

EVALUATION OF A TRAINING MODULE FOR THE ASSESSMENT  
AND DIAGNOSIS OF SEXUALLY TRANSMITTED DISEASES

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COLLEGE OF NURSING

BY  
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DENTON, TEXAS

AUGUST 1986

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July 21, 1986  
Date

To the Provost of the Graduate School:

I am submitting herewith a thesis written by Kathy Falkenhagen entitled "Evaluation of a Training Module for the Assessment and Diagnosis of Sexually Transmitted Diseases." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Nursing.

Judith McFarlane  
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We have read this thesis and  
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ABSTRACT

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Utilization of a training module significantly increased assessment and diagnosis practices of 12 volunteer examiners at a free standing STD clinic, as measured by an audit tool, compared to 12 volunteer examiners who did not use the training module. Demographic data were related to age, sex, work experience in the health care system, and length of time volunteering at the clinic. The majority of volunteer examiners (83.4%) had 1-4 weeks or minimal experience at the selected STD clinic, and no formal training or education, yet with the training module were able to perform better on assessment and diagnosis of STDs.

Recommendations are that orientation programs for volunteer examiners at free standing STD clinics include a formal training module followed with an audit tool, and dissemination of the training module and audit tool to private and public clinics that treat STDs.

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## CHAPTER 1

### INTRODUCTION

Sexually transmitted diseases (STDs) affect several hundred thousand Americans yearly, cause human suffering, strain our limited health and human resource agencies, and cost millions of public and private dollars (US Department of Health, 1982). Reasons for this health malady vary, depending on one's viewpoint. Behavioral scientists blame the peculiarities of a society that minimizes the importance of sex education and simultaneously encourages individual expression of sexuality. Medical sociologists point out that our medical care system has failed to provide accessible and acceptable health services for people at risk to and experiencing STDs. Political scientists say that our decision makers and the public are still unable to respond to an age-old problem rooted in apathy, ignorance, and neglect (Wiesner, 1980).

Regardless of the reason, some 20 STDs affect the world's population with major STDs, gonorrhea and syphilis, affecting worldwide 250 and 50 million persons, respectively (World Health Organization, 1980). In 1983 alone, in the United States, 900,435 cases of gonorrhea and 32,698 primary and secondary syphilis cases were reported (Center for

Disease Control, 1984b, 1984c). Since 1981, a totally new syndrome related to immune deficiency dysfunction has caused mass public alarm (Center for Disease Control, 1984a). In 1985, physicians and health departments in the United States reported 10,000 patients (9,887 adults and 113 children) meeting the surveillance definition for acquired immunodeficiency syndrome (AIDS) (Center for Disease Control, 1985). Of the affected population, homosexual men composed 72%, 17% were intravenous drug users, 4% included persons born in Haiti, 1% were patients with hemophilia, and 6% had other risk factors (Center for Disease Control, 1985).

The past decade has witnessed a growing awareness that homosexual men are at increased risk for a variety of STDs. The sexual liberation movement has allowed and encouraged open expression of their sexuality. Consequently, communities of homosexual males have tended to form and persist in urban settings. Both the increased prevalence of STDs among homosexuals and a lack of accessible and acceptable public and private care facilities has resulted in the emergence of free-standing volunteer clinics for the diagnosis and treatment of STDs. These clinics are frequently staffed by volunteers from a variety of health professions. Often, the volunteers are limited in their knowledge and experience regarding the assessment and care of the patients

with STDs (Ostrow, Sandholzer, & Feldman, 1983). To that end, this study was focused on the use and evaluation of a training module for volunteer examiners at a clinic specifically for the diagnosis and treatment of persons with STDs.

### Problem of Study

The following question was addressed in this study:  
Are assessment and diagnosis practices of volunteer examiners at a free-standing clinic for STDs improved following their completion of a training module?

### Justification of the Problem

Assessment and diagnosis practices of volunteer health care providers at free-standing clinics for STDs have not been studied (Ostrow et al., 1983). Presently there are no protocols for assessment of STDs specific for the predominantly volunteer staff of free-standing clinics. Therefore, an audit tool was used in this study to evaluate assessment and diagnosis practices of volunteer examiners who used a training module. The major outcome of this study could be the availability of a training module and audit tool for public and private clinics that treat STDs.

### Conceptual Framework

A conceptual model for the evaluation process proposed by Suchman (1967) was utilized in this study. Suchman's

model of the evaluation process is depicted in Figure 1.

Suchman defined the concept of evaluation as

the determination (whether based on opinions, records or subjective or objective data) of the results (whether desirable or undesirable; transient or permanent; immediate or delayed) attained by some activity (whether a program, or part of a program, a drug or a therapy, an ongoing or one-shot approach) designed to accomplish some valued goal or objective (whether ultimate, intermediate, or immediate, effort or performance, long or short range). (pp. 31-32)

Value formation begins the circular evaluation process.

Suchman (1967) defined value as any aspect of an object, event, or situation that is invested with a special interest, for example, as good or bad. Values are modes of organizing human activity--meaningful, affectively charged principles which determine both the goals of public service and social action programs and the acceptable means of attaining these goals. Values may be inherent in an activity or translated into an operative value as resultant action.

After or during the process of value formation, a goal is formulated (Suchman, 1967). Goal and objective formulation must take into consideration, in addition to the question of what to evaluate, the following questions:

1. What kind of change is desired (i.e., change in behavior or knowledge)?
2. To whom is the program targeted (i.e., individuals, groups or whole communities)?

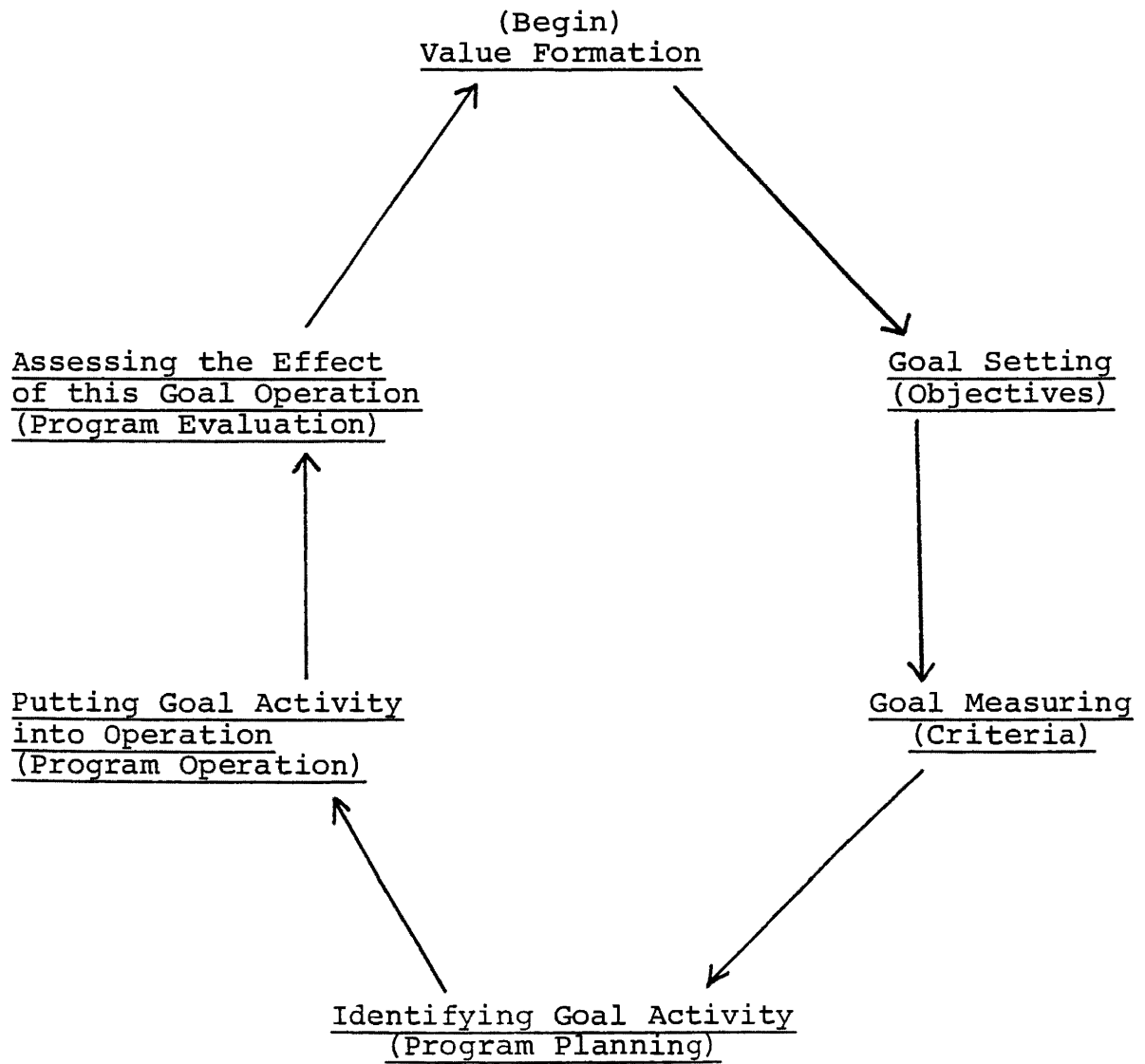


Figure 1. Suchman's (1967, p. 34) Evaluation Process

3. When will the change take place (i.e., short or long term change)?
4. Are program objectives unitary or multiple (single or serial change)?
5. What is the desired magnitude of program effect (i.e., widespread or concentrated results)?
6. What are the means by which change will occur (public service program, volunteer cooperation or legal sanctions)?
7. What are the signs by which the change will be recognized (i.e., increased productivity or knowledge)?

The nature of the evaluation depends largely on the type of measure available to determine the attainment of the objective. Thus, the last consideration in goal setting brings the circular evaluation process to the step of measuring goal attainment and describing the instrument or criteria which will be used in measuring program success (Suchman, 1967).

The next step involves the identification of a goal-attaining activity (Suchman, 1967). A new program is planned for or an established program is chosen in achieving the established goals. Then the goal-attaining activity is put into operation at the desired setting.

At some point, during or after program operation, the assessment of the goal-directed operation takes place. This

stage of assessment includes the evaluation of the degree to which the operating program has achieved the predetermined objectives.

Finally, on the basis of the program assessment and evaluation, a judgment is made as to whether the goal-directed activity was worthwhile. The judgment step completes as well as restarts the evaluation cycle and returns to value formation. At the end of the evaluation process, there may be a new value, or the need to reaffirm, reassess or redefine old values (Suchman, 1967). Suchman's model of the evaluation process is operationalized in this study and depicted in Figure 2.

The formation of values begins the evaluation process. A value inherent in evaluating a training module in a clinic for the diagnosis and treatment of STDs might be that STDs are communicable. The treatment could be conceived as necessary and operationally translated into a value of assessment, diagnosis and treatment for controlling transmission.

The goal and objective setting questions considered were answered as follows:

1. What kind of change is desired? Improved assessment and diagnosis practices are the changes desired.
2. To whom is the program targeted? Volunteer examiners were the target of this program.

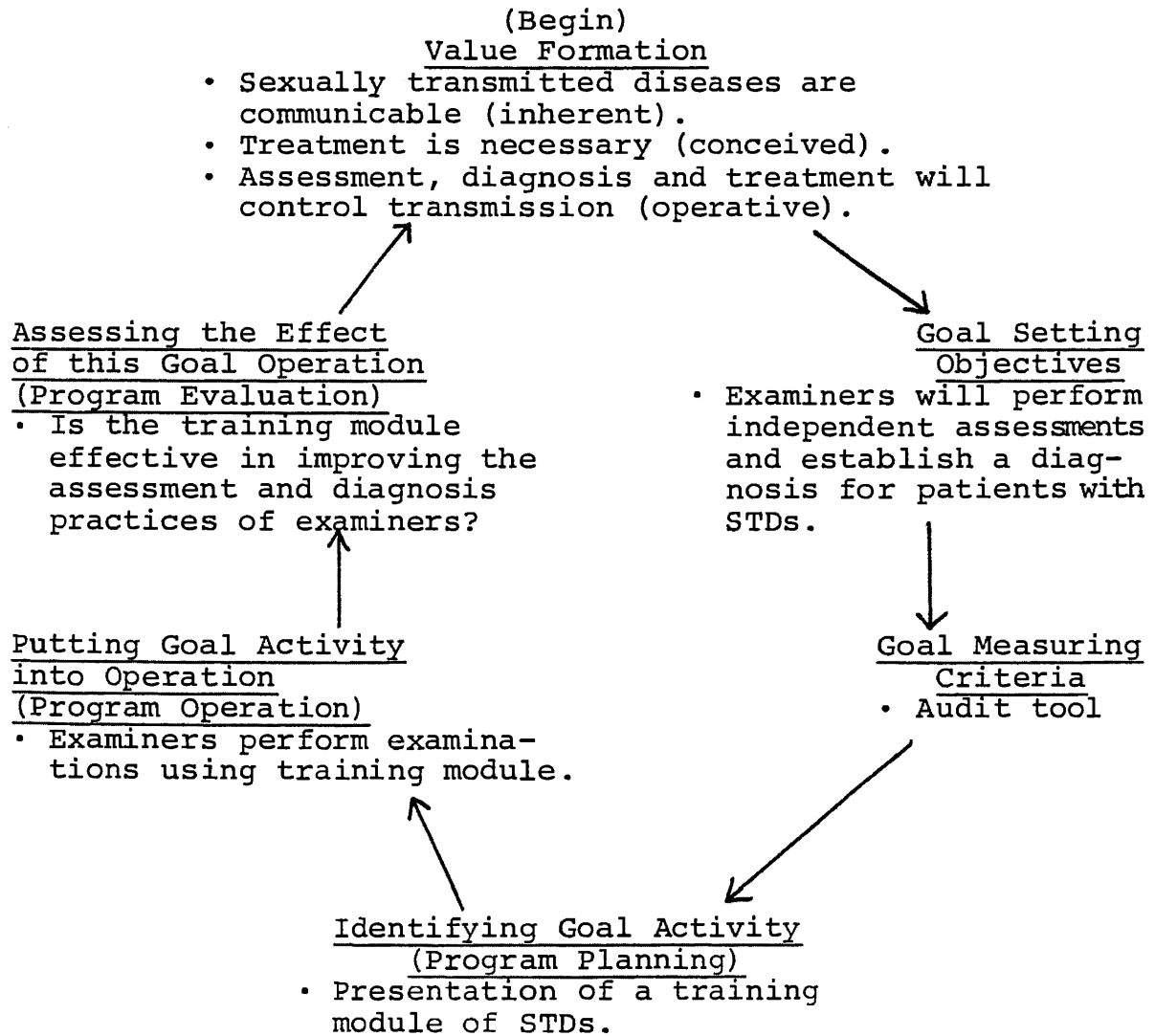


Figure 2. Operationalization of Suchman's (1967, p. 34) Evaluation Process



3. When will the change take place? Following utilization of the training module, a change will occur.
4. Are the program objectives aimed at single or serial changes? Serial change for all volunteer examiners is the desired change expected by the program objectives.
5. What is the desired magnitude of program effect?  
Utilization of the training module and audit tool by examiners in public and private clinics for the diagnosis and treatment of STDs is the desired program effect.
6. What are the means by which the change will occur?  
Training module usage will provide the means to effect change.
7. What are the signs by which the change will be recognized? Improved assessment and diagnosis practices as measured by the audit tool will indicate the desired change.

To summarize, an audit tool was used to evaluate the usefulness of the training module. Presentation of a training module on STDs was the goal activity. Putting the goal activity into operation was the examiner's performance on examinations by utilizing the training module. The assessment of the effects of the goal operation was achieved in this study through scored responses from the audit tool.

On the basis of that analysis, a judgment was made as to whether the goal-directed activity improved the assessment and diagnosis practices and was worthwhile in achieving the desired goal. This judgment completed as well as restarted the evaluation cycle.

### Assumptions

The following assumptions were inherent in this study:

1. Assessment and diagnosis skills can be measured with an audit tool (Suchman, 1967).
2. The training module can be evaluated with an audit tool (Suchman, 1967).
3. Audit-recorded activities are representative of actual practices (Suchman, 1967).

### Hypothesis

The following hypothesis was proposed:

Volunteer examiners taught assessment and diagnosis procedures through the use of a training module will have higher scores on assessment and diagnosis skills as measured by the audit tool than will volunteer examiners who do not use the training module.

### Definition of Terms

For the purpose of this study the following terms were identified:

1. Sexually transmitted diseases (STDs): refers to a group of diseases typically transmissible by sexual contact (Webster's, 1977); operationally defined as the following: syphilis, gonorrhea, chancroid, lymphogranuloma venereum, granuloma inguinale, and acquired immune deficiency syndrome (US Department of Health, 1984).
2. Training module: learning materials used to instruct (Webster's, 1977); operationally defined as Falkenhagen's Training Module (Appendix A).
3. Audit tool: an instrument to measure performance (Webster's, 1977); operationally defined as Falkenhagen's Audit Tool (Appendix B).
4. Volunteer examiner: one who inspects, assesses and appraises (Webster's, 1977); operationally defined as a volunteer with health care experience who functions independently to perform assessments and establish diagnoses for patients with STDs.

#### Limitations

The following limitations were inherent in this study:

1. The findings cannot be generalized beyond the study population because of the convenience sampling technique (Shortell & Richardson, 1978).

2. External validity was compromised because of the small size of the convenience sample.
3. Internal validity was compromised, in that numerous extraneous variables could not be controlled and may have influenced the results. These variables include: testing, maturation and historical effects on subjects, and instrumentation (Shortell & Richardson, 1978).

### Summary

The prevalence of STDs is increasing, and these diseases have become a major public health concern. Simultaneously, due to the lack of accessible and acceptable public and private care facilities, there has been a proliferation of free-standing clinics dedicated to screening and treatment of STDs. The use of volunteer examiners not prepared in the specifics of STD treatment and diagnosis has necessitated the development and implementation of a training module. This study utilized a conceptual model for the evaluation process proposed by Suchman (1967) to evaluate the effectiveness of the Falkenhagen Training Module and its usefulness to clinics that care for clients with STDs.

## CHAPTER 2

### REVIEW OF THE LITERATURE

Research in the field of sexually transmitted diseases (STDs) is abundant and has indicated that awareness and knowledge of the diseases are important tools for prevention, diagnosis and eventual eradication. This study was focused on the use and evaluation of a training module for volunteer examiners at a clinic specifically for the diagnosis and treatment of persons with STDs. Therefore, the literature review is confined to the following sections: (a) factors associated with the epidemic of STDs among homosexual men, (b) emergence of free standing clinics to treat STDs, and (c) role of health care providers working in free standing clinics for persons with STDs.

#### Factors Associated with the Epidemic of STDs among Homosexual Men

The past decade has seen a growing awareness that homosexually active men are at increased risk for a variety of STDs. Curran (1983) reported that at least 11 major STDs have been identified within the homosexual community. These major STDs include viral hepatitis, syphilis, amebiasis, gonorrhea, anal warts, genital herpes, giardiasis, nongonococcal urethritis, nongonococcal proctitis,

shigellosis, and scabies. The newest STD associated with homosexuality is acquired immunodeficiency syndrome (AIDS).

Among the first investigators to examine the prevalence and causes of STDs in homosexually active males was Flukes (1976). His descriptive study was concerned primarily with syphilis and gonorrhea among a sample of 47 heterosexual and homosexual males at a London Hospital. Flukes found that homosexual men experienced a higher rate of STDs (18%) than did heterosexual men (3%). Flukes concluded that viral hepatitis, rectal disease, and mucous colitis were pathological conditions associated with homosexual practice.

Ostrow, Sandholzer, and Feldman (1983) stated that several factors have been implicated in the epidemic of STDs among homosexual men. Perhaps leading the list is gay liberation, which began nationally in the late 1960s and which allowed a structured political viability to an oppressed minority. The liberation movement has allowed and encouraged homosexual men and women to express their sexuality openly and to overcome fears of social and political censure for their sexual preference. Increasingly through the 1970s, meeting places of all types sprang up to accommodate sexual freedom. According to Ostrow et al., bars, discos, and bath houses as well as nonsexually oriented meeting places were available to obviate the need

for clandestine sexual activity. Homosexual men were free to be sexually active, and with the freedom, these men, regardless of sexual orientation, were subject to the same consequences, except unwanted pregnancies and abortions, as the entire sexually active population. As noted by Ostrow et al., the anonymity of the sexual partners of many members of the single homosexually active male population, however, does contribute to STD incidence, since tracing the contacts of transmission is almost impossible. Also, as noted by the authors, the particular sexual practices of anilinctio, fellatio, and anal intercourse by homosexual men are the major risk factors toward the spread of infection.

According to Vaisrub (1983), homosexual men are at greater risk to STDs since, during sexual activity, each partner's penile epithelium and urethral mucosa are exposed to deep seated pathogens in any body orifice. Being excellent transmitters of infection, the penis and urethra are responsible for transferring these pathogens, especially during ejaculation.

Ostrow et al. (1983) analyzed a number of hypotheses to explain the emergence of STDs in homosexually active men. These hypotheses are grouped into four broad categories based on the factors through to be primary in the transmission of STDs. The first of these groups are

physical factors, such as the virulence and pathogenic characteristics of STD agents and male anatomic features, which can facilitate transmission and propagation of the pathogen, while often masking or hiding signs and symptoms. The second category are the behavioral factors, such as frequency of sexual activity and anonymity of sexual partners, as well as the nature of specific sexual practices. The third group are the cultural factors, such as attitudes towards homosexuals on the part of health care providers, which can act as barriers to utilization of STD treatment facilities by homosexuals and may result in improper diagnosis and treatment. The final and fourth category are the legal and political factors, such as changes in laws against homosexuality, which removed barriers against case reporting and led to artifactual increase in rates.

Out of the epidemic of STDs arose the need for proper and accessible medical treatment. Thus, free standing clinics began to emerge in an attempt to halt the increase of STDs.

#### Emergence of Free Standing Clinics

There are, in general, two traditional settings for STD service delivery: the private physicians office or institution and the public health clinic. Feldman and



Morrison (1982), in a study of 64 homosexual men, found that the men were deterred from seeking STD checkups in a private physician's office because this would require open admission of their sexual preference which may be accompanied by a great deal of anxiety. Sandholzer (1981) surveyed over one-third of the physicians in the United States and found that they were sometimes or often uncomfortable when treating homosexual patients. According to the author, a lack of concern and their own discomfort tends to cause many physicians to overlook the issue of the patient's sexual preference, although such information is of vital importance to proper management of this group.

In the United States, county and municipal governments are primarily responsible for providing diagnostic and treatment services for the STD population. According to Joyce Ayers (personal communication, November 11, 1985), in 1985 there were 3,000 part time and full time public health clinics in the United States that treat STDs.

Public health care facilities were studied by Judson (1982). In a study of 242 clinics, Judson stated that the majority of the public health care facilities were inadequately utilized and homosexual men were reluctant to trust their health to inadequately trained personnel or physicians.

Ostrow et al. (1983) reported that gay men have a variety of unique medical problems, such as unmet psychosocial needs and exposure to treatment-resistant diseases, that are related primarily to their sexual lifestyle. The authors pointed out that these problems have not been addressed by traditional health care. As a result of the lack of facilities and programs to meet the needs of homosexual men, free standing clinics for the diagnosis and treatment of STDs have emerged and persist in urban setting. Free standing clinics were defined by Ostrow et al. as non-profit organizations, often located in a large urban setting, dedicated to screening and treatment of STDs. The clinics have focused attention on the unmet health care needs of homosexual men. Additionally, the success of these clinics has demonstrated that community sponsored and organized clinics can do much to support urban gays in the area. Many free standing clinics have matured into major centers for the delivery of specialized health care.

Joe Blount (personal communication, January 2, 1986), from the Center for Disease Control in Atlanta, estimated that of the 3,000 public health clinics that treat STDs, about 28% or 840 are free standing. Ostrow et al. (1983) reported that the assessment and diagnosis practices of volunteer health care providers at free standing clinics had

not been studied. Further, Blount stated that as of early 1986, there were no published protocols for assessment of STDs specific to volunteer staff of these clinics.

#### Role of Health Care Providers at Free Standing Clinics for Persons with STDs

Perhaps the primary requirement for effective control of STDs is for the health care professional to approach the gay patient with an open and nonjudgmental attitude. This approach requires proper identification of the patient's sexual preference and practices. Ostrow et al. (1983) asserted that awareness of the patient's sexual preference can be the key to proper diagnosis and that a complete history of sexual practices is an essential part of primary medical care. Owen (1983) asked that physicians and health care workers be nonjudgmental and understanding of the special needs of gay patients. If the health professional feels uncomfortable with a homosexual patient, it is vital that he or she refer the patient elsewhere rather than avoid the topic of sexual practices. Many (Curran, 1983; Judson, 1982; Ostrow et al., 1983; Owen, 1983; Vaisrub, 1983) believe that what is needed is an ability by health care providers to tolerate different sexual preferences even if the practices are unacceptable to the health provider.

Finally, Feldman and Morrison (1982) reported that changing the approach to clinical patients may make significant differences in terms of accuracy of diagnosis and tracing of contacts. These authors emphasized that to accomplish the change, health care providers must establish rapport and indicate acceptance of variations in sexual orientation of patients with STDs.

#### Summary

Sexually transmitted diseases are a major health problem and are frequently associated with some homosexually active men. The prevalence of STDs among homosexual men appears to be due to characteristics both of organisms and of the various body sites involved, particularly the anatomic and functional properties of the rectum. The problems is compounded by a variety of sexual practices which includes having a large number of sexual partners. Liberalization of laws against homosexuality and an increase in available sex partners may have also contributed to higher morbidity from STDs among the population of homosexual men. Anti-gay attitudes, both real and imagined, compound the problem by deterring patients from seeking care and by preventing them from obtaining adequate care when they seek it. Free standing clinics for STDs sponsored by homosexual communities have been successful in motivating

patients to seek routine diagnostic treatment and services. Despite this success, STDs are epidemic in the homosexual community. As was noted in the literature, a primary requirement for effective control of STDs may well be the health care professional's approach to the gay patient. However, most of the research efforts to date have not been clarified the volunteer examiner's role in STD settings.

## CHAPTER 3

### PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This study followed a quasi-experimental two-group posttest only design (Shortell & Richardson, 1978). The experimental group included those volunteer examiners who were oriented by the Falkenhagen Training Module before they began to examine and evaluate the clients. The control group included those volunteer examiners without prior exposure to the Falkenhagen Training Module. For the purpose of this study, the posttest was the audit tool. The dependent variable was the audit performance score, and the independent variable was the use of the training module.

#### Setting

The setting for this study was a free standing clinic for STDs located in a large community of homosexuals within a large metropolitan area. The clinic is the second largest of its type in the United States. The clinic is housed in a former residence that has been renovated into separate areas designated as admitting, waiting, examination, storage, and offices. Hours of operation are Monday, Tuesday, and Thursday evenings from 6:00 to 9:30 p.m. and Sunday from 1:00 to 4:30 p.m. STD screening and other clinic services

are affordable and most can be reimbursed through medical insurance plans.

The clinic is a nonprofit organization which operates under a Board of Trustees and is a member of the Texas Hospital Association. Administrative staffing consists of four paid members: clinic manager, clinic sessions supervisor, secretary, and cashier. All other clinic staff members are volunteers. The number of volunteer examiners varies between 10 and 16. During operating hours, staffing consists of a staff clinic manager or clinic sessions supervisor, volunteer physician, examiners, phlebotomist, medication technician, and a receptionist. Patient visits average 300 monthly, totalling over 10,000 since the clinic's opening in October, 1981. The patient population is 95% homosexual and 5% bisexual with most referred by word of mouth. The volunteer staff of examiners has no formal orientation. In 1984, an examiner's training module, the Falkenhagen Training Module (Appendix A), was developed and used by clinic staff. To date, there had been no evaluation of the training module. To evaluate the effectiveness of the training module, this study used an audit tool, the Falkenhagen Audit Tool. The study was conducted during regular clinic hours between August, 1985, and February, 1986.

### Population and Sample

The target population for this study includes those persons who had been or were volunteer examiners at the selected STD clinic from January, 1985, through February, 1986. Subjects in this study were the first 12 volunteer examiners who performed independent assessment and diagnosis of clients with STDs after orientation by use of the Falkenhagen Training Module (experimental group). To measure the effectiveness of the training module, chart audits of client records prepared by the experimental group were compared to chart audits of client records prepared by 12 examiners who had been exposed to the Falkenhagen Training Module (control group).

### Protection of Human Subjects

A letter explaining the study proposal was sent to the Medical Director of the clinic for study approval (Appendix C). Also included was a letter to the potential participants explaining the study, assuring confidentiality, and asking for voluntary participation (Appendix D). Additionally, copies of both letters were sent to the clinic manager.

Although this study is exempt from Texas Woman's University Human Subjects Review Committee review, their guidelines were followed. Confidentiality was maintained at



all times and no identification of individual subjects was made during data analysis. Each examiner invited to participate was advised of the following before becoming a subject:

1. The general purpose and procedures of the study were explained.
2. Notification that participation or lack of participation did not affect continued volunteer work efforts at the clinic was stated.
3. Confidentiality of subjects was maintained at all times.
4. Research results were available from the investigator at the completion of the study.
5. No medical service or compensation were provided to subjects by the university as a result of any injury from participation in this research.
6. An attempt was made to respond to any questions from the examiners arising as a result of this study.

### Instruments

Instruments used in this study included a demographic data sheet, the Falkenhagen Training Module, and the Falkenhagen Audit Tool. Each was developed by the investigator. The demographic data sheet was completed by each volunteer examiner and included the following: sex,

age, work experience in the health care system, and length of experience volunteering at the clinic (Appendix D).

The Falkenhagen Training Module was developed by the investigator in the spring of 1984 and was used by the volunteer examiners since that time. It was structured according to the 1982 "Sexually Transmitted Treatment Guidelines" published by the Center for Disease Control in Atlanta, Georgia. As clinic procedures had been updated and the Center for Disease Control recommendations revised, the training module had been modified. Content of the module includes an introduction, description of major STDs, charting procedure and patient presentations with diagnostic procedures and medication guidelines (Appendix A). A panel of three experts consisting of the clinic's medical director, clinic manager, and session supervisor was consulted to establish content validity (Shortell & Richardson, 1978).

The Falkenhagen Audit Tool (Appendix B) was developed by the investigator and consists of 78 questions to measure assessment and diagnosis performance of the volunteer examiners. A three-member panel examined the audit tool for content validity. The panel consisted of a chairperson for quality assurance, a director of research, and an infection control nurse of a large research hospital.

### Data Collection

The data collection took place during a 6-month period from August, 1985, through February, 1986. All volunteer examiners in the experimental group received a verbal explanation of the purpose and study procedures. When the volunteer agreed to participate, a letter of informed consent was presented along with the demographic data questionnaire. When more than one volunteer examiner was present, a group inservice was given on the use of the training module. When only one examiner was present, the training module was reviewed on a one-to-one basis. The volunteer examiner was instructed to proceed with the use of the training module. The audit tool was used by the investigator to assess the diagnosis practices of the volunteer examiners, as recorded in the charts. In the control group, an audit tool was utilized by the investigator to do a retrospective chart review of charts of volunteer examiners who had completed an assessment and diagnosis of clients with STDs since January, 1985, but who have not had access to the Falkenhagen Training Module.

### Treatment of Data

Descriptive statistics were utilized to describe and summarize the data (Polit & Hungler, 1983). The mean, median, mode, standard deviation, frequency, and percentage

were calculated for the ratio levels of age and length of time volunteering at the clinic (Polit & Hungler, 1983). The mode and absolute frequency (percentage) were calculated for the nominal levels of sex and health care knowledge. A descriptive table was constructed to display the absolute and relative frequencies of the demographic variables of sex, age, health care knowledge, and length of time volunteering at the clinic.

A bar graph depicted the absolute and relative frequencies of audit scores of volunteer examiners who used the Falkenhagen Training Module as compared to those volunteer examiners who did not use the Falkenhagen Training Module. A two-sample  $t$ -test was used to compare the mean audit scores of volunteer examiners who used the Falkenhagen Training Module as compared to those who did not use the module. The level of significance was set at  $p \leq .05$ .

## CHAPTER 4

### ANALYSIS OF DATA

The quasi-experimental two-group posttest only study measured the difference between volunteer examiners who performed assessment and diagnosis of clients with STDs, after use of the Falkenhagen Training Module, and volunteer examiners not exposed to the Falkenhagen Training Module. A description of the sample is presented, followed by a report of the study findings. The chapter concludes with a summary of findings.

#### Description of the Sample

The sample included persons who had been volunteer examiners at the selected STD clinic from January, 1985, to February, 1986. The experimental group consisted of 12 volunteer examiners who performed independent assessment and diagnosis of clients with STDs following orientation by use of the Falkenhagen Training Module. The control group consisted of 12 examiners who performed independent assessment and diagnosis of clients with STDs without orientation by use of the Falkenhagen Training Module. Data were collected over a 6-month period from August, 1985, to February, 1986.

Demographic data were collected from each of the 12 volunteer examiners in the experimental group. Although demographic data were not available from the 12 volunteer examiners in the control group, there was no reason to believe these examiners were different from the experimental group. The demographic data included information on age, sex, work experience in the health care system, and length of time volunteering at the clinic. Specific characteristics of the volunteer examiners are presented in Table 1.

Age distribution for the experimental group of 12 volunteers varied from 21 to 39 years; the mode was 21 years. Ten (83.4%) of the volunteers were male, and 2 (16.6%) were female. A breakdown of the 12 volunteers' work experience in the health care system revealed that five (41.7%) had formal training in health care, including one medical student, two paramedics, and two technicians. The remaining seven persons described their background as other. The Other category included non health-related occupations, such as education, construction, and club management.

Regarding experience at the clinic, 10 (83.4%) of the volunteer examiners had 1-4 weeks of experience, 1 (8.3%) had 5-8 weeks of experience, and 1 (8.3%) had 9-12 weeks of experience. Hence, the majority of the 12 volunteer examiners had 1-4 weeks of experience at the clinic and did not have formal training in health care delivery.

Table 1  
Demographic Data of 12 Volunteer Examiners  
in Experimental Group

Characteristics	<u>n</u>	%
<u>Age (Years)</u>		
21-25	5	41.6
26-30	3	25.0
31-35	2	16.7
36-40	<u>2</u>	<u>16.7</u>
Total	12	100.0
<u>Sex</u>		
Female	2	16.6
Male	<u>10</u>	<u>83.4</u>
Total	12	100.0
<u>Work Experience in the Health Care System</u>		
Medical Student	1	8.3
Paramedic	2	16.7
Technician	2	16.7
Other (Educator, Construction, Club Manager)	<u>7</u>	<u>58.3</u>
Total	12	100.0
<u>Length of Time Volunteering at Clinic (Weeks)</u>		
1-4	10	83.4
5-8	1	8.3
9-12	<u>1</u>	<u>8.3</u>
Total	12	100.0

### Findings

The following hypothesis was proposed for this study: Volunteer examiners taught assessment and diagnosis procedures through the use of a training module (experimental group) will have a higher score on assessment and diagnosis skills as measured by the audit tool than will volunteer examiners who do not use the training module (control group).

The Falkenhagen Training Module was used as the training module, and the Falkenhagen Audit Tool was used as the audit tool. The experimental group consisted of 12 volunteer examiners who performed independent assessment and diagnosis of clients with STDs following orientation by use of the Falkenhagen Training Module. The control group consisted of 12 chart audits of client records prepared by examiners who had not been exposed to the Falkenhagen Training Module.

The total possible score on the Falkenhagen Audit Tool was 78. There were 78 questions; each correct response was allotted 1 point. Audit scores of the 12 volunteer examiners in the experimental group, oriented with the Falkenhagen Training Module, varied from 66 to 72 and are presented in Figure 3. Measures of central tendency of the 12 scores from the experimental group are as follows: the mean was 69.92; the median was 70.25; and the standard



deviation was 2.10. Audit scores of the 12 volunteer examiners in the control group, not oriented with the Falkenhagen Training Module, varied from 29 to 71 and are also presented in Figure 3. Measures of central tendency of the 12 scores from the control group are as follows: the mean was 52.25; the median was 52.75; the mode was 53; and the standard deviation was 12.17.

To determine if a statistically significant difference existed between the mean audit scores of the experimental and control groups, a two-sample  $t$ -test was completed. The  $t$  value was 4.8 with  $p \leq .05$  to support the hypothesis that there was a difference between the two groups. The experimental group, oriented with the Falkenhagen Training Module, scored significantly higher than the control group in measures of assessment and diagnosis.

### Summary of Findings

This quasi-experimental two-group posttest only study measured the effectiveness of the Falkenhagen Training Module. The experimental group consisted of 12 volunteer examiners who performed assessment and diagnosis of clients with STDs following use of the Falkenhagen Training Module. Age distribution varied from 21-39 years; 10 subjects were male and 2 were female. A breakdown of the 12 volunteers' work experiences in the health care system revealed that

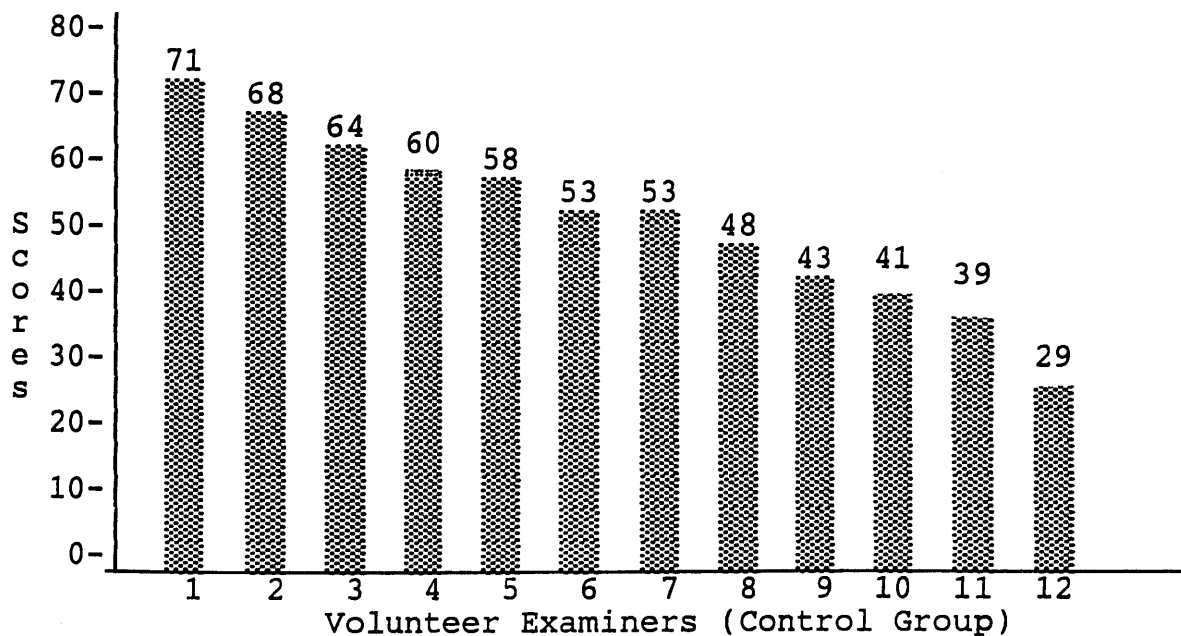
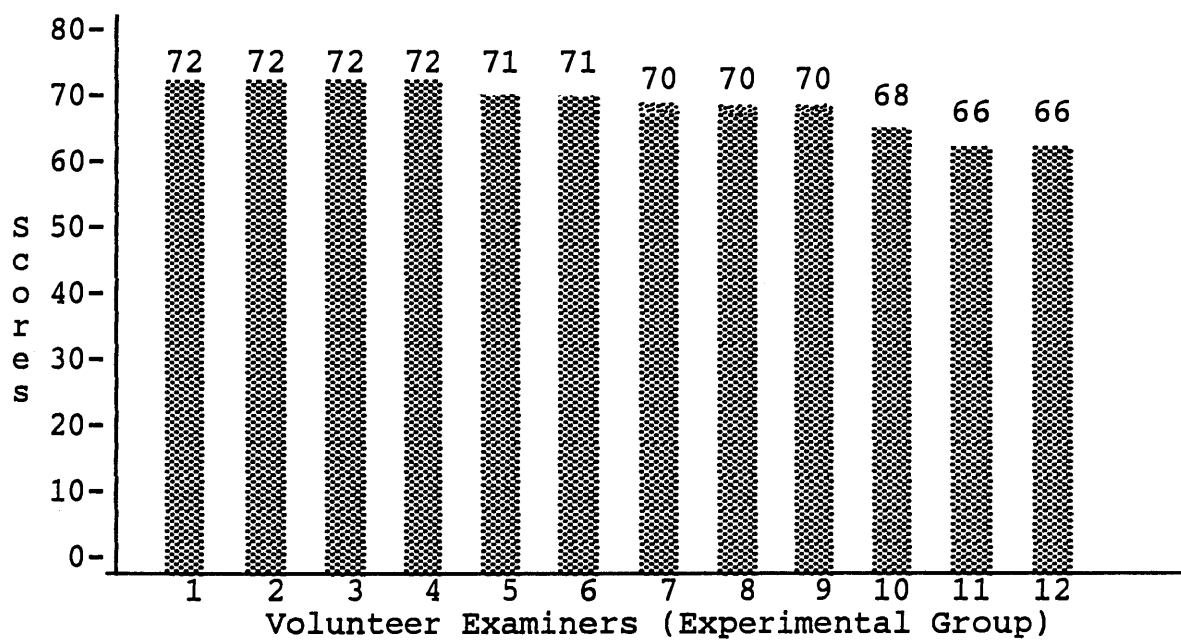


Figure 3. Chart Audit Scores of 12 Volunteer Examiners Exposed to Training Module (Experimental Group) and 12 Volunteer Examiners Not Exposed to Training Module (Control Group)

five (41.7%) had formal training in health care and included one medical student, two paramedics, and two technicians. The remaining seven persons described their background as other. The Other category included non health-related occupations such as education, construction, and club management. The majority of the 12 volunteer examiners had 1-4 weeks of experience at the clinic and did not have formal training in health care delivery. The mean audit scores of volunteer examiners who performed assessment and diagnosis of clients with STDs following use of the Falkenhagen Training Module were statistically significantly ( $p \leq .05$ ) higher than volunteer examiners who performed assessment and diagnosis of clients with STDs without use of the Falkenhagen Training Module.

## CHAPTER 5

### SUMMARY OF THE STUDY

The past decade has witnessed a growing awareness that homosexual men are at an increased risk for a variety of STDs. The sexual liberation movement has allowed open expression of their sexuality, and consequently, communities of homosexual males have formed in urban settings. Both the increased prevalence of STDs among homosexuals and a lack of accessible and acceptable public and private care facilities has resulted in the emergence of free standing volunteer clinics for the diagnosis and treatment of STDs. These clinics are frequently staffed by volunteers from a variety of health and non-health related professions. Often due to the varied backgrounds of the volunteers and their limited knowledge and experience, there could be no assumption that they are familiar with procedures in the care of the STD client (Ostrow, Sandholzer, & Feldman, 1983). Assessment and diagnosis practices of volunteer health care providers at free standing clinics for STDs have not been studied (Ostrow et al., 1983). Presently there are no accepted, standard protocols in use at free standing clinics. Therefore, the Falkenhagen Training Module was developed to see if its use would make a difference. The purpose of this

study was to determine if volunteer examiners taught assessment and diagnosis procedures through the use of a training module would complete a higher percentage of assessment and diagnosis skills as measured by an audit tool as compared to volunteer examiners who did not use the training module. A summary, discussion of the findings and conclusions and implications of the findings are presented along with recommendations for further study.

#### Summary

This study was a quasi-experimental, two-group posttest only design. The target population included those persons who had been or were volunteer examiners at the selected STD clinic from January, 1985, to February, 1986. The 12 volunteer examiners in the experimental group received a verbal explanation of the purpose and study procedures. The volunteer examiner was then instructed in the use of the training module. An audit tool was used by the investigator to assess the diagnosis practices. In the control group, the audit tool was utilized to do a retrospective chart review of 12 volunteer examiners who did not have access to the training module, but who had completed an assessment and diagnosis of clients with STDs. Variables of age, sex, work experience in the health care system, and length of time volunteering at the clinic were reported.

Age distribution for the experimental group of 12 volunteers varied from 21 to 39 years; 10 were male and 2 were female. Work experience of the 12 volunteers in the health care system revealed that 5 (42.7%) had formal training in health care, including one medical student, two paramedics, and two technicians. The remaining seven persons described their background as other. This category included non health-related occupations such as education, construction, and club management.

Regarding experience at the clinic, 10 (83.3%) of the volunteer examiners had 1-4 weeks of experience, 1 had 5-8 weeks of experience, and 1 had 9-12 weeks of experience. The majority of the 12 volunteer examiners had 1-4 weeks of experience at the clinic and did not have formal training in health care delivery.

To determine if a statistically significant difference existed between the mean audit scores of the experimental and control groups, a two-sample  $t$ -test was completed. The mean audit scores of volunteer examiners who performed assessment and diagnosis of clients with STDs following use of the Falkenhagen Training Module were statistically significantly higher ( $p \leq .05$ ) than volunteer examiners who performed assessment and diagnosis of clients with STDs without the use of the Falkenhagen Training Module.

### Discussion of Findings

After introduction of the Falkenhagen Training Module to the experimental group of volunteer examiners, chart audit of records prepared by volunteer examiners not exposed to the module, and comparison of mean scores, numerous findings were identified. The audit scores in the experimental group of 12 volunteer examiners oriented with the Falkenhagen Training Module varied from 66 to 72. The audit scores in the control group of 12 volunteer examiners not oriented with the Falkenhagen Training Module varied from 29 to 71. The mean score in the experimental group was 69.92. The mean score in the control group was 52.25. The statistically significant ( $p \leq .05$ ) difference of scores as measured by the  $t$ -test was 4.8. The majority (83.4%) of volunteer examiners in the experimental group had no formal medical training or education, yet with the training module they were able to score higher than volunteer examiners with no training module. The majority of the volunteer examiners had only 1-4 weeks of experience at the clinic. This is congruent with Ostrow et al. (1983) who reported that volunteers in free standing clinics are limited in their experience regarding assessment and care of clients with STDs.

Traditionally, there are two settings for STD service delivery, the private physicians' office and the public health clinic. Feldman and Morrison (1982) found that homosexual men are deterred from seeking STD checkups in private physicians' offices because of required open admission of their sexual preference. Sandholzer's (1981) research reported that over one-third of the physicians in private practice were uncomfortable when treating homosexual patients. Their own discomfort caused many physicians to overlook the issue of the patient's sexual preference.

Ostrow et al. (1983) reported that gay men have a variety of unique medical problems such as unmet psychosocial needs and exposure to treatment resistant diseases that are related to their lifestyle and have not been addressed by traditional health care. As a result of the lack of facilities and programs to meet these needs, the emergence of free standing clinics for the diagnosis and treatment of STDs have formed and persisted in urban settings. Free standing clinics, sponsored by homosexual communities, are dedicated to screening and treatment of STDs and have been successful in motivating patients to seek routine diagnostic and treatment services. The clinics focus attention on the unmet health care needs of homosexual



men and demonstrate that community-sponsored clinics have matured into major centers for delivery of specialized health care in support of the urban gay.

In this study, the utilization of a training module significantly increased competencies of volunteer examiners which demonstrated that education makes a difference in the role of the learner. During the past decade, learning modules have become practical ways of teaching. Mast and Van Atta (1986) reported that modules require minimal instructor involvement, can be portable and flexibly scheduled, and can creatively incorporate varied learning resources and strategies. Teaching strategies through the use of a training module, as described by Tornyay and Thompson (1982), enhances learner individualization, performance, and motivation, and allows the learner to control experiences.

In this study, the value of an appropriate training module increased assessment and diagnosis scores of volunteer examiners. This finding is in agreement with Bigge (1976), who reported that learning through an educational process is a change in knowledge, skills, attitudes, values, or commitments. Further, as learning continues, there is a process of gaining insights, outlooks, expectations, or changing thought patterns.

### Conclusions and Implications

Based on the findings of this study, utilization of a training module significantly ( $p \leq .05$ ) increased assessment and diagnosis practices of 12 volunteer examiners at a free standing clinic for STDs as measured by an audit tool, compared to 12 volunteer examiners who did not use the training module. Presently there are no accepted, standard protocols in use at free standing STD clinics. Therefore, orientation programs for volunteer examiners at free standing STD clinics should include a formal training module followed with an audit tool.

This study found that the majority of volunteer examiners had 1-4 weeks or minimal experience at the selected STD clinic, and had no formal training or education, yet they performed better on assessment and diagnosis of STDs following use of a training module. These clinics are frequently staffed by volunteers from a variety of backgrounds. Often, due to the varied background and limited knowledge and experience in the care of the STD client, there could be no assumption that volunteers are familiar with appropriate procedures (Ostrow et al., 1983). Most efforts to date have not been able to clarify the volunteer examiner's role in the STD clinic setting. The use of volunteer examiners not prepared in the specifics of

STD treatment and diagnosis has necessitated the development and implementation of a training module. These findings indicate that education through the use of a training module enhanced the learning process by a change in knowledge and skills. This is supported by Bigge (1976) who documented that as learning continues, there is a process of gaining insights, outlooks, expectations, or changing thought patterns.

Assessment and diagnosis skills of volunteer examiners in the selected STD clinic can be measured with an audit tool. The application and implication of appropriate assessment, diagnosis, and treatment of the STD client is essential in controlling transmission. Many of the volunteer examiners were actually clients of the clinic and therefore personally interested in the accuracy and completeness of client treatment. The volunteer examiners were enthusiastic and supportive of inservice and the use of the training module as a resource and method of patient interaction, assessment, and documentation.

The Falkenhagen Training Module can be evaluated with an audit tool. The development and availability of an audit tool to measure assessment and diagnosis practices through the use of a training module will encourage other free

standing community-sponsored STD clinics to focus attention on maximizing the delivery of specialized patient care.

Nurse educators could respond to the findings of this study by encouraging community oriented students to explore opportunities in related clinic settings. These opportunities would include the opportunity for future program development and implementation.

#### Recommendations for Further Study

Based upon the findings of this study, the following recommendations are offered:

1. This quasi-experimental two-group posttest only study should be replicated using a larger sample so the findings can be generalized beyond the study population.
  2. This study should be replicated utilizing a volunteer examiner group from a second free standing clinic for STDs as a control group to increase the sample size.
  3. A descriptive study should be undertaken to evaluate volunteer examiner satisfaction with the training module.
  4. The Falkenhagen Training Module should continue to be evaluated at 3, 6, and 9-month intervals after use.
- Also, clinic managers and tenured volunteer staff should be involved through their input, suggestions, and recommendations.

5. The Falkenhagen Training Module and the Falkenhagen Audit Tool should be disseminated to public and private clinics that treat STDs.

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APPENDIX A  
FALKENHAGEN'S TRAINING MODULE FOR  
SEXUALLY TRANSMITTED DISEASES

FALKENHAGEN'S TRAINING MODULE FOR  
SEXUALLY TRANSMITTED DISEASES

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### INTRODUCTION

The purpose of this training module is to provide volunteer examiners assistance in performing independent assessments and establishing a diagnosis for patients with suspected STDs. It provides introductory information on patient processing, major STDs, charting, diagnostic and lab procedures with medication guidelines.

### PATIENT PROCESSING

1. Upon arrival all patients will register with the registration clerk to prepare a medical record.
2. Clinic information can be received through the Patient Information Sheets and the Patient Information Bulletin Board.
3. Once registration is completed, the patient will pay the \$20 registration fee to include RPR, in-house STD exam, lab services and medications.
4. All patients proceed to the phlebotomy area to have their blood drawn for the RPR (Rapid Plasma Reagin Test for Syphilis). Additional tests will be determined by the screener.
5. The patient will return to the waiting area.
6. The registration clerk will place the charts in the following boxes:  
NEW PATIENT: New or former patient with a new problem.  
T.O.C.: Test of cure of treatment previously received.  
DOCTOR: Specific patient request and all females.
7. Volunteer examiners will call patients by chart numbers and proceed with examinations.
8. If in-house lab testing is required, the patient will wait in the waiting area for results. The patient's chart goes to the lab.
9. When in-house testing is completed, the volunteer examiner will call patients back to discuss results, treatment and follow up.
10. If medications are ordered, the patient and chart proceed to the treatment area.
11. Any unresolved problems or concerns should be referred to the clinic physician on duty.
12. All completed charts must be signed by the clinic physician.
13. Any questions concerning clinic procedures should be directed to the clinic manager or clinic sessions supervisor.

### DESCRIPTION OF MAJOR STDs

Gonorrhea: The causative organism for gonorrhea is *Neisseria Gonorrhoeae*, a gram-negative diplococcus. Gonorrhea infection generally causes burning or urination and/or discharge in men within the first two weeks of infection. Laboratory testing with a gram-stain smear and culture is needed to confirm diagnosis.

Nongonococcal Urethritis: Urethritis in men which is not caused by gonorrhea. Symptoms are similar but less severe than those of urethral gonorrhea. Diagnosis is via smear of discharge and culture to exclude gonorrhea.

Postgonococcal Urethritis: A variant of non-gonococcal urethritis, present when urethritis recurs after successful treatment for gonorrhea. A gram-stain smear is done to determine the cause. If the smear is negative for gonorrhea, the patient should be treated as a non-gonococcal urethritis. If the smear is positive for gonorrhea, the patient should be treated as a gonococcal urethritis treatment failure and medicated with Spectinomycin.

Penicillinase-Producing Gonococci (PPNG): Recurrent gonococcal infection after treatment with penicillin and often considered a treatment failure. All positive test of cure cultures should be screened by PPNG. Spectinomycin is the drug of choice.

Syphilis: A systemic sexually transmitted disease clinically occurring in several stages. Primary and secondary stages usually end six months to one year after the disease has been acquired. Latency may last several years.

Primary: Manifested by the appearance of a painless lesion or chancre. Usually appears three to four weeks after contact and often is accompanied by a non-tender swelling of nearby lymph nodes.

Secondary: Generally presents as a rash on the extremities after the appearance of the primary chancre. There may also be organ involvement.

Latent: Slowly progressive phase affecting the nervous or cardiovascular system. Occurrence can be 1 to 20 years later if untreated. Diagnosis is by serological testing.

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Source: U.S. Department of Health and Human Services. (1979). Sexually transmitted disease fact sheet. Atlanta: Public Health Centers for Disease Control.

Herpes Simplex: Herpes is a viral infection of the skin which can be transmitted via intimate contact. There are two viruses which can cause herpes simplex:

Type I: Infects the tissue around the lips or in the mouth.

Type II: Or genital herpes is usually found in the genital area. Both can be found in either location.

Primary infection of the genital area usually begins three to seven days after infection. The patient may note an area of burning, tingling or pain in the genital area; then small gro-ped blisters, which ulcerate, will appear. Associated with these lesions may be swollen lymph nodes and fever. The primary infection usually persists for several weeks, heals spontaneously, then may recur. Diagnosis is made from clinical presentation with cultures of lesions as indicated, by clinic physician.

Acquired Immune Deficiency Syndrome (AIDS): An acquired immunodeficiency syndrome (AIDS) which has been associated with the opportunistic infections of Kaposi's Sarcoma and Pneumocysti Carinii Pneumonia. Many symptoms associated with AIDS are nonspecific. They include: fatigue, fever, chills, night sweats, unexplained weight loss, swollen lymph nodes, shortness of breath, and persistent diarrhea. Diagnosis is determined by serological testing, skin testing and extensive patient interviewing to determine sexual history and practices (Center for Disease Control, 1984).

Hepatitis: An inflammation of the liver caused by infection, drugs, alcohol or chemicals. Type A is called infectious, Type B serum and Type C a non A/B hepatitis. All three are infectious and can be transmitted by intimate or sexual contact. Hepatitis B has emerged as an important STD, especially among homosexual men. Onset of symptoms varies and can include: fatigue, decreased appetite, nausea, vomiting, depression, fever, joint aches and dark brown urine. Diagnosis is by serological testing.

Granuloma Inguinale: Swelling and infection in the inguinal area, followed by grain-like ulcers. It is a contagious process. Diagnosis is by clinical inspection and smear from the exudate or by biopsy.

Lymphogranuloma Venereum: A painless lesion developing on the genital or anorectal area. Diagnosis is made by examination of the lesion exudate.

Moniliasis or Candida: A yeast-like fungus causing vaginal discharge in women or a watery urethral discharge in men. Diagnosis is made by microscopic examination of the discharge, and treated with nystatin cream and douches.

Condylomata Acuminata (Veneral Warts): A viral infection which presents as a cauliflower-like growth in the genital area. Diagnosed by their appearance and should be referred to the clinic physician. Treatment of small warts is with Podophyllin and may require several applications. Larger warts may be treated with electrocoagulation, freezing with liquid nitrogen or surgery.

Pubic Lice or Crabs: Caused by the crab louse which infects the hair of the pubic region where eggs or nits are attached to the hairs. Patients usually report itching and diagnosis is made by identification of the louse or eggs in the pubic hair. Treatment is with Lindane or Kwell Lotion, which require a prescription. To prevent reinfection, recommendation is made to launder all bedding and clothing.

Scabies: Superficial skin infection caused by the scabies mite which produces a rash most often located on the hands or wrists. Diagnosis is established by clinical presentation and identification of the mite. Treatment is with Lindane or Kwell Lotion, which require a prescription.

### CHARTING PROCEDURE

The patient's decision to come to the clinic is the first step toward rapport and implied trust. The examiner should be concerned, yet professional, in conducting the interview. Confidentiality should always be maintained. The initial history sets the tone for the examiner-patient relationship. The purpose of the interview is equally important in eliciting information essential to assure accurate definition of the problems and lead to successful patient management. The interview and documentation process is completed according to the SOAP approach as described below:

S = SUBJECTIVE DATA: The history and symptoms as described by the patient pertinent to the problem.

1. Basic medical history includes:
  - a. Reason for visit.
  - b. Patient symptoms.
2. Focus on the character of symptoms.
  - a. Onset, duration and severity.
  - b. Frequency in relationship to sexual intercourse.
3. Record associated symptoms such as rashes and any prior STDs types, episodes and treatments.
4. Review recent sexual activity.
  - a. Time since last sexual exposure.
  - b. Specific exposure site.
  - c. Medical problems of partners.
5. Record drug allergies and present drug usage.

O = OBJECTIVE DATA: Includes the patient's physical and laboratory findings.

1. Examine the patient: inspect skin, throat, mouth, lymph nodes, pubic hair, genital and rectal areas.
2. Observe specific symptoms such as a discharge, rash or lesions.
3. Determine appropriate laboratory requests from clinical presentation, to include blood work, smears and cultures.
4. Record findings in a descriptive manner on clinic chart.

A = ASSESSMENT: Includes the diagnosis or diagnostic conclusion.

1. Review patient history, symptoms and laboratory findings.
2. Review STD synopsis information to decide plan of action.

P = PLAN: The management of the problem by treatment rendered, further diagnostic procedures, counseling given, referral information and follow-up visits.

1. Communicate to patient the diagnosis, treatment plan, along with educational instruction and return visit information.
2. Document treatment plan and instructions for follow-up visit.



MAJOR CLINIC PATIENT PRESENTATIONSASYMPTOMATIC PATIENT:

Proceed with STD screening and examination.

- a. RPR for Syphilis
- b. History and Physical
- c. Smear and cultures from examination, as indicated.
- d. Treat all recent exposures to a STD as if the patient actually had an STD.
- e. Refer unusual problems, uncertain diagnosis or concerns to clinic physician.
- f. Refer all women to clinic physician.

SYMPTOMATIC PATIENT:

Usually presents in one of eight major categories below:

1. Gonorrhea
2. Nongonococcal Urethritis
3. Postgonococcal Urethritis
4. Penicillinase-Producing Gonocci (PPNG)
5. Syphilis
6. Hepatitis B
7. Herpes
8. AIDS

1. GONORRHEA:

CLINICAL MANIFESTATIONS:

URETHRAL: Urethritis with a purulent discharge often with burning on urination.

RECTAL: May be asymptomatic or present with rectal irritation, mucous or blood streaked stools.

ORAL: By exception. Refer to clinic physician.

Diagnosis is made by smear of discharge in house with immediate results. Cultures are also done and go to the City Health Department with results in four days. Refer to diagnostic procedure for smear and culture samples. Treatment includes following CDC medication guidelines listed under medication procedure. Follow-up will include instructing the patient not to have sex with another person for a minimum of one week. Any recent contacts should be notified and treated for gonorrhea exposure. Test-of-cure exam will take place one week after treatment and includes a urethral or rectal culture as indicated.

2. NONGONOCOCCAL URETHRITIS: Symptoms are similar but less severe than those of gonorrhea. Clinical examination and smear of discharge is the same as for gonorrhea. Patient is treated for exposure to nongonococcal urethritis and treated according to CDC medication guidelines listed. Follow-up and test-of-cure instructions are the same as those for gonorrhea.

3. POSTGONOCOCCAL URETHRITIS: Common complication following treatment for gonococcal urethritis, usually two to three weeks later. Patient presents with a mild dysuria and scant mucoid discharge. A smear is done to determine cause. If the in-house smear is negative, the patient is treated for non-gonococcal urethritis with appropriate medications. If the in-house smear is positive, the patient is treated as a gonococcal urethritis treatment failure or possible penicillinase producing gonococci which is resistant to penicillin and treated with Spectinomycin, according to the CDC guidelines.
4. PENICILLINASE-PRODUCING GONOCOCCI (PPNG): The patient in whom gonorrhea persists after treatment. Recurrent gonococcal infections after treatment may be due to reinfection or resistance to penicillin. All positive test of cure cultures should be screened for PPNG by doing another culture and marking it "possible PPNG." All suspected PPNG patients and their contacts should be treated with 2 gm of IM Spectinomycin and have follow-up.
5. SYPHILLIS: Clinical examination done to determine which stage the patient is in. In-house RPR gives only a positive or negative. Medications are ordered according to results. Health department RPR gives a titer reading, but takes four days. Cultures are done per physician and sent to city health department. Follow-up treatment includes instructing the patient not to have sex with another person for a minimum of one week. The patient should return for test-of-cure in one week and repeat RPR's in one, two, three, six, and twelve month intervals to make certain their titers continue to drop.
6. HERPES: Diagnosis is made on clinical presentation. Patients should be referred to clinic physician for cultures of lesions, as indicated.
7. HEPATITIS B: Interview patient and record symptoms. Explain screening and vaccination program to the patient. Have blood drawn for Hepatitis B screen. Blood is sent to a private lab and takes four days for results. Patient should return one week after initial exam for results. If results are positive, the patient does not need the vaccine. If the results are negative, the vaccination program begin.

8. PACE SCREENING PROGRAM FOR AIDS PATIENTS: Determine preliminary diagnosis on review of patient symptoms. Refer patient for physical examination and interview to clinic physician. Screening process is done on three different nights.

MONDAY - CBC with platelet differential is drawn. Forms and questionnaire completed.

TUESDAY - Skin testing with three antigens of tetanus, mumps and candida are completed by a nurse.

THURSDAY - Reading of skin test in 48 hours by clinic physician.

DIAGNOSTIC PROCEDURESURETHRAL SMEAR:

1. Utilize slide, labeling it with patient's name, number and source.
2. Utilizing thumbs, have patient strip urethra toward orifice to milk and express exudate.
3. Utilizing calcium alginate swab, insert into tip of penis and hold for no less than fifteen seconds.
4. Roll swab very gently on the slide to avoid cell damage.
5. Take slide to lab.
6. Log test desired on lab log sheet.
7. Place chart in pending lab rack in lab.

RECTAL SMEAR:

1. Utilize slide, labeling it with patient's name, number and source.
2. Place a sterile swab approximately one inch into the rectum.
3. Hold in place for fifteen seconds.
4. Roll swab very gently on the slide to avoid cell damage.
5. Take slide to lab.
6. Log test desired on lab log sheet.
7. Place chart in pending lab rack in lab.

URETHRAL CULTURE:

1. Obtain Martin-Lewis Agar plate.
2. Utilizing a calcium alginate swab, follow steps two and three for obtaining urethral smear.
3. Roll the swab gently over the upper one third of the culture plate.
4. Label plate with patient's name, number and source.

RECTAL CULTURE:

1. Obtain Martin-Lewis Agar plate.
2. Utilizing a sterile swab, place approximately one inch into rectum and hold for fifteen seconds.
3. Roll the swab gently over the upper one third of the culture plate.
4. Label plate with patient's name, number and source.

MEDICATION GUIDELINES

APPG 4.8 MU = Aqueous Procaine Penicillin G = CRYSTICILLIN or Pen G Procaine  
Suspension, 6000,000 units per 1.2 ml  
dose

4.8 MU = Two syringes of 5cc each. One injection in each hip.

1 G PROB. = One gram of PROBENECID = Two 500 gm tabs of Probenecid orally.

AMP. 3.5 GM = 7 of the 500 mg caps of AMPICILLIN

TCN = TETRACYCLIN

10 G = 500 mg Qid for 5 days =	20 pills
20 G = 500 mg Qid for 10 days =	40 pills
30 G = 500 mg QID for 15 days =	60 pills
60 G = 500 mg QID for 30 days =	120 pills

SPEC. 2 GM = SPECTINOMYCIN 2.0 GM IM

BICILLIN LA 2.4 MU = Two injections of 1.2 MU

ERYTHROMICIN = 30 GM = 4 tabs of 500 mg Qid for 15 days  
60 GM = 4 tabs of 500 mg Qid for 30 days

GONOCOCCAL INFECTIONS (LISTED BY ORDER OF CHOICE)URETHRAL

1. APPG 4.8 MG (IM) & PROB. 1.0 GM (P.O.)
  2. AMP. 3.5 GM & PROB. 1.0 GM
- IF ALLERGIC TO PENICILLIN
3. TCN 10 GM (P.O.)
  4. SPEC. 2 GM (IM)\*

ORAL

1. APP 4.8 MU (IM) & PROB. 1.0 GM (P.O.)
- IF ALLERGIC TO PENICILLIN
2. TCN 10 GM
  3. SPEC. 2 GM\*

SYPHILIS

1. BICILLIN LA 2.4 MU (IM)
- IF ALLERGIC TO PENICILLIN
2. TCN 30 GM
  3. ERYTHROMICIN 30 GM

RECTAL

1. APPG 4.8 MU (IM) & PROB. 1.0 GM (P.O.)
- IF ALLERGIC TO PENICILLIN
2. TCN 20 GM
  3. SPEC. 2 GM\*

NONGONOCOCCAL URETHRITIS (NGU)

1. TCN 20 GM (P.O.)
2. ERYTHROMICIN 500 MG x 7 days QID

LATENT SYPHILLIS

1. BICILLIN LA 2.4 MU (IM) TIMES 3 WEEKS
- IF ALLERGIC TO PENICILLIN
2. TCN 60 GM
  5. ERYTHROMICIN 60 GM

\*SPECTINOMYCIN SHOULD BE USED FOR TREATMENT FAILURES & PPNG.

PATIENTS WHO HAVE BOTH GONORRHEA AND SYPHILLIS AT THE SAME TIME SHOULD BE GIVEN BOTH TREATMENT REGIMENS: FOR GONORRHEA & APPROPRIATE TREATMENT FOR SYPHILLIS.

PLEASE CHECK CDC's "STD TREATMENT GUIDELINES" FOR OTHER DISEASE TREATMENTS.

GUIDELINES AVAILABLE IN TREATMENT ROOM.

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Source: Center for Disease Control (1982, August 20). Sexually transmitted diseases treatment guidelines--1982. Morbidity and Mortality Weekly Report, 31, 355-605.

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APPENDIX B  
FALKENHAGEN'S AUDIT TOOL



## FALKENHAGEN'S AUDIT TOOL

A. CHARTING AND DOCUMENTATION:	YES	NO	N/A
1. Records patients reason for visit.	( )	( )	( )
2. Documents character of patient symptoms.	( )	( )	( )
3. Records patients prior STD's and treatments.	( )	( )	( )
4. Identifies and documents drug allergies.	( )	( )	( )
5. Records specific anatomy examined.	( )	( )	( )
6. Documents diagnostic conclusion.	( )	( )	( )
7. Orders diagnostic smear specific to diagnosis.	( )	( )	( )
8. Orders diagnostic culture specific to diagnosis.	( )	( )	( )
9. Defines treatment plan in writing.	( )	( )	( )
10. Records instruction for follow up visit.	( )	( )	( )
11. Records patient status as symptomatic or asymptomatic.	( )	( )	( )
12. Refers all women to clinic physician.	( )	( )	( )
B. MAJOR CLINICAL PRESENTATIONS:			
1. Gonorrhea			
a. Identifies clinical manifestation:			
1. Records urethral gonorrhea as discharge with burning on urination.	( )	( )	( )
2. Records rectal gonorrhea as rectal irritation, mucous or bloody stools.	( )	( )	( )
3. Refers patients with sore throat or difficulty in swallowing to clinic physician.	( )	( )	( )
b. Demonstrates operational knowledge of diagnostic smear of discharge:			
1. Records patient's name and identification number from slide in log.	( )	( )	( )
2. Records desired test on log sheet.	( )	( )	( )

	YES	NO	N/A
c. Demonstrates operational knowledge of diagnostic cultures:			
1. Records patient's name and identification number from culture in log.	( )	( )	( )
2. Records source.	( )	( )	( )
3. Records dispatch to City Health Department.	( )	( )	( )
d. Records diagnosis from smear of discharge results:			
1. Urethral gonorrhea	( )	( )	( )
2. Rectal gonorrhea	( )	( )	( )
e. Documents medication treatment plan:			
1. APPG - 4.8 mu (IM) and PROB - 1.0 GM (P.O.), or	( )	( )	( )
2. AMP - 3.5 GM (P.O.) and PROB - 1.0 GM (P.O.)	( )	( )	( )
3. TCN - 10 GM (P.O.) if allergic to penicillin.	( )	( )	( )
4. Spectinomycin 2 GM (IM) if previous treatment failure.	( )	( )	( )
f. Records instructions for follow up visit:			
1. Documents instruction to refrain from sex for one week.	( )	( )	( )
2. Documents informing patient to notify all recent contacts for treatment to gonorrhea exposure.	( )	( )	( )
3. Records test-of-cure visit date one week from initial exam.	( )	( )	( )
2. Nongonococcal Urethritis			
a. Identifies clinical manifestation:			
1. Records burning on urination.	( )	( )	( )
2. Records urethral discharge on examination.	( )	( )	( )
b. Demonstrates operational knowledge of diagnostic smear of discharge:			
1. Records patient's name and identification number from smear in log.	( )	( )	( )
2. Records desired test on log sheet.	( )	( )	( )
c. Records diagnosis from smear of discharge results:			
1. Nongonococcal urethritis.	( )	( )	( )
d. Documents medication treatment plan:			
1. TCN 20 GM (P.O.), or	( )	( )	( )
2. Erythromycin 500 MG x 7 days QID.	( )	( )	( )

	YES	NO	N/A
e. Records instructions for follow up visit:			
1. Documents instruction to refrain from sex for one week.	( )	( )	( )
2. Documents informing patient to notify all recent contacts for treatment of STD.	( )	( )	( )
3. Records test-of-cure visit date one week from initial exam.	( )	( )	( )
3. Postgonococcal Urethritis			
a. Identifies clinical manifestations:			
1. Records recurrent urethritis	( )	( )	( )
b. Demonstrates operational knowledge of diagnostic smear of discharge:			
1. Records patient's name and identification number from smear on log.	( )	( )	( )
2. Records desired test on log sheet.	( )	( )	( )
c. Records diagnosis from smear of discharge results:			
1. Records diagnosis as nongonococcal urethritis for negative smear.	( )	( )	( )
2. Records diagnosis as treatment failure for positive smear.	( )	( )	( )
d. Documents medication treatment plan:			
1. TCN 20 GM (P.O.) or Erythromycin 500 MG x 7 days QID for non-gonococcal urethritis	( )	( )	( )
2. Spectinomycin 2 GM (I.M.) for treatment failure.	( )	( )	( )
4. Penicillin producing Gonocci (PPNG)			
a. Identifies clinical manifestations:			
1. Records persistant gonorrhea after treatment.	( )	( )	( )
2. Records urethral gonorrhea as discharge with burning on urination.	( )	( )	( )
3. Records urethral gonorrhea as rectal irritation, mucous or bloody stools.	( )	( )	( )
b. Demonstrates operational knowledge of diagnostic culture:			
1. Records patient's name and identification number from culture in log.	( )	( )	( )
2. Records "Possible PPNG" in log.	( )	( )	( )
3. Records dispatch to City Health Department.	( )	( )	( )

	YES	NO	N/A
c. Records diagnosis from clinical manifestations:			
1. PPNG	( )	( )	( )
d. Documents medication treatment plan:			
1. Spectinomycin 2 GM (IM)	( )	( )	( )
e. Records instructions for follow up visit:			
1. Documents instruction to refrain from sex for one week.	( )	( )	( )
2. Documents informing patient to notify all recent contacts for treatment of S.T.D.	( )	( )	( )
5. Syphilis			
a. Identifies clinical manifestation:			
1. Documents location of lesion.	( )	( )	( )
2. Refers patient with skin eruption to clinic physician for culture.	( )	( )	( )
3. Records patient symptoms of possible organ involvement.	( )	( )	( )
b. Records clinical phase:			
1. Reviews in-house RPR results.	( )	( )	( )
2. Primary.	( )	( )	( )
3. Secondary.	( )	( )	( )
4. Latent.	( )	( )	( )
c. Documents medication treatment plan:			
1. Bicillin LA-2.4 MU (IM for primary and secondary stages.	( )	( )	( )
2. TCN 30 GM (P.O.), or Erythromycin 30 GM (P.O.) if allergic to penicillin for primary and secondary stages.	( )	( )	( )
3. Bicillin LA - 2.4 MU (IM) x3 weeks for latent stage.	( )	( )	( )
4. TCN - 60 GM (P.O.), or Erythromycin 60 GM (P.O.) if allergic to penicillin for latent stage.	( )	( )	( )
d. Records instructions for follow up visit:			
1. Records test-of-cure visit date one week from initial exam.	( )	( )	( )
2. Documents patient instruction for repeat RPR's in one, two, three, six and twelve month intervals.	( )	( )	( )
6. Herpes			
a. Identifies clinical manifestations:			
1. Records location of lesion.	( )	( )	( )
2. Records associated symptoms.	( )	( )	( )
3. Refers to clinic physician for cultures and drug therapy.	( )	( )	( )

	YES	NO	N/A
7. Hepatitis B			
a. Interviews patient:			
1. Records onset of symptoms.	( )	( )	( )
2. Documents screening and vaccination program.	( )	( )	( )
3. Orders blood drawn.	( )	( )	( )
4. Documents instruction for patient to call clinic in four days for lab results.	( )	( )	( )
8. A.I.D.S.			
a. Interviews patient:			
1. Records onset of symptoms.	( )	( )	( )
2. Refer to clinic physician for physical exam and screening process.	( )	( )	( )

APPENDIX C  
AGENCY APPROVAL

#7 Boulevard Green  
Bellaire, Texas 77401

Dr. Bedner  
Clinic Director  
1215 Walker  
Houston, Texas 77002

Dear Dr. Bedner,

I am a registered nurse pursuing a Master's degree in Community Health Nursing at Texas Woman's University. In 1984, an examiner's training module was developed by myself and used by the clinic staff. To date, there has been no evaluation of the training module. As part of my thesis project, I am proposing a study to evaluate assessment and diagnosis practices of the volunteer who uses this module. The anticipated length of this research project will be six months from August, 1985, through February, 1986. The major outcome of this study could be the use of this training module and audit tool for public and private clinics that treat STDs.

I have met regularly with Tom Audette, clinic manager, to discuss my plans for conducting the research for this study. He has been most cooperative and is anxious to assist with the implementation relative to the volunteer examiners.

Attached is a copy of the study proposal, letter of informed consent, training module and audit tool to be used. Thank you for your attention in this matter.

Sincerely,



K. Falkenhagen, RN, BSN

KF/rb  
Attachment

cc: Tom Audette, Clinic Manager

TEXAS WOMAN'S UNIVERSITY  
COLLEGE OF NURSING  
DENTON, TEXAS 76204

72

DALLAS CENTER  
1810 INWOOD ROAD  
DALLAS, TEXAS 75235

HOUSTON CENTER  
1130 M. D. ANDERSON BLVD.  
HOUSTON, TEXAS 77030

AGENCY PERMISSION FOR CONDUCTING STUDY\*

THE Montrose Clinic

GRANTS TO Kathy Falkenhagen

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:

EVALUATION OF A TRAINING MODULE FOR THE  
ASSESSMENT AND DIAGNOSIS OF SEXUALLY  
TRANSMITTED DISEASES

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: 8/21/85

[Signature]  
Signature of Agency Personnel

[Signature]  
Signature of Student

[Signature]  
Signature of Faculty Advisor

\* Fill out and sign three copies to be distributed as follows: Original-Student;  
First copy - agency; Second copy - TWU College of Nursing.



APPENDIX D

EXPLANATORY LETTER WITH DEMOGRAPHIC DATA QUESTIONNAIRE

Dear Volunteer Examiner,

I am a graduate nursing student at Texas Woman's University. In 1984 I developed a volunteer examiner's training module that was used by the clinic staff. To date, there has been no evaluation of the training module. As part of my thesis project, I am proposing a study to evaluate the training module through the use of an audit tool to evaluate assessment and diagnosis practices of the volunteer who uses this module.

Participation in this study is voluntary. Lack of participation will not affect continued volunteer work at the clinic. If you choose to participate, I will audit your charting procedures. Your performance will be confidential; no individual will be identified during the process. No medical service or compensation is provided to subjects by the University as a result of any injury from participation in research. If you have any questions, please feel free to contact me at 661-6020 or call the clinic manager.

YOUR COMPLETION AND RETURN OF THE DEMOGRAPHIC DATA QUESTIONNAIRE CONSTITUTES INFORMED CONSENT TO PARTICIPATE IN THE STUDY.

Thank you,

A handwritten signature in cursive script that reads "Kathy Falkenhagen".

Kathy Falkenhagen, R.N.

Code No. \_\_\_\_\_

## DEMOGRAPHIC DATA QUESTIONNAIRE

Please place a ✓ in the appropriate space or fill in the blanks of the following questions.

Sex:

- \_\_\_\_\_ a. Male  
\_\_\_\_\_ b. Female

Age: \_\_\_\_\_

## Health Care Background

- \_\_\_\_\_ a. RN  
\_\_\_\_\_ b. LVN  
\_\_\_\_\_ c. Medical Student  
\_\_\_\_\_ d. Nursing Student  
\_\_\_\_\_ e. Paramedic  
\_\_\_\_\_ f. Technician  
\_\_\_\_\_ g. Other

Length of Experience Volunteering at the Clinic:

Number of Weeks \_\_\_\_\_

Number of Months \_\_\_\_\_

Number of Years \_\_\_\_\_