semester of formal education at a university in 1946. She attends workshops in Montana, such as the Ostomy Care at Fairmont last year, when funding was available. She belongs to one professional organization: the Montana Nurses Association, and she subscribes to the magazine, RN, and the Treasure State Health publication.
<table>
<thead>
<tr>
<th>CHN</th>
<th>R.N</th>
<th>Diploma Licensure</th>
<th>BSN</th>
<th>Prior CHN outside of Montana</th>
<th>Length of time at present CHN job</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1944</td>
<td>x</td>
<td></td>
<td>No</td>
<td>4 years</td>
</tr>
<tr>
<td>2</td>
<td>1975</td>
<td></td>
<td>x</td>
<td>No</td>
<td>3 years</td>
</tr>
<tr>
<td>3</td>
<td>1941</td>
<td></td>
<td>x</td>
<td>No</td>
<td>13 years</td>
</tr>
<tr>
<td>4</td>
<td>1974</td>
<td></td>
<td>x</td>
<td>No</td>
<td>7 months</td>
</tr>
<tr>
<td>5</td>
<td>1975</td>
<td></td>
<td>x</td>
<td>No</td>
<td>4.5 years</td>
</tr>
<tr>
<td>6</td>
<td>1951</td>
<td></td>
<td>x</td>
<td>No</td>
<td>8 years</td>
</tr>
<tr>
<td>7</td>
<td>1955</td>
<td>6</td>
<td></td>
<td>No</td>
<td>5 years.</td>
</tr>
</tbody>
</table>
Her major work area is in her home, but she has specific areas in the town where she holds community clinics, such as hypertension and immunization clinics. Her uniform varies, "usually whites, when I do clinics, and when I do home visits, I wear a white blouse, navy blue slacks, and a navy blue blazer."

Community health nurse 2 is employed full time in a small rural community with a population of 1200. In the last four years, she has attended many continuing education courses in nursing and the school nursing education program such as the School Nurse Action Program. She belongs to two professional organizations: the Montana Nurses Association and Montana Public Health Association. She subscribes, through the office, to *The American Journal of Nursing* and orders a new book every month, that is, reference books in nursing, nursing books designed for use with clients.

She has an office in the basement of the courthouse, and her uniform usually consists of a white blouse and blue slacks or skirt. She stated "I will even wear levis if the need arises."

Community health nurse 3 is employed full time in a small rural community with a population of 2700. In the last six months, she has attended many continuing education courses in nursing, such as a class on Pediatric Assessment. She belongs to three professional nursing organizations: the American Nurses Association, the Montana Nurses Association,
and the Montana Public Health Association and she subscribes to RN and budgets through the office for the Harvard Medical Monthly, Prevention Magazine, Community Home Health Journal and the Physician's Desk Reference.

Her office is located in a free standing community health building. Her dress consists of a white uniform, white stockings, and white shoes even when making home visits. She wears her nursing cap only in the office.

Community health nurse 4 is employed part-time in a small rural community with a population of approximately 4500. She belongs to one professional organization: the Montana Nurses Association, and she subscribes to one professional magazine, the American Journal of Nursing.

Her office is in the basement of the county hospital, and she always wears street clothes to work.

Community health nurse 5 is employed part-time in a small rural community with a population of approximately 4500. She belongs to one professional organization: the Montana Public Health Association, and she subscribes to the Journal of Maternal Child Health Nursing, Nursing 84, and RN.

Her office is in the basement of the county hospital, and she always wears street clothes to work.

Community health nurse 6 is employed full time in a small rural community with a population of approximately 3000. She is an active member of the Montana Nurses
Association, and she also belongs to the Montana Public Health Association and the School Nurse Association; she subscribes to Nursing 84.

Her office is in the basement of the courthouse and she does not wear a uniform. As she has said, "what is the point, I wear street clothes."

Community health nurse 7 is employed full time in a large rural community with a population of approximately 8,186. She has attended several nursing workshops since she took the community health nursing job in 1979, and she subscribes to Nursing Life and, through the office, to Nursing 84 and Diabetic Forecast. She belongs to the American Nurses Association, Montana Public Health Association, Diabetic Association, and the Arthritis Association.

Her office is on the first floor of the courthouse, and she always wears street clothes to work.

Ethnographic Content Analysis Regarding Community Health Nurses' Perceptions of What They Do

The purpose of this research study was to obtain information on what care the community health nurse delivers and her perceptions about providing optimal community health nursing care. According to Spradley (1980), analysis of any kind involves a way of thinking. It refers to the systematic examination of something to determine its parts, the relationship among parts, and their relationship to the
whole. Analysis is a search for patterns. Ethnographic analysis consists of discovering procedures which reveal patterns. Domain and taxonomy analysis are two types of ethnographic analysis and two aspects of content analysis. Community health nurse informants' perceptions on community health nursing were obtained by interview and from these data, domains and taxonomies were selected for analysis.

Domain and Taxonomy Analysis

According to Spradley (1980), domains are made up of three basic elements: cover term, included terms, and semantic relationship. A taxonomy differs from a domain in only one respect: it shows the relationships among all the included terms in a domain. A taxonomy reveals subsets and the way they are related to the whole. Several relationships found in this research study are illustrated in Table 2 with examples.

Taxonomic tables presented indicate the semantic relationship of each term within the domain. Domains that were most frequently mentioned among the community health nurse informants as a whole are presented. The responses are presented in Table 2 which shows semantic relationships, domains, and cover terms.
Table 2. Types of Semantic Relationships of Domains and Cover Terms

<table>
<thead>
<tr>
<th>Included Terms</th>
<th>Semantic Relationships</th>
<th>Cover Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings</td>
<td>is a kind of</td>
<td>necessary evil</td>
</tr>
<tr>
<td>Home visit</td>
<td>is a kind of</td>
<td>assessment</td>
</tr>
<tr>
<td>Referral</td>
<td>is a kind of</td>
<td>request</td>
</tr>
<tr>
<td>Screening</td>
<td>is a way to</td>
<td>prevention</td>
</tr>
<tr>
<td>Clinics</td>
<td>is a means of</td>
<td>education</td>
</tr>
<tr>
<td>Travel</td>
<td>is a way to</td>
<td>provide service</td>
</tr>
<tr>
<td>Documentation</td>
<td>is a result of</td>
<td>giving service</td>
</tr>
<tr>
<td>Obtaining</td>
<td>is a result of</td>
<td>expert</td>
</tr>
<tr>
<td>money</td>
<td>is a result of documentation</td>
<td></td>
</tr>
<tr>
<td>Home visit</td>
<td>is a part of</td>
<td>followup</td>
</tr>
<tr>
<td>Home visit</td>
<td>is a part of</td>
<td>referral</td>
</tr>
<tr>
<td>Home visit</td>
<td>is a part of</td>
<td>evaluation</td>
</tr>
<tr>
<td>Educational</td>
<td>are a result of</td>
<td>requests</td>
</tr>
<tr>
<td>classes</td>
<td>are a result of</td>
<td>demonstrated need.</td>
</tr>
<tr>
<td>Educational</td>
<td>are a result of</td>
<td></td>
</tr>
<tr>
<td>classes</td>
<td>are a result of</td>
<td></td>
</tr>
</tbody>
</table>
Meetings

Meetings as a Necessary Evil

Several of the community health nurses commented on meetings as a necessary evil. Meetings were something that had to occur. It was a requirement of the position and was part of their job but was not looked upon always as a positive aspect of the job.

Some of the comments on the subject of meetings included:

"Since I am using state and county money, I have to tell the county commissioners what I am doing."

"I meet with the county commissioners to make sure I am still within the budget."

"In the monthly meetings I answer to the county commissioners and the health officer."

"The meetings I attend with the county commissioners are to help prepare budgets, to analyze the budget and also to prepare for the future."

Meetings as Part of Being an Educator

Part of the job function that was stressed was the idea of being an educator. Many of the community health nurses believed meetings were a way of sharing information and educating several people at the same time. The meetings the community health nurses believed were positive as contrasted to "answering to" meetings, are those which they were requested to attend by people in the community to give educational information. Some of the comments included:

"I meet once a day with discharge planners at the hospital to provide continuity of care."
"I have weekly meetings with people in Social Rehabilitation and Services to coordinate care."

"I have meetings in the community on a general basis to educate the community about the role of the community health nurse."

"I feel these community meetings would help make the community health nurse more visible."

"I provide special in-service meetings to any group that requests them."

**Community Health Nurse's Day-To-Day Job**

In response to the question, "Describe what you do from day-to-day in your job and time spent in regular day-to-day activities", the community health nurse informants identified the domains listed in Table 2. The domains of screening, clinics, home visits, meetings, referrals, educational classes, documenting, and travel were perceived as the most important parts of their job function. Each domain is discussed separately in the following.

**Screening**

Each community health nurse informant mentioned screening as an important part of her job function. Table 3 presents the taxonomy of screening. Taxonomy differs from a domain in only one respect: it shows the relationships among all the included terms in a domain. Cover terms were the kinds of screening that take place and the kinds of attitudes about the screening that take place. Screening clinics that took place were delineated as preventive, educational, and assessment.
The attitudes of the community health nurses regarding screening as part of their job function were that the screenings were very satisfying because the screening served a definite need in the community. Many times the screenings were the only place some people received any nursing service.

Table 3. Screenings

<table>
<thead>
<tr>
<th>Taxonomy of Screenings</th>
</tr>
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<tbody>
<tr>
<td>Kinds of screening that take place</td>
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</table>

Kinds of attitudes about screening that take place

- very satisfying
- serve a definite need
- the only place some people receive any nursing care

Clinics

All of the community health nurses hold clinics in their county throughout the month. Table 4 presents the taxonomy of clinics. Clinics that operate on a monthly basis in all of the counties were preventive and educational clinics.
The attitudes of the community health nurses about clinics were that the nursing services offered were free to the clients or considerably less expensive than from a private provider. Also, the attitudes about the clinics are that the clinics allow the community health nurses to serve more clients in a certain time frame and that clinics are a good place for casefinding.

Table 4. Clinics

<table>
<thead>
<tr>
<th>Kinds of clinics that are offered</th>
<th>Preventive</th>
<th>Well Baby Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational</td>
<td></td>
<td>Immunization Clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypertension Clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family Planning Clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pap Smear Clinics</td>
</tr>
</tbody>
</table>

Kinds of attitudes about clinics that are offered

- considerably less expensive than from a private provider
- ability to see more clients in a certain timeframe
- good place for casefinding
Home Visits

All of the community health nurses make home visits in their counties. Home visits varied in regard to the kind of service provided. Services provided were such items as delivering skilled nursing care, providing moral support, evaluating a home situation, and delivering babies. Time spent on home visits also varied; more time was spent on home visits if the community health nurse delivered home health care in the county under the Medicare Reimbursement Program. Some of the comments from the community health nurse informants regarding home visits were:

"In doing a home visit, I give moral support, which is not doing too much, but in the long run, they know that if help is needed, I am there, and this is important to people."

"I go for months, and I think I am getting paid for nothing, and then a patient calls me for some help."

"When I arrive at the office every day, I set priorities as to what patients I am going to visit at home for that day."

"In our county, we provide the whole scope of services, and by doing home visits, we see the whole family, their problems, so we see the whole picture"

"I get requests at times to home visit to see if an elderly person is being cared for properly or to see if the person is able to care for themselves"

"I make home visits to assess parenting skills with young parents in their environment or to ascertain home conditions."

The domain of home visits is presented in Table 5.
Table 5. Home Visits

<table>
<thead>
<tr>
<th>Domain of Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>The home visit is a part of a program</td>
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<tr>
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<td></td>
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<tr>
<td>The home visit contact provides for</td>
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</tbody>
</table>

**Referrals**

According to Burgess and Ragland (1983), referral can not be looked upon as an entity; it is a process. One of the most frequently used skills of the community health nurse is that of referring clients to appropriate community resources. Implementing a referral is not simply a matter of giving a family the name and telephone number of an agency or provider who will meet required health needs; rather, making a referral is a process that involves several steps. These are assess needs; select resources; implement the referral; and evaluate referrals.

The referral process occurs through the mutual efforts of the nurse and the client, and it may be initiated by the family, community health nurse, or other human services workers; it may be written or verbal.
Although referrals were mentioned several times in the interviews, the community health nurses' never really defined what they meant by referral. Some of the comments about referrals were:

"I never get referrals from doctors"

"I will take a referral from anyone, regarding county nursing care"

"We get referrals from the adjacent city regarding complications of prenatal patients, and they would like us to see these patients once or twice, but this is not possible."

Educational Classes

The domain of educational classes was considered a definite service that all of the community health nurse informants delivered. Many of the informants believed that a great deal of time should be spent on this nursing service because it served a need in their communities, and many of the people of the community responded to various educational classes. Table 6 demonstrates a taxonomy of educational classes.

Statements from the community health nurses regarding educational classes were as follows:

"They help to teach people to take care of themselves"

"To teach young mothers better care of their children, it is a great place to start"

"The classes are geared to the public."
Table 6. Educational Classes

<table>
<thead>
<tr>
<th>Taxonomy of Educational Classes</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a result of requests</td>
</tr>
<tr>
<td>Cardio-Pulmonary Resuscitation</td>
</tr>
<tr>
<td>Weight Control</td>
</tr>
<tr>
<td>Excercise Classes</td>
</tr>
<tr>
<td>Stop Smoking Classes</td>
</tr>
<tr>
<td>Stress Management</td>
</tr>
<tr>
<td>As a result of demonstrated need</td>
</tr>
<tr>
<td>Family Planning</td>
</tr>
<tr>
<td>Prevention</td>
</tr>
<tr>
<td>Nutrition</td>
</tr>
<tr>
<td>definite programs</td>
</tr>
<tr>
<td>Lamaze</td>
</tr>
<tr>
<td>Prenatal</td>
</tr>
<tr>
<td>Smoking Cessation</td>
</tr>
<tr>
<td>Cardio-Pulmonary Resuscitation</td>
</tr>
</tbody>
</table>

Feeling about educational classes request
- demonstrated need
- programs
- serve more people
- Community response
- Definite need
- Better use of nurses' time
Documenting

Documenting was perceived by community health nurses as something to be done to get paid for services. It was viewed also as doing clerical work, recording on patients' records when a service was rendered, preparing grants, and writing grants to obtain more funding for services.

One of the community health nurses uses a dictaphone at the end of the day to record "what I have done for patients." Another of the community health nurses stated that "I spend about 5 hours a week on bookwork."

One nurse stated she "spends at least 25-30 percent of my time documenting; for instance, recording services to the clients, preparing and writing grants, and reporting to the commissioners."

One nurse sets aside a whole day to do the paper work at the health department. Another of the community health nurses stated "50 percent of my time is spent on paper work, grants, financial statements, charting, and ordering supplies."

Travel

Travel is viewed as a major part of community health nurse's job function. These community health nurses do not object to traveling when they consider it a community health service and the travel is within their county boundaries.
Questions regarding emergency and rural community health nursing received a variety of responses from community health nurse informants.

The first section includes responses to emergency situations; there were varied responses to the question about emergency situations or nursing care situations performed that are not part of the day-to-day description:

"There are few that I would consider emergencies: for instance, a cardiac problem in the home, a family would call me to call a doctor";

"Frequently, a doctor will call me to make a home visit; a patient is possibly having a bowel obstruction. The doctor orders enemas until clear, and I end up spending 2 to 4 hours in the patient's home, which really makes my day wacky." (sic)

A mother will call, "My child has a temperature, please come right away," the mother is in a state of panic, what to do, I instruct her what to do over the phone. I never let something go with a child, in fear it may be an emergency."(sic)

"Doctor calls me to make a home visit to do stat blood work"

"People will call me when they have an asthma attack or drug reactions. I treat them under standing orders from a doctor"

"I have delivered several babies in the valley"

"During the summer months, people get bee stings, and I can treat them under standing orders from a doctor"

"We do not have any emergency services through our health department. We are dedicated to preventive health services in this county, and we discourage people from calling the health department for emergency services"

"I can not think of any emergencies. I answer
frantic calls at times from families, especially home health patients. They will call me at night, in the morning and evenings, but I am really not involved in emergencies. The emergency medical technicians handle most of emergencies"

"I can not think of any emergency situations. The reason is that the emergency medical technicians are very, very active. They keep abreast of all the new knowledge. The doctors train them, and then they train the rest of the technicians."

Many events considered by rural people to be emergencies are not considered by nurses to be emergencies. There may be some variations among communities in regard to who handles emergencies, i.e., physicians, community health nurses, or emergency medical technicians, because there is variation in the availability of trained personnel.

The next section includes responses from the community health nurse informants in regard to doing anything different as a rural community health nurse in Montana. Comparison to nursing in other states was conjectural since none of the informants had worked in other states. The nurses' responses varied:

"It is probably different in Montana as many people in the community do not even know that there is a community health nurse"

"As a rural community health nurse, I feel that what we do differently from a city nurse is more hands on care, taking time to listen, just to be there. A patient can call me day or night, which I should never have started." (sic)

"As a rural community health nurse, I am more involved with people, more involved with families. The care we give is more personal"

"What is different in a rural area is that I am a one person health department. I am responsible for everything, involved with the whole family, much the
same as a generalized physician"

"As a rural community health nurse, I do the whole show; I do everything"

"I do nothing differently than other nurses in other states"

"I feel this county is unique in carrying on its affairs. There is nothing here for outsiders. It is a wild west town, rodeo, horse activities, and drinking. This town is very conservative; it does not want to change"

"We provide all services, less fragmented care."

The responses of the informants ranged from doing nothing different to identifying many differences. The many differences identified were more personal care, with the nurse being available day or night, multiple roles, and less fragmented care. Those who identified differences identified them in keeping with the rural context of care.
COMMUNITY HEALTH NURSES' PERCEPTIONS ON PROVIDING OPTIMAL COMMUNITY HEALTH NURSING CARE

Introduction

Section II presents the community health nurse informants' perceptions of how they provide optimal community health nursing care and how they would provide optimal community health nursing care under ideal conditions. The clarifying questions related to the identified domains are also presented. The community health nurse informants perceived several major needs for change in order for them to provide optimal community health nursing. Some of the specific informants' responses from the first interview were:

"I would like to have two more people. I never have enough time to do all that is needed in the community"

"I would have more nurses and a larger budget. If I had more funding, I would have more clinics, such as a Papanicolaou clinic twice a year and do blood pressure screening on the job"

"I would have more funding, to hire another nurse and to hire clerical help."

The responses from the informants from both interviews demonstrate they perceive that for them to provide optimal community health nursing, there is a need to increase the budget. Adequate funding would facilitate hiring staff to do the clerical work, hiring additional community health nurses to do home health nursing, and contracting to medical
doctors to have more medical coverage. They stated a need to expand existing programs and to do more community education. They also believed a need existed to add more programs such as working with high-risk infants and families and offering senior citizens day care in their homes.

From the interviews and data collected, it was evident that community health nurses are very preoccupied with the day-to-day tasks of delivering services within the real life environment. It is also evident that constraints are put upon them from the county commissioners and health officers in delivering community health nursing services in their counties.

Below are the responses from the informants to follow-up question 1., "Fantasize on what type of organization you would like to have to determine community health nursing in your county."

CHN 1. "I would like to have more well clinics, give immunizations to people who need them, and have a family planning clinic."

CHN 2. "The organization we have now is not too bad the way it is. We do need more nurses, though."

CHN 3. "We need an acting non-prejudiced board of health, not political, not one that is protecting its turf."

CHN 4. "The community is covered very well now with the organization of services we provide."

CHN 5. "I would have a paid community health officer, a full-time sanitarian, a nursing director, 3 to 4 staff
nurses, and a school nurse."

CHN 6. "I would deal more with preventive health, have volunteers to do social work with the older people in the community."

CHN 7. "I would have another nurse just to do home health nursing and one nurse to do just community education."

Below are the responses from the informants to follow up question 2., "Who would you, as the community health nurse, like to see make the final decision regarding community health nursing care in your county?"

CHN 1. "That question is really a hard one as I do not know who is qualified to make that decision. The county commissioners do make the decision now, but they do not know anything about health. I am not qualified, but I am more qualified than anyone."

CHN 2. "The head of county health department, that is, me. The county commissioners go along with what I say. They are real cooperative."

CHN 3. "I think it would be a Board of Health, the commissioners of the county sit on the board, some knowledgeable people with a background in community health nursing, and nurses or any people involved with public health who know what it is all about."

CHN 4. "I would like to have a free hand in the county, to setting up protocols, standards for care in the community and regarding patients in the community, be able to use independent judgement."

CHN 5. "I would like to see the nursing director make the final decision. Now I have to go to the county commissioners."

CHN 6. "Maybe a Board of Health, but no one in the county
is really qualified to sit on it."

CHN 7. "The community health nurses are the ones that see the real situation and know what is needed, so I would like to see the community health nurses make the final decisions, but that is not reality. The county commissioners make the final decisions now."

In working on a preliminary content analysis, it was necessary to do a follow-up interview by telephone to clarify definitions of terms the seven informants used. Table 7 will present the terms and brief compilation of the community health nurses' definitions which were obtained in the second interview.

Those of the community health nurse informants who provided the above services all agreed on the definitions. The community health nurse informants who did not provide the service in the community did not offer definitions. The community health nurses who defined the terms did so within the context of today's concepts of community health nursing.

Summary of Analysis

Specific data were presented in this chapter about the perceptions of what community health nurses do and how they provide community health nursing. Based on analysis of interviews, findings are summarized in the following statements. Community health nursing is not autonomous in the respective communities. The community health nurses
### Table 7. Follow-up Clarification

<table>
<thead>
<tr>
<th>Community Health Nursing Terms</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visit</td>
<td>Visit in the client's home to assess needs or provide a nursing service.</td>
</tr>
<tr>
<td>Home health</td>
<td>Home health is part of a nursing program, and it is skilled nursing done by a registered nurse.</td>
</tr>
<tr>
<td>Skilled nursing</td>
<td>Skilled nursing requires a background in nursing and a registered nurse to provide the service.</td>
</tr>
<tr>
<td>Homemaking</td>
<td>Homemaker is a person who delivers custodial care in the client's home.</td>
</tr>
<tr>
<td>Health</td>
<td>Health is multifaceted: physical, psychological, emotional and mental, not just the absence of disease.</td>
</tr>
<tr>
<td>Screening</td>
<td>Screening is picking up problems, usually done in a mass situation, to rule out major health problems.</td>
</tr>
<tr>
<td>Community health nurse</td>
<td>Community health nurse is a registered nurse who identifies health needs of the population, promotes well being through screening and health education, and provides preventive services.</td>
</tr>
<tr>
<td>Travel</td>
<td>Travel is part of a community health nurse's job and that requires travel anywhere in the county.</td>
</tr>
</tbody>
</table>

envision their roles as delivering day-to-day nursing tasks in their communities at the dictation of the county commissioners and health officers. They do not perceive the community as an aggregate needing community health nursing care. For the most part, the community health nurse informants do not see themselves as possessing any power,
and they do not envision themselves capable of changing their direction in providing optimal community health nursing care in their communities.

The next chapter provides discussion and interpretation of the findings in the Summary and Conclusions. Limitations, implications and suggestions for further study conclude the chapter.
Chapter 5

SUMMARY AND CONCLUSIONS

Discussion

This chapter presents the discussion of the research conclusions. The topics to be discussed are as follows: the congruency between the care given and perception of optimal nursing care; the three themes identified from content analysis of data which are incongruent with current literature on community health nursing care; nursing implications; limitations of the study; and recommendations for further research.

Congruency Between Care Given and Perception of Optimal Nursing Care

The specific purpose of this research was to study community health nurses' perceptions of what they do and what they perceive as optimal community health nursing care. Content analysis of interviews revealed that there is congruency between what community health nurses do and their perception of providing optimal community health nursing care. The community health nurse informants interviewed stated that the way they provide services in their county is by carrying out plans and orders of the county commissioners and the part-time health officers.

Although community health nursing practice is what
community health nurses do, their work is more than direct client care. Community health nursing synthesizes the body of knowledge from the public health sciences and professional nursing theories. The implicit overriding goal is to improve the health of the community by identifying subgroups (aggregates) within the community population which are at high risk of illness, disability, or premature death and directing resources toward these groups. This lies at the heart of primary prevention and health promotion. Community health nursing accomplishes its goal by working with groups, families, and individuals as well as by functioning in multi-disciplinary teams and programs. Success in the reduction of risks and improving the health of the community is dependent on a full range of consumer involvement, especially from those groups at risk as well as the community and its members, in health planning, in self help, and in individual responsibility for personal health habits which promote health and a safe environment (American Public Health Association, 1980).

The community health nurse informants' practice are not congruent with the above definition which is derived from the literature regarding optimal community health nursing practice. Based on evaluation of interviews from the community health nurse informants, the finding are as follows: community health nursing is not autonomous in the respective communities; the role of the community health
nurse is delivering day-to-day nursing tasks at the
dictation of the county commissioners and health officers,
and the community is not perceived as an aggregate needing
community health nursing care.

Themes Identified and Incongruency with Current Literature
on Community Health Nursing Care

The three themes identified in regard to current
literature review were

1 Community health nurses lack power;
2 Community health nursing consists of day-to-day
tasks of delivering services; and
3 Community health nurses are unable to implement
or change program direction in their community.

Based on the answers the informants gave to follow-up
question 2, Who would you, as the community health nurse,
like to see make the final decision regarding community
health nursing care in your county?, the first theme
identified was that community health nurses lack power.
Decision-making theory explains power in terms of who makes
the final decision. In the traditional pattern of female
role behavior, women, and thus nurses, who are largely
female, have been mostly without power. Also attributed to
acculturation is the fact that women often lack the
essential self-confidence and autonomy to succeed in the
world of power (Kalisch & Kalisch, 1982). The community
health nurse is called upon to exercise independent
judgement and take independent action without the built-in
network of supervision available to the hospital nurse. Community health nurses function in a variety of roles, and various skills are needed to function in these roles. Some important skills are communication, teaching and learning, interpersonal relationships, problem solving, and decision-making.

The community health nurse's role as a change agent is an important function in community health nursing. Participation in community health planning usually results in changes in the kinds of services offered to clients and often in the nurses' perception of themselves (Fromer, 1979). A major component of community health nursing is involvement in policy formation at various organizational and governmental levels. Community health nurses should be active in the policy arena, primarily because this is a crucial modality for influencing the health of defined population (Williams, 1983). In summary the community health nurse informants allow the county commissioners and part-time health officers to dictate their domain of community health nursing.

Based on the answers the informants gave to question 1 on the first interview. "Describe what you do from day-to-day in your job." and question 2 on the follow-up interview, "Now, fantasize on the type of organization you would like to have to determine community health nursing care in your county?", the second theme identified was that
Community health nursing consists of the day-to-day tasks of delivering services. The primary focus of community health nursing practice according to literature review is defining problems (assessment) and proposing solutions (treatment) for population groups or aggregates.

Today, the concept of community health nursing as one that embraces a broad range of services is widely accepted. The community health nurse must test and evaluate various concepts and theories drawn from nursing, such as behavioral sciences, microbiology, physics, chemistry, and economics, to devise a framework of nursing care. Data must be collected and systematized to formulate the health and social profile of the client. On the basis of this profile, family health problems are defined, priorities are set, and a nursing care plan is developed. Implementation of this plan is based on (1) the nurse's ability to coordinate needed services through direct care and/or appropriate referral to community agencies, and (2) the family's ability to understand the need for the plan and their willingness to participate in achieving the health goals (Benson & McDevitt, 1980). In summary, the community health nurses were unable to conceptualize broad-based community health nursing, and their orientation continues to be acute care.

Based on the answers the informants gave to question 5 on the first interview, "Tell me what you would see yourself doing if you were able to give optimal community health
nursing care," question 2 ," Now, fantasize on the type of organization you would like to have to determine community health nursing in your county...", and question 3, on the follow-up interview," Who would you like to see make the final decision regarding community health nursing care in your county?", the third theme identified was community health nurses are unable to implement or change program direction in their communities. Community health nurses must work within a community's political system or health planning structure to encourage change in a certain direction or to enlist support for specific health programs. Work toward established health goals is facilitated by community health nurses through their considerable knowledge of health and health risks for individuals, groups, and communities. Problem-solving, decision-making skills and strategies for change are part of the nurse's resources to implement and change program direction in their communities. In summary, community health nurse informants do not view themselves as change agents and thus, feel powerless in taking control of what should be their domain, community health nursing.

By comparison, the current literature reveals the following themes of community health nursing. The implicit overriding theme of community health nursing is to improve the health of the community by identifying subgroups (aggregates) within the community population which are at
high risk for illness, disability, or premature death and
directing resources toward these groups. The second theme
is directed toward primary prevention and health promotion.
Community health nursing accomplishes its third theme by
working with groups, families, and individuals as well as by
functioning in multi-disciplinary teams and programs. The
fourth theme to succeed in the reduction of risks and
improve the health of the community is dependent on a full
range of consumer involvement, especially from groups at
risk as well as the community and its members, in health
planning, in self help, and in individual responsibility for
personal health habits which promote health and a safe
environment.

This descriptive study gives information that there are
deficits in the delivery of community health nursing care in
Southwestern part of Montana. The deficits are as follows:
community health nurses lack power; community health nurses
in these rural areas do not conceptualize aspects of their
professional roles but respond pragmatically with programs
and specific assistance to individual family and community
problems they meet day to day in their jobs, and community
health nurses are unable to implement or change program
direction in their communities.

Nursing Implications

Implications for nursing include suggestions and
recommendations for hiring more qualified nurses, for considering the political context in which nurses work, and for nursing programs to emphasize power, political process and change processes. To provide up to date community health nursing in small rural communities, the primary aim is to hire community health nurses who believe they have power, who can deliver health care based on the broad based concepts of community health nursing, and who have the knowledge and ability to implement or change program direction in their communities.

For community health nursing practice to meet the standards and definition of community health nursing, it will be necessary to understand the political structure and work within this structure in the small rural communities. It is suggested that the nursing educational process focus on the need for nursing students to comprehend the concepts of power and political processes and on being change agents in the delivery of community health nursing practice in small rural communities. From the data collected, nursing educators must understand that the standards and definition of community health nursing are far from reality in small rural communities. Consideration of these recommendations would improve the quality of community health nursing care available to rural residents.
Limitations of this Study

A major criticism of ethnographic studies is investigator bias. The difficulty lies in the fact that the participant observer is the major research instrument, and the major source of data is the informant, both of whom are human beings notoriously unreliable, sometimes unethical, and always biased (Spradley, 1979). The ethnographic method was the best method for this researcher's purpose.

Ethnography is the work of describing a culture: in this case, describing the "culture of community health nursing in small rural areas that do not have a full-time health officer." The central aim of ethnography is to understand another way of life from the so-called native (community health nurses') point of view. Another way of saying that is "to grasp the community health nurses' view, their relations to life, and to realize their vision of their world." Rather than studying people, ethnography means learning from people.

The small sample is also a result of ethnography which is designed to discover nurses' perceptions. Further study could use other research methods.

Another study of the same type with key informants from other parts of the state would validate the findings of this study and provide a basis for recommendations to the State Health Department and county governments. In the process, elaborations of "grand tour" questions would be refined.
Recommendations for Further Research

The following are the recommendations for future research:

To replicate the study in other rural communities in Montana; and
To do a longitudinal study of rural community health nurses including the turnover rate of community health nurses in rural areas and the hiring process of community health nurses in rural areas.
APPENDICES
APPENDIX A

CONSENT FORM
APPENDIX A

Participation in thesis regarding community health nursing in rural Montana.

I-------------------, Community Health Nurse in county------------------, give permission to Margaret (Peggy) Winninghoff, RN, to interview me regarding my work as a community health nurse. I understand that I may withdraw from the study at any time. The purpose of this study is to describe actual and potential roles of community health nurses in sparsely populated areas. Once data are described, at no time will individual names be used, nor will the information be published in any way that will identify individuals. The information is requested for a thesis study. The information without identifying material may also be used for inservice programs, education and publications. Anonymous information in the form of a summary will be provided the Montana State Department of Nursing Services with the intention of improving or expanding health care in the state of Montana.

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Signature                Date

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Signature                Date
APPENDIX B

INTERVIEW QUESTIONS
APPENDIX B

Following are the initial questions and clarifying questions (if needed) that will be asked each community health nurse.

1. Describe what you do day to day in your job.
   a. How much time do you spend in each one of these areas.
   b. Comparitively, how much time do you spend on each one of these tasks?
   c. (If percentages) Can you give me anything else to add to that list? Do you have anything else to say about...

2. Describe any emergency situation or nursing care situations that you perform in your job that is not part of your day-to-day description.
   a. Ask for examples--
   b. Can you think of anything else you do?

3. Have you worked anywhere as a community health nurse outside of Montana or in a city/county health department—if yes, ask Question 4. If not, rephrase Question 4.

4. What do you believe you do differently in rural Montana as a community health nurse?
   (Rephrase)—Do you think you do anything different in rural Montana as a community health nurse than what other community health nurses in other states do?
5. Tell me what you would see yourself doing if you were able to give optimal community health nursing care?
   a. How would you see yourself providing optimal community health nursing care?
   b. Ask for examples--.

The investigator had difficulty asking for definitions of terms and elaboration because of familiarity with terms and the expected role. After collecting data, and listening to tapes, and working on a preliminary analysis, it was necessary to do a follow up interview to clarify definitions of terms and restate the questions about how nurses would envision their roles under ideal conditions. The following are clarification questions.

1. Setting aside the real situation in your particular county, if you were able to fantasize on providing optimal community health nursing, explain to me how you would do.
2. Now, fantasize on the typed of organization you would like to have to determine community health nursing in your county?
3. Who would you like to see make the final decision regarding community health nursing in your county?
4. You used the following terms in our first interview. Will you describe in detail or give me your definition of in your own terms: home health, home visit, homemaking, skilled
nursing, health, screening, community health nurse, and travel.
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