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Mary Margaret Rueff

University of Tennessee - Knoxville

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Running head: COMMUNITY HEALTH

Concepts in Community Health Nursing:

A Family Study

Mary Rueff

University of Tennessee, Knoxville

College of Nursing
Abstract

This project will explore concepts in community health nursing utilized in giving comprehensive nursing care to a client and family in the Knoxville community. Each phase of the nursing process will be discussed as well as appropriate tools and methods used in each phase. It will describe methods commonly used to assess the community environment, individual and family group needs, family strengths and coping abilities, and current and potential barriers to health care. It will also discuss current and potential interventions or resources used to assist the family and client toward a more optimum level of functioning. This project will include recommendations for incorporating community health concepts into the changing health care paradigm. Finally, the author will reflect on her personal and professional growth as a result of this nursing experience with the family and the community as client.
Community health nursing is a unique division of health care in that its focus is on populations rather than individuals. In this way, a nurse develops an awareness of health risks in her clients by assessing those of the community as a whole. Beddome, Clarke, and Whyte (1993) state that "health cannot be viewed in isolation from the social, political, and physical environments that people live" (p. 16). Rather, a health care provider must consider many factors that influence the health of a client "such as housing, literacy, nutrition, child care and employment" (p. 16). Clemen-Stone, Eigsti, and McGuire (1991) point out that by addressing "both the personal and environmental aspects of health [the nurse can] deal with community factors which either inhibit or facilitate healthy living" (p. 50). By focusing on preventive care rather than curative care, the community health nurse directs resources toward high risk aggregates and families. Ruth and Partridge (as cited in Clemen-Stone et al., 1991, p. 50) state that this allows available resources to be managed more efficiently.

Historical Perspective

The concept inherent in community health nursing has been in operation since before the turn of this century (Zerwekh, 1992, p. 84). Lillian Wald founded American Public Health Nursing during the 1890s in response "to the needs of the populations at greatest risk in our society" (p. 84). Wald
described the public health nurse's role as providing an entry point for health services into the lives of high risk populations who otherwise were not exposed to health care (as cited in Zerwekh, 1992, p. 84).

Zerwekh (1992) points out several characteristics of public health nursing in Lillian Wald's era that continue to be prevalent today. For example, Zerwekh describes the responsibility of public health nurses in the early 1900s to "make inquiries as to who was in need of help" (p. 86). She then states that "finding people in the community who are in need of services is a skill that still distinguishes community health nursing from acute care nursing" (p. 90). Therefore casefinding, a role unique to community health nurses today, has been such since the days of Lillian Wald.

The importance of building trust as the foundation for the client-nurse working relationship is another characteristic of community health nursing that remains unchanged. In the writings of Lillian Wald (as cited in Zerwekh, 1992), public health nurses are described as "steady, competent, and continuous" (p. 87) as they developed trust through persistence. Establishing trust continues to be essential in the therapeutic relationship in that most clients encountered by the community health nurse have little experience trusting outsiders (Zerwekh, 1992, p. 18).

Zerwekh (1992) states that the central goal of the public health nurse remains the same today as in the days of Lillian
This goal is to "encourage self-help by promoting capacity to make healthy choices" (p. 90). Clarke et al. (1993) refer to this concept of enabling clients to make informed decisions about their health as "empowerment" (p. 308). Zerwekh (1992) gives an example of this when she refers to the impact of community health nursing on maternal-child health care: "Instead of learned helplessness, the woman begins to learn self-helpfulness" (p. 19). In this way, the client plays an active role in her health care by making choices for herself and her family. This approach also preserves the client's rights which are often infringed upon when one enters the health care delivery system. These rights include "the right to be autonomous, the right to make an informed decision, and the right to one's domain, including one's body, life, property, and privacy" (American Nurses' Association, 1986, p. 3).

Home Visiting

The primary technique for assessing a community's health risks is home visiting. Despite the variations in family structure that are present in the United States today, "the family is still the basic social unit in our society" (Clemen-Stone et al., 1991, p. 184). This is important to consider in health care delivery due to the tremendous impact that the family has on one's health choices and behaviors. Through home visiting, "nurses enter the environment in which people live, and they practice in this environment, in sharp contrast to the situation where the client enters the nurse's
environment in a hospital or clinic" (p. 50). This is an especially valid point to consider when attempting to provide preventive care to clients and families who are relatively isolated and thus do not receive regular health care. Many aggregates served by community health nursing would otherwise have no or very little access to the health care delivery system. By utilizing primary and secondary prevention strategies, high cost emergency room visits may be avoided for these aggregates.

Unfortunately this is currently where most at risk groups enter the health care system when they are "forced to by pain or debility" (Reifsnider, 1992, p. 70). Home visiting also gives the nurse an opportunity to assess the family in context. Using this strategy allows the nurse to "uncover the causes of signs and symptoms that present in isolation in a clinic examining room" (Zerwekh, 1991, p. 30). Zerwekh (1991) points out that the task oriented nature of medical clinics often overlooks the biopsychosocial issues that impede health and well-being (p. 30). She goes on to say that "morbidity can be diagnosed in the clinic; [but] the environmental and psychosocial origins of morbidity are found where people live and work" (Zerwekh, 1993, p. 1677).

Critical thinking and intuition are essential in doing a home visit. Zerwekh (1991) emphasizes this point by studying the stories of several public health nursing experts. In all of the personal experiences of these nurses, there was one common thread: potentially dangerous patterns were identified in a
home visit that would not have been visible outside the client's environment. In other words, "home visits permit an accurate view of what is really going on" (p. 32).

Nursing Process

Assessment

Environmental Assessment

In assessing the home atmosphere, however, the nurse must do an equally accurate assessment of the environment surrounding the home. Mary Bayer (1973) states that this assessment is most telling when all of the nurse's senses are used to get a "feel" for the community (p. 712). There are numerous health hazards present in the community environment that can only be identified through this preliminary observation (Zerwekh, 1991, p. 34). Examples of these include, but are not limited to, inadequate sanitation, lack of proper waste disposal sites, open ditches, lack of recreational areas, stray animals, and unusual odors. One way for a community health nurse to complete this initial observation is by doing a "windshield" assessment of the client's or family's community (Stanhope & Knollmueller, 1992, p. 41). This type of evaluation is a process that helps the community health nurse in "identifying objective data which will help define the community, the trends, stability, and changes that will affect the health of the population" (p. 41). This gives the nurse a data base on which to build with additional information obtained from the family or client. She can then identify strengths, weaknesses, and potential
problems in the community, as well as available resources or lack there of. This provides a "basis for health planning . . . [and] a knowledge base to correct deficiencies in the health care system" (Clemen-Stone et al., 1991, p. 85-86). Correction of these deficiencies fulfills the community health nurse's primary responsibility to the community as a whole. Clemen-Stone et al. (1991) point out yet another use for this environmental assessment in that it provides rationale for marketing decisions about what nursing services are needed in a community and at what depth these should be maintained (p. 86).

The following is an environmental assessment performed in the community surrounding the home of a Knox County Health Department client on October 14, 1994. The residence is within a group of public housing projects. These homes are red brick dwellings connected to one another and in rows, surrounded by a black iron fence. There are openings in the fence without gates that give access to a busy two-lane street running in front of the homes. This client's home faces this busy street. There is one opening between each row of homes for a car to pass through into a concrete parking lot between each building. Therefore each parking lot has only one entrance/exit. The lawns of these homes are fairly well groomed. Most of the lawns behind the homes contain clothes lines. The homes on either side of the public housing projects are primarily wood homes. The lawns of these homes are not kept, and there is considerable debris and clutter visible around these houses. Many of them
have boards over the windows and doors, and thus appear to be condemned. Less than one street over (across the two-lane street mentioned above) are considerably nicer homes. They are wood homes close together, but these homes appear to be better maintained as evidenced by the condition of the paint and lawn. Many of these homes have bars on the windows or are surrounded by chain-link fences that have signs indicating security company protection.

The physical environment of the community is rather crowded and cluttered. There appears to be no open play areas or parks available for public use. Knoxville College is approximately 2 blocks from this home. Behind the college are two outdoor basketball courts and a track and field area. However, the college is surrounded by a chain-link fence and barbed wire. Thus it does not appear to be for public use. There is also a playground behind the Urban Community Vision establishment about ¼ mile from the home, but this too is fenced in. Several undeveloped vacant areas are present in the community. Approximately 100 yards from the home is a large gravel lot about the size of a basketball court. There are three cars parked in the area whose passengers seem to be conversing, so this is presumed to be a vacant lot rather that a parking lot. Adjacent to this area is another concrete vacant lot surrounded by a chain-link fence. There is a net set up in the lot, but a sign on the fence says, "No Trespassing." About 100-200 yards down the two-lane street from the home is a large lot surrounded
by a high chain-link fence. The lot is filled with hundreds of tires and considerable debris. It appears to be associated with an adjacent tire store, but tall weeds are visible growing through and around the tires. This gives the impression that this lot is essentially a junkyard. Less than a 1 1/2 miles from the home is a very large dirt hole that appears to be a swimming pool under construction. There are no fences or ropes around the area, and therefore this area may be hazardous.

There are several small community markets present in the community within 2 miles from the home. These include a Bi-Lo market, a snack bar, a supermarket, a Rexall drug store, and a liquor store. All of these establishments are quite small with virtually no available parking space. Most have bars on the windows and do not appear clean from the outside (i.e. litter and debris in front, broken sidewalks, unclean windows). There are also several buildings in the community that appear to have been stores at one time, but are now closed and boarded up.

There are three gas stations within this radius including Pilot, Fina, and Phillips 66.

Various industrial establishments are observed within a 2 mile radius of the home. These include the Knox County Extinguisher Company, a small furniture store, a window company, ADF Welding Shop, and the Coca-Cola Bottling Company. All appear to be in moderate to good repair from an outside windshield observation. No land used for agricultural purposes is observed in this community.
The streets in the community are all paved, though many potholes are present. These are the only type of geographical or topographical obstacles to travel noted. The residential streets are quite narrow with cars parked along the sides of the streets in front of the homes. There are also children's toys and bicycles along the curbs. The two-lane street running in front of the home is the most obvious geographical boundary noted. On one side of the street are the public housing projects, vacant lots, and boarded up or condemned buildings. On the opposite side are most of the nicer homes and small markets.

The sanitation of the community appears to be adequate from the windshield view. There is not a significant amount of litter visible. There is considerable clutter noted around the homes and in the lawns, but these items appear to be of a residential nature (i.e. furniture, toys, car parts). There is not as much clutter around the homes in the public housing project as there is around the other homes. There is a large trash receptacle behind each row of these homes. No unusual odors are noted, but the assessment takes place through a windshield.

Electric lines and utility poles are visible throughout the community. There are two public pay telephones in front of a market just across a street from this client's home. There are several clothes lines hanging throughout the housing projects and other homes in the community. A laundromat is located
Multiple domestic animals are noted wandering freely throughout the community. These are mostly dogs, and some are wearing collars while others are not. Cats are noted as well. In a few of the houses across the two-lane street from this client's home, the pets are kept inside a chain-link fence. Around the housing projects, however, the animals are not restrained. It is not distinguishable whether these are stray animals or pets belonging to people in the community.

The residents of this community are predominately black. The social atmosphere appears to be quite casual rather than structured. This is evidenced by the groups of adults and adolescents clustered in various places conversing. In the public housing sector, groups of adults sit on the porches while children play in the lawns in front of the homes. Behind the buildings, groups of young males stand talking to one another. Quite a few adults and children can be seen walking along the roads and sidewalks, some are in clusters and some are alone. Small children are noted crossing the street without adult supervision. As stated previously, Knoxville College is located about 2 blocks from this home, but these grounds do not appear to be open to the public. The Knoxville Police Academy Moses Center is about 4 blocks from this home. A child development center is in the vicinity of the home, approximately 3 blocks from the public housing projects. There is playground equipment visible behind this building enclosed in a chain-link fence.
Several public elementary schools can be found in the community. There is also a Head Start Program in the community less than \( \frac{1}{2} \) mile from this client's home. This building is adjacent to a fenced in playground as well. About five to seven school buses are parked in front of this building. There is a public library located less than \( \frac{1}{2} \) mile from the home. It is a brick one story building in good repair that is about the size of a small house.

In driving through the community, approximately nine churches are noted within no more than a 2 mile radius of the home. These include four Baptist churches, one Trinity Chapel, one AME Zion church, a House of Prayers, a Church of God in Christ, and one Methodist church. All of these churches are wood buildings in relatively good repair, but quite small and located among the homes. The Methodist church is an exception to this description. It is a much larger stone building located away from the homes with a fence enclosing much larger grounds. Several seemingly new vans are parked behind the church bearing the name of the church.

There are several small establishments that possibly serve as social gathering places for the members of this community. These include several bars and taverns, a billiard hall, small delis and cafes, and a lounge. Most of these establishments have varying degrees of clutter around them, and the windows are soiled with dirt and grease to the point that one cannot see through them. No movie theatres or auditoriums are found
in the community. The child development center mentioned previously is the only possible children's recreational center observed.

Several health centers are noted in the community in close proximity to this client's home. These include a community health agency, a dental center, and an eye center within 2 miles. A medical clinic is within 1 mile. Its hours of operation are Monday, Tuesday, Thursday, and Friday--9:30 A.M. to 1 P.M. and 3 P.M. to 6 P.M. Wednesday--3 P.M. to 6 P.M. and Saturday--9 A.M. to 1 P.M. The Knox County Health Department Main Clinic is within 1½ miles. East Tennessee Children's Hospital and its satellite Non-Emergency Care Center as well as Fort Sanders Regional Medical Center are all within 1½ miles.

Many automobiles are observed parked along the streets and driving through the community or behind the public housing projects where this client lives. It is interesting to note the wide variations in the value of cars observed. For example, they range from rather expensive and highly customized cars to inexpensive older cars in poor condition. At least two bus stops are noted within 2 blocks of this client's home, and this community is located less than 1 mile from access to Interstates 640 and 40. It is also within 1 mile of Western Avenue and Middlebrook Pike. There are at least two police cars noted cruising through this community, and several cruisers are parked in front of the police academy mentioned previously.
Neighborhood crime prevention signs can be seen tacked to numerous utility poles. There is a City Fire Department Station about 3/4 mile from the home, but no fire hydrants can be seen on the blocks containing rows of public housing projects.

The overall impression of this community is that of an unhealthy subgroup of the population. This assumption is based on the World Health Organization's definition of health as "complete physical, mental and social well-being and not just the absence of disease" (as cited in Clemen-Stone et al., 1991, p. 24). The disease state of this community cannot be accurately assessed in the windshield assessment. However, a glimpse into the mental and social well-being of the community is possible. The lack of recreational facilities or suitable play areas, and the lack of proper supervision of many children is evidence of incomplete social well-being. The bars on the windows of almost all commercial establishments and the distinct differences noted on either side of the two-lane street suggest impeded mental well-being in that these suggest feelings of disparity and insecurity. Clemen-Stone et al. (1991) state that the term health "assumes that people always have the potential for higher levels of functioning and that people in all stages of living, . . . , are growing and developing" (p. 53). This potential is not clearly represented in the community when one considers its crowded living conditions and lack of social development. However certain systems, such as the Head Start Program, numerous neighborhood watch signs, health clinics, and education programs,
are in place in the community as a possible attempt to promote more complete health and well-being in this population. A distinct opportunity exists for a community health nurse to develop this potential further by such activities as lobbying for a playground with safe equipment to replace the vacant lot, organizing community supervised play groups, or providing parenting education classes.

**Multidimensional Family Assessment**

After assessing the environment surrounding the client's home, the community health nurse must again employ all of her senses to assess the other factors that influence the health behaviors of her client. The next portion of this paper will explore the multidimensional factors affecting the health of J. R., a referral from the Pediatric Clinic of the Knox County Health Department. J. R. is being followed for a possible nutritional deficit and for a history of chronic otitis media. The purpose of this assessment is to form a data base to refer to when analyzing, planning, and intervening in the health promotion and illness prevention of J. R.

According to Clemen-Stone et al. (1991), "the actions and health status of one family member always affect the behavior and health status of all other family members" (p. 267). Therefore when attempting to positively influence the health and well-being of an individual such as J. R., the community health nurse cannot view the client in isolation. Clemen-Stone et al. (1991) refer to this comprehensive examination of family
health as discerning "functional and dysfunctional characteristics of family dynamics" (p. 268). It is essential, however, that when performing this assessment, the community health nurse keeps her personal values and beliefs separate from her clinical judgment (A. Blatnik, personal communication, November 4, 1994). This is "because dysfunctional or maladaptive behavior in one family can be functional or adaptive in another" (Clemen-Stone et al., 1991, p. 270). Therefore, to accurately determine whether the family unit is meeting the physical, emotional, growth, and development needs of its members, the "family's perceptions about how well it is functioning must be the key factor which helps a nurse to determine whether or not a family is reaching its potential" (p. 270).

Health needs.

The health needs of all family members must then be addressed to determine the needs of individuals and of the family unit as a whole (A. Blatnik, personal communication, November 4, 1994). If the community health nurse is attempting to provide health care for one family member in isolation, while ignoring the health concerns of other members, she may overlook an important barrier to health promotion of the client she is attempting to treat. Often all that is needed for another family member is referral, but in this way the nurse has identified other stressors in the family while emphasizing her role in serving the family as a unit. J. R. is an 18 month old male client with a history of anemia, chronic otitis media, chronic
respiratory infections, and possible developmental delay. He is currently enrolled in the WIC program, and WIC has been involved in encouraging J. R.'s mother to supply iron-rich foods for J. R. He underwent tube placement in both of his ears on November 2, 1994 at East Tennessee Children's Hospital. He receives breathing treatments at home every four hours which his mother administers. The supplies for these treatments are from Abbey Home Health Care. J. R. is believed to be developmentally delayed in that he is not yet able to walk and still drinks from a bottle. He receives primary care from Nancy Jackson, PNP at the Knox County Health Department. J. R.'s development seems to be his mother's biggest concern as evidenced by the amount of time that she spends talking about this in comparison with J. R.'s other apparent health needs. J. R. is currently enrolled in day care when both of his parents are working, and his mother states that he has adjusted quite well to that environment. J. R.'s mother describes herself and J. R.'s father as "pretty healthy" with no significant health problems. J. R.'s parents do not have a primary care provider and do not receive regular physical examinations. J. R.'s family needs to be followed quite closely to assist them in providing a more stimulating environment to foster J. R.'s physical and psychosocial development. This might include assisting the family in involving J. R. in a program for children at high risk for developmental delay. J. R.'s mother also needs guidance and support in providing appropriate food for J. R.
and taking steps to prevent further respiratory and ear infections. The parents need to be informed about the importance of providing primary care for themselves as well.

Home environment.

Upon entering the client's home, the nurse must alert herself to certain factors existing or not existing within the internal home environment that could affect the family's health status. These include the number of persons living in the home, the size and condition of the home, facilities for privacy, and safety features or hazards present in the home (A. Blatnik, personal communication, November 4, 1994). These factors clearly affect the health and opportunities for growth and development of the family unit and of its members. Therefore, assessment of this nature cannot be overlooked. J. R. and his mother and father live in a two-room apartment. The entry room contains a double bed, an end table with a television on it, a portable electric heater, a high chair, a lounge chair, a cabinet with stove and sink, a table, and a refrigerator. The room is very small, and there is very little room to move about. There are various items, such as a stroller, walker, and clothing, piled on the floor and on the counter top. There is a full dish drain on the counter and the sink is full of dishes as well. The double bed is covered with a mattress pad, a thin brown blanket, and two pillows without pillow cases. The mattress pad has brown and yellow stains on it, and the child is sitting in the middle of the bed eating cookies. Crumbs and dirt are noted
on the mattress pad as well. The floor around the bed is covered with a red carpet, which is soiled with crumbs, dust, and dirt. Adjacent to the kitchen area is a smaller room containing a crib, a couch, and a chest of drawers. A large portable radio is on top of the chest. The floor is covered with several laundry baskets and piles of clothing, and there is even less space to move about in this room. Adjacent to this room is a small bathroom with a sink, toilet, and bath tub. Insects are noted crawling along the sink, and piles of clothing and towels are noted in the floor. There is a window in the front room with curtains, but the only electric light source in this room is in the kitchen area. Therefore, the mother frequently keeps the door to the apartment open. There is a burnt out light bulb in the back room and a functioning electric light in the bathroom. The family needs guidance and support in ways that they can foster physical development in J. R. with the little space that they have available. They also need information regarding safety hazards in the home such as the portable heater and leaving the apartment door open.

Family structure.

The structure of the family is important to assess in that despite the recent societal changes in family life, the family remains the "most fundamental, powerful, and lasting influence" (White House Conference on Families as cited in Clemen-Stone et al., 1991, p. 184) on the lives and choices of individuals. However, the nurse cannot make assumptions about a family's
ability to provide for its members physically and emotionally based only on assessment of the family's organizational structure (Clemen-Stone et al., 1991, p. 187). According to Orr (1992) practitioners engaged in home visiting must be prepared to cope with diverse patterns of family units without viewing "deviations from the so-called 'normal' family unit . . . as problems needing special attention" (p. 123). Instead the nurse uses her information gathered about the family structure to analyze family strengths and needs, and to enhance family growth and support regardless of their family life-style. According to the traditional family structures presented by the 1970 White House Conference on Children and C. Ahrons (as cited in Clemen-Stone et al., 1991), J. R.'s family would be considered a "Nuclear family-- dual career" (p. 186). This conclusion is based on J. R.'s mother's report that she and her husband are both employed, and the two parents and one child are the only individuals living in the household.

The nurse should also be aware of how family patterns shift over time in relation to structure, function and circumstance (Orr, 1992, p. 124). Stanhope & Knollmueller (1992) present the stages of family development and the appropriate interventions for the community health nurse "in assisting families to move successfully through life stages, thereby reducing the risk of illness or crises" (p. 97). J. R.'s family is in the "family with preschool and school-age children" stage. The role of the nurse with this family would include monitoring
early childhood development, coordinating with pediatric services, counseling on nutrition and environmental safety in the home, and teaching hygiene measures (p. 97).

**Family culture.**

Exploring the cultural beliefs of a family is essential in the multidimensional assessment. This is because one's cultural environment "greatly affects how growth progresses and what decisions are made about how to handle activities of daily living" (Clemen-Stone et al., 1991, p. 202). The purpose of a cultural assessment in community health nursing is to gather information relevant to health and health practices and to identify patterns that assist or interfere with healthy behaviors and intervention (P. Miller, personal communication, September 12, 1994). Relevant information may include nutritional practices, "childrearing beliefs, attitudes toward health care, and personal faith in a deity" (Whaley & Wong, 1991, p. 210). An assessment of the religious orientation of the family must be included in the cultural assessment because it "dictates a code of morality as well as influencing the family's attitudes toward education, male and female role identity, and attitudes regarding their ultimate destiny" (p. 35). In addition to the impact that these attitudes have on health, the family's religious background has a direct impact on an individual's beliefs regarding illness, injury, or death (p. 49). Even if the family does not appear to be involved in an organized religion, the community health nurse cannot assume that
spirituality does not play a significant role in their life. Personal spiritual beliefs are often a source of comfort for a family dealing with crisis or an ill member (Clemen-Stone et al., 1991, p. 205). When the nurse is sensitive to the religious and spiritual implications of health-related treatment and intervention, "it is comforting to the family . . . to have this need recognized and respected" (Whaley & Wong, 1991, p. 49). The nurse can then individualize her planning and implementation strategies for each family.

Several characteristics of the culture of poverty as outlined by P. Miller (personal communication, September 12, 1994) are exhibited by the family of J. R. These include their lack of privacy, low level of education, and sense of confinement. However, these people do not seem to lack future orientation as evidenced by J. R.'s mother's comments concerning her desire to buy a house. This family does not appear to be involved in an organized religion in that the mother states that they go to a "Knoxville church every once in while but not much." There are various items in the home that reflect the family's spirituality such as a picture on the wall with the phrase "God Bless Little Boys."

Developmental assessment.

Assessing the developmental level of family members is essential in order to determine the family's perception of its own health status (Clemen-Stone et al., 1991, p. 270). According to Erikson's theory (as cited in Whaley & Wong, 1991), at
progressing stages of psychosocial development an individual is "confronted with a unique problem requiring the integration of personal needs and skills with social demands and cultural expectations" (p. 123). Erikson refers to the individual's struggle to adjust in the face of this problem as a "crisis" (p. 123), and believes that "the tension produced by societal demands must be reduced in order that a favorable outcome can be achieved" (p. 123). This outcome "provides the resources for coping" (p. 123). It is therefore essential to evaluate the developmental level of each family member, rather than only that of the individual client, to give insight into the family unit's resources for coping. Erikson describes the major task of the infant from 1 to 3 years of age as "autonomy vs shame and doubt" (p. 123). J. R. exhibits a few characteristics of this stage of development in that he attempts to manipulate his environment by crawling, reaching for things, and imitating adults to a limited extent. Erikson's previous stage of "trust vs mistrust" (p. 123) is characterized by an infant being able to tolerate "little frustration or delay in gratification" (p. 545) and continuation of oral stimulation as the primary mode of gratification (p. 545). J. R. continues to exhibit characteristics of this stage as well, as evidenced by his inability to accept delayed gratification and continuous use of the bottle. Erikson's stage of "intimacy vs isolation" (p. 124) is commonly associated with early adulthood. In this stage the individual develops intimate relationships with friends
and significant others rather than becoming socially isolated (p. 124). J. R.'s mother, age 25, exhibits characteristics of this stage in that socializing with neighbors seems to play a significant role in her daily life. J. R.'s father, age 26, is not present for this assessment. Based on Erikson's description of the young and middle adulthood stage of "generativity vs stagnation" (p. 124), in which an individual's energy is directed toward nurturing the next generation, it is possible that he would be included in this stage since he currently holds two jobs.

J. R.'s family is in need of intervention to help them cope with J. R.'s developmental delay. However, they also need assistance with understanding the level that J. R. is currently functioning and how this influences the kind of care that he needs. For example, J. R.'s mother needs to be aware of his emerging sense of autonomy and desire to manipulate his environment. This would mean that her stepping outside to smoke with her friends while J. R. plays on a bed is not appropriate, especially if an electric heater is on near the bed.

**Education.**

The educational level of the family members is another component of the multidimensional assessment of the client's family. According to White (as cited in Clemen-Stone et al., 1991), educative nursing is one of the main categories of community health nursing intervention (p. 55). To be effective, however, this intervention must be at an appropriate level for
family members and/or the client to grasp. This requires information about level of formal or informal education and training or skills required for a particular occupation (Whaley & Wong, 1991, p. 210). "This information is highly valuable in planning implementation of care (e.g., counseling, guidance, or teaching)" (p. 210). J. R.'s mother was a senior in high school when she dropped out of school. She is currently enrolled in GED classes and states that she will complete the program about this time next year. She states that her husband plans to enroll in the program when she finishes, but she does not know the highest level of formal education he obtained.

Financial assessment.

Discussion about education often provides a smooth entry into the sensitive area of assessing the family's economic resources. This is imperative to address in the multidimensional assessment because it ultimately affects how well a family can provide essential items (e.g., food, shelter, and clothing) for its members (A. Blatnik, personal communication, November 4, 1994). According to the U. S. Congress (as cited in Whaley & Wong, 1991), "availability of financial assistance is directly related to use of health care" (p. 209). Therefore, discussion of medical insurance must be included in this assessment. The community health nurse is in a position to determine if there is a need for public resources not currently utilized by the family. She can then operate as a referral agent or care coordinator to assist the family in meeting its needs as a whole.
or the special needs of an individual member. This serves the combined community health nursing purpose to "promote high-level wellness and to enhance self-care capabilities" (Clemen-Stone et al., 1991, p. 307). The family of J. R. is financially supported by a variety of means. J. R.'s father works for McDonald's and Weigel's, and J. R.'s mother is employed at Weigel's. The WIC program provides support in meeting the nutritional needs of J. R. The family also receives food stamps, though J. R.'s mother is unclear about how much the family receives in food stamps. The family is medically insured by TennCare through Blue Cross & Blue Shield of Tennessee. J. R.'s mother states that she is currently going through the application process of acquiring Supplemental Security Income for J. R. The needs of the family in this regard revolve around referral and care coordination. J. R.'s parents need to be referred to a primary care provider that is covered by their TennCare plan.

Family functioning.

Jayne Tapia (1972) developed a model for community health nursing depicting five levels of family functioning. This model is useful in application to families such as J. R.'s to determine the "nursing service appropriate to the needs of a particular family" (p. 267). J. R.'s family may be placed partially on levels II and III. Tapia describes the second level of family functioning as the "childhood or intermediate family" (p. 269). This type of family is slightly more organized than the level
one family, in that the family is more able to provide for the physical and security needs of its members. However, the level two family is "still unable to support and promote the growth of its members. . . . This family does not seek help actively and requires much assistance before the members are able to acknowledge their problems realistically" (p. 269). This family is more able to trust the community health nurse than the level one family, and thus "have more hope for a better way of life" (p. 269). In this type of family the nurse would attempt to promote the trust relationship which she uses as "a stepping stone to help the family begin to understand itself more clearly" (p. 269). Tapia describes the third level of family functioning as the "adolescent or family with problems" (p. 269). While she describes this family as "essentially normal" (p. 269), she states that this family has an unusual amount of problems. In this family, "members demonstrate greater trust in people, have the knowledge and ability to utilize some community resources, and are less openly hostile to outsiders" (p. 269). This family is better able than the level two family to recognize its problems and search for solutions through utilization of resources outside of the family (p. 270). The nurse's function in this type of family is aimed at helping the family to solve those problems identified by the members (p. 270). She does this "by providing teaching, information, coordination, referral, team-work, or special technical skills" (p. 270). For placement of J. R.'s family on Tapia's model of family functioning, refer
Family coping.

An assessment of family coping is another tool that is useful in helping the community health nurse individualize her care plan for a specific family. In 1964 Freeman and Heinrich developed a family coping index "as an approach to identifying the family need for nursing care and assessing the potential for behavioral changes, and as a method of determining in a more systematic way how the nurse can help the family to manage" (as cited in Stanhope & Knollmueller, 1992, pp. 79-80). Nine categories are included in the index. The first is "physical independence" (p. 80). This category deals with the family's competence in maintaining physical competence of its members. Even if one member of the family is dependent on the family unit for basic physical activities such as those of daily living, "if the family is able to compensate for this the family may be independent" (p. 80). The next category is "therapeutic competence" (p. 81), and deals with a family's ability to provide prescribed treatment of a medical condition. The third category is "knowledge of health condition" (p. 81). In assessing this category, the nurse evaluates a family's knowledge of "the particular health condition that is the occasion for care" (p. 81). Without this knowledge, the family cannot be expected to provide for the basic physical and developmental needs of its members. The next category is concerned with the family's independence in applying "principles of personal and general
30 Community

"hygiene" (p. 82). Examples of these principles include proper nutritional support, appropriate safety and sanitation in the home, and preventive health activities (p. 82). The next category deals with the family's general attitudes concerning health care and public health intervention (p. 82). The sixth category is "emotional competence" (p. 83). This deals with "the maturity and integrity with which the members of the family are able to meet the usual stresses and problems of life" (p. 83). This includes the members' ability to recognize the needs of the family unit as well as their personal needs and the discipline with which they accept behavior guidelines imposed by the family unit and society (p. 83). "Family living patterns" (p. 83) is the next category addressed in the coping index. This is concerned with the interpersonal relationships among the family members, the family process of decision making, issues of discipline, displays of affection, and respect that each member has for one another (p. 84). The eighth category is concerned with the physical environment surrounding the family and how this affects their health and well-being (p. 84). The nurse would pay attention to "condition for housing, presence of accident hazards, screening, plumbing, [and] facilities for cooking and for privacy" (p. 84). This category would also include those factors affecting health noted by the nurse during the assessment of the outside environment of the home such as available schools and transportation and social hazards such as gangs and pollution (p. 84). The final category addressed
by the family coping index deals with "the degree to which the family knows about and the wisdom with which they use available community resources for health, education and welfare" (p. 85). Whether or not a family has a particular need for such resources has no bearing on the coping index. Instead this addresses how well a family is able to cope when such services are needed, even if the condition prompting the resource utilization is not corrected (p. 85). Please refer to Appendix B for placement of J. R.'s family on the coping index.

**Family needs.**

The needs of the family based on the coping index include assistance with dealing with and providing for the special needs of J. R. in regard to his developmental delay. J. R.'s parents also need assistance with achievement of a higher level of therapeutic competence in maintaining the proper environment for a child with J. R.'s respiratory condition. They would also benefit from a greater understanding of strategies to prevent recurrent ear infections. Education about general personal hygiene such as importance of adequate rest and nutrition for all members of the family is needed. The parents of J. R. also need encouragement to obtain appropriate health care for themselves. Strategies to enhance the mother's emotional competence is needed as she appears unable to accept the degree to which J. R. may be delayed. Intervention is needed to assist the family in providing a safer home environment for J. R. in terms of awareness of physical safety hazards and
possible problems that could arise with intoxicated neighbors being with the child in the home. The family also needs further intervention focused on fostering the trust relationship, as they seem to feel threatened rather than assisted by community health nursing interventions of the student.

Establishing trust.

Before the needs of the family can be effectively addressed, the nurse and the family must build a working relationship. This relationship must have trust as its foundation for tasks to be accomplished (Zerwekh, 1992, p. 17). According to Clemen-Stone et al. (1991), this trust relationship must be established early because it is a "critical factor in helping the client [and family] determine whether or not to accept the assistance offered by the community health nurse" (p. 263). However, the trust relationship must strengthen over time to make a lasting impact in the life of the client and family. Zerwekh (1992) points out that the clients served in community health often "have little experience with trust" (p. 18). With these clients, persistence and consistency are required for the family to realize that the community health nurse will not desert or betray them (p. 18). J. R.'s family seemed very receptive to the student community health nurse initially. On the first home visit, J. R.'s mother was eager to answer questions about J. R.'s health status and agreed to make a list before the next visit of what she thought would be important to accomplish in the next home visit. At the second visit,
however, she had not compiled such a list and was considerably less receptive. This was evidenced by her hesitancy to make eye contact with the student and her brief responses. It was during this visit that a developmental screen was performed on J. R. She may have perceived this as a test of herself and her parenting abilities, and this possibly was why she was less interactive with the student.

According to Clemen-Stone et al. (1991), promoting trust involves "explaining the purpose of community health nursing visits, describing services the community health nurse can provide, and fostering a nonthreatening atmosphere which allows the client to share data at his or her own pace" (p. 263). These strategies were employed in the first visit with J. R.'s family and were reinforced in the subsequent visits. Zerwekh (1992) states that to build trust, the community health nurse must foster "a sense of worth among those who often considered themselves worthless" (p. 19). In order for J. R.'s mother to have confidence in her abilities as a parent in the face of J. R.'s considerable developmental delay, it was important for the student nurse to affirm the positive aspects of the care that she provides for J. R. The student was straightforward and honest while avoiding false reassurance and displays of disapproval. In this way the student's personal integrity was demonstrated without negatively affecting the mother's self esteem. Both purposes served to strengthen the trust bond.
Nursing Diagnosis

With trust as the foundation, the nurse and family can then work together in analyzing the needs of the client and family unit. In this phase of the relationship, data gathered in the assessment phase of the nursing process is synthesized to build on needs previously identified in order to make a nursing diagnosis (A. Blatnik, personal communication, November 11, 1994). Gordon defines a nursing diagnosis as an inference about "the individual's, the family's, or the community's health problem/condition and the primary etiological or related factor(s) contributing to the problem/condition that is the focus of nursing treatment" (as cited in Clemen-Stone et al., 1991, p. 272). In community health, nursing diagnoses are used to examine actual or potential problems as well as strengths of the client and family (A. Blatnik, personal communication, November 11, 1994). Diagnoses that identify actual or potential problems assist the nurse in providing needed anticipatory guidance as a primary prevention strategy (Clemen-Stone et al., 1991, p. 273). On the other hand, diagnosing strengths aids the nurse in choosing activities that promote independence in the family (p. 273). According to Clemen-Stone et al. (1991), when the client is actively involved in determining health needs, he or she is more likely to change health behaviors than one who has no voice in such decisions (p. 281). The diagnoses, therefore, must be validated by the client.

In working with J. R. and his family, it was important
to determine early if J. R. was indeed developmentally delayed and to what extent. The Denver Developmental Screening Test [DDST] assesses "a child's performance on various age-appropriate tasks. . . . [and] is valuable in screening asymptomatic children for possible problems, in confirming intuitive suspicions with an objective measure and in monitoring children at risk for developmental problems" (Frankenburg et al., 1992, p. 1). This was considered an appropriate tool to use with J. R. in that N. Jackson, PNP was suspicious of a delay. J. R.'s mother was concerned about his development, but did not seem to accept the reality of a delay. The objective nature of the DDST would confirm the suspicion while providing concrete data to work with in presenting the results to J. R.'s mother. According to Frankenburg et al. (1992), the test result is suspect if one or more delays are discovered (p. 13). Refer to Appendix C for the suspect test result of the DDST performed on J. R.

Planning

After diagnoses are established by the nurse and client, the relationship moves into the planning phase of the nursing process (Clemen-Stone et al., 1991, p. 279). In this phase client centered goals and objectives are formulated and interventions are identified (p. 279). A goal is defined as a "broad desired outcome toward which behavior is directed" (p. 279), and an objective "delineates client behaviors which reflect that a goal has been reached" (p. 279). The interventions are activities to be carried out by the client,
community health nurse, or other professional to help reach the identified goal (p. 279). Clemen-Stone et al. (1991) set forth three main principles to be considered in the planning process: "(1) individualization of client care plans; (2) active client participation; and (3) the client's right to self determination" (p. 280). Therefore, since each client has unique needs, the client must be actively involved in mutual goal setting with the nurse (p. 280). According to Twinn (1991) this philosophy of practitioner forming a partnership with the client is quite different from the traditional health care paradigm in which "practitioners generally work with clients in a directive manner" (p. 969). This active participation "also promotes client commitment to goal attainment and decreases resistance to change" (Clemen-Stone et al., 1991, p. 280). If the nurse were to enter the relationship and take over for the family, she may decrease the family's self esteem while fostering dependence or resentment of authority figures (p. 280). However, it is sometimes appropriate for the community health nurse to develop a nurse centered goal. This would be appropriate if the nurse identifies a problem that the family is not aware of and determines by professional judgment that it is necessary to increase the family's awareness of the problem (A. Blatnik, personal communication, November 11, 1994). Refer to Appendix D for a care plan containing nursing diagnoses, goals, and interventions developed in working with the family of J. R.
Implementation

After diagnosing needs and setting goals, the client and community health nurse must develop a contract which "clearly identifies what each person in the relationship can expect from the other person in the relationship" (Clemen-Stone, 1991, p. 281). This provides a framework from which to evaluate the effectiveness of interaction between the family and the nurse (p. 281). The contract must be mutually agreed upon and must be continuously negotiable (A. Blatnik, personal communication, November 11, 1994). The nurse and client work together towards an agreement, either written or oral, which outlines the responsibilities of each member in achieving the stated goals (Clemen-Stone et al., 1991, p. 281). In working with J. R.'s family, a written contract explaining the purpose of the family study and the duties of the student was signed by J. R.'s mother and the student on the first home visit. This written contract outlined the time parameter of the relationship, when visits would take place, and how many visits were to occur. (Refer to Appendix E for a sample contract.) There was also an oral contract between J. R.'s mother and the student made at the end of each visit regarding each party's duties in the week before the next visit. Before each termination the student and mother would come to a mutual agreement as to what would be accomplished by each in the coming week.

With the contract as a framework, the client and nurse move into the implementation phase of the nursing process in
which "activities are carried out to achieve client goals" (Clemen-Stone et al., 1991, p. 284). A supportive atmosphere should be developed by the nurse to reinforce accomplishments and provide positive feedback (p. 284). Throughout this phase, new data may be gathered that must be analyzed to determine the need for care plan revision (p. 284). As in all phases of the nursing process, the client must be involved in implementing the care plan. This aids the family in assuming responsibility for themselves as a unit rather than fostering dependency (p. 285). If the client fails to follow through with an agreed upon intervention, the nurse must determine why the client is not taking action (p. 285). Such a situation may precede the need for modification of the mutual goals and plans (p. 285).

**Evaluation**

Evaluation must take place throughout each phase of the nursing process so that the community health nurse can accurately identify what has or has not been accomplished (Clemen-Stone et al., 1991, p. 285). This process is facilitated by establishing objectives in the planning phase that contain the potential for evaluation (p. 285). It is also imperative to elicit ongoing feedback from the client and family in order to determine if interaction remains focused and effective (p. 285). Clemen-Stone et al. (1991) state that when evaluation is deleted from the relationship the process is prolonged (p. 285). Clearly this represents an ineffective use of resources.
Evaluation also aids the community health nurse in determining why goals have not been achieved (p. 286). However, outcomes of interaction must be examined rather than simply observing that the family is participating in the process (p. 286). When coordinating services among professionals, evaluation aids the nurse in determining the need for referrals or the need to terminate nursing services (p. 286). It is then necessary "to evaluate the effectiveness of referrals that have been made" (p. 286). Refer to Appendix D for evaluation of nursing goals and objectives in the care of J. R.

Termination

Through accurate evaluation, the community health nurse can make decisions regarding when nursing services are no longer needed. The client-nurse relationship then enters the termination phase (A. Blatnik, personal communication, November 18, 1994). However, certain interventions must be implemented by the nurse throughout the relationship in order to prepare the family for termination. These include:

1. Stating the termination date, if known, in the beginning of the relationship and throughout consecutive meetings
2. Discussing thoughts and feelings about termination prior to the last meeting
3. Identifying signs of separation anxiety in the family and personally
4. Encouraging the family to compare past separations with the present one
5. Promoting the family's evaluating and summarizing the relationship in terms of its goals, expectations, satisfactions, and dissatisfactions (Cronin-Stubbs, 1983, p. 405).

Kelly defines termination as "the period when the client and nurse deal with feelings associated with separation and when they distance themselves" (as cited in Clemen-Stone et al., 1991, p. 287). Strong feelings such as anger and sadness are often experienced by the client and nurse, and these feelings must be discussed and dealt with (p. 287). Clemen-Stone et al. (1991) state that it is the nurse's responsibility to initiate such a discussion in order to create a supportive atmosphere for the client to express feelings and emotions regarding the termination (p. 287). It is important for the client and nurse to review what has and has not been accomplished in their relationship and why termination is indicated (p. 288). The nurse must remind the client of the continued availability of health care services in the community even though the home visits will not continue (A. Blatnik, personal communication, November 18, 1994). Termination with J. R.'s family was less than ideal in that the time frame was predetermined rather than being based on evaluation of accomplishments. However, termination was integrated throughout the relationship in that a contract with a specified number of visits was signed by both parties at the first visit, and J. R.'s mother was reminded about the number of visits remaining upon each visit. At the
final visit the student initiated discussion about termination, and the client expressed little emotion about the reality of termination. Progress made was reviewed with the client, specifically that the mother was now more aware of age appropriate tasks for J. R., and she was aware of the importance of maintaining her own health. A list of family strengths identified by the student was shared with the mother. She seemed very pleased with the student's conclusions and added some items to the list. Plans for the mother's continued effort towards the goals identified were mutually agreed upon, specifically that the mother would follow up with N. Jackson, PNP regarding program placement for J. R., would obtain a thermometer, would apply for the Empty Stocking Fund, and would obtain an appointment for herself to have a physical exam. J. R.'s mother was reminded that the services of the Knox County Health Department are still available to the family despite the fact that home visits by the student nurse would not continue.

Family Strengths

Inherent in each phase of the nursing process is utilization of family strengths to increase successful achievement of goals. Herbert Otto (1973) defines family strengths as "those factors or forces that contribute to family unity and solidarity and that foster the development of the potentials inherent within the family" (p. 88). Once strengths are identified they can then be mobilized in working out problems that exist or arise within the family (p. 87). The community health nurse is in
a position "to support the family in exploring the application of family strengths to the problem configuration" (pp. 92-93). Pointing out the positive aspects of the family unit can prompt clients to realize that they are not helpless, but in fact are quite capable of developing more healthy patterns by making use of available resources. Often the community health nurse identifies "latent family strengths, or family potentials" (p. 92). Otto (1973) defines these as strengths that are present but not being utilized by the family (p. 92). Discovering and building on these strengths provides a positive balance in the community health setting. Often nurses become preoccupied with the pathologic patterns occurring in the family, and too little attention is paid to the positive potential of the family (p. 91). Recognizing strengths reminds clients that they are valuable individuals despite their areas of need. Refer to Appendix F for assessment of strengths in J. R.'s family.

Barriers to Health Care

In evaluating the progress that a client and/or family is making toward a goal, it is important for the community health nurse to be sensitive to the often invisible factors which obstruct progress. Clemen-Stone et al. (1991) cite "various reasons why clients are unable to alter their behavior in a way to help them resolve their stress appropriately" (p. 244). Often the family does not know why they are experiencing difficulty in taking action, yet they are aware "that something is wrong because symptoms of anxiety are present" (p. 244).
In these situations, the community health nurse must explore with the family the possible causes for their inability to take action and obtain the appropriate health care. Clemen-Stone et al. (1991) give examples of these causes which are primarily psychosocial: the client has not identified the specific nature of the problem; the client cannot acknowledge feelings or distinguish between feeling and fact; the client does not assume responsibility for feelings; the client has no problem solving experience; or the client has missed successful completion of tasks in skill development (pp. 244-245).

The community health nurse must also be aware of those factors that adversely affect the family's use of referral services. Clemen-Stone et al. (1991) define these factors as "barriers to utilization of the referral process" (p. 322) and give examples of barriers that are inherent in the resource and those that exist within the client or family. Resource barriers may include the attitudes of health care professionals, the accessibility of the resource to the community, and the cost of the service (pp. 322-323). Barriers within the client or family may include where the service falls on their list of priorities, how well they understand the need for the service, the family's motivation to act on the need that initiated the referral, the family's prior experience with utilization of referral services, the family's awareness of available services, the family's self image, cultural differences, and the family's ability to pay for the service and/or get to the facility (pp.
The community health nurse must be consciously looking for these factors because clients may not bring them to her attention due to embarrassment or their lack of awareness of the barrier. For example, a client or family may acknowledge a need but repeatedly fail to act on the need. The nurse must be able to differentiate between their readiness to work on the need as opposed to their awareness of the need. In this situation the nurse can assist the family in prioritizing needs that they are ready to act upon (p. 323). Refer to Appendix G for barriers to obtaining health care identified when working with J. R.'s family.

Utilization of Community Resources

Various agencies in the community are currently being used by this family. The agency that they use most frequently is the Pediatric Primary Care Clinic at the Knox County Health Department [KCHD]. This is a clinic in which health care is provided by physicians and nurse practitioners to those patients who do not have a primary care physician (K. Boggan, personal communication, August 26, 1994). The clinic offers "clinical services, sick care, immunizations and WIC" (KCHD, 1994, p. 2). It is not designed to be a walk-in clinic, but rather its purpose is to provide regular primary care. Without this service, these clients would probably go to the emergency room for sick care only. Here they would be seen by a different physician who was not aware of their personal health history on each visit (K. Boggan, personal communication, August 26,
1994). Thus the clinic provides for continuity of care, and it prevents unnecessary (and costly) visits to the emergency room. Nancy Jackson, PNP is the primary care provider for J. R., and Donna Richter is a social worker that operates through this clinic. Both were consulted in this case to discuss possible sources for obtaining developmentally stimulating toys for J. R. and options regarding J. R.'s placement in a special program for developmentally delayed children. This resource has several positive effects on this family's level of functioning. For example, the health care providers at the Pediatric Clinic discovered J. R.'s health problems and initiated home visits to this client by the student nurse. Without this intervention, this child's developmental delay and need for placement in a special program may have gone undetected until much more lengthy and costly intervention would be required. The family's ongoing rapport with the providers at the clinic has been a positive experience for J. R.'s family as evidenced by his mother's positive and affectionate comments about N. Jackson, PNP. This experience has a positive influence on the family's future use of health care services.

The Supplemental Food Program for Women, Infants, and Children [WIC] is a federally funded program offered through the KCHD that provides various food services to pregnant or breast feeding women and children under the age of five (KCHD, 1994, p. 2). To be eligible for the program, "participants must meet financial eligibility and have documented medical
Community

or nutritional risk" (p. 2). WIC offers vouchers redeemable at local grocery stores for items such as milk, cheese and cereal, and the program "includes mandatory nutrition education and health assessment" (McGuire, 1994, p. 7). The role of the community health nurse in WIC is to be aware of possible beneficiaries of the program and provide the client with information about how to contact the program. J. R. is currently enrolled in the WIC program due to his financial need and documented iron-deficiency anemia. The program has intervened to educate and encourage J. R.'s mother to feed him foods rich in iron and Vitamin C. These interventions were supported and reinforced by the student nurse.

J. R.'s family also receives nutritional support from the food stamp program. This is a federal-state assistance program designed "to improve the nutritional adequacy of low-income individuals and families" (McGuire, 1994, p. 7). The community health nurse should be able to identify possible candidates for food stamps and direct these clients to the State Department of Human or Social Services to apply for the program.

Supplemental Security Income [SSI] "is a federal-state assistance program for qualifying aged, blind or disabled individuals" (McGuire, 1994, p. 6). This program is designed "to develop a uniform national minimum cash income for the indigent aged, blind, and disabled" (Clemen-Stone et al., 1991, p. 117). J. R.'s mother is in the application process for obtaining SSI benefits for J. R. He has been evaluated for
physical and mental disability to determine if he is eligible. He has not been rejected or accepted by the program to date.

Children's Special Services [CSS] is a program offered by the KCHD that "provides comprehensive medical care for handicapped children from birth to 21 years of age who meet the medical and financial eligibility requirements" (KCHD, 1994, p. 3). CSS provides diagnostic evaluation, medical treatment, and speech and hearing screening tests (p. 3). Community health nurses play an essential role in CSS in that they identify possible beneficiaries of the program and provide information to the family. CSS nurses then act as care coordinators and provide evaluation, assessment, and health education in the home (p. 3). J. R. was referred by the student nurse to CSS for evaluation due to his considerable developmental delay. J. R.'s mother expressed concern that his inability to walk may be due to an orthopedic problem. The student thought that CSS would have resources to diagnose such a problem if it existed. The student also felt that further home visits were needed by this client, and that CSS would have the resources to continue these visits. The CSS program was discussed with J. R.'s mother, and she was given the phone number and instructed to make an appointment for evaluation of J. R. The appointment was made but not kept. When questioned about the missed appointment, J. R.'s mother stated that after discussing CSS with N. Jackson, PNP, she decided that she would explore other programs. She agreed to follow up with N. Jackson, PNP regarding
other options.

The Empty Stocking Fund is a program that "provides needy individuals and families with a Christmas basket of food and toys for children under 14 ("Milk Fund," 1994, p. A1). The program is funded by contributions and conducted by the Knoxville News-Sentinel. The program is designed to help those in the Knoxville community who would otherwise have no means to help them celebrate the holidays (Brown, 1994, p. A1). Individuals must apply for the baskets, and information is documented and verified to determine who will receive a basket (p. A1). It is possible that J. R.'s family would be considered in need of a basket due to their financial stress. Therefore, J. R.'s mother was given information about where, when, and how she could apply for the Empty Stocking Fund by the student nurse.

Recommendations

A commonly accepted opinion is that the American health care delivery system needs restructuring due to its inability to meet the health needs of many citizens (Knauth, 1994, p. 140). There appears to be "an oversupply of physician specialists and an undersupply of primary care services" (p. 140) -- an imbalance that leads to high cost and often inappropriate care for a few and inadequate care for many. However, governments continue to emphasize high tech secondary and tertiary health care and "lack faith in low-cost community-based [health care] activities" (Clarke et al., 1993, p. 308). As a result "public health nursing has been diverted from its
ideal of primary prevention to provide damage control for individuals and families already suffering from medical, psychological, and social problems" (Zerwekh, 1993, p. 1676). However, these health promotion and disease prevention strategies have been proven to be cost effective in that they prevent the need for more expensive forms of inpatient care (Hawkins & Higgins, 1990, p. 117). In studies of home visits by nurses in New York, cost effective outcomes included reduced emergency visits, fewer days on public assistance, higher levels of employment, and reduced instances of failure to thrive, foster home placement, or child abuse (Zerwekh, 1993, p. 1676). Another study of home visitation programs to socially disadvantaged women and children succeeded in improving women's health-related behavior during pregnancy resulting in increased birth weight of their babies (Olds & Kitzman, 1990). In the same study, postpartum intervention influenced improved childhood behavioral and developmental status and decreased emergency room visits and hospitalizations for injury, as well as decreased unintended subsequent pregnancies (Olds & Kitzman, 1990).

As trusted health professionals, community health nurses have the unique capability to move into communities and "bridge the gaps between science, policy, and the people" (Salman, 1993, p. 1675). In this way, communities that have previously not been reached by the health care system will be accessed and taught how to use the health care system. A reformed health care system that boasts universal access is not sufficient.
Salman (1993) uses school-aged children as an example and points out that just because a parent is able to take a child in for health care services does not ensure that this will take place (p. 1675). But even if parents access health care delivery (as J. R.'s parents have), "such services do not cover the scope of health-related activities necessary to ensure the health of all children" (p. 1675). There are many public health issues not present in the clinic that can be overlooked. For example, J. R. presented in the clinic with chronic respiratory and ear infections and developmental delay. These symptoms were being treated without getting to the root of the problem, which was found in the community, home, and interpersonal family environment. The root of J. R.'s chronic respiratory infections was related to the fact that the apartment door was kept open, and J. R. was dressed in inadequate clothing for the climate. Upon visits to the clinic, J. R. was dressed appropriately and the environment of his home could not be assessed. His chronic ear infections were related to the fact that he was still being bottle fed, and was often placed in his crib with a bottle propped, causing a reflux of milk into the eustachian tube creating a reservoir for bacteria to thrive. Insight into J. R.'s delayed gross motor development was also gained only through a visit to his environment. It is not surprising that the child was unable to walk considering the lack of space in the crowded apartment for him to move about. He spends most of his waking hours playing on the double bed in the entrance room of the
apartment which does not provide adequate opportunity for his large muscles to strengthen and develop coordination necessary for standing and walking. The contributing factors to J. R.'s chronic anemia and reported lack of appetite were also discovered through a visit to the home. Upon arriving to the home on each visit, the child was found sitting on the double bed nibbling on crackers, potato chips, candy, etc. It is not surprising that he was then not interested in eating at mealtime, and was not receiving the recommended amounts of essential nutrients. Obviously, the potential for injury and infection discovered only through a visit to his home, would not have been realized in a visit to the clinic.

Community health nurses present in the community are able to address these public health issues. Studies have shown that nurses, especially advanced practice nurses can provide comparable primary care at a lower cost than doctors do (Aiken & Fagin, 1993). Nurses are also more accessible to those communities most in need of primary care when one considers the current shortage of primary care physicians in the United States (Aiken & Fagin, 1993). However, nurses, even advanced practice nurses, are continually "restricted by the scope of practice laws, malpractice costs, admitting privileges, reimbursement procedures, and lack of prescriptive power" (Reverby, 1993, p. 1663). These restrictions tend to limit how the nation views and utilizes nurses for primary care.

In order to overcome these restrictions community health
nurses must be prepared to present their services as an essential piece in health care reform alternatives to the present system. Beddome, Clarke, and Whyte (1993) point out that just because preventive services have been identified as a key to better health does not mean that people will actively seek these services or that government will incorporate these services into a reformed health care system (p. 16). Another important concept in utilizing community health strategies more effectively involves empowering the public. *Nursing's Agenda for Health Care Reform*, a public policy statement written in 1991 by the National League for Nursing and the American Nurses Association, emphasizes the role of the consumer in health care decision making and encourages consumers to become better informed about the range of services and providers available (as cited in Knauth, 1994, p. 141). Providing primary health care in community-based settings is presented in this document as a strategy for enhancing consumer access in a restructured health care system (American Nurses Association, 1991). Public health nurses are trained to foster client autonomy while "developing mutually negotiable relationships" (Zerwekh, 1992, p. 104). However, it is counterproductive to encourage self-care when people lack environments conducive to health (Clarke et al., 1993, p. 308). Public health nurses are also trained to enter an unfamiliar environment, the patient's turf, and assess "the social determinants of health (e.g., housing, employment, literacy)" (p. 308). The nurse must then be prepared to use
this assessment data to influence public health policy locally and nationally (Twinn, 1991, p. 971). Clarke et al. (1993) suggest that nurses become active in influencing public policy towards an agenda that is focused more on prevention and health promotion rather than the present system which has an acute care focus (p. 308). This shift in focus would obviously require a redistribution of health care funding.

Registered nurses represent the largest subgroup of the healthcare work force ("The Nurses' Agenda", 1995). However, "as a group, nurses have tended to be reactive rather than proactive. . . .[and] choose not to be powerful or to become involved politically" (Bushy & Smith, 1990, p. 39). However, nurses are capable of using collective power to influence public opinion and policy effectively. Nurses can begin with "grass-roots activities to mobilize support and/or educate legislators and/or constituents" (p. 39). They can organize group power by writing letters to the editor of major newspapers and magazines and engaging in media activities to raise public awareness. Nurses can utilize their vast network of nursing journals to raise awareness in their own profession and thus elicit unity and group effort. Nurses can also use their professional organizations to support a candidate for public office that agrees with the nursing agenda for health care reform. The possibilities are endless if nurses as a group could combine creativity, knowledge, and professional strength with a genuine concern for the health of the public.
In reflection on my experience with this family and community, I feel that I grew both professionally and personally as a result. I experienced a bit of a shock when I first encountered this family and J. R. in that I had never experienced such need in my own country. Through involvement in a mission experience in Mexico, I had seen the face of poverty. But before this community health experience I suppose I was under the false notion that I had to leave America to serve the needy. I realized, however, that community health nursing is not charity. That is the unique beauty of it. When I first began working with this family, I saw so many things that I wanted to do for them. I wanted to bring them sheets and blankets. I wanted to buy toys for J. R. I even wanted to clean their apartment. However, I soon learned that while noble, these gestures were far from therapeutic for this family. I was there as a facilitator. My role was not to fix everything or even point out all that needed to be fixed. Rather, I was there to give the family information so that they could work with me to mutually identify problems. I then worked with them to set mutual goals for fixing those problems, and gave them the tools they needed to do so. This concept reminds me of an ancient Chinese proverb that was relayed to me by a very special woman who taught me in high school. It says, "If you give a man a fish, you feed him for a day. If you teach a man to fish, you feed him for a lifetime" (cited by Sr. L. deMarillac,
personal communication, 1989). In other words, empowering clients to help themselves is much more effective in the long run.

Nursing in the community had a positive influence on how I am able to interact with those that come from a different background and have different lifestyles than me. I often had to make a conscious effort to remain nonjudgmental in the first few visits with J. R.'s family. But as I became more familiar with community health concepts, I began to realize how vital this nonjudgmental attitude was to my relationship with this family. I began to see how J. R.'s mother and father looked to me for reassurance and reinforcement, and how my attitude towards them affected their attitudes toward themselves and their child. I realized that judging a family or client, either with approval or disapproval, serves no therapeutic purpose. Again, it was my role to supply them with information that they could use to come to their own decisions regarding necessary lifestyle adjustments.

Working with this family and community also helped me to learn about the many resources that are available in the community. I never really understood what the health department was about until this experience, and now I am amazed at the powerful impact it can have on people's health if they were only aware of its wide range of services. I was not aware of the WIC program either, and I believe this is a fantastic resource in that it serves so many people in such an essential
way. Resources such as these are intrinsically linked to community health nursing. Referring clients to such agencies, enables them to take initiative and help themselves.

Prior to this experience, I don't think I was aware of the many factors that influence one's health behaviors. I became aware of these factors while doing the multidimensional assessment. I also was ignorant of the ways that nurses must use all their senses in assessment. I had heard this concept before, but reading about and implementing the strategies described in Mary Bayer's (1973) article helped me to grasp how useful my five senses could be in improving my assessment skills.

Finally, this experience showed me yet another unique role that nurses play in health promotion. Prior to this, I suppose I still placed nursing primarily in the hospital. But working through the health department, and seeing how the satellite clinics are run by nurses independently, I saw what a difference nursing is making in preventive health. This experience opened my eyes to many more opportunities that nurses have to be independent professionals and influence public policy on a national level.
References


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Appendix A

Tapia's Model

Level II-III

Family placed at this level because:

This family is partially in Level II (childhood stage) because they are better able to meet their needs for security and survival than a family in Level I (infancy stage). However this family still seems unable to support the growth and development of its members as evidenced by J. R.'s developmental delay and his mother's lack of adequate rest. The family also needs help with acknowledging their problems realistically as evidenced by J. R.'s mother's inability to state her concerns about J. R.'s health. This family also exhibits characteristics of Level III (adolescent stage) as well in that they have the knowledge and ability to utilize some community resources and are not hostile to help from outside the family. The family also shows signs of a future orientation such as J. R.'s mother's comments about one day buying a house and her effort to obtain a high school diploma.

Nursing services and activities appropriate for this family based on the model:

Support of the trust relationship is very important, and this must be used to help the family see its problems and strengths more realistically. Activities must be performed consistently and with genuine concern so the family can get to the point where they are no longer speculative of the
intervention and begin to work on their problems. The nurse begins to help the family work through what they see as problematic by teaching and referring them to community resources. She works as a care coordinator, but constantly encourages the family to make their own decisions. In J. R.'s family, his mother is not hostile to the community health nurse but doesn't realize that the nurse is there to help rather than condemn. Therefore the trust relationship is the primary concern. Then J. R.'s mother must be assisted to come to terms with J. R.'s health problems as well as how those problems affect her own health and well-being. Care coordination is the next most important nursing service for this family by supporting WIC intervention and hooking them up with programs aimed at providing a more stimulating environment for J. R.'s development and growth.
Appendix B

Family Coping Estimate

Coping Area (Rating-- 0 Poor to 5 Excellent): Justification

1. Physical Independence (3): Mother is providing personal care for herself and partial care for J. R. However, certain physical care such as appropriate clothing and cleanliness are not being provided for J. R.

2. Therapeutic Independence (3): Mother provides breathing treatments for J. R. but leaves the door open to the apartment and J. R.'s play area is soiled with dust and dirt. J. R. is not kept properly clothed for the climate of the environment.

3. Knowledge of Condition (3): Mother understands the need for placement of ear tubes (for J. R.) and how to care for them, such as not emerging J. R. in water. She also is aware of symptoms of complications to watch for. However, she is not aware of how to prevent ear infections.

4. Application of Principles of Personal Hygiene (2): Father carries two full time jobs. J. R. rarely sleeps more than 3 hours at a time according to mother and is not dressed adequately in relation to weather. There is dirty laundry and dishes throughout the home and the diet of J. R. is questionable. Immunizations have been secured for J. R.

5. Attitude Toward Health Care (4): Mother accepts the need for health care for J. R. However, she and her husband do not receive preventive health care despite being insured by TennCare.
6. Emotional Competence (3): Father has not been observed. Mother seems unable to face the reality of J. R.'s developmental delay. She also frequently leaves the child unattended while outside smoking.

7. Family Living Patterns (3): Mother responds quickly to J. R.'s needs, but leaves him alone in apartment playing. Mother feels that she needs to discuss possible interventions with her husband (J. R.'s father).


9. Use of Community Resources (4): Mother is aware of community resources such as WIC, SSI, food stamps, adult GED program, and health department services. However she seems to not realize that the community health nurse is there to help rather than condemn.
Appendix D

Goals for Health Supervision and Interventions

Client Name: J. R. and family

The letter "M" indicates that the goal was mutually identified with the client.

1. **Nursing Diagnosis:** Altered growth and development related to lack of available play area and environmental stimulation, possible mental handicap.

   **Goal #1- M:** J. R.'s family will provide an environment that maximizes the developmental potential of J. R.

   **Nursing Interventions:**

   a) Perform DDST to confirm delay. Discuss with mother the implications of J. R.'s performance on the DDST and age appropriate tasks of an 18 month old child.

   b) Consult D. Richter, SW and N. Jackson, PNP about DDST results and possibility of enrolling J. R. in a specialized program for developmentally delayed children.

   c) Suggest strategies to maximize J. R.'s developmental potential with family such as giving him nontoxic crayons, giving him a spoon at mealtime, providing simple toys that he can manipulate easily. Suggest ways to make and places to obtain age appropriate toys for J. R. Give information about applying for Empty Stocking Fund.

   d) Refer client to CSS. Give mother phone number and encourage her to make and keep appointment for J. R.

   **Evaluation:** Objectives met-- Mother is able to identify
at least 4 tasks that an 18 month old child should have achieved and a strategy to promote each with J. R., mother is able to give examples of at least 2 age appropriate toys for J. R. and how to make or obtain them, mother can verbalize reasons for follow up with N. Jackson, PNP to discuss J. R.'s enrollment in a special program, mother made appointment with CSS. Objectives not met-- mother did not keep CSS appointment but agrees to follow up with N. Jackson, PNP instead.

2. **Nursing Diagnosis:** High risk for injury related to safety hazards present in the home and lack of appropriate protection from outside environment.

   **Goal #2:** J. R.'s family will provide a home environment free from safety hazards.

   **Nursing Interventions:**

   a) Provide anticipatory guidance regarding J. R.'s increasing mobility and curiosity and how certain physical hazards in the home could be harmful.

   b) Give suggestions about ways home environment can be modified to reduce risks of injury.

   c) Encourage mother not to leave child in apartment unattended, especially if he is eating or playing on an elevated surface (such as the bed in the front room).

   **Evaluation:** Objectives met-- mother is able to identify at least 3 age appropriate tasks of J. R. that require modifications in his environment, mother can explain importance of remaining inside apartment with J. R., mother keeps door
to apartment closed, mother can identify at least 2 ways that the home environment can be modified to reduce risk of injury, mother agrees to take the appropriate action to modify the home environment.

3. **Nursing Diagnosis:** High risk for infection related to history of respiratory infections and otitis media (OM), lack of appropriate clothing, frequent exposure to outside air, insects in home, and nutritional deficit.

   **Goal #3-M:** J. R.'s family will provide environment that reduces risk of infection.

   **Nursing Interventions:**

   a) Discuss importance of weaning J. R. from the bottle including tendency toward OM. Suggest strategies for doing so.

   b) Discuss importance of and guidelines for dressing J. R. appropriately for climate. Suggest resources to obtain warm clothes if needed (Goodwill, Ladies of Charity).

   c) Discuss importance of keeping door to apartment closed, i.e. decreasing insects in home and decreasing potential respiratory irritants that J. R. is exposed to.

   d) Provide information about where to obtain thermometer and cost range.

   e) Reinforce WIC interventions such as suggestions to increase iron rich foods and Vitamin C.

   f) Encourage to keep appointments at Pediatric Clinic at KCHD.
Evaluation: Objectives met-- mother keeps J. R.'s appointments at Pediatric Clinic, mother states she is implementing strategies to wean J. R. from bottle and can describe them, mother can verbalize guidelines for dressing J. R. appropriately and agrees to do so, mother keeping door to apartment closed, mother states she will obtain thermometer, mother verbalizes understanding of WIC interventions.

4. Nursing Diagnosis: High risk for altered parenting related to physical exhaustion of mother, child's inability to sleep more than 2-3 hours at a time.

Goal #4-M: Functional parenting patterns will be maintained.

Nursing Interventions:

a) Discuss the importance of mother's own health maintenance and her ability to meet J. R.'s needs. Assist her in locating provider that accepts Blue Cross TennCare and encourage her to make appointment.

b) Discuss strategies for promoting prolonged nocturnal sleep patterns for J. R. Encourage mother to establish consistent bedtime rituals and to place child in crib while he is awake. Suggest that bed be used for sleeping only. Encourage mother to offer last feeding as close to bedtime as possible (no bottles in bed) and increase daytime feeding intervals to 4 hours or more (Whaley & Wong, 1991, p. 568). Discourage allowing child to nibble between meals.

c) Discuss ways for mother to deal with nighttime crying
such as entering room and reassuring child, but avoiding holding or rocking, taking him to parents bed, or giving him bottle (p. 568).

d) Warn mother that these strategies are difficult to implement and encourage her to share them with her husband.
e) Identify sources of family support and encourage their use.

**Evaluation:** Objectives met-- mother indicates awareness of potential difficulties in parenting child with J. R.'s health needs, mother can verbalize the impact that her health has on caring for J. R. and the importance of maintaining her own health. Objectives not met-- mother did not make appointment with health care provider for herself before termination of home visits. Objectives in progress at termination: child will be sleeping through the night by the end of December 1994.
Appendix E
The University of Tennessee, Knoxville
College of Nursing
Nursing 403

Contract for Health Supervision in the Home

NAME OF CLIENT

CLIENT'S PHONE NUMBER

ADDRESS

CLINIC/PHYSICIAN

I hereby grant my permission to participate in a family study and to be visited by a senior nursing student from The University of Tennessee, Knoxville on a regular basis during the period specified. I understand that any and all information obtained by the student will be maintained in strict confidence and will be utilized only for the purposes of developing appropriate nursing care plans.

Guardian or Client's Signature

Date

I hereby assume responsibility for giving this family nursing care under the guidance of faculty and in collaboration with other members of the Health Team for the period of: (Date)

Signature of Student
Appendix F

Family Strengths

1. Parents are generally in good health
2. Parents seem genuinely concerned about child's welfare and express strong desire to provide for him properly as evidenced by their keeping appointments, their willingness to accept outside assistance, and their application to obtain SSI for J. R.
3. Parents are responsive to child's cues and speak to him verbally
4. Role flexibility is present in that father supports mother's efforts to obtain GED and plans to complete his GED when she is finished; both parents work and assume responsibility for child care
5. Close supportive relationship with J. R.'s maternal grandmother and aunts is described by J. R.'s mother; these people are available to keep child
6. Parents are friendly with neighbors in that they are able to use phone next door (could be weakness if substance abusing neighbors spend time in home with child)
7. Mother expresses future orientation in that she has plans to move into a larger home and is working on her GED
8. Parents encourage involvement of J. R. with other children his age (i. e. day care, children of friends); this represents an effort to broaden J. R.'s social development

Family's awareness of its strengths:
This is evidenced by J. R.'s mother's ability to expand on the above mentioned strengths and give specific examples of them.

**Ways that family can be helped to develop these strengths:**

Positive reinforcement was provided by the student to help J. R.'s parents realize that they are caring for their child well despite his problems and needs. Examples of how these strengths can be mobilized to foster J. R.'s developmental growth were suggested by the student (i.e. obtaining preventive health care for themselves, suggestions for providing a safer and more stimulating environment for J. R., utilizing support systems to allow time for physical and emotional rest).

**Latent strengths in this family:**

J. R.'s father was only present for about 10 minutes during one of the visits. In this short period of time, however, he seemed very eager to discuss J. R.'s condition and was very interactive with the child. The student also noted that this visit was the only one at which J. R. was dressed appropriately. The father's willingness to work with the student and his devotion to J. R. is a strength that was not able to be maximally utilized in this relationship due to lack of contact with him.
Appendix G

Barriers to Obtaining Health Care

Client Barriers:
1. Family has not specifically identified the nature of the problem (i.e. lack of environmental stimulation of child, possible mental disability)
2. Family has an interest in not identifying the problem
3. Family is unable to generate alternative options during problem solving
4. Other needs considered higher priority than utilizing referral services
5. Family is aware of problems but not yet ready to deal with them (lack of motivation)
6. Lack of knowledge about available resources
7. Lack of understanding regarding the need for referral
8. Limited financial resources, limited transportation
9. Physical exhaustion of mother
10. Limited educational background and lack of familiarity with patterns of growth and development
11. Mother doesn't give high priority to health care for herself

Resource Barriers:
1. Limited physical accessibility (not within walking distance)
*No other resource barriers identified as mother describes a positive rapport with health care providers, there is no cost for services rendered to J. R. at KCHD, and family is covered by Blue Cross & Blue Shield TennCare.