CUE SELECTION IN
CLINICAL NURSING JUDGMENT

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CHAPTER I

INTRODUCTION

Many clinical nursing judgments faced by community health nurses differ from those required by other professional nurses. The differences in the settings for practice and the predominant focus on the family and community in the scope of community health nursing practice, may change the nature of a judgment. The focus of community health nursing is the maintenance of health of the individual, group, or community rather than on acute care. The nurse includes other family members in the home in the process of intervening and helping an individual maintain or regain his maximum health potential. In this practice it becomes necessary for the nurse to consider different physiological, psychological, social, and environmental phenomena that tend to influence home health care for the client than is customary in the care of the institutionalized client.

Different attributes such as educational preparation, and length of nursing experience may influence the nurse in making clinical nursing judgments. Davis (1974) and Verhonick (1968) found negative correlations between years of experience and the type of observations and suggested nursing actions taken. They also found that nurses

with advanced academic degrees identified more observations and were more likely to relate their nursing actions to observations made. Because of these different attributes, nurses select cues varying in number and nature on which to base clinical nursing judgments. These variations in selection of cues could in turn lead to differences in the associated judgments which are made and utilized as the basis for a relevant decision.

The nursing judgment task is central to nursing practice; therefore, it is important for nurses to understand this process when they are actively engaged in giving direct care or are responsible for the education of nursing students. This study assessed the ways in which community health nurses selected and assembled clinical data to make a judgment about the state or condition of a client.

STATEMENT OF THE PROBLEM

The problem of this study was to identify the cues community health nurses select to make clinical nursing judgments.

STATEMENT OF THE PURPOSE

The purposes of this study were to:

1. Determine the responses of the community health nurses engaged in home health care in selection of cues.

2. Identify the pattern of cues community health nurses selected in relation to the clinical nursing judgments.

BACKGROUND AND SIGNIFICANCE

In the early years of nursing, Florence Nightingale (1916) emphasized that the most practical lesson that could be given to nurses was to teach them "what to observe--how to observe--what symptoms indicate improvement--which are of importance--which are of none. . . (Nightingale 1916: 105)." Thus, early recognition was given to the varying amounts of data available to nurses as a basis for making judgments about the state or condition of a patient.

Lesnick and Anderson (1962) identified as independent functions of the professional nurse, the responsibility to observe symptoms and reactions, and the requirement to evaluate or apply principles based on biological, physical, and social sciences. The responsibility to exercise judgment from observed clinical data is not limited to the execution of medical orders, but is a nursing diagnosis for which the nurse may be liable. Thus, making a nursing diagnosis is recognized as an independent, essential, and legal function of the nurse. The question of how to prepare

the nurse for this function is an instructional problem is schools of nursing today.

The problem of teaching clinical judgment skills is not unique to nursing. Williamson (1965) implied that despite the importance of clinical judgments, there was wide-spread dissatisfaction in medical schools with the available means to assess this skill and to provide the educational experiences that would most likely develop it. In the study "Assessing Clinical Judgment," Williamson (1965) defined three critical elements involved in assessing competence: measurement, criteria, and judgment. To study clinical competence, Williamson (1965) presented simulated patient problems and found that when physicians' responses were compared to reference group standards, 86 percent of their interventions were useful, though the subjects failed to provide 53 percent of the benefit considered possible by the criterion group. The study findings demonstrated that a negative correlation existed between performance and years in practice. Verhonick (1968) and Davis (1972) also found a negative correlation in their nursing studies. Verhonick (1968) showed that nurses with less than 1 year or over 30 years of experience ranked lower in observations made and appropriate nursing action taken. The highest ranked were nurses with 1-6 years of nursing experience.

Davis (1972) found that baccalaureate and clinical specialists' observational skills decreased with increased years of experience.

Feinstein (1967) approached the study of clinical judgment by examining the components of the judgment process. The clinician must gather three different types of data: description of a disease, the host, and the occurring illness. The clinician uses these data to make decisions about the present, past, and future of the patient. Clinical judgment, the method of acquiring the evidence and organizing clinical thought, is practiced by the clinician to make decisions regarding the therapeutic treatment of the patient.

The traditional belief that clinical judgment is beyond the reach of science has caused clinicians to fail to distinguish the different types of observations and reasoning that are components of clinical judgment. By dividing the observational data into descriptions of disease, host, and illness, and by analyzing the therapeutic and environmental decisions separately, clinicians can discern the ingredients of clinical judgment (Feinstein 1967). Therapeutic decisions deal with the mode of treatment, while environmental decisions are concerned with the management of the host. In the reasoning of the therapeutic decision,

Feinstein (1967) presented the patient as a case, a representative of disease and illness, for whom treatment is chosen after comparison with results obtained in similar previous cases. In the reasoning of environmental decisions, the patient is a unique person for whom each aspect of management must be individualized.

Clinical judgment has not received as much attention as other inanimate methods for observing and assessing tangible material; yet clinical judgment has a distinctive methodology for dealing with the tangible data of human illness (Feinstein 1967). Hammond (1964) and Kelly (1964a) found that nurses developed their own individual inference systems to multiple cues, and were consistent in their selection of cues even when data about the patient were incomplete.

Hansen and Thomas (1968) studied decision-making as it applied to role and situation-related differences in priority decisions, and found no criteria for their subjects' judgments and decisions. Similarly, signs and symptoms of disease and illness are listed in textbooks of clinical nursing, but nothing is found to indicate how the clinical data of the disease, host, and illness should be used to make clinical judgments.

The study was conducted to identify the clinical data that community health nurses used in the judgment process when given cues regarding the host's characteristics, diseases, and illness.

DEFINITION OF TERMS

For purposes of this study, the following terms were defined:

1. A community health nurse is a registered nurse with a baccalaureate degree in nursing who is licensed to practice in one of the fifty United States. She utilizes a synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations. The dominant responsibility of the nurse is to the population as a whole (American Nurses Association 1973).

2. Clinical Nursing Judgment is the method of acquiring evidence and organizing clinical thought used by a nurse when presented with multiple cues related to the patient in the clinical situation (Kelly 1966).

3. Cues are signs, symptoms, and other information related to the patient which are available to the nurse (Kelly 1964).

4. Client and Family Characteristics are personal and social properties of the client and family, such as age,

race, sex, education, geographic location, occupation, financial and social status (Feinstein 1967).

5. Signs and Symptoms are pertinent complaints, physical and behavioral observations, and past history elicited by the nurse from the patient and his family (Sherman 1976).

6. Physiological Data are laboratory findings (Sherman 1976).

DELIMITATIONS

The study was concerned with the following delimitations of the sample, and was limited to those community health nurses who:

1. had a baccalaureate degree in nursing
2. had no administrative responsibility for nursing service
3. provided home health care to clients

ASSUMPTIONS

For the purpose of this study, the following assumptions were identified:

1. Subjects willing to volunteer for this study would respond to the situation questionnaire honestly.
2. Making clinical nursing judgments and acting on them are essential activities of nursing practice.

3. The respondent would reply to given simulated patient situations in the same manner as if the situations were authentic cases.

SUMMARY

This study was conducted to identify the clinical data that community health nurses use in the judgment process when given cues regarding the host's characteristics, diseases, and illnesses. Chapter II, the Review of Literature, presents an overview of the importance of judgments, theories of judgments, the judgment task of the nurse, and different methods of the judgment process used by the nurse. The Procedure for Collection and Treatment of Data is discussed in Chapter III. In Chapter IV, the Analysis of Data presents the analysis of information submitted via the research tool. Chapter V includes the Summary, Conclusions, and Recommendations derived from the study.

CHAPTER II

REVIEW OF LITERATURE

Importance of Judgment

Approximately four hundred years B.C., Hippocrates addressed these remarks to his fellow physicians:

> If the nature of a disease cannot be perceived by the eye its diagnosis will involve more trouble and certainly more time than if it can. What escapes our vision, we must grasp by mental sight, and the physician, being unable to see the nature of the disease nor be told of it, must have recourse to reasoning from the symptoms with which he is presented (Hippocrates 1950:87).

Even though Hippocrates was speaking of the diagnostic task of the physician some of his words are applicable to the judgment process of the nurse.

Observation was again emphasized in the early years of nursing by Florence Nightingale when she stressed that the most practical lesson that nurses could be taught was sound observation. Nightingale (1916) stated that,

> . . .in dwelling on the vital importance of sound observation, it must never be lost sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort (Nightingale 1916:125).

At the same time Nightingale warned against the habit of observing conditions and making a judgment on the basis of

insufficient information. The "power of forming any correct opinion as to the result must entirely depend upon an inquiry into all the conditions in which the patient lives (Nightingale 1916:120)." Early recognition was given to the complexity of the data presented to nurses as a basis for making judgments about the state or condition of a patient. Observation of a patient's condition continues to be a primary nursing function, and one which precedes any nursing action (Verhonick 1968).

Lesnick and Anderson (1962) identified as independent functions of the professional nurse, the responsibility to observe symptoms and reactions, and the requirement to evaluate or apply principles based on biological, physical, and social sciences. The responsibility to exercise judgment from observed clinical data is not limited to the execution of medical orders, but is a nursing diagnosis for which the nurse may be liable. Making a nursing diagnosis is recognized as an independent, essential, and legal function of the nurse.

In the early years of nursing, the observational task of the nurse consisted of three activities, observing recording, and reporting. During recent years the observational process has been precisely described to include three specific operations:

1. Observation - the recognition of signs and symptoms presented by the patient.
2. Inference - making a judgment about the state of the patient and/or the nursing needs of the patient.
3. Decision-Making - determining the actions which should be taken that will be of optimal benefit to the patient (Kelly 1966:24).

The operations described by Kelly (1966) can best be defined as cognitive functions. Doona (1975) stated that "it is judgment that constitutes professional nursing. It is the linkage of perception and action with cognition that elevates professional nursing (1975:18)." Judgment as a cognitive skill, is seen by the profession as essential to a nurse's ability to perceive needs for nursing care and to provide that care (Doona 1976).

Making judgments is a central task in nursing practice and is incorporated into the nursing process. The nursing process is:

> . an orderly, systematic manner of determining the client's problems, making plans to solve them, initiating the plan or assigning others to implement it, and evaluating the extent to which the plan was effective in resolving the problems identified (Yura 1973:23)

The concept of the nursing process is not new, but the evaluation of the nursing action in terms of maximum effectiveness warrants a deliberate evaluation of nursing behavior from a critical perspective or competent nursing care (Judy 1975).

Judy (1975) stressed that professional judgment is an inherent factor in professional responsibility. A requisite for competent nursing process skills is updated knowledge on which to base nursing judgments and the consequental nursing behaviors. The nursing process provides a core or foundation from which nursing behavior and sound prudent nursing judgments are set into action. While observation and making judgments are important components of the nursing process, one must determine exactly what these judgments are and how they are obtained.

Theories of Judgment

According to Doona (1975), two major philosophers, Aquintas and Dewey, were among the first people to express their views on judgment. Their ideas were synthesized into a new theory which combined the interaction of sensory and intellectual data, and emphasized the evolutionary process of making a judgment (Doona 1975).

Essentially, judgment is a natural inclination of the human being, in which each individual is compelled to judge. According to Schilder (1951), judgment is a basic form of thinking based on cognition of various relationships, whether true or false. The goal of judgment, that is of recognizing relationships, is to achieve knowledge of a state of affairs (Schilder 1951).

Judgment may be facilitated by what Piaget calls, predominately egocentric thought or by communicative intelligent thought (Piaget 1951). Egocentric thought or intelligent thought in judgments may occur in a situation of immediacy or in a period of reflection (Manaser 1968). Bieri (1966) and has associates expressed that any theory of judgment must incorporate: 1) stimulus variables or the nature of the input, 2) output or response variables, including the nature of the judgment task, 3) characteristics of the judge, who must function as a transmitter of the information, and 4) situational variables, which include the kinds of restraints imposed upon the setting within which the judgment occurs, as well as the unexpected outcome or consequence of the judgment (Bieri 1966).

Doona (1975) defined judgment as occurring when the individual stretched beyond himself to interact with the sensory world. The facts of the sensory world act on him as he acts on them. The intellect attempts to maintain an equilibrium between the organism and its environment as raw fact and concept interact. Following this interaction of organism and environment, the intellect orders and composes the concepts in a proposition. The proposition, the prospective judgment, is considered during a reflective pause, following which the judgment is made. Every judgment

has a history based on past judgment behavior, a future in that it reaches toward a goal, and the immediacy of the moment. Each judgment, then, is a unique statement of the individual and his contextual position. The future is determined and created in each judgment venture (Doona 1975).

Doona (1975) further operationally defined judgment as follows:

1. The individual has a signatory position prior to the judgment,
2. The individual equilibrium is disturbed,
3. The disequilibrium is viewed as problematic,
4. The particular facts of the problem are sought,
5. Ideas from previous judgments are recalled,
6. Facts and ideas are refined by one another,
7. Concepts are ordered and arranged,
8. A prospective judgment is created,
9. There is a reflective consideration of the prospective judgment,
10. Prospective judgment is considered satisfactory,
11. Prospective judgment is affirmed or denied,
12. An increment of knowledge occurs,
13. Consequences of the judgment are scrupulously and discriminately observed,
14. New knowledge is considered a new working hypothesis (Doona 1975:19).

Each act of judgment has three distinct phases. Coona (1975) described these as:

1. ANTECEDENT PHASE	a. Signatory position of the individual
2. INTERACTIVE PHASE	a. Inception (1) Disequilibrium (2) Collection of raw facts (3) Recall of concepts (4) Refinement of percepts and concepts b. Development (1) Ordering and arrangement of concepts (2) Formulation of prospective judgment (3) Reflective consideration of the prospective judgment c. Fulfillment (1) Affirmation or defial or prospective judgment (2) Increment of knowledge (3) Establishment of new equilibrium
3. CONSEQUENT PHASE	a. Scrupulous discriminative observation of the consequences b. Use of new knowledge as a working hypothesis (Doona 1975:28).

The Antecedent Phase is actually the nurse's point of view from which she assesses the nursing situation. It is in this phase where Hansen and Thomas (1968), Verhonick (1968), and David (1974) found that the nurse's length of experience and educational preparation may affect the nature of the judgment made. In the Interactive Phase, data are gathered and arranged to state a prospective judgment. The Consequent Phase focuses on verifying the consequences of the judgment by observation. These phases present a way of combining

perceptual and conceptual data into judgments that include principles and raw data. It also presents a synthesis of deduction and induction which is essential to nursing as a practice discipline (Doona 1976).

Because nursing situations vary from the very simple to the extremely complex, there are a variety of judgments necessary. According to Doona (1976), common sense judgments occur when specific problems are solved without considering their universality or possibilities for generalization beyond them. Judgments made from combinations of concepts rather than concepts and facts, are sepculative judgments. Other nurses prefer considering principles of practice only minimally and prefer to immerse in the existential nursing situation. This is pragmatic judgment. Ideal judgment is multidimensional and is the interaction between nursing concepts and nursing facts. The judgment evolves from the refinement process of the concepts acting on facts, and the facts acting on the concepts (Doona 1976).

Judgment Task of the Nurse

The nurse's task is to make judgments about the state of the patient using data which are often uncertain and incomplete. The data which are available to her may be of many kinds. Some may have a high information value,

while others may be irrelevant or inconsequential (Kelly 1966). The kind of data which are ordinarily available to the nurse are:

1. Physical signs and symptoms
2. Patient's complaints
3. Physician's orders
4. Clinical laboratory reports
5. Medical history
6. Medical diagnosis
7. Social history
8. Cultural background
9. Physical and psychological factors in the environment (Kelly 1966:24).

From a vast field of data, the nurse must select and utilize those cues which enable her to make a judgment about the state of a patient. Her responsibility is to make decisions about the nursing action which should be taken.

The actions which are taken by nurses may have serious consequences for the patient for these actions will of necessity influence the course of medical and nursing therapy. Each judgment made by the nurse involves the risk of error. Efforts must be made to reduce to a minimum the nurse's chances of making an incorrect judgment about the state or condition of a patient (Kelly 1966).

One of the characteristics of the inferential task of the nurse is that judgments, decisions, and actions take place within a span of a few minutes or less (Kelly 1966). Judgment is closely related to action and within a short time-span, out of judging, comes the intention to

act or not to act (Manaser 1968). Another characteristic of the inferential task of the nurse is the complexity of the task. Henderson (1964) illustrated the complexity of the nurse's task when her study demonstrated that between 400 to 500 separate nursing activities were carried out by nurses within the hospital setting for the benefit of the patient.

The role of the nurse is becoming increasingly more complex. Very early in the history of nursing, the nurse relied almost entirely on the objective signs and subjective symptoms as a basis for judgment of the patient's condition (Kelly 1966). Today the nurse needs to use available data and organize it in a way to make a judgment and take nursing action.

The Judgment Process

Judgment is crucial to the continued development of professional nursing. The question of how to prepare nurses for the judgment function is an instructional problem in schools of nursing today. Kelly (1966) stated that if the above assumption was accepted that the judgment task was central to all nursing practice, then efforts to improve clinical teaching and practice should be directed toward learning more about the process.

Little is known about the specific kinds of inferences made by nurses or about how they select and utilize information available to them in making the inference. Kelly (1964a) and Hammond (1964) approached the study of clinical inference by using the Brunswik "Lens Model of Behavior." This method begins with the state or condition of a patient. The nurse next receives cues or signals related to the state of the patient from which she makes an inference and takes nursing action toward the end goal for the patient. No prior studies had been reported concerning the signal-receiving system of nurses or nurses' cue utilization behavior.

In applying the Lens Model, Hammond (1964) and Kelly (1964b) conducted a survey of the nurses on the wards of a large university hospital in order to: 1) identify the cognitive tasks which occurred, 2) how often the tasks occurred in a 25-hour period, and 3) what the cue characteristics of the most frequently occurring tasks were (Hammond 1964). As a result of this survey, 381 nurse patient incidents were described with the most frequent nurse-patient incident being that of the patient complaining of pain. Cue-characteristics could not be identified due to the large number of incidents identified and the large quantity of different decisions made than the

researcher had been anticipated. There were also more cues reported than had been expected. Due to these findings, a second study was proposed to carry out a narrower and more focused study (Hammond 1966a).

Hammond (1966a) in Field Study II narrowed the focus of the study to include only complaints of abnormal pain following abdominal surgery. Professional nurses from 30 hospitals in 12 states provided 212 detailed descriptions of nurse-patient situations in which patients complained of abdominal pain following abdominal surgery. The nurses provided 165 cues and 17 different actions were taken in the 212 cases of abdominal pain. The frequency of occurrence of these actions varied markedly. Analysis of the data provided a frequency tabulation relating 67 of the cues to 14 selected actions of the 212 reported cases. Data from both of the preceding studies suggested that none of the cues analyzed had provided the basis for action. The sample provided the first set of cognitive tasks drawn from actual nurse-patient incidents (Hammond 1966a)

From the nurse-patient data collected in Field Study II, Hammond 1966c) moved into the next phase of research. In this phase, the study of cue utilization and inferential processes was undertaken in an attempt

to determine what units of information from the patient were responded to by the nurse. The study of cue utilization was done through an experiment in which 100 descriptions of patients were randomly selected from the 212 abdominal pain incidents collected in Field Study II (Hammond 1966a). Six nurse subjects were presented with the descriptions of patients and their task was to infer the state of the patient from the data (cues) provided in the case material. Information theory analysis was then undertaken to: 1) identify those single cues, if any, when constituted a message unit, and 2) identify the cue-groupings, if any, which constituted a message unit (Hammond 1966a). No single cue was found to convey more than a trivial amount of information to the nurse-subjects. The researcher also found groups of cues which were arranged in various ways, were not related to the inferences made by the nurse-subjects about the state of the patient. And finally, it was identified that these nurse-subjects did not discriminate consciously between the usefulness of various cues, nor did their confidence in their decisions vary over different cases (Hammond 1966a). The results of this study indicated that questions concerning the message unit, which is coded by the sender and receiver of the message and is involved in cognitive tasks

encountered by the nurse, can be investigated. The question of what units of information are used by the nurse still need to be answered (Hammond 1966c).

Other researchers of the clinical judgment process include Williamson (1965) and Feinstein (1967). Williamson (1965) became interested in clinical judgment because of the widespread dissatisfaction in medical schools with the available means to assess this skill and to provide the educational experiences that most likely would develop it. His study dealt with the concept of competent assessment and how this could be measured through a problem solving instrument. Williamson (1965) defined measurement, criteria, and judgment as the elements necessary for the assessment of clinical competence. Each of these 3 elements should be considered in assessing the 2 separate components of competence: efficiency, measured from a physician's performance, and proficiency, measured from the results of his performance noted in the patient (Williamson 1965). In 8 community hospitals, Williamson presented 232 physicians with a test booklet of simulated patient problems. The physician was instructed to read the description and then select diagnostic, and therapeutic responses that would assist him in making subsequent decisions about the patients' management. The physicians'

performance in decision-making was compared with accepted criteria, established by a panel of experts, in order to establish judgment quality. Analysis of the data determined that 86 percent of the interventions selected for the patients would be useful. Ninety percent of the diagnostic actions would be useful, but 36 percent of their therapeutic decisions would have been irrelevant or harmful. By comparison to the reference group standards, the doctors elicited only 49 percent of the necessary diagnostic information and provided only 30 percent of available therapeutic assistance. A negative correlation between performance and years in practice was also found (Williamson 1965).

Verhonick (1968) and Davis (1974) also found negative correlations in their nursing studies. Verhonick (1968) surveyed 1,965 nurses at 2 national nursing conventions using filmed patient simulated situations to determine the observations made regarding a patient-situation by a large group of nurses, and to determine what action nurses would take as a result of observation and evaluation. To establish reliability of the observation, a panel of experts reviewed the 5 situations and designated the "relevant" observations and recommended nursing action.

Findings of the study demonstrated that nurses with 1-6 years of experience had the highest percentage of relevant observations (37 percent), and those with over 30 years had the least percentage (21 percent). Respondents with 25-30 years of experience also reported the largest percentage (3 percent) of inappropriate observation while those nurses with less than 1 year experience recorded none. Sixty-seven percent of all actions taken were supportive, 30 percent were therapeutic, and only 2 percent were inappropriate. When relationships of observations and nursing actions were compared, the more advanced the academic degree held, the more supportive actions and less therapeutic actions were taken in relation to the observations made (Verhonick 1968).

Davis (1974) utilized Verhonick's (1968) filmed patient situation instrument to: 1) determine if different levels of education made a difference in quality and quantity of patient care, and 2) ascertain if quality and quantity of patient care declined with increased years of experience. The sample consisted of 40 clinical specialists, 20 baccalaureate, and 27 diploma nurses. They viewed 5 patient situations commonly encountered in the hospital and were asked to observe the situations, recommend actions and list reasons for the actions.

It was found that clinical nurse specialists made significantly more relevant observations, suggested more relevant actions, and gave more appropriate reasons for their actions than did baccalaureate or diploma nurses. As years of experience increased for all subjects, a decrease in the level of performance was determined but correlation for each of the groups separately did not reveal a consistent level of decline in all areas tested (Davis 1974).

Dincher and Stidger (1976) presented a written simulation format for clinical nursing judgment. The instrument was composed of simulated patient situations to which the subjects selected a choice of action on inquiries. The instrument was piloted on 11 subjects chosen from a graduating class of baccalaureate nursing students. Reliability was measured by examining consistency between scores assigned to the actions and the weight awarded them by a panel of experts. Validity was established by submitting the instrument to the subjects who were asked to respond to the situations and choose appropriate actions or information. As a result of this study, limitations were revealed in the instrument. Reliability and validity were computed on results from a small sample and utilized data obtained from a questionable method of coding.

Some difficulties were encountered by the examinees in understanding the written directions. The study suggested that further investigation with a revised tool, revised scoring procedure, and a large sample be used in future research to establish better validity (Dincher and Stidger 1976).

Feinstein (1967) approached the study of clinical judgment by examining the components of the judgment process. For each client who undergoes treatment, a clinician observes at least 3 different types of data: description of a disease, the host, and the occurring illness. The clinician uses these 3 types of data to make decisions about the present, past, and future of the patient. The decisions consist of determining a present diagnosis, a past etiology, and pathogenesis and a future prognosis and therapy. Clinical judgment, the method of acquiring the evidence and organizing clinical thought, is practiced by the clinician in making decisions regarding the therapeutic treatment of the patient (Feinstein 1967).

Clinical judgment has not received as much attention as other inanimate methods for observing and assessing tangible material; yet Feinstein (1967) has introduced a distinctive methodology for dealing with the tangible data of human illness. The traditional belief that

clinical judgment is beyond the reach of science has caused clinicians to fail to distinguish the different types of observations and reasoning that are components of clinical judgment. By dividing the observational data into descriptions of disease, host, and illness, and by analyzing the therapeutic and environmental decisions separately, clinicians may discern the ingredients of clinical judgment (Feinstein 1967). Therapeutic decisions deal with the mode of treatment, while environmental decisions are concerned with the management of the host. In the reasoning of therapeutic decisions, the patient is a case, a representative instance of disease and illness, for which treatment is chosen after comparison with results obtained in similar previous cases. In the reasoning of environmental decisions, the patient is a unique person for whom each aspect of management must be individualized (Feinstein 1967).

Judgment is crucial to the continued development of professional nursing. The study of judgment is directed toward understanding and improving the heart of professional nursing-observing the patient, making inferences (judgments) based on these actions and then taking appropriate action.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The study was descriptive and exploratory in nature and utilized a nonexperimental method of obtaining data, to identify the cues community health nurses selected to make clinical nursing judgments. The primary purpose of an exploratory descriptive study is to develop and describe the phenomena under study (Abdellah 1965).

Setting

The study was conducted in community health agencies in a large southwestern metropolitan area of over one million persons. A governmental community health agency located in the northern section of a large metropolitan area and 2 district offices of a nongovernmental community health agency located in the West and East sections of a large metropolitan area were utilized to obtain data. Within the governmental agency, a small, well-lighted auditorium was used to accommodate staff nurses during the phase of data collection. In the nongovernmental agency, a well-lighted conference room was used in both districts to accommodate staff nurses during the data collection phase. The auditorium was furnished with 50 folding chairs with

desk arms. The district conference rooms were furnished with a conference table with 8 chairs around it. The staff nurses were introduced to the purposes and process of the study in the auditorium and conference rooms. These areas were used by the nurses to complete the Situation Questionnaire. Written permission to conduct the study had been obtained from the community health agencies prior to the collection of data (Appendix A).

Population

The sample for this study was selected by convenience sampling (Abdellah 1965). The subjects selected were community health staff nurses who held the baccalaureate degree in nursing and were employed full-time to provide home health care in community health agencies. Twenty staff nurses were admitted to the study population during the investigational phase of the study which extended from 9:00 A.M. on August 4, 1977 to 5:30 P.M. on August 5, 1977.

Subjects were informed regarding the purpose of the study by means of both a written and an oral explanation provided by the researcher (Appendix B). Each subject who consented to participate in this study signed a consent form stating they understood their involvement and agreed to participate (Appendix C). In order to ensure

anonymity, the researcher requested that no names appear on the questionnaire.

Tool

The instrument utilized to identify cue utilization was a simulated patient Situation Questionnaire (Appendix D). No published instrument was found for use in this study; therefore, the instrument was developed by the researcher.

Section 1 of the questionnaire consisted of demographic data on age, year of graduation from basic nursing program, additional education, present position, length of time in present position, amount and type of past work experience.

Section 2 consisted of 5 written scenarios which depicted simulated patient situations. Multiple cues commonly encountered by the nurse in the community were included within the scenarios. The scenarios were submitted to a panel of 3 experts. The panel consisted of 3 nurses enrolled in a doctoral nursing program who were considered to be experts in clinical nursing judgment. These nurses had completed advanced course work in clinical judgment. They reviewed the scenarios and selected cues which were in one of three placed categories. For purposes of validating the instrument, the researcher determined

that the rate of agreement acceptable would be that at least 2 out of 3 panel members agreed. The panel participants suggested that several statements on the Situation Questionnaire be rephrased to facilitate better understanding.

Respondents were required to identify the cues they would select to make a clinical nursing judgment and the action they would take. Each cue was assigned a value of 1. The possible range of scores for the subjects was from 0 to 82. The range of total scores for all 20 subjects was for 0 to 1,640. When the cues were totaled by categories, the range of scores for the subjects was from 0 to 25 for client and family characteristics, 0 to 45 for sign and symptoms, and 0 to 12 for laboratory data. The range of total scores for all 20 subjects was from 0 to 500 for client and family characteristics, 0 to 900 for sign and symptoms, and 0 to 240 for laboratory data.

A pilot study was conducted to pretest the instrument. The sample for the pilot study, which was conducted on August 1, 1977, consisted of community health staff nurses employed full-time to provide home health care in a private community health agency located in a metropolitan area of over one million persons. The sample were nurses who met the criteria established for the study. During the

pilot study, the researcher provided the four subjects with both the written and an oral explanation of the study (Appendix B). Each subject who consented to participate in this study signed a consent form stating that she understood her involvement and agreed to participate (Appendix C). In order to ensure anonymity, no names were requested on the questionnaire.

The pilot study was used to further validate the instrument and to test its usefulness with a small number of subjects with similar characteristics of the proposed study population. As a result of the pilot study, the directions were rephrased and additional information was added to one situation for more clarity.

Data Collection

The data for the study were collected by means of the self constructed Situation Questionnaire through convenience sampling from August 4, 1977 to August 5, 1977. Sampling was done from groups of assembled staff at each community health agency district office. Each subject at the governmental community health agency was seated at a chair in a small auditorium and was given a copy of the Situation Questionnaire. Subjects were seated at a conference table at the district offices of the nongovernmental

community health agency. The researcher presented the questionnaire and awaited its completion by the subjects. Verbal as well as written directions were given to explain the questionnaire (Appendix D). The subjects were given 30 minutes to complete the form.

Treatment of Data

Demographic data were used to describe the sample more fully. Demographic data were also available for the researcher to determine if any correlation existed between the subject's questionnaire score and individual demographic items.

Scores were tabulated for total cue selection by the individuals and the total sample. Further tabulation was done for the scores of cues selected by categories for the individual subject and total sample. The researcher then examined the data to determine if there were a patterning of selection of cues with regard to categories most often and least often represented in the subject's responses. If the subject selected a predetermined cue but placed it in the wrong category, the cue did not receive a score.

Content analysis was performed on the nursing actions described by the subjects. The findings were classified after they had been examined by the researcher.

Summary

Chapter III has presented the methodology utilized in this study. The results of the analysis appear in Chapter IV of the study and are augmented by tables and descriptive explanation.

CHAPTER IV

ANALYSIS OF DATA

This study was concerned with identifying the total scores for cue selection by the individual and the total sample. Twenty community health nurses were involved as subjects in this investigation. The results of this study are presented in this chapter.

Description of the Sample

The sample consisted of 20 community health staff nurses with a baccalaureate degree in nursing who were employed full-time to provide home health care. Data collection was conducted during a period of 2 days from August 4, 1977 to August 5, 1977. Table 1 shows each subject with relevant demographic data. This table indicates the subject's age, date of graduation from a baccalaureate program in nursing, education prior to entry into a baccalaureate program, length of time in present position, and total months of nursing experience. Table 1 also presents the age range which was from 20 to 60 years with 55 percent of the subjects being in the 20-29 year age range. Fifteen staff nurses (77 percent) graduated from baccalaureate programs in nursing from 1970-1976, two (1 percent) from 1965 - 1970, one (.5 percent) from 1960-1965, and

TABLE 1

DEMOGRAPHIC DATA OF THE SUBJECTS

N*	Age Group	Date Graduated From Baccalaureate	Education Prior To Baccalaurcate	Months In Present Position	Months of Nursing Experience
1.	30-39	1970		9	85
2.	20-29	1974		4	38
3.	20-29	1976		2	14
4.	20-29	1975		11	26
5.	20-29	1973		2	49
6.	30-39	1971	A.D.	50	93
7.	20-29	1975		2	26
8.	20-29	1975		10	26
9.	20-29	1975	A.D.	18	26
10.	20-29	1974	B.A.	36	39
11.	50-59	1955		36	259
12.	20-29	1975		4	27
13.	20-29	1976	Diploma	3	30
14.	40-49	1961	Diploma	70	162
15.	30-39	1968		1	108
16.	40-49	1975	B.A.	2	24
17.	30-39	1975	A.D.	3	30
18.	40-49	1956		3	216
19.	30-39	1967		120	120
20.	20-29	1976		7	12

*N=20

two (1 percent) from 1955-1960. Three of the subjects had graduated from an associate degree program, and 1 in a diploma program prior to entry into the baccalaureate nursing program. Two staff nurses had acquired a baccalaureate degree in another field before completing the baccalaureate nursing program. The average length of time in the present positions ranged from 1 month to 10 years. Ten staff nurses (50 percent) had been employed in their present position for 1-6 months (20 percent), four staff nurses (20 percent) from 7-12 months, and six (30 percent) for 13 months and over. The average length of total nursing experience was 70.50 months with the range being from 1 month to 259 months of total nursing experience.

Presentation and Analysis of Data

Content analysis and tabulation provided a basis for interpreting the data. Content analysis enables the researcher to quantify abstract impressions and concepts and to provide for long-term analysis of the materials under study. Most often, content analysis is used to make a descriptive statement concerning an attitude, word or concept, frequency, a change or social condition (Treece and Treece 1977). Tabulation is simply the recording of

the number of types of responses in the appropriate categories, after which statistical analysis follows (Kerlinger 1973).

Subjects were required to identify the cues they would select to make a clinical nursing judgment and the nursing action they would take. Each cue was assigned a value of 1. Table 2 presents the values of the scores of the number of cues selected for each subject and the total sample. Total scores of each subject were obtained by adding the individual scores of total cues selected from the five patient nurse situations. Subject scores were computed according to the three categories established for cue selection. The possible range of scores for the individual was from 1 to 82. Individual scores ranged from 12 to 57 with the average score of 33 (39 percent). The possible range of scores for the individual by category was 0-25 for client, family characteristics, 0-45 for signs and symptoms, and 0-12 for laboratory data. When cues were totaled by categories, the average score for the subjects was 9 for client family characteristics, 17 for signs and symptoms, and 7 for laboratory data. Table 3 presents the total scores of cues selected by the 20 subjects. The total score for the sample was 652 (40 percent) of a possible 1,640. The possible range of

TABLE 2

FREQUENCY OF CUES SELECTED BY CATEGORY FOR THE SUBJECTS

Subject	Client/Family	Signs and Symptoms	Laboratory Data	Total
1	10	13	5	28
2	8	27	12	47
3	3	8	1	12
4	13	26	12	51
5	13	32	12	57
6	5	15	9	29
7	12	19	7	38
8	6	14	2	22
9	8	19	7	34
10	10	12	11	33
11	8	15	7	30
12	10	11	1	22
13	11	23	12	46
14	1	6	7	14
15	9	14	4	27
16	11	20	7	38
17	9	20	7	36
18	7	11	3	21
19	7	14	2	23
20	12	29	3	44
Total Sample Score	173	348	131	652

scores by the categories for the subjects was: 0-500 for client/family characteristics, 0-900 for signs and symptoms, and 0-240 for laboratory data. When the cues were totaled according to categories, the scores were: 173 (35 percent) for client / family characteristics, 348 (39 percent) for signs and symptoms, and 131 (54 percent) for laboratory data. Table 3 shows that only 40 percent of all possible cues were selected by the subjects. By category, laboratory data were identified as the highest percentage of cues selected out of those possible.

TABLE 3

FREQUENCY AND PERCENTAGE OF CUES

Cues	Number Possible for all Respondents	Number Identified	Percentage
Client/Family	500	173	34
Signs and Symptoms	900	348	39
Laboratory	240	131	54
TOTAL	1,640	652	40

Demographic characteristics of individual subjects were compared to individual questionnaire scores. Table 4 demonstrated that nurses with 7-12 months of experience in their present position identified the most cues.

TABLE 4

MEAN SCORE OF INDIVIDUALS BY LENGTH OF EXPERIENCE IN PRESENT POSITION

Experience in Present Position	Number of Subjects	Mean Individual Score	Percentage
1-6 months	10	34.4	42
7-12 months	4	36.25	44
13 months and over	5	27.16	33

Data in Table 5 show that by total length of nursing experience, subjects who had 1-6 years of experience selected 45 percent of the possible number of cues. Those with 7-12 years selected 33 percent, while those with 13 years and over selected only 26 percent of the possible cues.

TABLE 5

MEAN SCORE OF INDIVIDUALS BY LENGTH OF TOTAL NURSING EXPERIENCE

Total Nursing Experience	Number of Subjects	Mean Individual Score	Percentage
1-6 years	13	36.92	45
7-12 years	4	26.75	33
13 years and over	3	21.66	26

Tabulation was done to determine if there was a patterning of selection of cues with regards to the category most often and least often selected by the sample. Table 6 summarizes the total scores and identifies the category most often and least often selected. Signs and symptoms were identified most often with laboratory findings selected least often on which to base a judgment regarding a nursing action. See Appendix E for subjects' cue frequency per situation, and Appendix F for the frequency of cues selected by percentage of the subjects by category and situation.

TABLE 6

TOTAL FREQUENCY OF CUES BY PERCENTAGE OF SUBJECTS PER CATEGORY

Percentage of Subjects	Client/Family	Signs and Symptoms	Laboratory Data
1-25%	12	20	1
26-50%	7	13	6
51-75%	5	7	6
76-100%	1	5	1

Nursing actions were examined in regards to individual and total scores. The possible range of scores for nursing actions was 0-15 for individual scores and 0-300 for the sample. Table 7 presents the scores of the sample. Individual scores ranged from 1-12 with the average score of 7.25. The total score was 145 (48 percent) of a possible 300. This figure shows that nurses could identify only 48 percent of all appropriate nursing actions.

Table 8 presents the data for frequency of occurrence of nursing actions by each situation for all subjects. Each subject had to identify 3 nursing actions she would take per situation; action A, action B, and Action C.

TABLE 7

FREQUENCY AND PERCENTAGE OF NURSING FOR THE SUBJECT

Subject	Nursing Action	Percentage
1	9	60
2	7	47
3	10	67
4	8	53
5	9	60
6	3	20
7	5	33
8	5	33
9	9	60
10	5	33
11	3	20
12	7	47
13	12	80
14	9	60
15	8	53
16	9	60
17	1	0.7
18	9	60
19	9	60
20	8	53
Total	145	48.3

TABLE 8

FREQUENCY OF PERCENTAGE OF OCCURRENCE OF NURSING ACTION PATTERNS BY SITUATION

Nursing Actions	Situation 1	%	Situation 2	%	Situation 3	%	Situation 4	%	Situation 5	%
A	4	20	2	10	1	5	5	25	2	10
B	3	15	-		1	5	1	5	-	
C	-		3	15	3	15	3	15	-	
ABC	2	10	-		4	20	5	25	1	5
AB	2	10	2	10	-		-		2	10
AC	4	20	13	65	1	5	-		4	20
BC	2	10	-		8	40	2	10	-	
None	2	10	-		-		-		-	
Not Completed	-		-		2	10	4	20	11	55

This table represents each combination of nursing action and frequency that was chosen. See Appendix G for a more detailed explanation of what nursing actions A, B, and C are in each situation. The patterning of nursing actions most frequently chosen were in Situation 1, A (20 percent), and AC (20 percent). In Situation 2, AC (65 percent), BC (48 percent) in Situation 3, B (25 percent) and AB (25 percent) in Situation 4 and in Situation 5, AC (20 percent).

Nursing actions were compared to demographic data. The results are shown in Tables 9 and 10. Table 9 demonstrates that nurses with 1-6 months of experience in their present positions identified the greatest number of nursing actions.

TABLE 9

MEAN SCORE OF INDIVIDUALS BY LENGTH OF EXPERIENCE IN PRESENT POSITION FOR NURSING ACTIONS

Experience in Present Position	Number of Subjects	Mean Individual Score	Percentage
1-6 months	10	7.7	51
7-12 months	4	7.5	50
13 months and over	5	6.4	43

In Table 10, the total length of experience of the subjects shows little difference in years of experience and the number of nursing actions taken.

TABLE 10

MEAN SCORE OF INDIVIDUALS BY LENGTH OF TOTAL NURSING EXPERIENCE FOR NURSING ACTIONS

Total Nursing Experience	Number of Subjects	Mean Individual Score	Percentage
1-6 years	13	7.3	49
7-12 years	4	7.2	48
13 years and over	3	7.0	47

Analysis of the data indicates that subjects identify only 40 percent of the available cues on which to base a judgment concerning the nursing action. Nurses utilized cues from the signs and symptoms most often, with laboratory data being identified least often. Only 48 percent of all pertinent nursing actions were taken and patterning of nursing actions was done.

Summary

From the results of analysis of data obtained from the questionnaire, nurses do not use a large percentage

of data available to them in making a judgment about what nursing action to take. When the individual scores were examined, less than 50 percent of cues were identified. Analysis of the demographic data revealed that subjects who had been employed in their present positions for 7-12 months, scored the highest in the selection of cues. The data showed that the number of cues selected decreased as total years of nursing experience increased for the subjects. The results showed that 48 percent of all nursing actions were chosen. The demographic data revealed that subjects with 1-6 months of experience in their present positions scored the highest and that the number of nursing actions selected remained similar as years of total nursing experience increased.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study was conducted to identify cues community health nurses select to make clinical nursing judgments. The purposes were to: 1) determine the responses of the community health nurses engaged in home health care in selection of cues, and 2) to identify the pattern of cues community health nurses select in relation to clinical nursing judgment.

The research was conducted in governmental and nongovernmental community health agencies in a large metropolitan area of over one million persons. Sampling was done by the convenience method. Twenty subjects were selected from community health nurses who held a baccalaureate degree in nursing and were employed full-time. A simulated patient Situation Questionnaire constructed by the researcher was utilized to collect data from each of the participants in this study.

Analysis of Data was conducted by content analysis and tabulation. The results of this analysis were utilized to identify cues community health nurses selected and to

identify the patterns of cues. The results of the data analysis demonstrated less than 50 percent of the cues were selected by the subjects. These findings support those of Kelly (1964) and Hammond (1964) who found nurses had their own unique inference systems and were highly inconsistent in their use of these systems.

Cues were arranged in three categories according to Feinstein's (1967) procedure for collection of data. These categories were client/family characteristics, signs and symptoms, and laboratory data. The cues selected most frequently by the subjects were from the category of signs and symptoms. The category of laboratory data was least often chosen as important to consider for a nursing action. Demographic data when compared to individual scores revealed that cue selection decreased as total nursing experience increased. Nursing actions also followed this same pattern with the number of appropriate nursing actions decreasing as years of nursing experience increased. These findings are supported in studies by Verhonick (1968) and Davis (1974). Their findings also demonstrated that the number of nursing actions and cues selected dedreased with increased years of experience. The total score of nursing actions to be taken as indicated by the

subjects was consistent with the cue selection score in that both were below 50 percent.

Conclusions

The purpose of the study was to identify cues community health nurses selected in making clinical nursing judgments. Cues were identified from the data analysis and permitted the researcher to draw the following conclusions:

1. The percentage of cues selected by the individual was less than 50 percent.

2. The percentage of cues selected by the total sample was less than 50 percent.

3. Nurses employed in their present positions for 7-12 months, chose the most cues.

4. With increased years of total nursing experience, the number of cues selected decreased.

5. The category of signs and symptoms was chosen most frequently and the category of laboratory data the least, on which to base a judgment concerning the nursing actions.

6. The percentage of nursing actions identified by the individual was less than 50 percent.

7. The percentage of nursing actions identified by the sample was less than 50 percent.

8. Nurses employed in their present positions for 7-12 months, chose the most appropriate nursing actions.

9. The study indicated that with increased years of total nursing experience, the number of nursing actions identified decreased, but would need to be studied with a larger sample.

At the present state of development, the patient-nurse Situation Questionnaire is recommended to be used as a method of understanding of the way in which nurses select, assemble, and use cues in reaching a judgment about the state of condition of a patient. Because nurses engage in the judgment process in professional nursing, it is essential that methods be explored to assist the nurse in identifying the information on which she bases her judgment, and what importance she assigns to that information.

Recommendations

The following recommendations are offered for subsequent research studies in the area of clinical nursing judgment:

1. Further research related to concepts of clinical nursing judgments.

2. Additional investigation into implications of the process and methods utilized for nurses in making clinical nursing judgments.

3. Further research to study the relationship of cues and nursing actions.

4. Further study to identify the importance nurses place on data from which to make a judgment.

5. Investigation of the utilization of clinical nursing judgment and its effect on professional development of staff nurses.

6. Further study to identify the patterning of cues in relation to nursing actions taken.

APPENDIX A

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Home Health Services of Dallas, Inc.

GRANTS TO Susan Dougherty

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem: Cue Selection in Clinical Nursing Judgment

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.

2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.

3. The agency (wants) (does not want) a conference with the student when the report is completed.

4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.

5. Other: The agency requires a copy of or a synopsis of the completed report.

Date July 27, 1977

Matthew Manzyuk RN, MS
Signature of Agency Personnel
Clinical Director

Susan Dougherty
Signature of student

Jean Stair
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS

DALLAS CENTER
1810 Inwood Road
Dallas, Texas 75235

HOUSTON CENTER
1130 M.D. Anderson Blvd.
Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Dallas City Health Department

GRANTS TO Susan Dougherty

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem: Cue Selection in Clinical Nursing Judgment

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date 7/28/77

Sandra Strickland
Signature of Agency Personnel

Susan Dougherty
Signature of student

Jean Stair
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

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Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE ~~Visiting Nurses Association~~

GRANTS TO Susan Dougherty

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem: Cue Selection in Clinical Nursing Judgment

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other: Health Care Administrator to receive copy of abstract.

Date 7/29/77

Susan Dougherty
Signature of student

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

APPENDIX B

Dear Nurse:

As part of the requirements for the Master's degree, I have developed an instrument to identify the cues community health nurses select to make clinical nursing judgments. This instrument was developed from previous research and reviewed by a panel of experts.

Studies have shown that nurses use no standard method of organizing patient data and analyzing the therapeutic and environmenal decisions. I would like your participation in this present study.

In five patient situations describing a nursing situation, I have asked that you identify characteristics of the client, signs and symptoms, and laboratory findings from the situation presented. I have asked also that you list the information into the three categories identified. There is an orange sheet included with the Situation Questionnaire which states definitions of the three categories of data: characteristics of client/family, signs and symptoms, and laboratory findings. Please detach this sheet to use as you respond to the five situations. Upon completion of organizing the data under the three categories, please state the immediate nursing action that you would take. List only three you consider to be of greatest importance.

It is expected that nurses will select different information. The time involved will be approximately thirty minutes. Your identity will not be revealed in the study. Do not sign your name on the questionnaire. An abstract of the final research report will be available to you in the nursing supervisor's office after August 15, 1977.

If you agree to participate in this study by filling out a questionnaire, please read and sign the attached consent form. Thank you for your cooperation.

Susan Dougherty, R.N.

APPENDIX C

TEXAS WOMAN'S UNIVERSITY

(Form B-- Oral presentation to subject)

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time.

Signature _____ Date _____

Witness _____ Date _____

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

Signature _____ Date _____

Position _____

Witness _____ Date _____

APPENDIX D

SITUATION QUESTIONNAIRE

DEMOGRAPHICAL DATA: Please complete the following questions:

A. Age: ( ) 20-29 ( ) 40-49 ( ) 60-69
( ) 30-39 ( ) 50-59

B. Date of graduation from Baccalaureate program: _____, 19____.

C. Education prior to entry into Baccalaureate degree in nursing:
Diploma program _____, 19____
A.D. program_____, 19____
L.P.N. (L.V.N.) program_____, 19____

D. Additional Education:

( ) workshops (1 day) attended 9/76 - 9/77:_____

( ) conferences (2 or more days) attended from 9/76 - 9/77:

_____

( ) meetings (monthly) attended from 9/76 - 9/77:_____

( ) graduate courses: number of hours completed_____ Major:_____

E. Present position:_____

F. How long in present position:_____

G. Total length of nursing experience (including present position):

_____years _____months

H. Past employment experience and length of past employment:

_____ _____

_____ _____

_____ _____

_____ _____

DIRECTIONS:

In this questionnaire, you will be presented with five patient-nurse situations. Please read each situation carefully and then identify what information you would use to follow through with patient care. Please list the information under the categories of client/family characteristics, signs and symptoms, and laboratory findings. There is an orange sheet included with the Situation Questionnaire which states the definitions of the categories. Please detach this sheet to use as you respond to the five situations. Limit your selection to data presented in the descriptions provided. Do not include additional information. If you do not find any pertinent data in the situation for each category, leave the category blank. Upon completion of organizing the data under the categories, please state the immediate nursing action that you would take. List only three you consider to be of greatest importance.

Client and Family Characteristics refer to personal and social properties of the client and family, such as age, race, sex, education, geographic location, occupation, financial and social status.

Signs and Symptoms refer to pertinent complaints, physical and behavioral observations, and past history elicited by the nurse from the patient and his family.

Laboratory Findings

PLEASE DETACH THIS SHEET TO USE AS YOU RESPOND TO THE QUESTIONNAIRE.

Situation 1:

It was the practice of the health agency to follow all premature infants for one year. The nurse had scheduled her last visit to see Johnny Brown, a one-year-old, only child of John and Shelia Brown. She found that while Mrs. B. had been home with Johnny during his first year, she would be returning to her teaching job next week.

Mrs. B. greeted the nurse at the door and expressed hurriedly that Johnny seemed not to be feeling well. "I usually don't worry but he is always so active and plays with his toys for hours, but today all he does is just sit there and doesn't play. I did notice that he seems to have broken out with something during the night. He wasn't sick yesterday at all, but now he is hot to touch and has been fussy all morning."

The nurse examined the baby and found his temperature to be 101°F rectally. He had raised pinkish red spots, the size of pinpoints on his neck, arms, and trunk. No discharge was apparent in the auditory canal or in the nasal cavity, his lungs were clear and his respiration was 30 per minute. The nurse suspected rubella and proceeded to tell Mrs. B. that the rash Johnny had resembled that of measles.

In order for you (the nurse) to proceed, what information or facts from the above situation would you want to consider? List these facts under the appropriate category.

Client/Family Characteristics	Signs and Symptoms	Laboratory Findings

After considering the above specified information, what nursing-care actions would you take? List only three immediate actions which you consider to be of greatest importance.

1.

2.

3.

Situation 2:

A call was received by the community health nurse from the daughter of an elderly woman, Mrs. Harris, who had been discharged from the hospital two days ago. Mrs. Harris had been diagnosed as having coronary occlusion with myocardial infarction and Dicumarol 2 mg. q.d. had been prescribed. The daughter was worried because she had to return to her own home in another part of the state and her mother was having trouble remembering to take her medication. She told the nurse that her mother was often confused and tired easily. The nurse agreed to come to the home to discuss the future management of Mrs. Harris' care.

As part of her assessment the nurse found Mrs. Harris to be confused and not orientated as to time. She had a B.P. reading of 150/82, her radial pulse rate was 72, and her respirations were 24 per minute. The daughter showed the nurse a laboratory report from the hospital which stated laboratory findings as follows; Prothombrin time 16 seconds, CBC normal, Hemocrit 36% and Hg. 11 gm %. The nurse also questioned Mrs. Harris in regards to her medication regimen and found that she took it whenever her daughter gave it to her. Mrs. Harris said she hadn't had any headaches, bleeding, soft stools, or any blood in the stools. When asked when she was to return to the doctor for laboratory tests, she looked surprised and said she didn't have a return appointment.

In order for you (the nurse) to proceed, what information or facts from the above situation would you want to consider? List these facts under the appropriate category.

Client/Family Characteristics	Signs and Symptoms	Laboratory Findings

After considering the above specified information, what nursing-care actions would you take? List only three immediate actions which you consider to be of greatest importance.

1.

2.

3.

Situation 3:

Mary Smith, who is unmarried and expecting her first baby, was referred to the community health nurse for home followup. Her medical supervision is to be through the hospital prenatal clinic. Information on the referral form stated:

Social: 16 year old girl, living with her mother. Has quit high school and plans to keep the baby.

Clinic Visit: Came alone to the clinic; pregnancy of 4 months was confirmed. Ht. 5 ft.; 145 lbs., urine clear, negative sugar and albumin. B.P. 118/78. Diet counseling and 1200 calorie diet prescribed. Patient has not returned for her six months checkup and has no phone listed. She has not responded to postcards sent regarding her return to the clinic.

The nurse visited Mary at home with her mother present and found Mary to be shy and generally uncommunicative. Mary constantly looked to her mother before answering a question and responded cautiously in a very quiet voice. Mary explained that she had not returned to the clinic because she felt well and her mother said she didn't have to since she wasn't sick. On questioning Mary about her diet and change in weight, the nurse learned that Mary had gained 28 pounds since she made her clinic visit three months ago.

In order for you (the nurse) to proceed, what information or facts from the above situation would you want to consider? List these facts under the appropriate category.

Client/Family Characteristics	Signs and Symptoms	Laboratory Findings

After considering the above specified information, what nursing-care actions would you take? List only three immediate actions which you consider to be of greatest importance.

1.

2.

3.

Situation 4:

Mrs. W. is a 57 year old widow who lives alone in a modestly furnished home. Mrs. W. is neat, well groomed, and moderately overweight. She watches her diet closely and tries to control any further increase in weight.

Mrs. W. asks the nurse to visit her at home and reports that she has experienced periods of drowsiness, excessive thirst, and frequency of urination. An unusual craving for carbohydrates has caused her to become careless about her normally well balanced diet. Her co-workers at the insurance firm where she works had pointed out her behavior had changed from a stable, well organized pattern to one or erratic demands and unpredictable outbursts. Mrs. W.'s annual physical is due in one month.

Mrs. W. also told the nurse she became concerned about the changes which were taking place and remembered that in her last physical she had no abnormal findings. Her blood pressure, CBC, and Hg were normal. Urinalysis had shown clear urine with no sugar or albumin present. Because she had talked with the doctor about her tendency to gain weight easily, he has prescribed a 1200 calorie diet.

In order for you (the nurse) to proceed, what information or facts from the above situation would you want to consider? List these facts under the appropriate category.

Client/Family Characteristics	Signs and Symptoms	Laboratory Findings

After considering the above specified information, what nursing-care actions would you take? List only three immediate actions which you consider to be of greatest importance.

1.

2.

3.

Situation 5:

Mrs. Doe, a 69 year old woman with a diagnosis of "Inoperable Metastic Carcinoma," was discharged from the local hospital two days ago. Mrs. Doe is continuing to live with her daughter. The community health nurse has been called for assistance in the management of Mrs. Doe's care at home.

Upon her visit to the home, the nurse finds Mrs. Doe to be a small, thin person who is listless and pale. Both the daughter and the mother have been informed by the physician that her condition is terminal and will become worse. The nurse finds Mrs. Doe's blood pressure to be 130/78, a radial pulse rate of 62 and respirations of 24 per minute. Mrs. Doe has generalized weakness which limits her ambulation and prevents her from moving freely about the house. Most of her time is spent in bed. She is incontinent frequently during the day because of her inability to get to the bathroom in time and is also troubled with nocturnal frequency. Mrs. Doe's dependence on others is increasing and her ability to become independent in activities of daily living is unlikely.

In order for you (the nurse) to proceed, what information or facts from the above situation would you want to consider? List these facts under the appropriate category.

Client/Family Characteristics	Signs and Symptoms	Laboratory Findings

After considering the above specified information, what nursing-care actions would you take? List only three immediate actions which you consider to be of greatest importance.

1.

2.

3.

APPENDIX E

FREQUENCY AND PERCENTAGE OF CUES SELECTED
PER SITUATION AND CATEGORY

SITUATION 1

	Frequency	%
Client Family		
1. Premature	3	15
2. One year old	12	60
3. Only child	4	20
4. Mother anxious	1	15
5. Mother planning to return to work	5	25
Sign and Symptoms		
1. Child was well yesterday	1	15
2. Decreased activity	13	65
3. Skin hot to touch	5	25
4. Fussy	12	60
5. Temperature	15	75
6. Rash	20	100
7. Ears clear	4	20
8. Nose clear	4	20
9. Lungs clear	7	35
10. Respiration	9	45
Laboratory Data		
None		

FREQUENCY AND PERCENTAGE OF CUES SELECTED
PER SITUATION AND CATEGORY

SITUATION 2

	Frequency	%
Client Family		
1. Discharged two days ago	4	20
2. Elderly woman	12	60
3. Coronary occlusion with MI	2	10
4. Daughter returning home	7	35
5. No appointment for follow-up	1	15
Signs and Symptoms		
1. Confused	14	70
2. Disoriented	16	80
3. Blood pressure	11	55
4. Respiration	8	40
5. Pulse	10	50
6. Tires easily	7	35
7. Dicumarol	2	10
8. No headaches	6	30
9. No bleeding	8	40
10. No sofe stools	4	20
11. No blood in stools	5	25
Laboratory Data		
1. Prothrombin	20	100
2. CBC normal	10	50
3. Hemocrit	14	70
4. Hemoglobin	13	65

FREQUENCY AND PERCENTAGE OF CUES SELECTED
PER SITUATION AND CATEGORY

SITUATION 3

	Frequency	%
Client Family		
1. Unmarried	12	60
2. 16 years old	17	85
3. First baby	7	35
4. Quit school	4	20
5. Plans to keep baby	13	65
6. Lives with mother	5	25
7. Not returned for revisit to the clinic	7	35
Sign and Symptoms		
1. Height	6	30
2. Weight	8	40
3. Blood pressure	7	35
4. Weight gain of 28 lbs. in three months	16	80
5. Not on 1200 calorie diet	1	15
6. Shy	4	20
7. Uncommunicative	4	20
LABORATORY Data		
1. Urine clear	9	45
2. Negative sugar	12	60
3. Negative albumin	11	55

FREQUENCY AND PERCENTAGE OF CUES SELECTED
PER SITUATION AND CATEGORY

SITUATION 4

	Frequency	%
Client Family		
1. 57 year old	15	75
2. Widow	7	35
3. Lives alone	3	15
4. Employed at insurance firm	9	45
Sign and Symptoms		
1. Moderately overweight	6	30
2. Drowsiness	17	85
3. Excessibe thirst	16	80
4. Frequency of urination	15	75
5. Craving for CHO	11	55
6. Blood Pressure	2	10
7. 1200 Calorie diet	2	10
Laboratory Data		
1. CBC nomal	6	30
2. Urine clear	5	25
3. Negative sugar	10	50
4. Negative albumin	10	50
5.	9	45

FREQUENCY AND PERCENTAGE OF CUES SELECTED
PER SITUATION AND CATEGORY

SITUATION 5

	Frequency*	%
Client Family		
1. 69 years old	7	35
2. Living with daughter	9	45
3. Terminally ill	4	20
4. Spends most of day in bed	0	0
Sign and Symptoms		
1. Blood pressure	4	20
2. Pulse	4	20
3. Prepiration	4	20
4. Generalized weakness	9	45
5. Nocturnal frequency	5	25
6. Small	7	35
7. Thin	3	15
8. Decreased mobility	3	15
9. Increased mobility	5	25
10.	2	10
Laboratory Data		
None		

*9 Subjects did not complete this situation

APPENDIX F

FREQUENCY OF CATEGORY OF
CUES SELECTED BY PERCENTAGE OF
SUBJECTS PER SITUATION

Situation 1

Category of Cue Selected	1-25%	26-50%	51-75%	76-100%
Client/Family	4	---	1	---
Signs and Symptoms	4	2	3	1
Laboratory	N/A	N/A	N/A	N/A

Situation 2

Category of Cue Selected	1-25%	26-50%	51-75%	76-100%
Client/Family	3	1	1	---
Signs and Symptoms	3	5	2	1
Laboratory	---	1	2	1

Situation 3

Category of Cue Selected	1-25%	26-50%	51-75%	76-100%
Client/Family	2	2	2	1
Signs and Symptoms	3	3	---	1
Laboratory	---	1	2	---

Situation 4

Category of Cue Selected	1-25%	26-50%	51-75%	76-100%
Client/Family	1	2	1	---
Signs and Symptoms	2	1	2	2
Laboratory	1	4	---	---

Situation 5

Category of Cue Selected	1-25%	26-50%	51-75%	76-100%
Client/Family	2	2	---	---
Signs and Symptoms	8	2	---	---
Laboratory	N/A	N/A	N/A	N/A

*N/A = Not Applicable

APPENDIX G

RECOMMENDED NURSING ACTIONS TO BE TAKEN PER SITUATION

Situation 1

A. Discuss with the mother how to reduce the fever.
B. Call the physician if condition appears worse.
C. Teach the mother concerning dehydration and forcing fluids.

Situation 2

A. Explore with patient and her daughter possibilities of how to arrange for her medication regimen.
B. Arrange an appointment with the doctor and daughter for further information to help the daughter in planning for the care of her mother.
C. Arrange a return clinic appointment.

Situation 3

A. Do a further history and physical assessment.
B. Discuss the importance of nutrition and weight gain during pregnancy.
C. Do patient teaching with the mother and daughter concerning aspects of pregnancy; i.e., fetal development, and pre-natal care.

Situation 4

A. Do a urinalysis for glucose level.
B. Encourage Mrs. W. to change her appointment to a sooner date.
C. Check vital signs and gather more past history related to her symptoms.

Situation 5

A. Offer emotional support to Mrs. Doe and her daughter.
B. Prevent skin breakdown by adequate care.
C. Discuss methods of handling the incontinent and nocturnal frequency problem.

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