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

Abstract:
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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.

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by

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of the requirements for the degree

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APPROVAL

of a thesis submitted by

Margaret Clare Riley Winninghoff

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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Chapter I

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 Metropolitian 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 semistructued 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 taxonony 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