A Methodological Study of the Development of a Home Health Care Patient Assessment Instrument

by

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A Methodological Study of the Development of a Home Health Care Patient Assessment Instrument

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Abstract

The purpose of the study was to apply the methodological research process to the development of a valid and reliable instrument which would be used by registered nurses during the initial assessment of patients admitted to a home health care agency for services. The methodological research design was applied to the processes of instrument development and validity and reliability estimation.

Eight nurses employed by the study agency volunteered to participate in a series of meetings during which they discussed their experiences and observations regarding patient assessment. As a result of the meetings, two pages of the four-page assessment tool previously used by the agency were modified. The new instrument included additional items related to assessment of psychosocial and caregiver issues as well as revisions in terminology and response formats. Information is presented regarding professional experience and educational preparation of the study agency nurses who volunteered to participate.

Content validity was established by an expert panel of 13 nursing professionals who rated each of the draft instrument's 15 sections as "good", "fair", or "poor". The overall mean "good" rating of .89 surpassed the expected overall mean "good" rating of .80. A number of revisions suggested by the panel were included in the new instrument.

Data regarding professional experience and educational preparation of the expert panel are presented.

During the latter half of the study, the study agency began the process of merging with a hospital-based home care agency. As a result of difficulties encountered during the merger process, proposed plans for determining interrater reliability were terminated.

Involving agency nurses in a collaborative process to develop a patient assessment instrument provided a number of benefits to the nurses and to the practice of nursing. Study agency nurses had the opportunity to question established practice and to participate in a process which balanced clinical practice with nursing research. Nurses' involvement promoted potential acceptance of the instrument by agency nurses.

Further research must acknowledge the fast-paced changes taking place in the health care market. More studies are needed which include nurses and which examine the content and process of patient assessment. The validity and reliability of assessment instruments must be clearly supported by multiple estimation methodologies.

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My admiration and respect go to the study agency program manager and to the nurses who volunteered to participate in the study during a difficult period of time. Without their assistance, this research would not have been possible.

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Chapter 1: Introduction

Home care is the umbrella term which identifies public and private for-profit and non-profit home health agencies, home care aide organizations, and hospices according to the National Association for Home Care (NAHC) (1995). Home care, also known as home health care, includes a broad range of health-related services provided by trained professionals to individuals of all ages in their homes. Services are designed to promote, restore, or maintain a level of client wellness or comfort. Services may include nursing care, rehabilitative measures, personal care assistance, and social support. Home care provides personalized attention, encourages the involvement of family and friends in the patient's care, and supports the patient's efforts to maintain a level of independent functioning not available in a hospital or other institutional setting.

As early as 1985, home care was viewed as an efficient and cost effective form of care. In a 1985 article, V. J. Halamandaris, who has served as president of NAHC since 1982, claimed that home care costs were a fraction of hospitalization and nursing home costs.

Nearly two-thirds of all national health care expenditures in 1995 went for hospital care and physicians' services. All home care expenditures, on the other hand, comprised approximately three percent of total health care expenditures. NAHC reports 1992 daily hospital charges at

$1,459 versus per visit home care charges of $75. Estimates reported by NAHC for 1995 daily hospital charges and per visit home health care charges are $1,810 and $86, respectively (NAHC, 1995).

Health care delivered in the home by a home care agency is a rapidly growing component of the health care industry. In 1995, there were 17,561 home care agencies. The number of home care agencies increased by 5% from 1990 to 1991, but increased by 49% in the 1990-1995 period. Of all home care agencies, growth has been fastest for hospital-based and proprietary agencies since the late 1980's (NAHC, 1995).

According to NAHC (1995), there are between nine and eleven million individuals who require home care. Individuals requiring home care will receive that care from informal or formal caregivers. Informal caregivers are identified as family and friends who are not compensated for their services. Formal caregiver services are those provided by trained individuals affiliated with a home care agency.

NAHC estimates that approximately 3.5 million Medicare clients will receive home care services in 1995, nearly double the 1990 figure. The number of Medicaid clients receiving home care services has also nearly doubled in the same period of time, from 0.7 million in 1990 to 1.3 million in 1995 (NAHC, 1995).

Harris (1988) cites changing demographics for the increase in home health care demand. The 65-and-older

segment of the population is growing and living longer. Caregiving spouses, who in the past provided most of the in-home care, are more likely to be approximately the same age as the patient and consequently more likely to be experiencing illnesses of their own. With increases in the number of single parent households, the number of families in which both adults work, and the number of families who live at a distance from their relatives, there may not be a caregiver in the home or one who is available and capable of providing adequate patient care.

Patient Classification Systems

As the demand for home care services has increased, home health agency administrators have faced an increasing need for effective resource management methods. Patient classification systems have gained attention as effective tools by which nursing resources may be managed.

Patient classification systems started receiving attention in the literature in 1979 when the Joint Commission on Hospital Accreditation made them a requirement (Dijkers, Paradise, and Maxwell, 1986). Wrona-Sexton (1992) traces the roots of patient classification systems to industrial engineering models of productivity measures. Tasks and the time to complete the tasks have historically been linked to staff projections in both industry and the healthcare field.

Patient classification, in nursing, generally refers to

"categorization of patients according to some assessment of their nursing care requirements over a specified period of time" (Giovannetti, 1979, p. 4). There are two primary types of patient classification systems: the prototype evaluation system in which patients are rank ordered with respect to nursing care requirements; and, the factor evaluation system in which the time required to provide nursing care is measured in some fashion (Dijkers et al., 1986).

In the home health care field, patient classification is the categorization of patients by the assessment of a number of variables, the assessment of which translates into skilled nursing care needs. Both prototype and factor evaluation systems are found in home health care. Patient assessment is the essential process, the keystone strategy in the patient classification system for planning patient care as well as for projecting and allocating skilled nursing care utilization. The need for classification systems in nursing is reinforced by Moorhead, McCloskey, and Bulechek (1993) as a means of addressing patient needs and healthcare costs.

Study Agency

The home care agency which is the subject of the study is located in a small community in Maryland. Prior to merging with a hospital-based home care agency early in 1996, the agency mirrored the nationwide trend toward increased demand for home health care services described

earlier.

According to reports obtained from the agency manager, the total number of home care visits increased by 23% from fiscal year 1993 to fiscal year 1995. Actual numbers have been omitted at the request of the agency manager. Home care visits included those made to clients by skilled nursing personnel (registered nurses), physical therapists, occupational therapists, speech therapists, medical social services personnel, and home health aides. Visits made specifically by skilled nursing personnel in fiscal year 1995 accounted for 50% of total home visits.

Prior to the study, registered nurses employed by the agency assessed new patients during an initial agency admission visit in the patient's home. A four-page assessment form was used as a guide to evaluate the patient's body systems as well as diet, environment, activities of daily living, senses, sleep, pain, psychological function, wound care, and advanced directives (see Appendix A). The assessment form had been in use for a number of years and had been judged by the agency manager to be less than adequate for purposes of projecting the number of home care visits per week relative to the patient's health status. At a 1994 meeting of agencies similar to the study agency, in answer to a question about adequacy of patient assessment, the study agency manager was able to determine that of the agencies represented at the meeting,

not one felt it had a patient assessment instrument that effectively assessed patient needs as those needs related to delivery of nursing care.

Purpose

The purpose of the study was to apply the methodological research process to the development of a valid and reliable instrument which would be used by the agency's registered nurses to assess patients upon admission to the agency for services. Integral to the study's design is the involvement of nurses in the instrument development process. The value of including nurses in a collaborative research effort to improve client care, and to enhance clinical nursing research, is underscored by Henry, Schmitz, Reif, and Rudie (1992). Nagaprasanna (1988) notes that internally developed patient classification systems receive wider acceptance by the nurses who use them.

Polit and Hungler (1991) note increasing interest by nurses in the methodological research design. The value of the methodological research process to validity and reliability issues is cited by LoBiondo-Wood and Haber (1994). Methodological research is an appropriate way for nursing to develop its own measures rather than borrowing from other disciplines (LoBiondo-Wood & Haber, 1994). Martin, Scheet, and Stegman (1993) cite a lack of studies which examine the practice of nursing with home health clients and which are designed and conducted by nurses, the

primary providers of home care.

The home care market abounds with a number of software packages designed to link patient assessment with nursing resource allocation, outcomes assessment, and third-party reimbursement requirements. The foundation for accurate and effective patient assessment, however, will remain a product of nursing judgment supported by sound research.

The patient assessment instrument development process described in this study was, therefore, based on a review of the literature to identify patient classification systems, patient characteristics, and methodological issues, and on the observations and experiences of the agency's registered nurses who were involved in patient assessment at the time of the study. The processes for determining the degrees of instrument validity and instrument reliability were examined with the final goal being that of replacing the agency's previous patient assessment instrument with the new instrument.

Summary

Home health care refers to health-related services provided to individuals in their homes. This chapter presented information about the growth of the home health care industry. Patient classification systems were explained as a means by which home health patient care is planned and home health nursing resources are allocated. The home health agency which is the subject of the study was described. The

three-fold purpose of the study was specified: the development of a patient assessment instrument, the estimation of instrument validity, and the estimation of instrument reliability. The next chapter will provide a review of the literature about patient classification systems and methodological issues involved with the development of assessment instruments.

Chapter 2: Review of the Literature

The selection of studies included in the review of literature was based on the need to examine patient classification systems, assessment instruments, and development methodologies to aid in the construction of an effective patient assessment instrument for use by the study agency. Research on patient classification over the years has taken place in a variety of health care settings: hospitals, health departments, rehabilitation facilities, and visiting nurse associations. Regardless of the setting, however, the recurring theme is the perceived need to ascertain details about a patient's health status that will lead to the best delivery of patient care.

A dual approach is taken in the review of literature. The first section examines a number of patient classification and assessment systems and related issues; the second section, while focusing on specific assessment systems in some instances, primarily emphasizes methodological issues inherent in instrument development.

Patient Classification and Assessment

In one of the earliest patient classification studies, Daubert (1979) cites pressure from regulatory agencies and third-party payment sources and the rising cost of health care as the motivation for health agencies to design objective systems for categorizing patient care and evaluating patient outcomes. The categorization system

described by Daubert, the Rehabilitation Potential Patient Classification System, establishes five rehabilitation potential groups.

Patient assignment to a group is based on medical diagnosis, identified health needs, and caregiver's assessment of needs. Patients assigned to Group I have acute, nonchronic, episodic-type disease or disability with the rehabilitation potential for a pre-illness level of functioning. Assignment to Groups II through IV is based on a declining potential for rehabilitation. Patients in Group V have end-stage illnesses. Each grouping has a program objective and subobjectives which can be utilized for outcome assessment. For example, the program objective for Group II is ". . . management of chronic health problem(s) by patient/family without ongoing VNA (Visiting Nurse Association) service" (p. 451). A subobjective in Group II is "Patient/family will recognize signs of significant physical or emotional changes and will communicate these changes to the appropriate health care provider" (p. 452). Upon discharge, patients are assessed according to whether or not the pre-determined objectives were met.

The system, designed to meet six disciplines of home care (nursing, home health aide, physical therapy, speech therapy, occupational therapy, and social work), was found to save documentation time, facilitate statistical processing, and provide data regarding effectiveness and

cost of services. The selection of the five rehabilitation potential groups and the development of definitions and sets of objectives for each patient group, however, were not described. Validity and reliability issues were not addressed.

A system based on patient problems was developed by the Visiting Nurse Association of Omaha (Simmons, 1980). This classification system, known as the Omaha System, has been adopted by a number of other agencies.

Patient problems were identified by retrospective review of 93 randomly selected client records from the association. No mention is made regarding the methodology for identifying the problems. Data collected from 338 families admitted to the association for care during a subsequent three-month period were used to refine the initial list of problems and to develop a draft assessment instrument. The instrument was then tested with a sample of 99 currently active families representative by age and diagnosis of the agency's overall caseload. After further refinements, the instrument was tested for reliability with 92 clients from a public health nursing agency association in Des Moines, 84 clients from the Delaware Department of Health and Social Services, and 97 clients from the Visiting Nurse Association of Dallas. Statistical analysis was performed by a commercial firm; no details are presented.

In the Omaha System, patient problems are grouped into

one of four domains: environmental, psychosocial, physiological, and health behaviors. Each patient problem is further delineated by problem label, modifier, and sign or symptom. To illustrate, consider the following example: domain - health behaviors; problem label - therapeutic regime noncompliance; modifier - medical/dental supervision; sign or symptom - fails to seek care for symptoms requiring medical/dental evaluation.

The 80-page instruction manual includes an extensive listing of all domains, problem labels, modifiers, and signs or symptoms from which the individual performing the assessment may choose. No mention is made regarding the extent of involvement by nurses in the development of the system.

Ballard and McNamara (1982) describe a retrospective review of records of 397 cardiac and cancer patients served by nine home health care agencies in which patient factors most predictive of nursing and agency service requirements were determined. Selected records represented a random sample of all patients with a diagnosis of cancer or cardiac disease who were discharged from one of the nine agencies in 1979 and 1980. Patients had a mean age of 70.9 years.

Patient records were reviewed using the Health Status Scale (HSS), an 18-item instrument developed and validated by Ballard and McNamara, as well as a list of other variables. Independent variables in the HSS include age,

gender, number of diagnoses, and patient problems. Other independent variables assessed were race, marital status, living arrangements, primary care provider, support system, payment source, discharge status, and agency providing service. Dependent variables were number of nursing services per patient per day and total agency visits per patient per day. Multiple regression analyses were performed and results indicated that the total score on the HSS was the single best predictor of patient resource utilization ($r = .3079$, $p < .001$).

No information is presented regarding development of the HSS. The article indicates that content validity was established by submitting the instrument to an unspecified number of professionals in community health. Interrater reliability was 94.5% in a pilot study; no further details are presented. Study clients were limited to those with cardiac and cancer diagnoses. Lack of consistency in recording systems among agencies is cited by Ballard and McNamara as the chief limitation of the study.

Information regarding use of the HSS was requested by personal correspondence with one of the researchers. A seven-page checklist entitled "Chart Review Tool for Quantifying Nursing Needs in Home Health Care" was received in response to the request; no instructions for completing or scoring the checklist were received, however.

Hospital-based patient classification systems provide

information relevant to the development of home health care patient assessment instruments. Johnson (1984) reports on her experience in developing a patient classification system for daily staffing decisions and budget considerations in a hospital medical-surgical unit.

Time constraints and experience were cited as the reasons for choosing a prototype evaluation system comprised of five patient classification categories: self care, minimal care, moderate care, extensive care, and intensive care. Within each category, patients were assessed for activities of daily living, general health, teaching and emotional support, and treatments and medications. Concurrent with development of the classification system, data were collected on patients by staff nurses twice daily and calculated regarding time required to provide direct and indirect care activities.

It is unclear how staff nurses were involved in the development of the patient classification categories. Evaluation of the system was limited to oral and written evaluations by nurses and by comparison with other institutions of nursing care hours per day.

Allen, Easley, and Storfjell (1986) study patient assessment from the perspective of a classification system based on time required to provide patient care and the level of difficulty encountered in providing that care. Following the premise that assigning an equal number of patients to

each home health agency nurse does not ensure equal workloads among nurses, an integrated patient classification and nursing services allocation system was developed.

Cases are assigned one of four described difficulty levels, ranging from minimal (level 1) to very great (level 4), based on six criteria: clinical judgment, teaching needs, physical care, psychosocial needs, multi-agency involvement, and number and severity of problems. Time values range from 1 (monthly or less) to 4 (3-5 times per week).

Difficulty levels and time values for all the cases assigned to each nurse are plugged into a caseload analysis formula, providing a numerical value representing each nurse's caseload. Caseload information interpreted in this graphic fashion is used by supervisory personnel for caseload analysis and future case assignment. No information is presented regarding development of the system, data collection, or data analysis.

The instrument development phase of a larger study undertaken by the Visiting Nurses Association of Los Angeles to develop a patient classification system for home health patients is described by Churness, Kleffel, Jacobson, and Onodera (1986). In this study, patient care and nursing activity time were simultaneously documented by the nurse performing the care activities and by a licensed vocational nurse, trained as an observer, using an existing agency

activities list for 158 home visits from five area offices, representing a variety of nursing activities and patient demographics.

Patients ranged in age from three weeks to 97 years; 65% were 65 and older. Development of the agency activities list is not described. Of the 158 visits, only 17 were new admission assessment visits. Criteria for selection of the sample is not described.

Descriptive statistics revealed that overall mean visit time was 36 minutes. Means and standard deviations were computed for each activity, as well. A factor evaluation classification instrument was developed based on the original nursing activities list. Details of the development of the factor evaluation classification instrument are not provided.

Each activity category is classified into five levels of care based on factor weights in ascending order of time required to perform the activity. Scores are assigned to each category and a total score is obtained. For example, a patient with a total score between 1 and 19 is classified into level I, a level which translates into an average of 30 minutes nursing time for each home visit. A patient with a score between 20 and 29 is classified into level II, a level requiring an average of 45 minutes nursing time per home visit. Validity and reliability studies were not conducted. Sampling bias was introduced when the Directors of Nursing

selected the nurses who participated in the study.

Development of a patient classification instrument based specifically on patients' nursing care requirements in a community health setting is discussed by Peters (1988). Drawing on definitions and research by Daubert (1979), Giovannetti (1979), Simmons (1980), Ballard and McNamara (1982), Johnson (1984), and Churness et al. (1986), Peters developed the Community Health Intensity Rating Scale (CHIRS).

Using the Omaha System as a foundation, an unspecified number of community health nurse experts derived 15 community health parameters for the four domains (environmental, psychosocial, physiological, and health behaviors). For example, in the psychosocial domain, four community health parameters were enumerated and defined: community networking, family system, emotional response, and individual growth and development. The four steps of the nursing process - assessment, planning, implementation, and evaluation - were defined for each parameter and four levels were established for each parameter, reflecting incremental increases in patient nursing care requirements.

During a pilot study, nurses from three agencies performed a retrospective review of 15 patient charts. Overall percentage-of-agreement for chart rating was 78%. Brief mention is made of establishing concurrent validity of the CHIRS during the pilot study by correlating the CHIRS

ratings with ratings from the Ballard and McNamara Health Status Scale.

In a subsequent wider study, a total of 560 charts from two home health agencies, representing hospital discharges for fiscal year 1986, were reviewed and rated by community health nurses using the CHIRS. Mean patient age was 63 years. One hundred sixty-nine Diagnostic Related Groups were represented. Ten percent of the charts were re-reviewed by the researcher yielding a reliability coefficient of .77. Content and concurrent validities had already been estimated during the instrument development process and the pilot study. Peters cited the involvement of nursing staff during both instrument development and pilot study stages as a strength of the study. The CHIRS has subsequently been modified and is currently included in a commercial, fully integrated computer software system for home health providers (personal communication with Dr. Peters, March 17, 1995).

Pavasaris (1989) describes a study in which a patient classification tool is developed to measure time, in minutes, spent by the home care nurse with clients by specific diagnosis. The purpose of the study was to develop a patient classification system which would provide accurate data for Diagnosis Related Group (DRG) reimbursement rates set by Medicare for home care. Diagnostic Related Groups for hospital reimbursement are based on data specific to

hospital settings. Application of that reimbursement system to home care would not, according to Pavasaris, take into consideration variables unique to the home care environment, including client functional limitations, coping skills, learning ability, caregiver issues, and treatment regimens.

The patient classification system described by Pavasaris, developed by the Brockton Visiting Nurse Association, Brockton, Massachusetts, tracked the amount of time spent by the physical therapist, medical social worker, registered nurse, and occupational therapist with clients with various diagnoses. System development was not described. No estimates of validity or reliability are presented. Study limitations cited by Pavasaris include small sample size (n=10), lack of consistent instructions for staff in use of the tool, and the need to correlate time data with client DRGs.

The value of nursing judgment in the patient classification process is supported by Cox, Wood, Montgomery, and Smith (1990). They describe a patient classification study focused on admissions variables rather than patient characteristics for the purposes of predicting outcomes and resource utilization.

Data were retrieved, retrospectively, from the charts of 50 acutely ill patients discharged from a hospital to the hospital-affiliated home care agency. The nature of sample selection is not described. The 50 patients accounted for 93

admission events. Mean patient age was 76.8 years.

Chart audits assessed the following admissions variables: primary diagnosis, secondary diagnosis, agency admission prognosis (determined by the nurse's assessment and subjective judgment), duration of services, number and intensity of visits, hospital readmission diagnoses and length of stay, patient outcome, decision-maker regarding home care admission, and primary caregiver in the home. The criteria and process for deciding on the variables are not mentioned.

Pearson product moment correlations and chi-square analyses of all variable pairs were used to examine the data. Multiple regression was used to predict service use and patient outcome. The strongest predictor of the outcome of each admission was the nurse's assessment of the patient's prognosis at the admissions visit ($r = .54$, $p \leq .001$). The researchers, while stressing caution in interpretation of the study's findings, urge home health care administrators to carefully reconsider the allocation of services based on traditionally recorded patient classification data, citing the value of the nursing assessment process.

An assessment system which specifically addresses caregiver factors, as well as patient factors, and the relationship of caregiver factors to recovery of stroke patients discharged to home care is examined by Evans,

Bishop,and Haselkorn (1991). Data were gathered over a two-year period on 135 stroke patients and their caregivers at five weeks poststroke and one year poststroke.

Patients were assessed for self-care agency with the Barthel Index and for cognition with the Cognitive Capacity Screening Exam. Caregivers were assessed for depression using the Center for Epidemiologic Studies-Depression Scale, for health status with an unspecified self-rating scale, and for knowledge of stroke care with the Stroke Care Information Test. Additional caregiver demographics included age, gender, and marital status. Family functioning was measured with the Family Assessment Device. Recovery outcome was measured with the ESCROW profile.

Frequencies for each variable were calculated for subjects who were considered successful or unsuccessful outcomes at one year poststroke. Criteria for determining successful or unsuccessful outcomes were not indicated. Satisfactory stroke outcome is related to caregivers who are less depressed initially, who are more knowledgeable about stroke by the time the patient is discharged from the hospital, who are married to the patient, and who report healthy family function.

No description is provided about the home care agency or the types of home care services provided to the clients and caregivers. Of the assessment instruments administered, only the Center for Epidemiologic Studies-Depression Scale

was cited as having demonstrated both validity and reliability.

Saba and Zuckerman (1992) provide a generalized description of the use of the Home Health Care Classification (HHCC) system of assessing home health Medicare clients in order to predict their nursing care needs and to measure outcomes. Information was collected regarding characteristics of home care clients, variables that influenced resource allocation, and length of care from a retrospective review of 8,961 home care cases in a nationwide sample of 646 home care agencies. Methodologies for sample selection and data collection are not described. From this collection of data, an assessment instrument was developed. Details regarding development of the instrument are not presented. Although researchers refer to the system as "clinically sound and statistically significant" (p. 29), specific statistical data are not included in the article.

Upon admission to the home care agency, the nurse provisionally determines the expected outcome of the case (improved, stabilized, or deteriorated) and predicts the client's length of service by the agency (<30 days, 30-120 days, or >120 days). Both determinations are based on the nurse's professional judgment in four enumerated areas: nursing diagnoses, medical assessment, functional assessment, and sociodemographic assessment. Values are assigned to each of the four areas and the predicted number

of nursing and other provider visits is calculated. Clients are reassessed every 30 days. A discharge assessment compares predicted care with actual care.

A patient classification system based on nursing acuity score is described by Van Ruiswyk, Hartz, Guse, Sigmann, Porth, and Buck (1992). The study sought to show that nursing acuity data is a useful predictor of patient length of stay and risk of death or complications.

Data were collected on 96 pneumonia patients admitted to the intensive care unit over a two-year period at a Wisconsin teaching and research hospital. Variables assessed by the hospital's nursing acuity instrument include nursing activities: feeding, bathing, medication administration, positioning, teaching, and counseling; and patient characteristics: level of consciousness, sensory impairments, hygiene, nutrition, elimination, and activity level. It is not clear whether the data was collected retrospectively or as part of a longitudinal study.

Although no mention is made of the methodology, the nursing acuity variables are assigned weighted scores with higher scores indicating greater nursing acuity and greater staff requirements. Spearman correlation coefficients indicate nursing acuity score is significantly associated with death or inhospital complications (Overlap Index = .45, $p < .05$) and with patient length of stay ($r = .35$, $p < .05$).

Martin, Scheet, and Stegman (1993) examine the use of

the Omaha System, described earlier in Simmons (1980), as applied to home health clients from four home care agencies in Nebraska, New Jersey, and Wisconsin. The Problem Classification Scheme component of the Omaha System groups client problems into one of four domains: environmental, psychosocial, physiological, and health behaviors. Each domain is further subdivided into problem label, modifier, and sign or symptom. It is this Problem Classification Scheme phase of the Martin et al. study that is of interest to the review of patient assessment.

Demographic and nursing care data were collected on 2,403 home health clients from the four agencies during a two-year period. Median client age was 68.6 years. Mean length of home care service was 34.74 days. Participating nurses were selected based on employment of at least three months at their respective agencies, participation in a four-hour inservice, and use of the Omaha System of patient assessment.

Frequency of client problems for each of the four domains was calculated. Seventy-one percent of all problems fell into the physiological domain, followed by 23%, 5%, and 1% in the health behaviors, psychosocial, and environmental domains, respectively. Similar results were found across all four agencies.

The researchers support use of the Omaha System based on the results of their descriptive study. They also call

the study "unique because it was designed from a nursing perspective . . ." (p. 1733) and encourage nursing-designed research studies which examine client variables.

Methodological Issues

Giovannetti (1979) provides a descriptive examination of methodological issues involved in the development, use, and evaluation of patient classification systems in hospital settings. According to Giovannetti, the chief value of a patient classification system is the efficient allocation of nursing personnel.

Definitions are provided for patient classification, in general, patient classification in nursing, and patient classification systems. The latter term "refers to the identification and classification of patients into care groups or categories, and to the quantification of these categories as a measure of the nursing effort required" (p. 4). A prototype evaluation classification system is based on groupings of patient characteristics, whereas a factor evaluation classification system is based on groupings of care requirements. The latter system is cited by Giovannetti as the most common type.

Giovannetti is an advocate for establishing estimates of validity and reliability of patient classification systems. In determining interrater reliability, Giovannetti claims it is essential to include as many individuals in the process as possible from those who will be using the final

assessment product. Over time, as personnel and procedures change, the reliability of a classification instrument must be monitored. A periodic inservice education program for all nurses who assess patients is essential for maintaining a high level of reliability.

Giovannetti discusses two types of validity, content and criterion-related. A major weakness occurs when studies fail to adequately describe the process by which a particular instrument has been validated. Furthermore, the process of establishing criterion-related validity is questionable because it assumes that an assessment instrument proven valid in another setting is comparable to the one being tested. This assumption, according to Giovannetti, weakens a claim of validity.

The processes of establishing validity and reliability are examined by Kearney and Fleischer (1979). The researchers describe a methodological study of the development of the Exercise of Self-care Agency Scale, a tool to measure a client's exercise of self-care.

Four graduate nursing students from the University of Southern Mississippi and their nursing research instructor developed a framework by which a person's exercise of self-care agency could be identified. The framework was initially developed by the five individuals from a question-and-answer format followed by discussion of each of the questions. After rating items as good, fair, or poor, and eliminating

duplicates, a self-care agency tool with 44 identifying elements was developed. An example of a positive indicator of self-care agency is "I perform certain activities to keep from getting sick" (p. 28). An example of a negative indicator is "I have no interest in learning about my body and how it functions" (p. 28). Items are scored 0 to 4 with 0 equal to very uncharacteristic of the respondent and 4 equal to very characteristic of the respondent.

To determine content validity, five graduate nursing program faculty members served as a panel of experts and rated the items proposed for the self-care assessment instrument. All faculty members had used self-care as the conceptual framework for their teaching. Panel members rated each of the 44 items as a good, fair, or poor indicator of self-care agency. There was 80% agreement on 29 of the original 44 items; these items remained unchanged. The remaining 15 items had 60% agreement; one item was reworded and one was omitted. Final percentage-of-agreement is not indicated.

Reliability of the tool is measured from the approaches of stability and internal consistency. The tool was administered to volunteer nursing and psychology students. Seventy-six nursing students completed both test administrations for test-retest reliability, yielding a correlation coefficient of .77. Seventy-nine students completed the first test administration, 84 students

completed the second test administration, and 153 students completed the third test administration for split-half reliability correlation coefficients of .80, .81, and .77 respectively.

Giovannetti and Mayer (1984) address methodological issues in their theoretical description of a hospital-based patient classification system. Well-designed and implemented orientation and inservice educational programs are crucial to the proper use of any patient classification system. Predictive validity is cited as the most important measure of validity because future staffing is influenced by patient classification. An interrater reliability coefficient of .90 or greater is acceptable. System monitoring and frequent system reliability and validity testing must be done to respond to changes in personnel, practice, and institutional policies.

The issues of reliability and validity are addressed by Kaspar (1986). Two methods for estimating interrater reliability are specifically cited. In one method, called the percentage-of-agreement method, the number of observations in agreement is divided by the total number of observations. This method is commonly used because its ease of calculation facilitates regular monitoring over time. Kaspar considers agreement in the 85% to 90% range acceptable.

The other method for estimating interrater reliability

is the application of the kappa statistic, illustrated in the article, which corrects for chance, a flaw cited by the author of the percentage-of-agreement method. Giovannetti and Mayer (1984) also criticize the percentage-of-agreement method due to the overestimation of reliability attributed to chance.

Regarding validity, Kaspar cites concurrent validity as the approach most often used to evaluate assessment and classification systems. In concurrent validity, the results of the categorization of patients according to one assessment process are compared to the results obtained with another assessment process, assuming a second validated process or instrument exists. The use of a panel of experts to determine content validity is discussed. Experts, such as nurses experienced with patient assessment and classification, determine important patient and care categories followed by a comparison between their determination and the categories identified by the instrument in question. Kaspar cites time and money as potential drawbacks to the use of a panel of experts.

Helberg (1989) specifically examines the interrater reliability of a home health patient assessment instrument, citing lack of such information with the systems developed by Daubert (1979), Allen et al. (1986), and Churness (1986). Helberg criticizes the Omaha System for its length, omission of information regarding actual nursing assessment and

interventions, and lengthy training time.

Reviews of patient records and the literature and a review by home health agency administrators identified categories of nursing activities provided by community health nurses. The resulting list of 26 activities was divided into two groups: those nursing behaviors by which objective and subjective patient data are collected, called assessment needs, and the patient's needs for nursing treatments based on assessment of total health care status, called intervention needs.

Interrater reliability was determined by two separate approaches. In the first approach, 34 New York home health agency supervisors and administrators, community health faculty members from several local colleges, and home health staff nurses responded to nursing assessment and interventions presented in narrative descriptions of simulated home visits. The exact nature of the responses was not described although Helberg indicates that interrater reliability was calculated on all 26 activities. Individual item reliability coefficients ranged from .49 to 1.00; the overall reliability coefficient was .90.

In the second approach, the researcher accompanied 17 community home health nurses on 35 home visits. Both the researcher and the nurse used separate copies of the instrument to identify nursing activities. Using the percentage-of-agreement method, reliability coefficients

ranged from .59 to 1.00 with the mean reliability coefficient equal to .95.

Subsequent evaluation revealed that some of the activities with the lowest reliability coefficients were those activities identified by the nurses as those performed most frequently. For example, the health counseling/guidance activity reliability coefficient was .69. On the other hand, nursing activities identified as technical skill activities, such as taking vital signs, inserting a catheter, dressing a wound, and administering IV therapy had reliability coefficients of 1.00.

Henry, Schmitz, Reif, and Rudie (1992) describe a model of collaboration between nurses, administrators, and researchers for the purpose of developing an assessment program to identify prenatal clients at risk for poor birth outcomes. The nursing directors and staff nurses from two community health agencies and two nursing faculty members with research backgrounds from a small liberal arts baccalaureate nursing program comprised the research project team. The nursing directors handled administrative and fiscal responsibilities. The staff nurses, with their knowledge of the prenatal client population, contributed observations and experiences for the development of data collection tools and procedures. The nursing faculty members designed the data collection tools and provided data analysis and interpretation.

Advantages and disadvantages of the collaborative model are presented. For staff nurses, advantages include recognition by them of the practical value of research to clinical practice with a subsequent tendency to seek research-based evidence for other areas of practice. Disadvantages include initial resistance and a shift in time commitment from direct client service to project-oriented activities. For researchers, a major advantage of the collaborative model is the availability of subjects provided by the clinical setting. Disadvantages cited include the inability of researchers to totally control the data collection process. Administrators realized fiscal benefits because costs associated with the project were spread among the two agencies and the research institution. Administrators found, however, that additional time was required of them to establish a communication system that crossed traditional boundaries and to accommodate staff's shifting time commitments.

Marsee, Lovett, and McMillan (1995) selected a panel of six critical care nurse experts to rate 25 therapeutic indicators on a patient acuity assessment instrument modeled after the Johns Hopkins Hospital Oncology Center's patient classification tool to determine the instrument's content validity. Instrument development for the special care unit of the academic, research oncology hospital took place after an initial period of use of the Johns Hopkins instrument by

the entire nursing staff. The Johns Hopkins instrument was revised to reflect more specifically the unit's staffing care hours for various types of patients served by the unit.

The nurse experts rated the new instrument by assessing patients during a series of three rounds. Mean ratings ranged from .20 to 1.00 with an overall mean of .85. The one item with a mean rating of .20 was eliminated after discussion among the panel.

Interrater reliability was determined by the percentage-of-agreement method. The patient care manager and all staff nurses assigned to patients each independently assessed patients at the same time using separate copies of the patient acuity instrument after a period of instruction in use of the instrument. Assessment in this manner of 85 patients over a six-month period produced a Pearson product moment correlation coefficient of $r = .84$ ($p < .001$).

Integrity of the instrument is checked quarterly by assessing the interrater reliability of a sample of unit patients. If the interrater reliability coefficient drops to .90 or lower, staff instruction and monthly reliability testing are initiated.

Summary

The purpose of the review of literature was the examination of patient classification and assessment instruments and instrument development methodologies as a means of aiding in the process of constructing an effective

patient assessment instrument for use by the study agency. The review of literature demonstrated that patient assessment instruments are developed for a number of administrative and evaluation purposes and are used in a broad range of settings: hospitals, home health agencies, visiting nurse associations, health departments, and rehabilitation facilities. Patient assessment instruments, regardless of setting, have as their primary purpose, however, the determination of patient variables which guide nurses in the delivery of patient care.

As illustrated in the review of literature, by both objective and subjective assessment measures, patient care needs may be determined by examining any number of variables: type and number of medical diagnoses; psychosocial, environmental, and physiological factors; activities of daily living; rehabilitation potential; living arrangements; support system; caregiver factors; teaching needs; and demographic data including age, gender, and marital status. Methodological issues related to the development of patient assessment instruments address, to some extent, issues of involving nurses in instrument planning, testing, and internal and external evaluation processes.

The current study builds on the research of others to describe the development of a patient assessment instrument, based on research and nurses' experiences, with acceptable

levels of validity and reliability for use by the study agency. The next chapter will describe the study design.

Chapter 3: Methodology

This chapter focuses on the design of the research study including specific information regarding the setting, population and sample, data collection, and procedures for instrument development and estimations of validity and reliability of the instrument. The chapter concludes with a description of the limitations of the study and a summary of the chapter.

The design of the study is considered methodological because it addresses the development of a tool, the patient assessment instrument, and the procedures for evaluating the validity and reliability of the tool. There appears to be agreement among Wilson (1989), Polit and Hungler (1991), and LoBiondo-Wood and Haber (1994) that a methodological research design has, in its broadest interpretation, the goal of examining procedures for gathering, organizing, and evaluating data. Research sources further agree that the methodological research design is a distinct design approach. LoBiondo-Wood and Haber (1994) indicate that the methodological design approach does not include traditional research steps.

Disagreement exists among sources, however, as to further classification of the methodological research design. For example, the methodological design is considered a type of nonexperimental research design by LoBiondo-Wood and Haber (1994) but as neither experimental nor

nonexperimental by Polit and Hungler (1991).

As a methodological research design, the current study examines the development of a patient assessment instrument with acceptable levels of validity and reliability for use by the study agency. Integral to the design was inclusion of the agency's registered nurses in the instrument development process.

In order to explore the factors which best assess a patient's health status and nursing care needs, a series of meetings was held with registered nurses from the study agency. The draft instrument which was developed as a result of the meetings with the nurses was submitted to a panel of home health professionals in order to estimate instrument validity. Arrangements were initiated to accompany nurses on agency admission visits in order to estimate instrument reliability.

Patient Assessment Instrument Development

The study agency, located in a small community in Maryland, serves a share of the home health needs of a rural population whose economy is primarily based on agriculture, seafood, and tourism industries. The agency is licensed by the State of Maryland Department of Health and Mental Hygiene and is Medicare certified. Thirteen full-time and part-time registered nurses were employed by the agency as home health nurses at the beginning of the study in the Spring of 1995.

Approval to conduct the study was obtained from the State of Maryland Department of Health and Mental Hygiene Institutional Review Board and the Salisbury State University Committee on Human Volunteers (see Appendixes B and C). To begin the study, a presentation about the study and a request for volunteers were made by the agency manager and the researcher to all 13 nurses. Nurses who volunteered to participate, called nurse-participants, reviewed the disclosure statement and signed the consent form (see Appendix D).

The researcher held a series of meetings with the nurse-participants to discuss their observations and experiences regarding the assessment of home health patients admitted to the agency for care. The stated goal of the meetings was to develop a new patient assessment instrument with acceptable levels of validity and reliability for use by the agency. At the conclusion of the series of meetings, nurse-participants' comments were incorporated into a draft instrument. The draft was submitted to the nurse-participants for review and comment. In addition, the draft was submitted to three university nursing faculty members who serve on the thesis committee and who also have home health care clinical experience for review and comment.

Data were collected anonymously from the nurse-participants on a Respondent Data Sheet regarding professional experience and educational preparation. Nurse-

participants were asked to indicate the number of years experience in: direct patient care (home health, hospice, acute, and other), administration (home health, hospice, and other), and teaching. Educational preparation included the following categories: diploma, associate's degree in nursing or other field, bachelor's degree in nursing or other field, master's degree in nursing or other field, and doctoral degree in nursing or other field.

Estimation of Instrument Validity

Validity is the estimation of an instrument's ability to actually measure that which it is constructed to measure (Polit & Hungler, 1991). Validity of the patient assessment instrument developed with the study agency was established by a method similar to that used by Kearney and Fleischer (1979). In that study, a panel of five experts reviewed an assessment instrument to determine how well the items included in the instrument measured the phenomenon under study. The use of experts is also supported by Kaspar (1986) as a means by which an instrument's content validity may be estimated.

In the current study, names for the panel of experts were solicited from nursing faculty members from a local university, a local nursing school, and home health nurses outside the study agency. A panel of experts from Maryland and Delaware was compiled. Following a preliminary telephone contact to determine interest in participating in the study,

a packet containing a two-page cover letter, Rating Form Instructions, a three-page Rating Form, Patient Assessment Instrument marked into sections, Respondent Data Sheet, request form for receiving a copy of the final instrument, and a pre-addressed and stamped reply envelope was sent to each expert panel member (see Appendix E).

Experts were asked to complete the Instrument Rating Form, based on their review of the instrument, and the Respondent Data Sheet, indicating professional experience and educational preparation, and to return the two items to the researcher. Names were not requested although the experts were given the opportunity to request a copy of the final instrument by providing name and address. Instrument Rating Forms were identified by number in order to match returned forms with work categories and states; experts were instructed to remove the identifying number if they wished to maintain total anonymity. Expert work categories included county health departments, private for-profit home health care agencies, and nursing educators. Returned Instrument Rating Forms were considered countable if at least 13 of the 15 instrument sections were rated by the expert.

The panel of experts was asked to rate each of the marked sections of the Patient Assessment Instrument as "good", "fair", or "poor" on the Instrument Rating Form according to the following definitions:

A good rating indicates the item is relevant and necessary to an accurate assessment of the client's status and needs; without this information, adequate planning of nursing care cannot occur.

A fair rating indicates the item is somewhat relevant and necessary to an accurate assessment of the client's status and needs; adequate planning of nursing care can be achieved to some degree without this information.

A poor rating indicates the item is irrelevant and/or unnecessary to an accurate assessment of the client's status.

If the expert indicated a "good" or "fair" rating for a section, space on the Instrument Rating Form was provided for the expert to write in suggestions for improvement. If a "poor" rating was indicated, the expert was asked to indicate the reason, or reasons, for that rating.

For the purpose of supporting instrument validity, an overall mean "good" rating of .80 on the 15 instrument items was selected. This standard was selected based upon the literature review of other methodological studies. In the Kearney and Fleischer (1979) study, validity of .80 was supported on 29 of the 44 instrument items. Marsee et al. (1995) achieved a mean rating of .85 on all instrument items. Giovannetti (1984) cites the importance of examining instrument validity but does not support a specific level of

validity. Information regarding specific validity values is scarce in the articles included in the review of literature.

Estimation of Instrument Reliability

In order to estimate instrument reliability, it was necessary to assess agency patients with the draft instrument. Establishment of the reliability of the study instrument was modeled after the approaches employed by Helberg (1989) and Marsee et al. (1995). In both studies, reliability was estimated by a series of simultaneous, independent assessments of patients by a nurse and a researcher using the same form of the assessment instrument. The percentage-of-agreement method was used to calculate reliability coefficients. Based on the aforementioned studies, reliability of the study instrument would be determined by the percentage-of-agreement between the nurse-participant and the researcher on simultaneous assessment of agency patients while using the draft instrument during agency admission visits.

Initial approval for the study from the State of Maryland Department of Health and Mental Hygiene Institutional Review Board was contingent upon submission and approval of the draft assessment instrument by the Board prior to testing its reliability with patients. The draft instrument was submitted to the Institutional Review Board and approval was received to proceed with assessing agency patients (see Appendix F). A Client Consent form (see

Appendix G), procedures for obtaining consent, and measures to safeguard the identities of the patients were developed. To limit bias in interpretation of results, a system was developed to pair the instrument completed by the nurse-participant with the one completed on the same patient by the researcher without disclosure of the nurse-participant's name. Prior to conducting joint visits to new patients, an inservice education session was planned for the purposes of orienting the nurse-participants to the new tool and the process for obtaining patient consent.

Limitations of the Study

The instrument development and validity estimation processes of the study were carried out as planned. The reliability estimation process was not implemented, however, due to the agency's merger with a hospital-based home care agency. The merger occurred over a period of months during the latter half of the study. During this transition period, a number of nurses left the agency creating larger caseloads for the remaining nurses. Larger caseloads reduced the amount of time the remaining nurse-participants had for research study activities.

The issue of subjectivity is a limitation in the design of the study. Assessment of patient characteristics is a subjective process dependent upon patient responses and nursing judgments. The development of the assessment instrument is based on the subjective observations of the

nurse-participants and the subjective interpretation of those observations by the researcher. The inclusion of more than one nurse in the instrument development meetings, also referred to as the use of multiple informants (Dempsey & Dempsey, 1992), was an attempt to exert control over the subjective nature of the instrument development process.

The compilation of a panel of experts for the estimation of validity was based on subjective recommendations from other nursing professionals. In recognition of the subjective nature of the selection process, 35 experts were included in the instrument rating process, a relatively large number of experts as compared to the Kearney and Fleischer (1979) and the Marsee et al. (1995) expert panels which consisted of five and six members, respectively.

The definitions of the ratings "good", "fair", and "poor" on the Instrument Rating Form were subjectively developed by the researcher. An effort was made to focus the definitions of the three ratings on the necessity and relevance of each instrument section to the adequate planning of nursing care.

Summary

The methodological research design described in this chapter focused on the settings, populations and samples, data collection, and procedures for the development of a new patient assessment instrument with estimates of validity and

reliability for use by the nurses in the study agency. The next chapter will describe characteristics of the sample and major findings for the process of instrument development and for the processes for estimating instrument validity and reliability.

Chapter 4: Results

Sample characteristics and major findings for the three processes examined in the study are presented in this chapter. The three processes examined in the study include: patient assessment instrument development, estimation of validity, and estimation of reliability.

Patient Assessment Instrument Development

Eight of the agency's 13 registered nurses volunteered to participate in the study. The nurse-participants completed Respondent Data Sheets regarding their nursing experience and educational preparation.

The nurse-participants had worked for the study agency at the time of the study from 6 months to 10 years (see Table 1). All nurse-participants had acute care experience, ranging from 1½ to 12 years. Other nursing experiences specified by the nurse-participants included home health and hospice administration, nursing home, U.S. Army field hospital, doctor's office, lab tech, jail nurse, and peer review. Regarding educational preparation, six of the nurse-participants had diplomas in nursing with one of the six having an associate's degree in nursing and another having an associate's degree in General College Studies (see Table 2). Two nurses held associate's degrees in nursing.

The researcher held a series of four weekly meetings with the nurse-participants to discuss patient assessment. The stated goal of the meetings was the development of a new

Table 1

Professional Experience: Nurse-Participants

	Type of Experience in Years							
	Direct Patient Care				Administrative		Other	
Nurse	Home health	Hospice	Acute	Other	Home health	Other	Teaching	Other
A	10.0	10.0	8.0	-	6.0	2.0	-	8.0
B	0.5	0.5	12.0	0.5	-	-	-	5.0
C	3.5	3.5	1.5	-	-	-	-	-
D	5.0	5.0	8.0	-	-	-	-	-
E	1.0	1.0	3.0	14.0	-	-	-	-
F	1.5	1.5	3.9	0.5	-	-	-	-
G	1.0	1.0	10.0	2.0	-	-	-	-
H	1.0	1.0	10.0	-	-	-	-	5.0

Note. Number of years experience for home health and hospice direct patient care is identical because nurse-participants admit and provide nursing care to both home health and hospice patients.

Table 2

Educational Preparation: Nurse-Participants

		Type of Educational Preparation							
		Associate's degree		Bachelor's degree		Master's degree		Doctoral degree	
Nurse	Diploma	N	O	N	O	N	O	N	O
A	x	x							
B	x								
C	x								
D	x								
E	x		x						
F	x								
G		x							
H		x							

Note. N = Nursing, O = Other

patient assessment instrument for use by agency nurses with patients admitted to the agency for nursing care. Discussions were directed by the researcher to move from general information about assessment of patient factors to specific assessment observations and experiences with home health patients. Comments were recorded by the researcher, as they occurred, on large pads of newsprint posted in front of the group.

The first meeting focused on explaining the research study and discussing home health care patients and the patient assessment process. Nurse-participants' observations were noted. During the second meeting, and after reviewing comments from the first meeting, the nurse-participants reached their first consensus that the current four-page assessment tool included some basic information which should be retained in the new assessment instrument. The nurse-participants agreed, however, that items on the current tool were too general in some areas and omitted other areas considered critical to the assessment process. By the end of the second meeting, the nurse participants agreed that pages one and three of the current four-page tool, those which addressed body systems, diet, environment, activities of daily living, senses, sleep, pain, and psychological function, would be the focus of their discussions and revisions. Pages two and four of the current instrument addressed wound care and advanced directives, had recently

been added to the assessment tool, and were judged acceptable. Pages two and four, therefore, would not be included in the nurse-participants' discussions and would not be revised.

During the third meeting, the nurse-participants reached a second consensus that the review of physiological systems should be retained, with expansion and clarification of terms and response formats, and that additional items should be included. The additional items to be included addressed the caregiver, the patient/caregiver relationship, the patient's environment, and psychosocial issues. The nurse-participants acknowledged the need to balance the inclusion of additional items with the need to limit the length of the instrument in recognition of the patient's compromised health status. Specific language for the additional items was developed during the fourth meeting.

After the fourth meeting, a draft instrument was constructed by the researcher from the nurse-participants' discussions and suggestions. The draft instrument included revisions to pages one and three of the four-page instrument currently used and was divided into 15 sections (see Appendix E). Seven sections referred to physiological systems: neuromuscular, cardiovascular, respiratory, integumentary, skeletal, gastrointestinal, and genitourinary. The skeletal system, not included in the previous instrument, was added as a result of the nurse-

participants' discussions of important patient assessment areas. The remaining eight sections included: psychosocial, environmental, diet, senses, pain, sleep, past medical/surgical history, and medications. All sections were revised to some extent from the previous instrument, reflecting changes in both terminology and response formats. For example, in the respiratory section, lung sound choices were revised from "clear, rales, wheezes" to "clear, crackles, wheezes, rhonchi". As another example, in the cardiovascular section, the "yes" and "no" choices for "edema" were expanded to include "amount: trace, +1, +2, +3, +4".

The original psychosocial section included three items: appropriate affect, coping, and memory. The specific descriptors "appropriate", "flat", "agitated", and "grieving" were suggested as replacements in the affect item for the "yes/no" response format. The existing coping and memory items remained unchanged.

Items added to the psychosocial section by the nurse-participants included: knowledge deficit, compliance potential, and religion. The knowledge deficit item included the response choices: "health status", "medications", "treatment plan", "prognosis", "agency involvement", "diet", and "other". Response choices for the compliance potential item were "good", "fair", and "poor". The religion item included space for noting a specific denomination or church

and a contact name.

The number of descriptors for the living situation item in the environmental section was expanded to include: "neat", "clean', "dirty", "infested", "cluttered", "isolated", "pets", "steps", "scatter rugs", "fire/smoke alarm", "not secure", "adequate", and "inadequate". Four items related to the patient's caregiver were added. The added items addressed the identity of the caregiver, the caregiver's capabilities and influence, and patient/caregiver issues that could affect the patient's health status.

Other additions included a pain intensity scale and pain type item to the pain section. An item was added to the medications section to assess medication allergies. An assessment of touch was added to the senses section.

The draft instrument was submitted to the nurse-participants and the agency manager for review and comment. One of the nurse-participants suggested a minor revision to the descriptors included for the hygiene item in the integumentary section. No other revisions were suggested.

In addition, the draft instrument was submitted to three university nursing faculty members for review and comment. One faculty member suggested revisions in both content and response format. The suggested revisions were evaluated by the researcher in relation to the nurse-participants' discussions during the four meetings regarding

instrument content and length. Suggested revisions viewed by the researcher as consistent with the nurse-participants' comments were included in the draft instrument. The nurse-participants were specifically consulted about two suggested revisions. Final revisions as suggested by the faculty member included the following additions: balance assessment in the neuro/muscular section, orthopnea in the respiratory section, catheter insertion date in the genitourinary section, cultural considerations and descriptors regarding short term/long term memory in the psychosocial section, and caregiver coping ability in the environmental section.

Estimation of Instrument Validity

The panel of 35 experts was asked to rate each of the draft instrument's 15 sections included on pages one and three as "good", "fair", or "poor" on the Instrument Rating Form. Of the 35 experts, responses were obtained from 16, yielding a 45.7% rate of return.

A response was considered countable if at least 13 of the 15 instrument sections were rated. Of the 16 responses, four were from health departments and two of the four were countable; eight were from private for-profit home health care agencies with seven of the eight countable; all three of the educator responses were countable; and one anonymous response was received, having had the place-of-work category identity number removed. Of the 16 returns, therefore, 13 were countable. Of the three uncountable responses, one

expert returned the instrument but not the Instrument Rating Form, one failed to complete the second page of the three-page Rating Form, and one declined to complete the Rating Form, citing internal agency problems. The 13 countable responses from the panel of 35 experts, therefore, represent a 37% countable response return rate.

Twelve of the thirteen experts returned the Respondent Data Sheet. Experience among the 13 experts in direct patient care in the home health setting ranged from 2 to 24 years (see Table 3). Acute care experience ranged from 1½ to 18 years. Five of the experts had experience as home health/hospice administrators. Teaching experience included instruction in the following areas: medical/surgical, obstetrics, maternal/child health, and family health. Other experience included Medicare Medical Review and community health nursing.

Of the 13 experts, 6 had a diploma with 4 of the 6 having an additional degree (see Table 4). Three experts had an associate's degree in nursing, eight had a bachelor's degree in nursing, and three had bachelor's degrees in areas other than nursing, including political science and education. One expert had a master's degree in nursing and four had master's degrees in areas other than nursing, including education, education administration, and psychology. Two experts indicated they were currently in a Master of Science degree program. There were no experts with

Table 3

Professional Experience: Panel of Experts

	Type of Experience in Years							
	Direct Patient Care				Administrative		Other	
Nurse	Home health	Hospice	Acute	Other	Home health	Other	Teaching	Other
A	14.0	1.0	6.0	-	3.0	-	-	-
B	9.5	9.5	2.5	-	1.0	-	-	-
C	24.0	-	7.0	-	1.0	4.0	-	-
D	20.0	-	-	-	4.0	-	-	-
E	-	-	-	10.0	-	-	15.0	1.0
F	5.5	-	4.0	-	-	-	-	-
G	7.0	-	1.5	11.5	-	-	-	-
H	5.0	-	12.0	-	5.0	-	-	-
I	4.0	2.0	3.0	-	4.5	-	9.0	-
J	2.0	-	2.0	-	-	-	2.0	10.0
K	5.0	-	-	-	-	-	3.0	15.0
L	-	-	18.0	-	-	-	11.0	-

Table 4

Educational Preparation: Panel of Experts

	Type of Educational Preparation								
		Associate's degree		Bachelor's degree		Master's degree		Doctoral degree	
Nurse	Diploma	N	O	N	O	N	O	N	O
A	x			x					
B				x	x				
C	x								
D	x								
E	x			x	x		x		
F				x					
G		x							
H		x			x				
I	x			x			x		
J		x		x			x		
K				x		x			
L	x			x			x		

Note. N = Nursing, O = Other

a doctoral degree.

For the purpose of supporting instrument validity, an overall "good" rating of .80 for the 15 instrument items was selected by the researcher. The means for each of the three ratings were calculated by individual item and for the overall instrument. Results indicate that the mean "good" rating on individual items ranged from .77 to 1.00 (see Table 5). The instrument had an overall mean "good" rating of .89, surpassing the goal of an .80 estimate of validity.

Two sections, psychosocial (section 8) and past medical/surgical history (section 14), had the lowest mean "good" ratings of .77. For the psychosocial section, experts suggested adding items related to learning potential and client self-assessment. These suggestions were viewed by the researcher as consistent with the nurse-participants' views and, therefore, were added to the psychosocial section. Adding more response space to the past medical/surgical history section was a consistent suggestion made by the experts for improvement and was included in the revised instrument.

One of the experts suggested adding "penile bleeding/discharge" to the genitourinary section as a parallel item to "vaginal bleeding/discharge" already included. This revision was viewed as a reasonable addition and, therefore, was included. With inclusion of the revisions made as a result of the validity estimation

Table 5

Mean Ratings of Patient Assessment Instrument Sections by the Panel of Experts (N = 13)

Instrument section	Mean Rating		
	Good	Fair	Poor
1	.92	.08	.00
2	1.00	.00	.00
3	.85	.15	.00
4	.85	.15	.00
5	.85	.15	.00
6	.85	.15	.00
7	.85	.15	.00
8	.77	.23	.00
9	.92	.08	.00
10	1.00	.00	.00
11	1.00	.00	.00
12	.92	.08	.00
13	.85	.15	.00
14	.77	.15	.08
15	.92	.08	.00

process, the final draft instrument was ready for the reliability estimation process (see Appendix H).

Estimation of Instrument Reliability

The procedure for the estimation of reliability was to have been the determination of the percentage-of-agreement between the nurse-participant and the researcher on simultaneous assessments of home health patients during the admissions visit using the draft instrument. As stated in Chapter 3, however, the study agency was in the process of merging with a hospital-based home care agency during the latter half of the study. During this period of time, nurses were uncertain about the opportunity for continuing employment with the new hospital-based agency. A number of nurses left the agency to seek employment elsewhere.

Of the eight nurse-participants who contributed to the development of the new assessment instrument, one left the agency and returned to acute care nursing at the local hospital and one moved into a school nurse position. Two nurses stopped admitting new patients to the agency: one nurse became involved with internal agency responsibilities and one worked primarily in a discharge liaison role with the local hospital.

The remaining four nurse-participants acquired increased workloads as a result of recent staff resignations. Two of the four nurse-participants were oriented to the use of the draft instrument and the

procedure for obtaining client consent, one declined to continue with participation in the study, citing stress and time constraints, and one was on leave for a period of time due to injury.

Several attempts were made by the researcher over a period of two months to accompany the two nurse-participants who had been oriented to use of the draft instrument and who were willing to continue in the study. As a result of workload and scheduling conflicts, no joint patient assessment visits were conducted and the period of time during which the joint visits could have been made prior to the merger ran out. Consequently, the reliability phase of the study was terminated.

Summary

The patient assessment instrument development process and the estimation of validity process described in this chapter were completed as initially planned. Eight nurse-participants contributed to the development of the new instrument in a collaborative process with the researcher. Thirteen home health care nursing professionals served as a panel of experts in supporting the validity of the instrument. The reliability phase of the research study was terminated as the sample of nurse-participants decreased in size and the agency merged with a hospital-based home care agency.

The next and final chapter will present a summary of

the results and will offer suggestions about how the results may be interpreted. The implications of the results for nursing practice and further research will be presented.

Chapter 5: Summary and Conclusions

A summary of the study results and suggestions for the interpretation of the results are presented in this chapter. The implications of the results for nursing practice and for further research will be offered.

The purpose of the study was to apply the methodological research process to the development of an instrument, with demonstrated validity and reliability, which would be used by the study agency's registered nurses to assess patients upon admission to the agency for home health care services. The three processes examined in the study were development of the patient assessment instrument, estimation of instrument validity, and estimation of instrument reliability.

Summary of Study Results

Eight registered nurses employed by the study agency contributed to the development of a draft patient assessment instrument. The draft instrument included items which had not been assessed previously, including the skeletal system and a number of psychosocial and caregiver issues, and included revisions in terminology and response formats for other areas. Revisions in the draft instrument were also suggested by a university nursing faculty member.

To estimate instrument validity, a panel of 13 experts rated each of the instrument's 15 sections as "good", "fair", or "poor". The actual overall mean "good" rating of

.89 surpassed the anticipated mean of .80. The phase of the study involved with estimating instrument reliability was terminated as a result of a decline in the number of nurse-participants and other difficulties encountered as the study agency merged with a hospital-based home care agency.

Interpretation of Study Results

It is of interest to note that both the nurse-participants and a number of the experts expressed the need to direct more attention toward psychosocial and caregiver issues in the process of patient assessment. The emphasis placed on psychosocial and caregiver issues by both groups of nurses is recognition of the perceived significant role the issues play in the assessment of an individual's health status.

Differences were noted in the number of years of professional experience and the level of educational preparation between the nurse-participants and the experts, although it was not the intent of the study to compare and contrast characteristics of the two groups. In general, the experts had more years of professional experience and higher levels of educational preparation than the nurse-participants.

The overall mean "good" rating of .89 was higher than expected. Of the studies included in the review of literature, no more than six experts were used to estimate the validity of the instrument under study. In this study,

thirteen experts responded to the request to rate the instrument items. Perhaps the use of so many experts in this study, relative to other studies, increased the likelihood of a higher estimation of validity.

Implications for Nursing

Assessment is the foundation of the clinical judgment process. Nursing assessment occurs along a broad continuum, from applying subjective judgment based on education and experience to administering internally developed tools or complex, computerized software assessment systems. Nurses need to question the tools they use for assessment. How were the tools developed? With what patient population were the tools developed? Were nurses involved in the development of the tools? Do the tools have demonstrated validity and reliability estimates? Utilizing a tool without answers to these questions may mean incomplete or erroneous assessment of critical patient factors related to the delivery of effective nursing care.

Involving agency nurses in the development of the patient assessment instrument provided a number of benefits to both the agency's patients and to the nurses. As the individuals most responsible for providing skilled nursing care to home health patients, the involvement of nurses in the development of those measures which determine the type and quantity of care delivered is essential. The direct involvement of nurses in the development of an instrument to

be used by nurses, therefore, was a logical approach in the design of the study. As direct providers of nursing care, nurses should be included on a regular basis in research which affects the delivery of nursing care. Improvements in nursing care benefit the consumers of nursing care, or, in this study, the agency's patients.

Including agency nurses in a collaborative process provided the nurse-participants with a sense of ownership, not only ownership of the content of the instrument, but also of the process for developing the instrument. Had the study not been prematurely terminated, the involvement of the nurses in the development process may have increased the likelihood that the instrument would have been accepted by them for use with agency patients.

Inclusion of the nurses in the instrument development process provided a balance between clinical practice and nursing research, a balance that is sometimes absent in the research process. The review of literature provided insight into research-based issues of instrument development; the meetings with the nurse-participants contributed essential information about actual clinical experiences and observations with the patient assessment process. Nurse-participants were given the opportunity to view the value of their clinical practice in relation to, not separate from, the research process.

The inability to carry out the estimation of

reliability process as a result of the study agency's merger with a hospital-based home care agency is a direct reflection of the fast-paced changes taking place in the health care industry. The uncertainties experienced by the nurse-participants and other nurses in the study agency regarding job security, resignations, shifting duties, and increased workloads exemplify the stressors nurses are encountering in the shifting health care market.

Implications for Further Research

The process described in the study for developing the assessment instrument combined research, in the form of the review of literature, and clinical practice, in the form of meetings with nurses from the study agency. The specific sample and setting of this study impose restrictions on the generalizability of the study's results to other home health care delivery systems. The pending merger of the study agency with a hospital-based home health agency introduced an element of instability into the study. The combination of research and practice, however, can be generalized to other instrument development studies. The combination approach is, in fact, encouraged.

In any study in which an assessment tool is developed for the purposes of guiding a patient's responses and a nurse's subjective judgments about that patient's health status, extra effort must be directed toward assuring that the tool adequately and consistently measures those patient

characteristics which are the basis for making decisions about the delivery of effective nursing care. Confidence in the adequacy and consistency of an assessment tool for clinical decision-making can be enhanced by incorporating more than one type of validity and reliability testing into the design of the study.

For example, in this study, the estimation of validity focused on one type of validity, content validity. Assessing the predictive validity of the assessment tool relative to patient outcomes would add to the credibility of the assessment instrument. A study of the instrument's construct validity, perhaps correlating assessment of the psychosocial section with another construct or trait, would strengthen the instrument's value in the clinical decision-making process. The use of a five-point Likert scale for rating instrument sections, with choices such as "excellent", "good", "neutral", "poor", and "not applicable", rather than the three choices offered, may produce a more specific evaluation of instrument sections by the panel of experts.

Reliability in this study was to have been estimated from the equivalence approach by calculating the percentage-of-agreement, or interrater reliability, from simultaneous assessments of patients by two individuals using the draft instrument. To strengthen the credibility of the instrument, another measure of reliability, such as the split-half technique, could be included in the design of the study.

In conclusion, the study demonstrated one approach for developing a patient assessment instrument and one approach for estimating instrument validity. The instrument development process focused on a collaborative relationship between nurse-participants and the researcher that may be applied to other practice settings. The use of a panel of experts was shown to be an effective method for involving home health care nursing professionals in the estimation of instrument validity.

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Appendix A

HOME HEALTH/HOSPICE AGENCY
INITIAL NURSING ASSESSMENT AND VISIT

Patient's Name:_____
Date:_____ Time:_____
Purpose of Visit:_____
_____
Vital Signs: Temp_____ P_____ R_____ BP_____ Wt_____

NEURO/MUSCULAR
Level of Consciousness:_____
Coordination: Good Fair Poor
Seizures: Yes No
Hemiparesis: Yes No Right Left
Paraplegia: Yes No
Quadriplegia: Yes No
Aphasia/Speech problem: Yes No
Headaches: Yes No
Vertigo: Yes No
Swallowing Difficulty: Yes No
Active ROM all Extremities: Yes No
Other:_____

CARDIOVASCULAR
Edema: Yes No Pitting: Yes No
Location:_____
Distended Neck Veins: Yes No
Angina: Yes No
Palpitations: Yes No
Dysrhythmias: Yes No
Gen Color: Good Pale Dusky Cyanotic
Nail Bed Color: Pink Pale Cyanotic
Extremity Color: Good Pale Cyanotic
Extremity Temp: Warm Cool Cold
Pedal Pulses: Present Absent
Quality:_____
Other:_____

RESPIRATORY:
Lung Sounds: Clear Rales Wheezes
Location:_____
Cough: Productive Non-productive N/A
Charac of Sputum:_____
_____
Dyspnea: Yes No
Smokes: Yes No
Oxygen:_____
Other:_____

INTEGUMENTARY
Skin Color: Good Pale Dusky
Flushed Cyanotic Jaundiced
Turgor: Good Fair Poor
Diaphoresis: Yes No
Rash or Decubitus: Yes No
Location:_____
Appearance:_____
Tx:_____
Hygiene: Good Fair Poor
Bathing: Indep Assist Total Care
Other:_____

WOUND ASSESSMENT/WOUND CARE
see next page

GASTROINTESTINAL
Ascites: Yes No
GI Bleeding: Yes No
Distention: Yes No
Tenderness: Yes No
Nausea/Vomiting: Yes No
Bowel Sounds: Yes No
Other:_____
Bowel funct: Indep Assist Total Care
Regular: Yes No
Date Last BM:_____
Diarrhea: Yes No
Incontinent: Yes No
Constipation: Yes No
Laxatives: Yes No Kind:_____
Enemas: Yes No Type:_____
Stool Color:_____
Colostomy: Yes No
Indep with care: Yes No
Irrig: Yes No Frequ:_____
Equip/Care:_____
_____

GENITOURINARY
Bladder Training needed: Yes No
Bladder Function:
Indep Assist Total Care
Urgency: Yes No
Frequency: Yes No
Burning: Yes No
Incontinent: Yes No
Nocturia: Yes No
Cath: Yes No
Size:_____ Type:_____
Change Interval:_____
Irrigation: Yes No
Urinary Diversion Equip/Care:_____
_____
Vaginal Bleeding/Discharge: Yes No
Other:_____

WOUND CARE

Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:

Cleaned/rinsed:
Dressings (method & supplies):

WOUND CARE

Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:

Cleaned/rinsed:
Dressings (method & supplies):

WOUND CARE

Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:

Cleaned/rinsed:
Dressings (method & supplies):

WOUND CARE

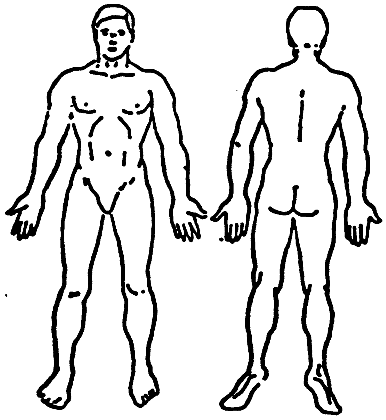
Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:

Cleaned/rinsed:
Dressings (method & supplies):

WOUND CARE

Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:

Cleaned/rinsed:
Dressings (method & supplies):



Patient's Name _____

DIET
Prepare Meals (light/full):
Indep Assist Unable
Eats: Indep Assist Feed
Appetite: Good Fair Poor
Special Diet:_____
Supplements: Yes No
Kind:_____
Fluid Intake: Good Fair Poor
Diff Swallowing/Chewing: Yes No
Denture problems: Yes No
Recent Wt Loss: Yes No Amt:_____
Obesity: Yes No
Other:_____

PSYCHOLOGICAL
Memory intact: Yes No
Affect appropriate: Yes No
Coping Well: Yes No

PAIN
Location:_____
Freq/Duration:_____
Relief Msrs:_____
Other:_____

SLEEP
Hours per night:_____
Insomnia: Yes No Naps: Yes No
Sleeping Pill: Yes No
Other Relief Msrs:_____
Other:_____

SENSES
Hard of Hearing: Yes No
Hearing Aide: Yes No
Uses Phone: Indep Assist Unable
Poor Vision: Yes No
Glasses: Yes No
Blind: Yes No
Taste: Normal Affected
Smell: Normal Affected

ENVIRONMENTAL/SOCIAL
Equipment Needed: Yes No
Living Situation: Neat Clean Dirty
Unkept Adequate
Caregiver: Yes No
Interfere w/ pt POT: Yes No
Housekeeping: Indep Assist Tot Assist
Prsnl Lndry: Indep Assist Tot Assist
Hndlg Money: Indep Assist Unable
Alcohol Use: Yes No
Specify:_____
Drug Use: Yes No
Specify:_____
Needs Assistance - Referrals
Desired or Indicated: PT____ OT____
Speech____ HHA____ MSW____

PAST MEDICAL HISTORY
Surgeries:_____
_____
_____
_____

REVIEW OF OVER THE COUNTER DRUGS:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Patient's Name _____

PATIENT CONSENT/ADVANCED DIRECTIVES
DOES PT HAVE LIVING WILL AND/OR DURABLE POWER OF ATTORNEY: YES NO
PERSON GIVEN DPOA: _____
BILL OF RIGHTS GIVEN: YES NO
ADVANCED DIRECTIVE INFO GIVEN: YES NO
CONSENT FOR CARE SIGNED: YES NO
HOSPICE: YES NO PROGNOSIS: _____
LEVEL OF FUNCTIONING: _____
(FOR HOSPICE PATIENTS ONLY)
NURSING/TEACHING: _____

COMMUNICATION: _____

NEXT VISIT: _____
PLAN: _____

_____ _____
DATE SIGNATURE

Appendix B

STATE OF MARYLAND

INSTITUTIONAL REVIEW BOARD
DEPARTMENT OF HEALTH & MENTAL HYGIENE
Dr. Diane Matuszak, Chair
6 ST. PAUL PLACE
SUITE 1301, ROOM 1361
BALTIMORE, MD 21203
410-767-8453

March 24, 1995

Rebecca Rader, R.N.
29406 Maple Avenue
Trappe, MD 21673

REFERENCE NUMBER 95-18

Dear Ms. Rader:

I have received the modifications of your consent and protocol which you submitted in response to the requests of the Institutional Review Board (IRB). Your protocol entitled, "A Methodological Study of the Development of a Home Health Care Patient Assessment Instrument" is now approved contingent upon your submission of your final instrument and its review and approval by the IRB. You may not begin enrolling participants or begin the actual client based study until this contingency has been met.

Please refer to the above reference number in any future correspondence or modifications pertaining to the above named study.

You are reminded of the following requirements:

1. The IRB shall suspend or terminate approval of this research if the IRB finds it is not being conducted in accordance with the IRB's requirements or that it is associated with unexpected serious harm to subject.

2. The Program Administrator shall notify the Chairperson of the IRB of contemplated substantive changes in the study that may affect the interests or rights of human subject and seek approval for the changes prior to implementing same.

Dr. Diane Matuszak,
Chair

3. For any projects which extend beyond one year, the Program Administrator is responsible for presenting to the Chairperson of the IRB, a completed Form DHHH 2125, Annual Review Notice, forty-five days prior to the anniversary date of the approval of this project.

4. The Program Administrator shall promptly report new information of unanticipated problems involving possible risks to human subjects or others to the Chairperson.

If you have any questions, please call me at 767-8453.

Sincerely,

Diane L. Matuszak, M.D., M.P.H.
Chairperson
Institutional Review Board

RJD:rjd

cc: IRB Members

Appendix C

STATEMENT OF APPROVAL

COMMITTEE ON HUMAN VOLUNTEERS

SALISBURY STATE UNIVERSITY

Date April 26, 1995

MEMO TO: DR. KAREN BADROS/REBECCA L. RADER

FROM: Chairman, Committee on Human Volunteers

SUBJECT: A METHODOLOGICAL STUDY OF THE DEVELOPMENT OF A HOME HEALTH CARE PATIENT ASSESSMENT INSTRUMENT
Title of Study

N/A (NURSING)
Grant Application No.
Sponsoring Agency

DR. KAREN BADROS / REBECCA L. RADER
Principal Investigator or Program Director

REBECCA L. RADER
Student Investigator

The Committee on Human Volunteers has considered the above application and, on the basis of available evidence, records its opinion as follows:

(1) The rights and welfare of individual volunteers are adequately protected.

(2) The methods to secure informed consent are fully appropriate and adequately safeguard the rights of the subjects (in the case of minors, consent is obtained from parents or guardians).

(3) The investigators are responsible individuals, competent to handle any risks which may be involved, and the potential medical benefits of the investigation fully justify these studies.

(4) The investigators assume the responsibility of notifying the Committee on Human Volunteers if any changes should develop in the methodology or the protocol of the research project involving a risk to the individual volunteers.

Chairman Dr. Francis I. Kane

11/94

Appendix D
DISCLOSURE STATEMENT
- NURSES -

I am currently conducting a study to develop a new instrument to assess patients admitted to the (name of study agency). The new instrument will be developed by a collaborative research-based process involving input from the registered nurses who work for the (study agency) and from information derived from the literature. It is the intent of the study to examine patient variables, the assessment of which leads to effective planning and delivery of nursing care to (study agency) patients.

Several measures are being followed to develop a valid and reliable assessment instrument and to protect the rights of study participants and patients. Validity of the instrument will be established by submitting the draft instrument to experts in the home health field for review. The instrument will be submitted to the Department of Health and Mental Hygiene's Institutional Review Board for approval. An in-service session will be conducted for nurses prior to use of the instrument with patients. Reliability of the instrument will be based on actual patient assessment performed concurrently by (study agency) nurses and the nurse researcher. The nurse researcher will accompany (study agency) nurses on the admissions visit and will complete a copy of the assessment instrument while the (study agency) nurse is assessing the patient and completing a copy of the assessment instrument; agreement between the two completed instruments will be calculated. Nurses will have the opportunity to evaluate the instrument prior to completion of the study.

In recognition of the nurses' caseloads and time constraints, the amount of time required of nurses beyond current responsibilities to the (study agency) will be limited to three group meetings. Every effort will be made to keep all nurse and patient information confidential. Nurses and patients will be identified only by number to the nurse researcher. Patient assessment instruments completed by (study agency) nurses will be handled by the (study agency) in the same manner as currently handled.

Your participation and cooperation, while essential for implementation of the study, are strictly voluntary. You may choose to not participate or to terminate participation at any time during the study without consequence.

Results of the study will be provided to you upon request. Should there be questions, you may contact Dr. Karen Badros, Chair, Department of Nursing, Salisbury State University, at (410) 543-6402.

Your participation and cooperation are appreciated.

DISCLOSURE STATEMENT
- NURSES -
-page 2-

I have read the Disclosure Statement regarding the study to develop a new instrument to assess patients admitted to the (study agency). I have had the opportunity to have my questions answered.

My signature indicates my willingness to participate in the study described above.

_____	_____
Date	Signature of Study Subject
_____	_____
Date	Signature of Nurse Researcher

Appendix E

29406 Maple Avenue
Trappe, MD 21673
August 7, 1995

RN
Clinical Care Supervisor

Dear Ms.

I contacted you about a week ago by telephone about participating in a research project to develop a valid and reliable patient assessment instrument for a home health care/hospice agency. The project is the subject of my Master's in Nursing thesis at Salisbury State University. You indicated at that time your interest in participating.

Let me give you some brief background on the project to place your participation in context. The agency with which I am collaborating uses an Initial Intake form and an Initial Nursing Assessment and Visit form. The Initial Intake form requests information that is required on the Medicare Plan of Care (Form 485). That form, as you know, requires brief information regarding patient demographics, ICD-9 codes, medications, medical supplies and equipment, safety measures, allergies, functional limitations, activities permitted, mental status, prognosis, orders, goals, etc. The agency will continue to use the Initial Intake form for gathering agency data.

The Initial Nursing Assessment and Visit form currently used by the agency, and the subject of this study, assesses patient factors important for determining appropriate nursing interventions. The revision of this form, developed during this study, represents an attempt to improve upon patient data assessed during the initial admissions visit.

During a series of meetings with the agency's home health/hospice nurses, patient characteristics and factors important for determining appropriate nursing care were identified from the nurses' experiences and were discussed at length. The current Initial Nursing Assessment and Visit form was reviewed, as well, to determine which factors from that form could be retained and/or modified for inclusion in the new patient assessment instrument. A review of the literature on patient assessment provided additional factors which were offered to the home health/hospice nurses for consideration. And, finally, comments and observations were solicited from nurses with home health/hospice experience outside the agency.

From these meetings, a new patient assessment instrument was developed. Of the enclosed four-page yellow Initial Nursing Assessment and Visit form, pages one and three are those that are the subject of this study; pages two and four will remain part of the agency's current assessment process and are not under study. I am asking that you review pages 1 and 3 of the instrument and rate the items as indicated on the attached white Rating Form.

I also request that you provide brief information on the blue Respondent Data Sheet relative to your background for statistical consideration; names are not required and names will not be used in study results. A tracking number appears on the Rating Form to facilitate telephone follow-up on non-returned forms; you may cut off the number if you wish to assure confidentiality.

Once you have completed the Rating Form and the Respondent Data Sheet, please return them in the enclosed pre-addressed and stamped envelope. Your response by Friday, August 18th, will expedite completion of the study.

I sincerely appreciate your interest and your willingness to participate. Your responses are critical to determining instrument validity. The next steps in the project include an in-service for the nurses in using the new instrument and actual use of the instrument by the nurses and myself with new patients to determine instrument reliability. Should you wish to receive a copy of the final instrument, please fill out the enclosed green request form and include it with the returned forms.

Thank you again. Should you have questions or comments, I would be happy to talk with you. I can be reached by phone in the evening at (410) 476-3729, or by mail at 29406 Maple Avenue, Trappe, MD 21673.

Sincerely,

Becky Rader, BS, RN

RATING FORM INSTRUCTIONS

INSTRUCTIONS: Items for rating on pages 1 and 3 only of the Initial Nursing Assessment and Visit form are circled and identified as Item #1, Item #2, etc. After reviewing each item, place a check (✓) or an "X" in the GOOD, FAIR, or POOR space reflecting your opinion of the item as it relates to the assessment of a new home health care/hospice patient during the initial admissions visit with the patient. Additional information regarding improvements/reasons would be appreciated. Thank you.

Key: A GOOD rating indicates the item is relevant and necessary to an accurate assessment of the client's status and needs; without this information, adequate planning of nursing care cannot occur.

A FAIR rating indicates the item is somewhat relevant and necessary to an accurate assessment of the client's status and needs; adequate planning of nursing care can be achieved to some degree without this information.

A POOR rating indicates the item is irrelevant and/or unnecessary to an accurate assessment of the client's status.

RATING FORM

ITEM #1 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #2 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #3 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #4 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #5 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

RATING FORM - page 2

ITEM #6 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #7 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #8 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #9 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #10 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

RATING FORM - page 3

ITEM #11 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #12 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #13 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #14 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

ITEM #15 *GOOD* ___ *FAIR* ___ *POOR* ___

If GOOD, any suggestions for improvement:_____

_____

If FAIR, how could item be improved or made more relevant:_____

_____

If POOR, reason: _____

_____

HOME HEALTH/HOSPICE AGENCY
INITIAL NURSING ASSESSMENT AND VISIT

Patient's Name:_____ Age: _____ Date:_____ Time:_____
Visit Purpose: Admit to: Home Health ___ Hospice ___ Race: W B H O Marital Status: S M W D Sep
Vital Signs: Temp _____ P _____ R _____ BP _____ Wt _____

NEURO/MUSCULAR Item # 1
Mental status:
Oriented/Disoriented/Forgetful/Depressed/
Comatose/Lethargic/Agitated/Other _____
Coordination: Good Fair Poor
Balance: Good Fair Poor
Seizures: Yes No
Hemiparesis: Yes No Right Left
Paraplegia: Yes No Quadriplegia: Yes No
Aphasia/speech problem: Yes No
Able to communicate needs: Yes No
Headaches: Yes No Vertigo: Yes No
Active ROM all extremities: Yes No
Other:_____

CARDIOVASCULAR Item # 2
Edema: Yes No Amount: Trace +1 +2 +3 +4
Location _____
Distended neck veins: Yes No
Angina: Yes No
Palpitations: Yes No Dysrhythmias: Yes No
General color: Good Pale Dusky
Cyanotic Jaundiced Flushed
Nail bed color: Pink Pale Cyanotic
Extremity color: Good Pale Cyanotic
Extremity temp: Warm Cool Cold
Pedal pulses: Present Absent
Quality _____
Other:_____

RESPIRATORY Item # 3
Lung sounds: Clear Rales Wheezes Crackles
Location _____
Cough: Yes No Productive Non-productive
Character of sputum:_____
Dyspnea: Yes No Orthopnea: Yes No
Smokes: Yes No
Oxygen:_____
Other:_____

INTEGUMENTARY Item # 4
Turgor: Good Fair Poor Ecchymosis: Yes No
Diaphoresis: Yes No
Rash/decubitus: Yes No
Location _____
Appearance _____
Tx _____
_____
Hygiene: Clean/Neglected/Soiled/Excessive Odor
Bathing: Indep. W/assist Total care
Other:_____

WOUND ASSESSMENT/WOUND CARE - see next page

SKELETAL - circle and describe in space below
Joint stiffness Amputation Prosthesis
Joint deformity Swelling Other
_____ Item # 5 _____
_____
_____
_____

GASTROINTESTINAL Item # 6
Ascites: Yes No GI bleeding: Yes No
Distention: Yes No Tenderness: Yes No
Nausea/Vomiting: Yes No Bowel Sounds: Yes No
Bowel funct: Indep. W/assist Total Care
Regular: Yes No
Date last BM:_____
Diarrhea: Yes No
Incontinent: Yes No
Constipation: Yes No
Laxatives: Yes No Kind _____
Enemas: Yes No Type _____
Stool Color:_____
Colostomy: Yes No
Independent with care: Yes No
Irrigation: Yes No Frequency _____
Equipment/care:_____
_____
Other: _____

GENITOURINARY Item # 7
Bladder training needed: Yes No
Bladder function: Indep. W/assist Total care
Urgency: Yes No Frequency: Yes No
Burning: Yes No Hematuria: Yes No
Incontinent: Yes No Nocturia: Yes No
Catheter: Yes No Size:_____
Type:_____
Change interval:_____
Irrigation: Yes No
Date current one inserted:_____
Urinary diversion equip/care:_____
_____
Vaginal bleeding/discharge: Yes No
Other:_____

NOTES_____
_____
_____
_____
_____

Patient's Name ____

WOUND CARE

Site: ____________________
Size: ____________________
Drainage (color, consistency, amount, odor): ____________________
Appearance: ____________________
Cleaned/rinsed: ____________________
Dressings (method & supplies): ____________________

WOUND CARE

Site: ____________________
Size: ____________________
Drainage (color, consistency, amount, odor): ____________________
Appearance: ____________________
Cleaned/rinsed: ____________________
Dressings (method & supplies): ____________________

WOUND CARE

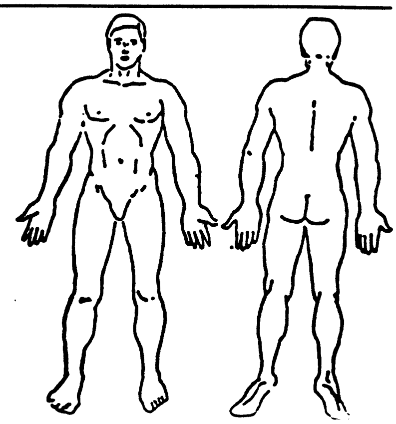
Site: ____________________
Size: ____________________
Drainage (color, consistency, amount, odor): ____________________
Appearance: ____________________
Cleaned/rinsed: ____________________
Dressings (method & supplies): ____________________

WOUND CARE

Site: ____________________
Size: ____________________
Drainage (color, consistency, amount, odor): ____________________
Appearance: ____________________
Cleaned/rinsed: ____________________
Dressings (method & supplies): ____________________

WOUND CARE

Site: ____________________
Size: ____________________
Drainage (color, consistency, amount, odor): ____________________
Appearance: ____________________
Cleaned/rinsed: ____________________
Dressings (method & supplies): ____________________



Patient's Name _____

PSYCHOSOCIAL Item # 8
Memory intact: Yes No Short Term/Long Term
Coping: Yes No
Compliance potential: Good Fair Poor
Affect: Appropriate Flat Agitated Grieving
Knowledge deficit: Health status/Medications
Treatment plan/Prognosis/Agency involvement
Diet/Other:_____
Religion:_____Contact:_____
Cultural considerations:_____

ENVIRONMENTAL Item # 9
Living situation:
Neat Clean Dirty Infested Cluttered
Isolated Pets Steps Scatter rugs
Fire/Smoke alarm Tub rails Bed rails
Secure Not secure Adequate Inadequate
Utilities: Adequate Inadequate
Neighborhood influence: Positive Negative
Housekeeping: Indep. W/assist Total care
Shopping: Indep. W/assist Total care
Persl. laund: Indep. W/assist Total care
Handling $: Indep. W/assist Total care
Transportation:_____
Alcohol use: Yes No Specify:_____
Drug use: Yes No Specify:_____
Caregiver: Yes No Spouse Other
Caregiver capable: Yes No
Caregiver influence: Positive Negative
Caregiver coping ability: Good Fair Poor
Patient/caregiver issues:_____
Equipment needs:_____
Indicated or desired assistance/referrals:
PT OT Speech HHA MSW Clergy Volunteer
Other:_____

DIET Item # 10
Meal prep: Indep. W/assist Total assist
Eats: Indep. W/assist Total assist
Appetite: Good Fair Poor
Difficulty swallowing/chewing: Yes No
Denture problems: Yes No
Nutrition: Adequate Inadequate
Recent weight loss: Yes No Amt:_____
Obesity: Yes No
Special Diet:_____
Supplements: Yes No
Kind:_____
Fluid intake: Good Fair Poor
Other:_____

SENSES Item # 11
Hearing: Good Fair Poor None
Uses hearing aid(s): Yes No Right/Left
Uses phone: Independent W/assist Unable
Vision: Good Fair Poor Blind
Wears glasses: Yes No
Taste: Good Fair Poor
Smell: Good Fair Poor
Touch: Good Fair Poor
Other:_____

PAIN Item # 12
Intensity (1-5):_____
Location:_____
Type:_____
Frequency/duration:_____
Relief measures:_____
Other:_____

SLEEP Item # 13
Hours/night:_____
Insomnia: Yes No Naps: Yes No
Sleeping med: Yes No
Other measures:_____
Other:_____

PAST MEDICAL/SURGICAL HISTORY Item # 14

MEDICATIONS Item # 15
Allergies:_____
Prescribed:_____
OTC:_____
Pharmacy:_____

NOTES

Patient's Name _____

PATIENT CONSENT/ADVANCED DIRECTIVES

Does patient have living will and/or durable power of attorney: Yes No
Person given DPOA:_____
Bill of Rights given: Yes No
Advanced directive information given: Yes No
Consent for Care signed: Yes No
Hospice: Yes No
Level of functioning:_____
(for Hospice patients only)

NURSING/TEACHING

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Communication:_____
_____
Next visit:_____
Plan:_____
_____

_____ _____
Date Signature of Admissions Visit R.N.

RESPONDENT DATA SHEET

EXPERIENCE: For each type of work experience you have had, indicate number of years for that experience.

	Number of years
Home Health direct patient care	_____
Hospice direct patient care	_____
Acute care	_____
Direct patient care other than acute care (specify): _____	_____
_____	_____
_____	_____
_____	_____
Administrator in Home Health/Hospice	_____
Administrator in other than Home Health/Hospice	_____
Teaching (specify area): _____	_____
_____	_____
_____	_____
Other (specify): _____	_____
_____	_____

EDUCATIONAL PREPARATION: Please check all applicable choices.

Diploma ____

Associates Degree in Nursing ____

Associates Degree in other than Nursing ____

Specify degree major:_____

Bachelors Degree in Nursing ____

Bachelors Degree in other than Nursing ____

Specify degree major:_____

Masters Degree in Nursing ____

Masters Degree in other than Nursing _____

Specify degree major:_____

Doctoral Degree in Nursing ____

Doctoral Degree in other than Nursing ____

Specify degree area:_____

I would like to receive a copy of the final version of the patient assessment instrument.

Name _____

Agency _____

Address _____

City _____ State _____ Zip _____

Appendix F

State of Maryland

INSTITUTIONAL REVIEW BOARD
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

6 St. Paul Street BALTIMORE, MARYLAND 21202 (410) 767-8453
Suite 1301 Diane L. Matuszak, M.D., M.P.H., Chairperson

October 12, 1995

Rebecca Rader, R.N.
29406 Maple Avenue
Trappe, MD 21673

REFERENCE NUMBER: 95-18

Dear Ms. Rader:

I have received and reviewed your submission of the final instrument to be used in your protocol entitled, "A Methodological Study of the Development of a Home Health Care Patient Assessment Instrument" per the IRB's request of March 24, 1995. Your protocol is now approved.

You are reminded of the following requirements:

1. The IRB shall suspend or terminate approval of this research if the IRB finds it is not being conducted in accordance with the IRB's requirements or that it is associated with unexpected serious harm to subjects.

2. The Program Administrator shall notify the Chairperson of the IRB of contemplated substantive changes in the study that may affect the interests or rights of human subject and seek approval for the changes prior to implementing same.

3. For any projects which extend beyond one year, the Program Administrator is responsible for presenting to the Chairperson of the IRB, a completed Form DHMH 2125, Annual Review Notice, forty-five days prior to the anniversary date of the approval of this project.

4. The Program Administrator shall promptly report new information of unanticipated problems involving possible risks to human subjects or others to the Chairperson.

Please refer to the above reference number in any future correspondence or modifications pertaining to the above named study.

If you have any questions, please call me at (410) 767-8453.

Sincerely,

Diane L. Matuszak, M.D., M.P.H.
Chairperson
Institutional Review Board

RJD:rjd

cc: IRB Members

Appendix G

CLIENT CONSENT

Rebecca Rader is a registered nurse and a graduate student at Salisbury State University. She is conducting a research project with the nurses at the (study agency) to develop a new patient assessment form.

Mrs. Rader will be accompanying home health care nurses as they meet with new clients and assess them for nursing care services. She and the nurses will be filling out a patient assessment form which may include items about the patient's body systems, diet, environment, activities of daily living, neurological senses, sleep, pain, psychological function, and other care providers.

The information recorded by Mrs. Rader will be maintained in a confidential manner and will be used solely for research purposes. Upon completion of the study, all forms will be returned to the (study agency) program manager.

You may choose not to participate in the study and you may stop participating at any time without consequence. If you decide at any time that you do not want to participate, your decision will in no way prevent you from receiving home health care services.

I have read, or have had read to me, the above information regarding the research study and I have had the opportunity to have my questions answered. My signature indicates my willingness to participate in the study.

_____ _____

Date Client signature

_____ _____

Date Nurse Researcher signature

HOME HEALTH/HOSPICE AGENCY
INITIAL NURSING ASSESSMENT AND VISIT

Patient's Name:_____ Age: _____ Date:_____ Time:_____
Visit Purpose: Admit to: Home Health ___ Hospice ___ Race: W B H O Marital Status: S M W D Sep
SS#:_____ Vital Signs: Temp_____ P_____ R_____ BP_____ Wt_____

NEURO/MUSCULAR Item #1
Mental status:
Oriented/Disoriented/Forgetful/Depressed/
Comatose/Lethargic/Agitated/Other _____
Coordination: Good Fair Poor
Balance: Good Fair Poor
Gait: Smooth Shuffling
Seizures: Yes No
Hemiparesis: Yes No Right Left
Paraplegia: Yes No Quadriplegia: Yes No
Aphasia/speech problem: Yes No
Able to communicate needs: Yes No
Headaches: Yes No Vertigo: Yes No
Active ROM all extremities: Yes No
Other:_____

CARDIOVASCULAR Item #2
Edema: Yes No Amount: Trace +1 +2 +3 +4
Location _____
Distended neck veins: Yes No
Angina: Yes No
Palpitations: Yes No Dysrhythmias: Yes No
General color: Good Pale Dusky
Cyanotic Jaundiced Flushed
Nail bed color: Pink Pale Cyanotic
Extremity color: Good Pale Cyanotic
Extremity temp: Warm Cool Cold
Pedal pulses: Present Absent
Quality _____
Other:_____

RESPIRATORY Item #3
Lung sounds: Clear Crackles Wheezes Rhonchi
Location _____
Cough: Yes No Productive Non-productive
Character of sputum:_____
Dyspnea: Yes No Orthopnea: Yes No
Smokes: Yes No No./day:_____
Oxygen:_____
Trach: Yes No Suction: Yes No
Other:_____

INTEGUMENTARY Item #4
Turgor: Good Fair Poor Ecchymosis: Yes No
Diaphoresis: Yes No
Rash/decubitus (circle): Yes No
Location _____
Appearance _____
Tx _____
_____
Hygiene: Clean/Neglected/Soiled/Excessive Odor
Bathing: Indep. W/assist Total care
Other:_____

WOUND ASSESSMENT/WOUND CARE - see next page

SKELETAL - circle and describe in space below
Joint stiffness Amputation Prosthesis
Joint deformity Swelling Jt. Replacemt.
_____
_____
Item #5
_____
_____

GASTROINTESTINAL Item #6
Ascites: Yes No GI bleeding: Yes No
Distention: Yes No Tenderness: Yes No
Nausea/Vomiting: Yes No Bowel Sounds: Yes No
Bowel funct: Indep. W/assist Total Care
Regular: Yes No
Date last BM:_____
Diarrhea: Yes No
Incontinent: Yes No
Constipation: Yes No
Laxatives: Yes No Kind _____
Enemas: Yes No Type _____
Stool Color:_____
Ostomy: Yes No
Independent with care: Yes No
Irrigation: Yes No Frequency:_____
Equipment/care:_____
_____
Other: _____

GENITOURINARY Item #7
Bladder training needed: Yes No
Bladder function: Indep. W/assist Total care
Urgency / Frequency / Burning / Hematuria /
Incontinent / Nocturia
Vaginal bleeding/discharge: Yes No
Penile bleeding/discharge: Yes No
Prostate enlargement: Yes No
Catheter: Yes No Size:_____
Type:_____
Change interval:_____
Irrigation: Yes No
Date current one inserted:_____
Urinary diversion equip/care:_____
_____
Other:_____

NOTES_____
_____
_____
_____
_____

Patient's Name ______________________________

WOUND CARE

Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:
Cleaned/rinsed:
Dressings (method & supplies):

WOUND CARE

Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:
Cleaned/rinsed:
Dressings (method & supplies):

WOUND CARE

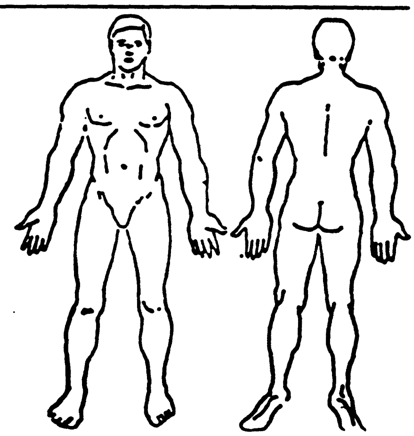
Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:
Cleaned/rinsed:
Dressings (method & supplies):

WOUND CARE

Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:
Cleaned/rinsed:
Dressings (method & supplies):

WOUND CARE

Site:
Size:
Drainage (color, consistency, amount, odor):
Appearance:
Cleaned/rinsed:
Dressings (method & supplies):



Patient's Name _____

PSYCHOSOCIAL Item # 8
Memory intact: Yes No Short Term/Long Term
Coping: Yes No
Learning potential: Good Fair Poor
Compliance potential: Good Fair Poor
Affect: Appropriate Flat Agitated Grieving
Knowledge deficit: Health status/Medications
Treatment plan/Prognosis/Agency involvement
Diet/Other:_____
Religion:_____Contact:_____
Cultural considerations:_____
_____
Self-assessment:_____
_____

ENVIRONMENTAL Item # 9
Living situation:
Neat Clean Dirty Infested Cluttered
Isolated Pets Steps Scatter rugs
Fire/Smoke alarm Tub rails Bed rails
Secure Not secure Adequate Inadequate
Utilities: Adequate Inadequate
Neighborhood influence: Positive Negative
Housekeeping: Indep. W/assist Total care
Shopping: Indep. W/assist Total care
Persl. laund: Indep. W/assist Total care
Handling $: Indep. W/assist Total care
Transportation:_____
Alcohol use: Yes No Specify:_____
Drug use: Yes No Specify:_____
Caregiver: Yes No Spouse Other
Name(s):_____
_____
Caregiver capable: Yes No
Caregiver influence: Positive Negative
Caregiver coping ability: Good Fair Poor
Patient/caregiver issues:_____
_____
_____
Equipment needs:_____
_____
_____
Indicated or desired assistance/referrals:
PT OT Speech HHA MSW Clergy Volunteer
Other:_____

DIET Item # 10
Meal prep: Indep. W/assist Total assist
Eats: Indep. W/assist Total assist
Appetite: Good Fair Poor
Difficulty swallowing/chewing: Yes No
Denture problems: Yes No
Nutrition: Adequate Inadequate
Recent weight loss: Yes No Amt:_____
Obesity: Yes No
Special Diet:_____
Supplements: Yes No
Kind:_____
Fluid intake: Good Fair Poor
Other:_____

SENSES Item # 11
Hearing: Good Fair Poor None
Uses hearing aid(s): Yes No Right/Left
Uses phone: Independent W/assist Unable
Vision: Good Fair Poor Blind
Wears glasses: Yes No
Taste: Good Fair Poor
Smell: Good Fair Poor
Touch: Good Fair Poor
Other:_____

PAIN Item # 12
Intensity (1-5):_____
Location:_____
_____
Type:_____
Frequency/duration:_____
_____
Relief measures:_____
_____
Other:_____

SLEEP Item # 13
Hours/night:_____
Insomnia: Yes No Naps: Yes No
Sleeping med: Yes No
Other measures:_____
_____
Other:_____

PAST MEDICAL/SURGICAL HISTORY Item # 14
_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS Item # 15
Allergies:_____
_____
Prescribed: See Intake
OTC:_____
_____
_____
_____
_____
_____
_____
_____
_____
Pharmacy:_____ Phone:_____

NOTES
_____
_____
_____

Patient's Name _____

PATIENT CONSENT/ADVANCED DIRECTIVES

Does patient have living will and/or durable power of attorney: Yes No
Person given DPOA:_____
Bill of Rights given: Yes No
Advanced directive information given: Yes No
Consent for Care signed: Yes No
Hospice: Yes No
Level of functioning:_____
(for Hospice patients only)

NURSING/TEACHING

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Communication:_____
_____
Next visit:_____
Plan:_____
_____

_____ _____
Date Signature of Admissions Visit R.N.

Curriculum Vitae

Rebecca L. Rader

PERSONAL

Address: 29406 Maple Avenue
Trappe, MD 21673
Telephone: (410) 476-3729
License: Registered Nurse, State of Maryland
License No. R122274

EDUCATION

1996 — Master of Science in Nursing
Salisbury State University
Salisbury, MD 21801

1994 — Bachelor of Science in Nursing
Salisbury State University
Salisbury, MD 21801

1985 — Master of Education
(Area of concentration: Counseling)
Salisbury State University
Salisbury, MD 21801

1971 — Bachelor of Arts
(Major: French)
Muskingum College
New Concord, OH 43762

EMPLOYMENT

1994 to present — Community Health Nurse II
Talbot County Health Department
Easton, MD 21601

1993-1994 — Nursing Assistant (Part-time)
Memorial Hospital at Easton
Easton, MD 21601

1991-1993 — Consultant
Eastern Shore of Maryland
Educational Consortium
Centreville, MD 21620

1980-1990 — Chesapeake College
Wye Mills, MD 21679

Associate Dean for Student Support Services, 1986-1990

Curriculum Vitae
(continued)

	Administrator of Student Life, 1985-1986
	Coordinator of Student Life, 1983-1985
	Marketing Specialist, 1982-1983
	Student Services Coordinator, 1980-1982
1978-1980	Realtor-Associate Spedden and Associates Cambridge, MD 21601
1973-1978	Assistant Advertising Manager Cambridge Wire Cloth Company Cambridge, MD 21613
1971-1973	Teacher, Secondary Level Board of Education of Dorchester County Cambridge, MD 21613

PROFESSIONAL AFFILIATIONS

American Nurses Association
Maryland Nurses Association, District 4
Sigma Theta Tau, International Honor Society of Nursing

CERTIFICATION

CPR, Level C, American Heart Association
First Aid, American Red Cross
Disaster Health Services I and II, American Red Cross