THE IMPACT OF THE COMMUNITY REFERRAL PRESENTATION UPON CLIENT DISCHARGE TEACHING.

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TEXAS WOMAN'S UNIVERSITY

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I am submitting herewith a thesis written by Mary Dahlgren Gunnels entitled "The Impact of the Community Referral Presentation Upon Client Discharge Teaching." 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 Health Education.

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ABSTRACT

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The community referral presentation [CRP] is an educational strategy to enhance the ability of the registered nurse to provide effective client discharge teaching. The purposes of this study were to determine the effectiveness of the CRP and to evaluate the frequency of community referrals, provided by registered nurses in the emergency department of an urban public hospital in the southwestern United States. A sample of 64 registered nurses was utilized in this study. Analysis of the data revealed that the 32 nurses who attended the CRP provided more community referrals than the 32 nurses who did not attend the CRP. There was no correlation between the number of years in professional nursing and a higher frequency of community referrals. The final results of the study indicated that educational presentations which provide patient education strategies for nurses in the emergency department are feasible.

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CHAPTER 1

The Problem and Its Background

The new national prominence of the phrases community-oriented primary care and managed care signal renewed interest in client education in all health care settings (Nutting, 1990; Burns, 1993). The integration of the concepts of ambulatory care, community medicine, and primary care form the basis of these traditional ideas, which have resurfaced in the face of modern health care reform (Kark, 1981).

The emergency department setting of the urban public hospital is profoundly affected by the community in which it is located. Health care professionals must consider the impact of community upon the client in order to provide effective continuity of care (Grumbach, Keane, & Bindman, 1993). One response to this challenge is the development of a new academic discipline, Community Responsive Medicine, which incorporates health promotion and community medicine within the ambulatory setting (Smith, Anderson, & Boumbulian, 1991).

The Emergency Nurses Association (1993) has recognized client education and the promotion of

community efforts to meet the health care needs of the public to be a component of the emergency nursing scope of practice. The role of the emergency nurse in client discharge teaching and health promotion is therefore acknowledged by its professional voice. Educational programs which facilitate the role of the emergency nurse as a health educator are feasible.

The Problem

How does the Community Referral Presentation [CRP] impact the client discharge teaching, in regard to the frequency of community referrals, provided by registered nurses in the emergency department of an urban public hospital?

Statement of the Purposes

The purposes of this study were to:

1. Determine the effectiveness of the CRP.
2. Evaluate the client discharge teaching process, in regard to the frequency of community referrals, provided by registered nurses.
3. Develop a profile of the sample.

Hypotheses

There are two null hypotheses presented in this study:

1. There is no significant difference in the frequency of community referrals during the client discharge teaching process provided by registered nurses who attend the CRP and those who do not attend the CRP.

2. Among those registered nurses who attend the CRP, there is no correlation between the number of years in professional nursing and the frequency of community referrals provided during the client discharge teaching process.

Definitions of Terms

Definitions of key terms presented in this study:

1. **The Community Referral Presentation** [CRP]. A fifteen minute educational presentation which emphasizes guidelines for the community referral process, to include documentation.

2. **Client discharge teaching**. The after-care instruction provided for the client by the registered nurse [RN] at the time of discharge from the emergency department [ED].

3. **Community referral**. The identification and subsequent referral of a community agency, organization, or support group which may facilitate the client's after-care instruction.

4. **Registered nurse**. A professional nurse who has met the requirements of the State Board of Nursing and who practices as a licensed RN in the State of Texas.

5. **Number of years in professional nursing**. The actual number of years of full-time practice as an RN in any health care setting.

6. **After-care instruction form** [ACI]. The form on which client discharge teaching is documented by the RN in the ED.

7. **Patient education**. The provision of health information or teaching to a patient in a health care setting by a health care professional.

Assumptions

There were four key assumptions in this study:

1. The client discharge teaching process is complex, and its impact can be measured.

2. Registered nurses coordinate the client plan of care in the ED setting.

3. Registered nurses will document community referrals on the after-care instruction [ACI] form.

4. Registered nurses will provide client discharge teaching to the best of their abilities.

Limitations

There were three limitations noted in this study:

1. The study results may not be generalizable due to the unique Discharge Area in this ED setting.

2. The client discharge teaching process is affected by client interest and literacy.

3. The client discharge teaching process is affected by the varying noise level, available resources, and client volume in the ED.

Delimitations

There were three delimitations noted in this study:

1. The study will be conducted in the Discharge Area of the ED of one urban public hospital in the southwestern United States.

2. Only registered nurses who practice professionally as full-time employees in the ED will be included in the study.

3. The sample size will consist of the first 32 CRP attendees. The CRP will be provided to the 32 other registered nurses at the conclusion of the study.

Significance of the Study

This study provides a means to measure the impact of educational programs among registered nurses in the hospital ED setting. The CRP may influence the RN to incorporate adult learning theories and community

nursing models within their scope of emergency nursing practice (Schutzenhofer, 1992; Jowett, 1992).

ED management may reinterpret the importance of educational programs to enhance the emergency nurse's teaching skills. With effective client discharge teaching, the number of client revisits may decrease and therefore reduce nonessential financial expenditures by the client (Burns, 1993; Grumbach, Keane, & Bindman, 1993).

CHAPTER 2

Review of Literature

The community-oriented primary care [COPC] model represents a unique theoretical basis for the delivery of health care in the United States. The traditional concepts of primary care and community medicine within the ambulatory setting are integrated within the COPC model. Patient education is an important component of the COPC delivery model. With the modern trend toward integrated health care delivery systems, COPC is an important factor during this time of American health care reform.

The integration of community health education within the ED setting presents an important yet unique component of the client education process. Current emphasis upon the continuity of care for the emergency client after discharge coincides with the implementation of the COPC model of health care delivery (Kark, 1981; Nutting, 1990).

Key Concepts

A composite of three theoretical bases are evident in the COPC health care delivery model. These three bases are derived from the important concepts of ambulatory care, community medicine, primary care. Despite its new national prominence, COPC stresses a return to traditional health care practices prevalent in the nineteenth century United States (Kark, 1981).

The concept of ambulatory care denotes the provision of medical care for the walk-in client, which includes those who are wheelchair-bound. The ambulatory care setting treats clients with nonurgent illnesses (Nutting, 1990). The typical setting consists of a physician office or a clinic, and may be located within or apart from a hospital complex. Ambulatory medicine is now considered a significant health care field due to current emphasis upon hospital costs and ED overcrowding (Grumbach, Keane & Bindman, 1993).

The crisis of escalating health care expenditures has contributed to renewed interest in the second key concept, community medicine. Treatment of the client within the community setting, and with consideration of

important sociocultural needs, promotes positive health outcomes (Nutting, 1990). Development of patient education programs specific to community needs, such as parenting classes, are valid extensions of the practice of community medicine.

Primary care, the third key concept, is analogous to the broad spectrum of health care services provided by a family physician (Nutting, 1990). The client is followed by one physician for the majority of health care services required for a lifetime. The primary care practitioner knows and understands the health needs particular to the client, which includes preventive and curative aspects (Kark, 1981).

Historical Development

The origin of the COPC concept and its methodology is attributed to Sidney Kark, an Israeli public health physician and scientist. Kark first implemented primary care programs in the Polela Health Center, South Africa as a means to provide health care for the poor masses subject to apartheid medicine in the late 1940s (Kark, 1981). The Kark/Abramson COPC model, developed with physician colleague Joseph Abramson in Israel, has been recognized as an effective health care delivery model by international public health leaders since the second World War (Nutting, 1990). Kark later

studied the application of COPC relative to 'mother and child' health programs in the Hadassah Community Center, Jerusalem during the early 1960s. Dr. Kark's body of work comprises the foundation of the COPC model.

Two health care programs represent historical variations of the COPC model in the United States. The first program was the extensive coordination of health care services for the Native American populations by the Public Health Service [PHS] in 1955 (Nutting, 1990). The second program, the Health Maintenance Organization [HMO], was developed by Kaiser Permanente to address the health needs of the private sector. These programs, both currently operational, approach the health care problems of specifically defined populations in a manner similar to the COPC model.

Community Health Education

Of important note is the impact of traditional community health education principles upon the historical development of the COPC model. The World Health Organization [WHO] has been promoting community health education programs since its inception for years prior to the development of the Kark/Abramson COPC model (Flahault & Roemer, 1986). The phrases public health and community health have often been used

interchangeably during the past 50 years. The modern development of public health education programs which have emphasized community health principles and the substantial impact of the unlimited variation within the community setting.

The late Guy W. Steuart, internationally renowned public health physician and educator, emphasized the intimate relationship between health care provision and the community. Steckler, Dawson, Israel, and Eng (1993) present these comments by Steuart:

> The significance of health education is rooted in the recognition that the culture of a community has a deep and abiding influence on its health. It has, therefore, a peculiar affinity for medicine and public health that is socially oriented in its interpretations of the epidemiology of health and disease. (p. S29)

Steuart's body a work contains numerous similar references to the relationships between health services provision and the community served.

During the 1960s, federally funded community programs with a health education component were emerging in the United States. Professional organizations during the 1970s (e.g., the American Public Health Association [APHA] and the Society for Public Health Education [SOPHE]) expanded the

scope of public and community health practice to include an emphasis upon health education in all settings (Breckon, et al., 1989).

Primary Care

The influence of the international progression of the primary care model worldwide greatly impacted the development of the COPC model. Primary health care programs were endorsed by WHO in the early 1970s and financially supported by powerful agencies such as the World Bank (Stone, 1992).

The 1978 international WHO conference on primary health care at Alma Ata, U.S.S.R. resulted in the popular resurgence of primary care extension to the community health setting (Nutting, 1990). The phrase, primary care worker, was interchanged synonymously with community health care worker (Flahault & Roemer, 1986). The general public began to understand that primary health care programs could not only treat illness but provide cost effective means to prevent illness as well (Bryant, 1990).

Simultaneously, the concept of primary health care gained prominence in the United States. The Institute of Medicine published A Manpower Policy for Primary Health Care in 1978 (Institute of Medicine Division of Health Care Services [IMDHCS], 1982). This key

governmental agency attributed this newfound public recognition of primary health care to the community activism prevalent during the 1960s and 1970s:

> From the civil rights movement of earlier years to the consumerism of the 1970s, the role of the community and the patient had become more prominent in the delivery of health services. Departments of community and social medicine had grown up in medical schools, and increasing numbers of medical students and young health professionals sought career opportunities in community responsive practice settings. (p. x)

Growing public and professional interest in primary health care was evident.

The Alma Ata conference therefore inspired the new development of COPC programs throughout the United States. The National Academy of Sciences of the American Institute of Medicine published its COPC delivery model in the early 1980s (Institute of Medicine, 1982). In 1984, the National Academy of Sciences initiated formal studies of the COPC model, and numerous studies are in progress today (Nutting, 1990).

The COPC delivery model is currently being implemented in a variety of American health care

settings (Nutting, 1990). COPC symbolizes a return to the ways of the traditional family physician of years past, with emphasis upon patient education. In order to clearly define the COPC model of health care delivery, analysis of its key concepts follows.

Community-Oriented Primary Care: Definition

The COPC model is a conglomerate of the key concepts of ambulatory care, community medicine, and primary care. Nutting (1990) describes COPC as an appropriate remedy for the historical separation of community medicine and primary care:

> COPC expands the primary care model to include a defined population and a process by which the health problems of that population are systematically identified and addressed. (p. xix)

Implementation of COPC therefore integrates the more traditional focus of the primary care practitioner with the community and epidemiological aspects to provide comprehensive health care services (Flahault & Roemer, 1986).

In the face of national health care reform, COPC offers one means to address the health problems of many Americans. Ron Anderson, public health physician, (1992) defines COPC to be an effective alternative in the provision of care for the poor and medically

underserved population of the United States:

> Each COPC center (in the Dallas County Hospital District) offers a comprehensive blend of preventive health care, health promotion, health education, primary care, and public health... we would argue that COPC should become a prevalent model of care for public hospitals that expect to survive. (p. 10)

As a national leader in public health and COPC advocate, Dr. Anderson recognizes the significance of the COPC delivery model, which was first implemented in Dallas, Texas in 1987.

Contemporary Concept

Due to the contemporary nature of the development of COPC as a health care delivery model in the United States, the professional literature reflects only its practical application during the past twelve years. As a result, there are two major resource textbooks which are devoted entirely to the examination of the COPC concept.

Kark (1981) authored the first textbook which describes COPC as a complete health care delivery model effectual in varied community settings. Kark's forty-plus years of community work are summarized, to include his original studies in South Africa and Israel. The

second resource is a comprehensive textbook by Nutting (1990), which delineates the concept of COPC from its origin to its modern application in the United States. Current scientific literature emphasizes two key issues relative to COPC implementation in the United States, patient education and barriers to the delivery of COPC.

Patient Education

The COPC delivery model provides the continuity of care which allows patients to make more appropriate choices regarding health care needs. For the past twenty years, clients without a primary health care provider, particularly those who are of lower socioeconomic means, often utilize the hospital ED for nonurgent health problems (Grumbach, et al., 1993).

The obligation to provide patient education exists for all health care providers, regardless of the setting. The urban community hospital is profoundly affected by its many clients requiring health care services, to include patient education. Anderson (1991) views the integration of the community hospital and the COPC model of care to be one solution for patients requiring health education:

> With COPC, Parkland [Hospital] is promoting health and well-being and practicing patient-oriented medicine out in the community where our patients

> live. COPC was established out of necessity. Parkland outgrew its capacity to serve those needing routine care. Recognizing that many health problems are a consequence of lifestyle choices, we need a system to help patients rebound by teaching them how to make positive choices. (p. 8).

The COPC model stresses the successful integration of health care services by all community providers, therefore offering access to health educators and support services which assure the continuum of health care (Anderson, 1992).

Centers for Disease Control [CDC] medical epidemiologist Jeffrey Newman (in Nutting, 1990) describes potential health care collaborators in the COPC patient education process to include:

> ...Public health agencies, health care facilities, schools, voluntary agencies, media, professional societies and foundations, and local, state & federal government programs. (p. 389)

Implicit is the importance of an integrated information systems network, in which all health care providers offer referrals to their clients.

Of mention is a comparison of the COPC model to the Planned Approach to Community Health Model [PATCH]. PATCH represents a community health promotion strategy in which the need for coalitions and partnerships among

providers is evident (Green & Kreuter, 1992). COPC incorporates an integrated system of health care delivery. PATCH and other similar models are significant in that they demonstrate the importance of coordination of health care interventions within a community.

The shift toward the health care providers, such as the urban community or public hospital, recognizing the value of patient education is now apparent. These providers, including physicians and nurses, are correlating patient education with decreased length (and cost) of hospital stays (Breckon, et al., 1989). Referrals to community agencies and support groups can promote health education. The COPC model can provide health education interventions for the client in any health care setting.

Barriers

COPC presents a viable alternative to the worsening health care crisis, and is one means of providing primary care to poor and underserved populations. Its application to the private sector is realistic. COPC incorporates preventive health concepts in its delivery model, juxtaposed with the new advanced and technological world of medicine. Four barriers which confront the successful implementation of the COPC

delivery model highlight discussion in health care professional circles.

The first barrier is the transitory state of health care delivery in the United States. The movement toward universal health insurance is in progress, and its impact upon the American health care system cannot yet be measured (Geiger, 1993).

One solution presents the expansion of the scope of services provided by ambulatory centers while hospitals manage only critically ill patients (Zuckerman, 1993). One study predicts that the estimated 4000 ambulatory care facilities in the United States will increase and significantly expand their client services, thereby integrating primary care within the community setting (Bigelow, 1991). New emphasis upon cost effective and quality health care services is stressed by Burns (1993):

> 1993 will be the year outpatient care moves to the forefront of health care reform. (p. 42)

The COPC model is workable if this trend occurs.

The second barrier is the seemingly anachronistic nature of the COPC model relative to modern American medicine. Computers and scientific research, to the microcellular level, dominate the medical profession. COPC is associated with conventional primary medicine in the "low tech" community setting.

One view is that the COPC model is feasible in a modern integrated system of health care (Cassidy, 1993). The Institute of Medicine (1982) predicts the potential for innovation within the COPC model:

> Several factors represent opportunities for COPC. The advances in microcomputers, which make handling of data both relatively simple and inexpensive, facilitate the aggregation of demographic and epidemiologic data that is a basic feature of COPC. And, the current tightening of federal funding, which will force state and local agencies once again to assume responsibility for such functions as health care, may provide the necessary climate for COPC to flourish. (p. xv)

With the new emphasis on COPC nationally, the potential for government impetus regarding information systems and research is evident.

The third barrier is the limited inclusion of primary care and community medicine in current medical school curricula. The American Medical Association [AMA] lists approximately 294,000 practicing members, with 126 medical schools and 400 teaching institutions in the United States. The majority of these physicians are specialists or subspecialists (Pallarito, 1992). The compartmentalization and subsequent involution of

medicine is perpetuated by these same physicians (Smith, Anderson, & Boumbulian, 1991).

One proposed solution to this problem is a call for nonelective organizations other than the AMA, such as the Institute of Medicine, to support medical school reform. A newly developed academic discipline, entitled 'Community Responsive Medicine,' blends primary care and public health (Smith, et al., 1991). New models of residency education for physicians and incentives such as state-of-the-art ambulatory teaching centers present practical solutions (Geiger, 1993; Wartmann, O'Sullivan, & Cyr, 1992).

The fourth barrier is the lack of physician incentives within the COPC model. These disincentives include but are not limited to; decreased financial rewards, more limited intellectual and strictly scientific pursuits, lifestyle effects such as longer working hours and less glamorous work environments, and limited prestige (Pallarito, 1992).

Renewed efforts by key organizations, such as AMA and the Robert Wood Johnson Foundation, which offer scholarship programs and grant monies demonstrate one solution to the lack of physician incentives. Medical schools are now promoting a new role for the primary care practitioner (Pallarito, 1992). Governmental interventions to increase primary care reimbursement

and investment in the COPC model are other positive indicators (Geiger, 1993).

The COPC Health Care Delivery Model

The practical application of the COPC model is receiving national attention due to the popularized need for comprehensive health care in the community setting. In the face of health care reform, it is necessary for the acute care setting (e.g., the urban public hospital) to understand the community which it serves. The probable integration of community health care systems mandates careful consideration of the application of the COPC model.

The COPC model stresses primary care, to include the importance of patient education. This is considered to be an important strategy for ambulatory medical practice, which incorporates the emergency department setting, in the community or public hospital (Burns, 1992). The COPC core concepts are congruent with a mandated call for health care accessible to all Americans (Anderson, 1986).

Unfortunately, COPC will face obstacles despite the many positive aspects of the COPC model. The natural tendency to resist change as one national health care delivery system adapts to varied settings may pose a problem to implementation. The predominance of 'high

the public health care system in the publication Healthy People 2000 United States Department of Health and Human Services [USDHHS], 1990):

> Increase to at least 90 percent the proportion of hospitals, health maintenance organizations, and large group practices that provide patient education programs, and to at least 90 percent the proportion of community hospitals that offer community health education programs addressing the priority needs of their communities. (p. 262)

Healthy People 2000 includes a mandate for provision of ongoing primary care in order to coordinate health care delivery for preventive and episodic needs. These goals are consistent with national application of the COPC model of care. Access to care and clinical preventive services is a key responsibility of the community or public hospital. The provision of surveillance and computerized information systems networks is another component of the delivery of patient education in all health care settings. This objective is congruent with the emergence of COPC and its impact upon health care delivery in the hospital ED setting.

The urban public or community hospital is frequently recognized to be the entry point for access

by many Americans to the health care system (Grumbach, et al., 1993). Limited access to or no association with a primary care physician results in the urban ED becoming the predominant means for entering the health care system for these clients. One Pennsylvania study describes a successful nurse-managed collaborative primary care practice model which worked with the ED to provide comprehensive health care delivery (Middleton & Whitney, 1993). Middleton (1993) recognized the problems with primary care delivery in the ED:

> Few ER units are designed to increase access to primary care for individuals or families. These inadequacies have produced disconnected care, repeated visits without cure, inappropriate referral or follow-up, and poor preventive care. (p. 31)

This Pennsylvania model integrated multiple levels of collaboration to provide a system in which referrals and continuity of care were successful.

Many strategies to deliver primary or the newly termed 'managed care' in the hospital setting have been developed out of necessity (Burns, 1993). The risks associated with patients who leave the ED without treatment or who frequently utilize the ED inappropriately are great, as physicians cannot treat

these patients in an efficient and economical manner (Hass, Kunst, Lerner, Hutson, Baker, Stevens, Brook, Bindman, Grumbach, Kellerman & Newton, 1992). The community or public hospital which attracts this patient population could therefore be a likely source of development for projects which promote integrated information and health care systems.

A recent San Francisco study reported that 45 per cent of a 700 patient sample group had access barriers to primary care and consistently sought primary care in the public hospital ED (Grumbach, et al., 1993). This California hospital boasted a large clinic system and community-based health care programs. Therefore, this public ED could be a likely candidate for patient education focus programs targeted toward clinic and community referrals.

Another California study validated the successful relationship between the urban ED and the community it served by implementation of the COPC model (Nutting, 1990). This delivery model emphasized the sophisticated information systems networks so closely associated with California's computer mecca 'Silicon Valley'. Nutting (1990) states:

> Those (community hospitals) interested in primary care or COPC can look to their experiences and

> their patients' experiences in community hospitals as opportunities to promote COPC. (p. 454)

Implicit is the importance of the coordination of the community referral process and the community or public hospital, to include the ED entry or access point.

Recognition of the community or public hospital ED as an essential provider of health care delivery for many patients in need of preventive and primary care services is widespread. The Joint Commission for the Accreditation of Hospitals [JCAHO] studied the impact of public hospital overcrowding relative to the provision of quality care in the urban ED (Joint Commission, 1992). JCAHO concluded that quality patient care, to include patient education, faces many impediments and that JCAHO would assist hospitals to resolve this issue.

Two large Texas urban hospitals have developed responses to the difficulties of health care delivery in the ED. Baylor University Medical Center of Dallas developed a new nursing role, the ED clinical coordinator, to facilitate patient care. This ED developed the role as an adjunct to ED primary nursing (McCarthy, 1991). Parkland Memorial Hospital, the public hospital in Dallas County, adopted the COPC model of care and expanded its emphasis upon patient education to the ED setting. This ED was completely

renovated and a separate patient education area was designed to better serve emergency clients. The promotion of patient-centered, patient-valued care was extended to the Parkland ED through this innovative plan (Boumbulian, Day, Delbanco, Edgeman-Levitan, Smith, & Anderson, 1991).

Modern awareness of patient-focused care emerged with the 1972 publication of the 'Patient Bill of Rights' by the American Hospital Association (Budassî & Barber, 1981). Patient education was then officially recognized as an obligation of all health care providers (Budassi & Barber, 1981):

> ...every hospital patient (has a right) to be informed of procedures used in providing care and methods of providing self-care following dismissal from all health agencies. (p. 215)

Popularized by the media, patient education has since become in the minds of many Americans a legal and ethical responsibility of all health professionals, including ED physicians and nurses.

The urban ED represents a health care setting with tremendous challenges to as well as opportunities for patient education. Studies indicate factors such as patient overcrowding and noise to be obstacles to provision of quality health care in the ED (Grumbach, et al., 1993).

However, innovative programs to overcome such obstacles have recently emerged. Nutting (1990) offers the COPC model of care as a feasible solution:

> The basic elements of COPC must be adaptable to the unique environments of clinicians practicing in different communities, under different organizational structures, financed through different fiscal arrangements. (p. xxii)

COPC programs evolve differently in response to the health care needs of a defined patient population. The community hospital urban ED can provide the setting for health care delivery consistent with the COPC model.

In order to more clearly comprehend the realistic application of patient education programs in the dynamic ED setting, explanation of the role of the nurse is imperative. Consider now the scope of practice of the professional RN, with emphasis upon patient education as a fundamental component of practice.

Nurses as Patient Education Providers

In order to examine the delivery of health care, specifically patient teaching, in the urban or community hospital ED setting, the role of the nurse as a provider of patient education must be defined. The

broad description of the patient educator in the hospital setting as well as the historical and legal definitions of the RN scope of practice comprise the foundation of this role.

Broad Definition

Emphasis upon the role of the nurse as a provider of patient education has coincided with the modern focus on health care reform in the United States (Clinton, 1993). The federal government groups all nurses within its primary care provider category (United States Department of Health and Human Services [USDHHS], 1990). Healthy People 2000 (USDHHS, 1990) delineates priority areas for health care provision to include health promotion, health protection, and preventive services in which nurses are involved in educational, community-based programs. Nurses are designated members of interdisciplinary teams which share the responsibility for health promotion as well as health education and counseling. Nursing functions and interventions range from preventive teaching about sexually transmitted diseases to pre-operative explanation of clinical procedures.

It is significant that the role of the nurse is described in Healthy People 2000's national objectives. Collaborative responsibility for health education spans

many disciplines and is applicable to all health care settings. The USDHHS (1990) illustrates this collaborative practice model:

> America's physicians, dentists, nurses, pharmacists, medical technicians and other health professionals must not only be knowledgeable in the basic and clinical sciences; they also must be life-long learners, excellent communicators, good team players, managers of scarce resources, health care visionaries and community leaders. The day of the sole practitioner, dealing with the patient in isolation from other health professionals, is past. (p. 87)

This broad definition of health education practitioner is analogous to a generalist (Steckler, Israel, Dawson, & Eng, 1993). This definition is in contrast with the role of the health education specialist (National Commission for Health Education Credentialing [NCHEC], 1985).

The role of the nurse as a provider of patient education is now mandated in the comprehensive national directives delineated in Healthy People 2000 (USDHHS, 1990). In order to understand the modern definition of the RN as a patient educator, the historical evolution of the role must be presented.

Historical Definition

The word nurse inspires images from ancient healers to Florence Nightengale to crisply uniformed matrons in white. Ancient references to nurses typically refer to maternal activities. One such function of the nurse was to suckle and otherwise care for an infant... whether a 'wet nurse' or a 'dry nurse' (Davis & Davis, 1992). However, throughout the colorful history of nursing recurs the theme of the nurse as a teacher of patients.

The word patient conjures the image of a stoic person who endures suffering (Davis & Davis, 1992). The intimate relationship between nurse and patient is dynamic and consistently reflects the dependence of the patient upon the nurse for counsel and advocacy. Clarke (1991) presents the historical perception of the nurse as a teacher and counselor of patients:

> Since Nightengale, nurses have realized the importance of teaching their clients about health and illness. Today, the role of the nurse as a health educator and as a role model has gained more importance for a variety of reasons. Clients expect to be more involved in decisions about their health and they want to learn about maintaining and improving their health. (p. 1178)

The historical emphasis upon the teaching abilities of nurses is largely responsible for the inclusion of patient education in the legal scope of nursing practice. This fundamental aspect of practice has enabled the professional nurse to overcome negative historical images such as the stern matron or 'battleaxe' and the 'doctor's handmaiden' (Clarke, 1991).

The bond between the nurse and the patient has been recognized by professional organizations such as the National League for Nursing [NLN]. The NLN has been preparing nurses for the role of health educator since the early nineteenth century (Close, 1988). Close (1988) maintains that the NLN and its leaders define teaching to be an essential component of patient care today:

> Contemporary leaders of nursing add their reasons for believing that nurses are potentially the most significant teachers of patients. (p. 205)

The American Nurses Association [ANA] officially designated the recipient of nursing care, which included health education, to be the patient or client in 1971 (Davis & Davis, 1992). The unique and dynamic nurse-patient relationship has adapted to hundreds of years of change, from home health care delivery by

horseback to computerization in modern hospitals (Schutzenhofer, 1992).

Collaborative and interdisciplinary practice models have now emerged in the American health care system. Nurses are now in a position to capitalize on their role as patient educators. Schutzenhofer (1992) cites a reference by social commentator George Will regarding the new and empowered role of the professional nurse in the United States:

> A nurse is a social remarkable artifact, and there are not nearly enough nurses, in part because of backward attitudes packed in phrases like 'merely a nurse'. This 'merely a nurse' attitude reflects a fear of power, a fear rooted in a misunderstanding of what power is and is not. We read and talk much of empowering nurses today. If we truly believe in such empowerment, then nurses will become skilled in using power. (p. 18)

As the modern professional nurse is empowered to pursue the role of the health educator, consider now the legal scope of nursing practice.

Legal Definition

Nurses are bound by the legal scope of practice as well as the professional expectation of ethical

practice. The American Nurses Association [ANA] estimates that nearly 68% of the 1.67 million working RNs are employed in hospitals to provide patient care. These RNs work twenty-four hours per day... three hundred and sixty-five days per year (ANA, 1991). ANA is the largest and most influential professional organization for American nurses. Two fundamental tenets of the ANA Code of Ethics stress public protection from misinformation and collaboration to promote community and national efforts to meet the health needs of the American public (ANA, 1985).

ANA considers patient education to be a fundamental element of nursing practice. The ANA position statement (1985) clarifies this mandate in its Code of Ethics preamble:

> Nursing encompasses the protection, promotion, and restoration of health; the prevention of illness; and the alleviation of suffering in the care of clients, including individuals, families, groups and communities. (p. i)

An ANA descriptive brochure (1991) further advertises its definition of this key nursing function to the public:

> Nurses teach patients and their families about their conditions, why and how their treatment plans should be followed, how to care for themselves

> while they recuperate, how to avoid relapse or complications, and when to seek advice from a health care professional. Nurses also coordinate the activities of many other members of the health care team and provide support and counseling to patients and families. (p. 4)

This governing body for nursing practice clearly delineates the role of the nurse as a health educator, particularly in the hospital setting. However, NCHEC does not support this description of the nurse as health educator (NCHEC, 1985).

The ANA represents the professional ruling body for nursing, however, each state individually defines the legal scope of practice for nurses. The state boards of nursing legislate practice acts. In Texas, the state branch of the ANA, or the Texas Nurses Association [TNA], coordinates and publishes the RN practice act. With regard to patient education, TNA (1993) defines the RN responsibility in Article 217.11:

> Item 7. To promote and participate in patient/client education and counseling based upon health needs.
>
> Item 8. To collaborate with members of health disciplines in the interest of the patient's/client's health care.
>
> Item 9. To consult and utilize community agencies/resources for continuity of patient/client care.

The Texas Practice Act for RNs therefore emphasizes care for the patient at all points in the health continuum, from initial observation and assessment to rehabilitation. Patient advocacy is considered to be a fundamental tenet of professional nursing practice at all levels as well (ANA, 1985; Faherty, 1993).

Implicit in the professional and state legislated definitions of nursing practice is the responsibility of the RN to coordinate patient care. This role is particularly essential in the ED setting (Emergency Nurses Association, 1993). With emphasis upon the RN professional and legal obligation to provide patient education in all health care settings, consider now the contemporary issues which affect this practice component.

Contemporary Issues

Positive and negative factors affect the ability of the RN to provide effective patient education. Positive influences include the keen assessment skills of the RN, the perception by nurses that patient education is a nursing function, and the fact that nurses are well-positioned as the largest body of health care professionals in the United States. Negative influences include the varied educational levels and skills of the RN, the perception by the

public that the physician is a more credible source of health information than the nurse, and the inconsistency in delivery of patient education by the RN.

The first positive factor is the inherent ability of the RN to assess the basic needs of the patient. This important practice component prepares the RN to apply this skill to the area of patient education (ANA, 1985).

The second positive factor is the commonly perceived responsibility of the nurse to provide patient education. One British author notes that this nursing perception is prevalent in 'western medicine' (Wilson-Barnett, 1988). The three primary approaches by RNs toward patient education are information-giving, patient teaching which stresses skills training or behavior changes, and patient counseling which empowers the recipient to discover his own coping mechanisms. Nurses generally perceive that patient education is an important nursing function desired by most patients (Tilley, Gregor, & Thiessen, 1987).

The third positive factor is the recognition of nurses as a large and significant workforce relative to health care delivery in the United States (USDHHS, 1990). The federal government and combined professional organizations such as ANA and NLN,

recognize the enormous potential that nearly 2 million nurses can have upon the health care delivery system (ANA, 1991). As nurses now recognize the significance of their role as providers of patient education, they can expand their influence to this realm of health care delivery.

The obstacles to the application of nursing practice to patient education must now be considered. The first negative factor is the inadequacy of preparation for nurses to teach patients due to the varied educational levels of RNs (Tilley, et al., 1987). RNs can receive a state license without a college degree, and degreed nurses can attend two-year or four-year college programs (TNA, 1993). Therefore, the RN can begin practice with limited or no formal training in patient education.

The second negative factor is the common public perception that the physician is the best source of health information. One study interpreted this view as nurses having a general teaching function while physicians are preferred by patients as health educators. Physicians receive extensive formal education and have traditionally received far greater public respect than nurses in general (Tilley, et al., 1987). One study noted that 69 per cent of a physician

sample viewed patient education as a nursing or allied health responsibility (Close, 1988).

The third negative factor is the difficulty in the consistent delivery of patient education by nurses. RNs work in a variety of health care settings and often have lack of support for the provision of patient education as it is not a high priority among many nurse administrators (Tilley, et al., 1987). Different settings with variables such as noise or limited staff detract from the RN's ability to plan and offer health education to patients (Close, 1988).

Despite the obstacles to the delivery of patient education by nurses, it appears that nurses remain an important force in patient education. Conclusions based on ten different patient satisfaction surveys demonstrated that patients desire a nurse's ability to teach and provide care (Messner, 1993). The nurse-patient relationship can serve as the foundation for health education. Means to address barriers include appropriate training for nurses relative to teaching strategies and public awareness of the nursing role as a patient educator. National application of collaborative and primary practice models such as COPC and the implications of a reformed health care system may provide the support for this important nursing role.

> How the public regards relations with nursing services will be heavily influenced by their experiences with nurses. It is true that nursing services have elements of both "doing for" and "working with" ... Whether caring for patients or counseling clients through the complexities of the healthcare system, the meaning of 'nurse' still directs its professional practitioners toward enriching the lives of those who receive their services. (p. 43)

National nursing leader Leah Curtin states that professional nurses, especially mid-level practitioners such as midwives and case managers, represent a major component in the future health care provider workforce (Curtin, 1990).

Governmental leaders are acknowledging the role of the nurse as change agents and leaders of the health care system in the United States (Shalala, 1993). United States Secretary of Health and Human Services Donna Shalala (1993) promotes the role of the nurse as patient educator:

> Nurses were the handmaids of the medical profession. And now, through the gallant and sometimes arduous efforts of women and men, nursing as redefined itself. It has staked out its territory and that territory is health; prevention,

> self-sufficiency, and mobility for the elderly, care for the poor, women's health, health education. (p. 289)

Health care reform leader Hillary Clinton (1993) concurs with Shalala's view of the professional nurse as a valued health care provider during an address to the NLN convention:

> In our effort to stop lives from being ruined by preventable diseases, nurses need to be given greater recognition as being paramount to the quality of America's health care. Each, as a valued provider, makes daily differences in the lives of individuals and communities. (p. 286)

The importance of the professional nursing role is amplified in the face of modern American health care reform.

The Role of the Emergency Nurse

The RN is defined to be the coordinator of client care in the ED (Emergency Nurses Association [ENA], 1993). ENA is the professional organization for emergency nurses in the United States, with current membership exceeding 20,000 RNs. The emergency nurse is often described as a generalist who practices in a unique critical care setting (Budassi & Barber, 1981; Steckler, et al., 1993).

The emergency nurse faces the daily challenge of providing patient education and discharge teaching in an often chaotic environment. JCAHO requires the RN to provide and document individualized instruction regarding health needs during ED discharge, including the patient response to the teaching done (Budassi & Barber, 1981).

The emergency nurse is frequently the only health care provider available to offer client discharge teaching. Despite public perception to the contrary, many physicians view patient education as a nursing function (Hass, et al., 1992). RNs in the ED setting traditionally provide patient discharge instructions, rather than reinforce ED physician teaching. Modern collaborative practice models of ED patient care are emerging to offer successful strategies for improved patient education (McCarthy, 1991).

Professional Role

ENA meticulously delineates the role of the emergency nurse in its position statement regarding the RN scope of practice in the ED (ENA, 1993). The ENA position statement defines the emergency nurse to represent a focal point on the continuum of health care. The scope of practice is complex and has been expanded to include the diversity of ED settings (from

small rural EDs to helicopters in the field to large urban EDs). The legal boundaries of the RN scope of practice must comply with individualized state nurse practice acts in all settings.

This professional voice emphasizes the dynamic nature of emergency nursing, and includes the delivery of care to consumers through education, research, and consultation (ENA, 1993). This emphasis upon patient education and diversity of ED nurse practice settings is congruent with the community referral process.

Emergency nurses can obtain advanced certifications through nationally standardized examinations. National Certification in Emergency Nursing [CEN] is a mechanism for validation of the competency of the emergency nurse (Board of Certification for Emergency Nursing [BCEN], 1994). ENA acknowledges the significance of the CEN in the professional and public domain.

The advanced certification for the health education specialist [CHES] can be obtained by nurses who meet the educational and professional criteria (NCHEC, 1991). There are core responsibilities and competencies specifically defined for health educators in the standardized national examination for the CHES (NCHEC, 1985). Nurses without four-year college degrees would be ineligible for the CHES.

Knowledge of patient education processes represents 2% of the CEN examination. The 'assessment, analysis, planning, and intervention' phases of the traditional nursing process are incorporated in the emergency nurse's patient teaching strategies (BCEN, 1994). Patient education in the ED is presented primarily at the time of patient discharge.

The ED RN is obligated to reassess the client's key or chief complaint during the discharge process, including a general assessment of the patient's overall mental and physical status. Documentation of this reassessment is required per ENA and JCAHO practice standards (Rich, 1993). Mandatory reporting of legal concerns such as child or elderly abuse must occur prior to discharge if this did not occur in the treatment area.

Leaders in emergency nursing confirm the importance of teaching ability as an asset of the ED nurse. Vicki Bradley, past president of the national ENA, describes the ED nurse's role in patient teaching to be challenging and comprehensive due to the patient's tendency to return or telephone the ED nurse if problems arise after discharge (Meyer, 1992).

Feasibility

Three positive factors contribute to the realistic application of patient education by the emergency nurse. The first factor is the recent successful emphasis upon primary care in the ED setting (McCarthy, 1991). Primary care and other collaborative practice models facilitate ED patient education, justifying the implicit dedication of nursing time toward this intervention. The second factor is the development of fast-track systems within many EDs (Middleton & Whitney, 1993). These systems, in which nonurgent patients are prioritized in an efficient manner, decrease nursing time expended on unnecessary tasks and increase available time for patient education. The third factor is the advent of computerization in the ED, which positively impacts the process of patient education by the emergency nurse as well (Prescott, et al., 1991).

Four obstacles negatively impact the role of the emergency nurse in patient education. The first barrier is the consumption of nursing time by the large volume of ED patients with nonurgent health care needs (Hass, et al., 1992). The second barrier is the low priority assigned to patient education in the ED setting by the ED nurse due to the overwhelming number of tasks to be performed (Middleton & Whitney, 1993).

The third barrier is the possibility that appropriate patient teaching and community referral may result in shortening waiting times, which actually increases the volume of ED clients (Grumbach, et al., 1993). The fourth barrier is the divergent relationship between the low priority patient education process and the high priority emergency triage and response in the ED setting (Middleton & Whitney, 1993).

Despite the four obstacles previously cited, the emergency nurse is obligated to provide patient education. Patient education is an integral component of health care provision, and the emergency nurse is legally and professionally bound to provide this service.

Summary

The evolution of modern health care delivery models such as COPC emphasize the need for continuity of care for patients in all settings. The urban ED setting is an important arena for health care provision. The challenges of modern health care delivery by the RN are significant, however new models of care which emphasize patient education and continuity of care in the community are promising. The emergency nurse can implement the RN role as a patient educator.

Computerization, collaborative and innovative COPC models, and redesigned ED settings are means to enhance the emergency nurse's role in patient education. Educational strategies, such as the CRP, which facilitate the emergency nurse's role in patient education, are feasible.

CHAPTER 3

Methodology

This quasi-experimental study was conducted in the emergency department [ED] of one urban public hospital in the southwestern United States.

Population and Sample

The population consisted of registered nurses [RNs] working full-time in the ED at a selected urban public hospital. The sample was comprised of 64 RNs, employed full-time in the ED, who voluntarily attended the CRP. The first 32 volunteers, the convenience sample, attended the CRP and the remainder of the population was offered the CRP at the conclusion of the study. Refer to Appendices A and B for the cover letter and consent form.

The nonequivalent control group pre-post-test design involved the division of the RN population into two groups, those who attended the CRP and those who did not attend the CRP. The study group was comprised of nurses who attended the CRP.

The CRP was offered twice, at 7:15am, in order to enable nurses from day and night shifts to attend. The CRP was a brief educational presentation which defined the community referral process, including documentation on the ACI form. The CRP was approximately eight minutes in duration. The entire presentation was fifteen minutes in length, to include explanation of the study and the consent form for study participants. Refer to Appendix C for the presentation outline.

Data was collected from twenty ACI forms per study participant prior to the presentation of the CRP. The investigator then collected data from twenty ACI forms per study participant after the CRP. The data collection remained confidential.

The entire data collection process was conducted within sixty days. The ACI form audits conducted after the CRP were completed by the principal investigator during a three week time frame.

The instrument was the hospital after-care instruction or ACI form, currently being utilized in the ED. Refer to Appendix D for a copy of the ACI form. There was no pilot study.

Protection of Human Subjects

The coding strategy consisted of the use of group

data without names. Each full-time RN study participant was assigned a number (1-64). Data was collected from the ACI form and tabulated by code numbers.

The permission of the agency Nursing Research committee was acquired. Refer to Appendix E. The study did not require approval by the hospital Institutional Review Board [IRB] because it was noninvasive and met all criteria for expedited review by the agency Nursing Research committee. The study was exempt from the Texas Woman's University Human Subjects review. Refer to Appendix F.

Treatment of Data

1. Descriptive statistics were used to profile the sample.

2. ANOVA was utilized to test hypothesis 1.

3. Pearson product-moment linear correlation coefficient measured the relationship between the frequency of community referrals and the number of years in professional nursing (hypothesis 2).

4. The p-value level of significance was < 0.05. Appropriate tables and graphs were used to present the summarized results of the analysis of variance and the Pearson product-moment linear correlation measurement.

CHAPTER 4

Study Findings

Demographic Profile of the Study Population

The study population was comprised of 64 registered nurses [RNs] who worked full-time in the busy emergency department [ED] of an urban public hospital in the southwestern United States. The demographic profile presents information regarding age, gender, and the ethnic, educational, and professional practice background of the study participants.

Age

The study participants ranged from 23 to 61 years of age. The mean age was 33.17 years while the median age was 32 years. The mean age is higher than the median age because there were greater extremes within the higher age ranges. One RN was 61 years of age. The modes were 25 and 35 years, with each recurring six times. Refer to Table 1 and Figure 1.

Table 1

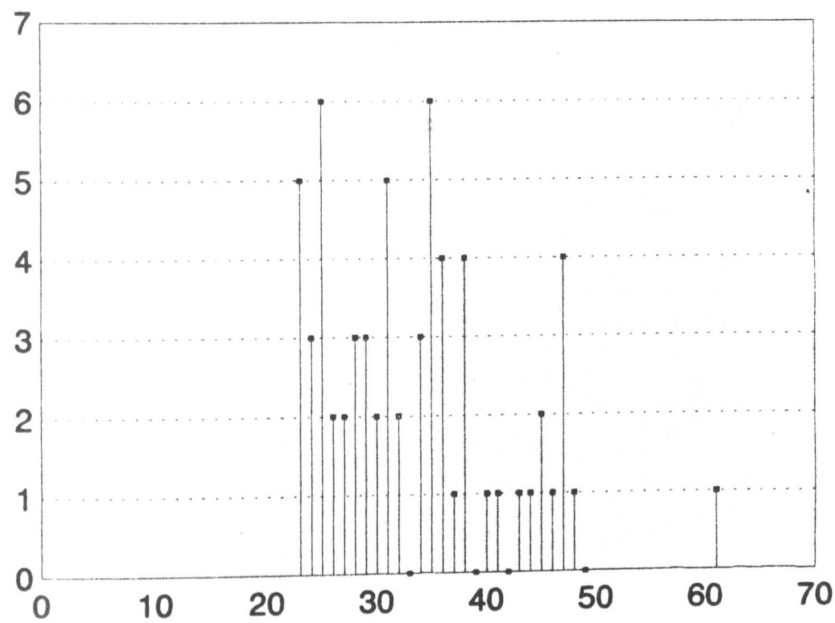
Age Range of RN Population

Range(years)	20-29	30-39	40-49	50-59	60-69
Number(RNs)	24	28	11	0	1

Note. Mean = 33.17 years. Median = 32 years.

Figure 1

Frequency Distribution of Age Range



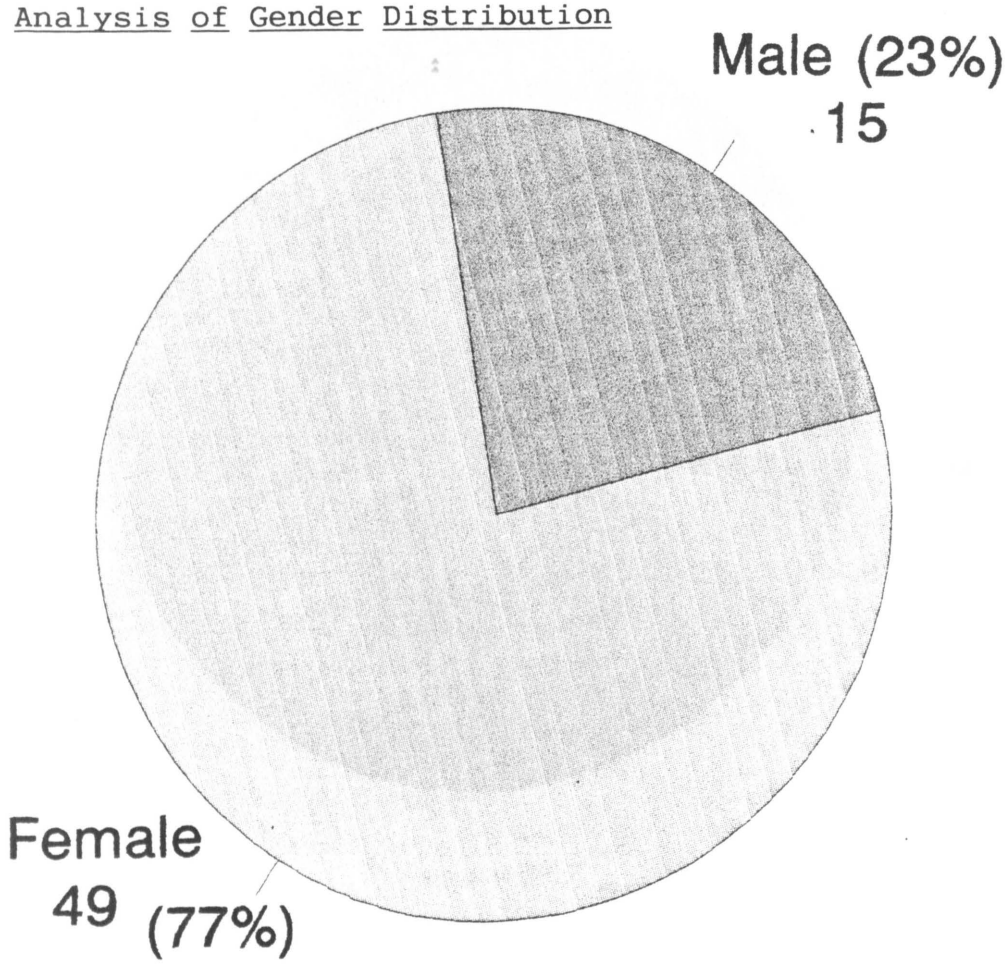
Note. (x = actual age, y = rate of occurrence)
Mean = 33.17, Median = 32, Modes = 25,35.

Gender

The gender distribution consisted of 23% males and 77% females. Refer to Figure 2. There is historically a greater percentage of male nurses working in the critical care or ED setting. This may be the reason for this percentage being significantly higher than the national distribution of male nurses, which is approximately six per cent of all working RNs (ANA, 1991).

Figure 2

Analysis of Gender Distribution

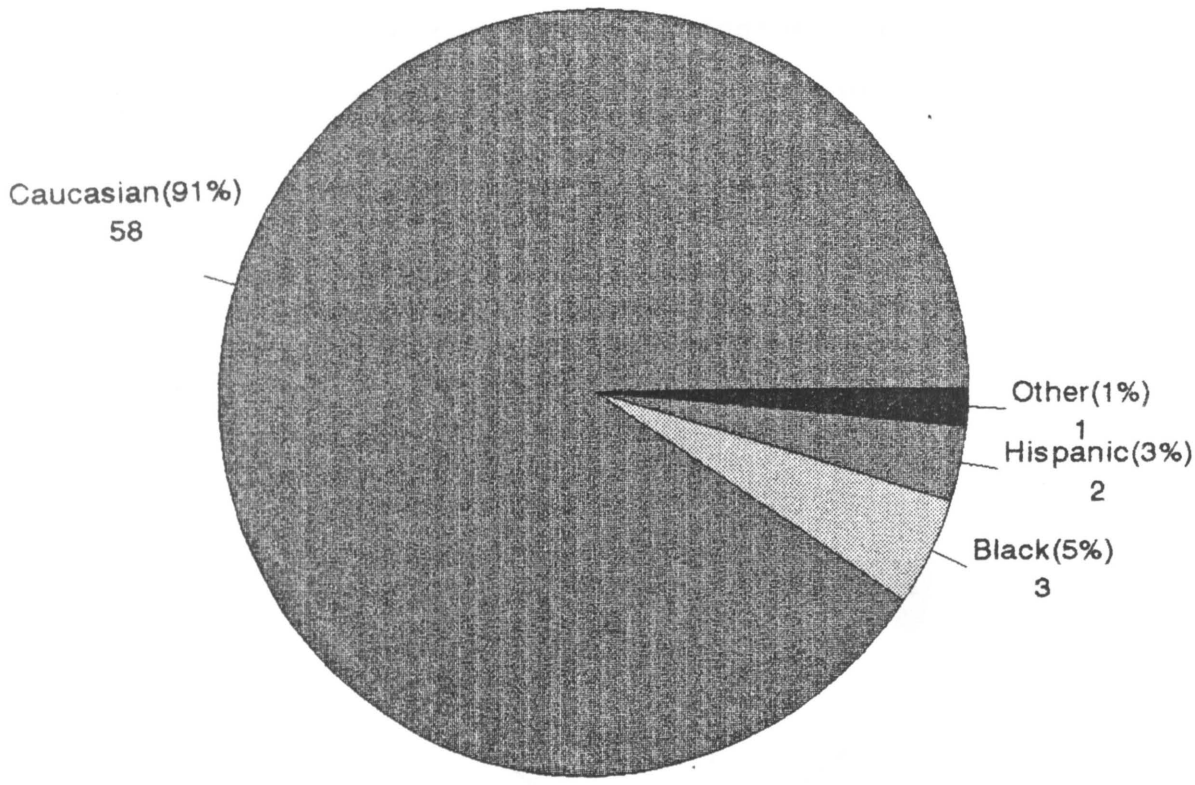


Ethnicity

The study population consisted of 91% Caucasian nurses, which represented the majority of the study participants. There were 4.5% Black American nurses, 3% Hispanic American nurses, with the remainder percentage representing a nurse of Indian origin. There were no Native American nurses among the study participants. Refer to Figure 3.

Figure 3

Ethnic Configuration

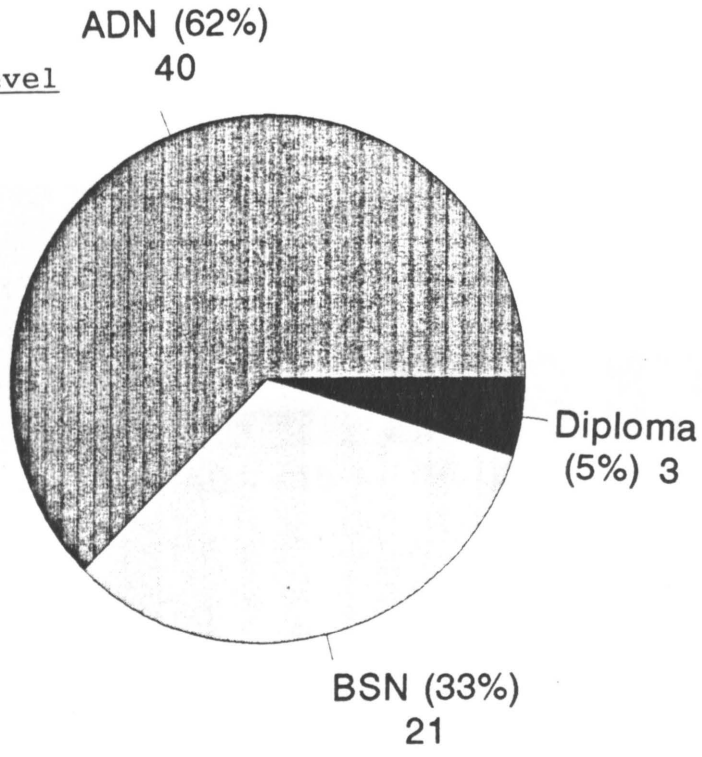


Educational Level

The majority, 62%, of study participants had earned a two-year, or Associate, degree in nursing [ADN]. The remaining third, or 33%, of study participants possessed a four-year, or Bachelor, degree in nursing or with an emphasis in nursing [BSN]. Three nurses, or 5%, received diplomas in nursing from hospital schools and did not receive formal college or university degrees. Refer to Figure 4. There were no study participants with graduate degrees, however 2 nurses were actively pursuing Master degrees. Of mention were 3 nurses who had earned Bachelor degrees in other fields and had entered nursing as a second career.

Figure 4

Educational Level

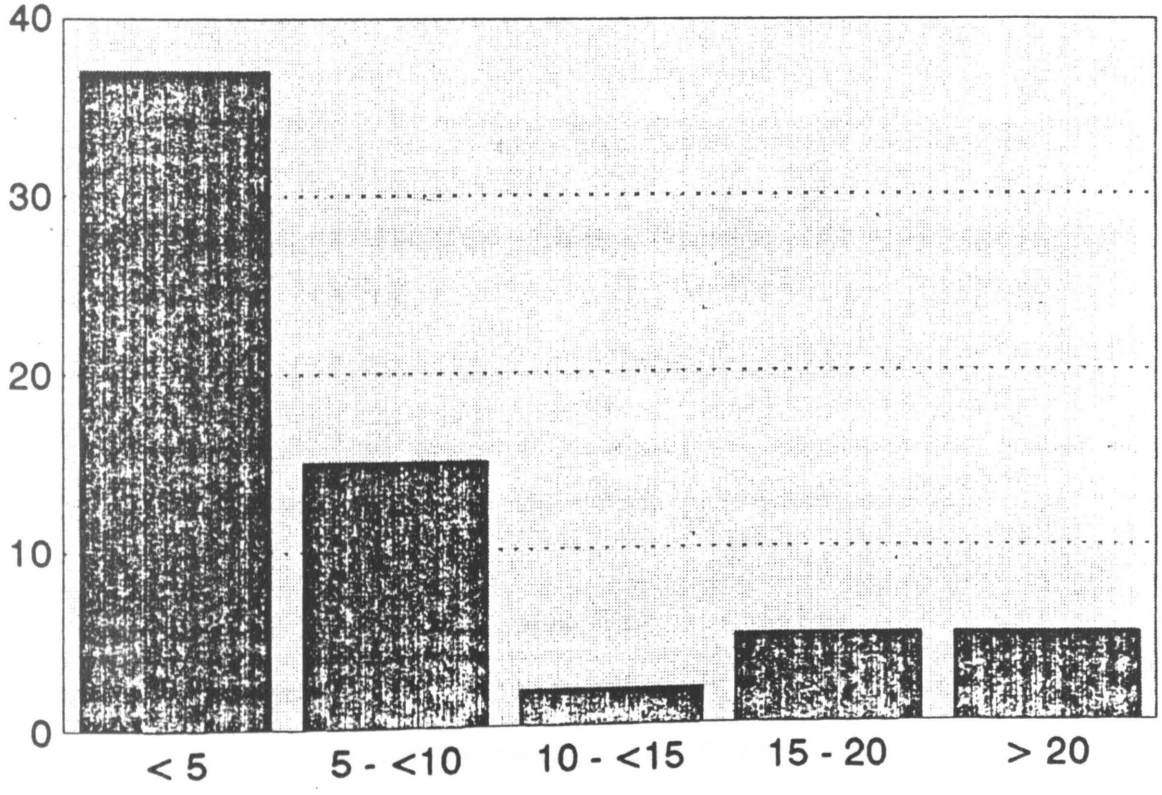


Professional Background

The number of years of RN practice as a full-time professional nurse varied from less than three months to greater than thirty years since licensure. The majority of study participants, or 58%, had practiced less than five years. Refer to Figure 5.

Figure 5

Professional Background



Hypothesis 1

An Analysis of Variance [ANOVA] was the statistical test used to analyze Hypothesis 1.

Hypothesis 1:

There is no significant difference in the frequency of community referrals during the client discharge teaching process provided by RNs who attend the CRP and those who do not attend the CRP.

Table 2 presents the ANOVA data for the 64 RN study participants.

Table 2

ANOVA (Hypothesis 1)

Source	Sum of Squares	Mean Square	DF	F Ratio
Between	50.77	50.77	1	20.43
Within	154.09	2.49	62	
Total	204.86		63	

The impact of the CRP upon the frequency of community referrals is confirmed with the statistical application of the ANOVA test. The F ratio and the differences between the sum of squares between and within groups are quite significant, and support the rejection of the first null hypothesis.

Hypothesis 2

Pearson product-moment linear correlation was the statistical test used to analyze Hypothesis 2.

Hypothesis 2:

Among those RNs who attend the CRP, there is no correlation between the number of years in professional nursing and the frequency of community referrals provided during the client discharge teaching process. The Pearson r value = 0.27. The Pearson r therefore does not confirm the relationship between the number of years in professional nursing and the frequency of community referrals. The Pearson r = 0.27 is not statistically significant, and does not support the rejection of the second null hypothesis.

CHAPTER 5

The impact of the CRP upon the client discharge teaching provided by registered nurses [RNs] in the emergency department [ED] of one urban public hospital was measured by testing two null hypotheses. The frequency of community referrals provided by RNs during the client discharge teaching process was the dependent variable in both hypotheses. The effect of the CRP upon community referral provision was analyzed by using the Analysis of Variance [ANOVA] statistical test. The relationship between the number of years in professional nursing and the number of community referrals was analyzed by using the Pearson product-moment correlation test.

The study was quasi-experimental in design, with the nonequivalent control group pre-post-test design involving the division of the RN study participants into two groups. The groups consisted of those RNs who attended the CRP and those RNs who did not attend the CRP. The study group was comprised of RNs who attended the CRP.

Data was collected from twenty after-care instruction or ACI forms per study participant prior to and twenty after the CRP. There were 64 RN study participants in the total population.

The significance of the study was based upon the impact of the CRP. The incorporation of adult learning theory and and community nursing models into the ED RN role was one potential effect of this educational presentation. The possibility of decreased numbers of client visits and the financial implications as a result of the effectiveness of the CRP may influence ED management to consider emphasis upon patient education.

The current literature and trends in the modern United States support the RN role in the patient education process. The CRP and community referral process are congruent with modern expanded systems of health care which integrate the acute care setting with the community served.

The RN role as a health educator is supported by the broad and legal definitions of the contemporary professional nurse. Patient education by the RN has historical precedent and is mandated by state nurse practice acts.

The urban ED is a challenging setting, however it is critical that an ED client receives appropriate teaching and referrals before returning to the

community. The ED nurse is not only bound by the legal and professional scope of practice, but by the public expectation that patient education is a right. The ED RN remains at a key point of entry for clients requiring health care and health education.

Conclusions

Hypothesis 1 stated:

There is no significant difference in the frequency of community referrals during the client discharge teaching process provided by registered nurses who attend the CRP and those who did not attend the CRP. This null hypothesis is rejected based upon the ANOVA statistical findings.

This conclusion is based upon the F ratio = 20.43. This difference is statistically significant, and supports rejection of the null hypothesis. Additional data which support this conclusion are the differences in the group means and the sum of squares between and within the groups. The group means = 1.94, .16. The difference between the group means implies statistical significance. The sum of squares between the groups = 50.77 and the sum of squares within the groups = 154.09. This difference is consistent with statistical significance.

The rejection of the first hypothesis implies that the frequency of community referrals, the dependent

variable, during the client discharge teaching provided by RNs was greater among those RNs who attended the CRP than those who did not attend the CRP. The CRP, the independent variable, was therefore an effective educational presentation in this sample which influenced the RNs to provide more community referrals during the client discharge process in the ED.

Hypothesis 2 stated:

Of those (RNs) who attended the CRP, there is no correlation between the number of years in professional nursing and the frequency of community referrals. This null hypothesis is not rejected, based upon Pearson product-moment correlation statistical analysis.

This conclusion is derived from the Pearson r = .27. This Pearson value is not statistically significant and does not support a relationship between the two variables. Therefore, there is no correlation between the number of years in professional nursing and the provision of more community referrals by the RNS in this sample.

The Pearson r is an appropriate means of statistical analysis because there were more than 30 subjects in the sample and a linear relationship existed between the two variables.

The Problem

How does the CRP impact the client discharge teaching, in regard to the frequency of community referrals, provided by RNs in the ED of an urban public hospital? The CRP, and its simple explanation of the community referral process, was a means to increase the number of community referrals made in this sample.

The CRP represents a teaching strategy which succinctly emphasizes key concepts and processes for the health care provider. This teaching strategy is commonly known as an 'in-service' in the hospital setting. RNs are accustomed to this style of presentation.

Demographic Profile

The demographic profile of the study population revealed interesting data. The 64 RNs who participated in the study ranged from 23 to 61 years of age, with the span between the youngest and oldest RN being 38 years. The largest segment, 28%, of RNs were between 30 and 39 years of age. The next largest group was the 20 to 29 age range, with 24% of the RNs in this category. Therefore, the RN population is relatively young, with 52% of the study population being less than 40 years of age.

The mean and median ages, 33.17 and 32 years respectively, were slightly skewed due to the fact that only one RN was greater than 50 years of age. Without the RN who was 61 years of age, the overall study population would have been relatively younger. The mean and median age values would have been lower as well.

The gender distribution revealed a significantly higher percentage of male nurses, 23%, than expected according to national averages (ANA, 1991). The female RNs represented 77% of the study population.

Ethnic distribution yielded a predominant Caucasian majority within the study population. The Black, Hispanic, and other categories represented only 9% of the total number of study participants. This is an unexpected finding, particularly since this urban ED setting serves primarily poor and underserved clients of ethnic origins other than Caucasian.

The educational level of the RNs was inconsistent with the national trend of RNs in critical care settings typically completing more years in advanced educational settings (ANA, 1991). The two-year or Associate Degree in nursing [ADN] component represented 62% of the study population, while only one-third of the RNs had acquired four-year or Bachelor degrees in nursing or with an emphasis in nursing [BSN].

Contemporary emphasis upon advanced certifications and graduate degrees was also inconsistent with the absence of Master of Science [MS], or graduate, degrees among the RN study participants (ANA, 1991). There were 3 RNs who graduated from anachronistic hospital schools of nursing, with diplomas, and all were greater than 40 years of age.

The years in professional practice indicated that 37% of the study participants had practiced as RNs less than five years. The fact that only 19% of the total population had worked greater than ten years in the field of professional nursing suggests that this setting is not routinely selected for practice by more experienced RNs. Perhaps the rigor of 24-hour schedules and the dynamic ED setting itself attracted younger and newer nurses.

Can the stereotypical ED nurse of this urban hospital setting be described? The answer is yes. The RN would be approximately thirty years of age and female. She would be Caucasian and have completed her ADN, while practicing less than five years as an RN to date. The study population, however, remains diverse due to the extreme ranges among the demographic variables of age and years in professional nursing, as well as the surprisingly large number of male nurses.

Limitations

There was one limitation and one delimitation with regard to study sampling. The limitation of the convenience sample of 32 RNs who chose to attend the CRP may actually represent the RNs who had the greatest interest in patient education. The sampling delimitation was the need for 64 RNs who worked full-time to participate in the study. The total number of RNs in this category was 83, however study participation was obtained without difficulty.

The limitation and delimitation relative to the study setting was the existence of a designated discharge area in this ED. Most EDs are not designed with a private area dedicated to patient education. The majority of EDs in the United States are poorly designed to meet patient needs because they focus on the provider needs (Middleton & Whitney, 1993).

The limitation with regard to instrumentation was the use of the after-care instruction or ACI form already in place in this hospital ED setting. Two areas designated for the documentation of community referrals were noted on the ACI form. The instrument demonstrated content validity because it was in use, economical, and accessible to the principal investigator.

The other limitations of the study were attributed to either ED patient characteristics or ED setting variables. Patient characteristics which impacted the study were the unpredictable and fluctuating volume, and the literacy and interest of patients. The ED nurse faced periods of overcrowding as well as patients disinterested in receiving health care instruction. It may be that the attitude of nurses toward patients who frequently returned to the ED despite patient education offered also contributed to the difficulty in providing discharge teaching. The ED setting characteristics included the varying noise level and lack of privacy due to frequent interruptions by other patients awaiting ED discharge. The limitations are common to most ED settings, and contribute to the difficulty of the RN in carrying out the role of patient educator (Budassi & Barber, 1981; Close, 1988; Prescott, et al., 1991).

Implications

The CRP is an effective teaching strategy in this urban ED setting. The RNs who attended the CRP provided community referrals at a higher frequency than those who did not attend the CRP. Surprisingly, the number of years in professional nursing did not correlate with an increased frequency of community

referrals. The CRP is an important example of the feasibility of educational presentations in the urban ED setting. Emphasis upon community referrals during the client discharge teaching process is congruent with the emergence of integrated health care delivery systems in modern America.

Recommendations

Programmatic recommendations for this study focus on design and population. The first suggestion is to study the impact of the educational presentation over a longer period of time. It may be that the significance of the CRP with regard to the frequency of community referrals would have been less if the data collection had not occurred within thirty days of presentation. The second suggestion would be to compare the result of the CRP within different populations. The ED RNs in this study setting worked in a major trauma center designed with emphasis upon emergency triage and response. It may be that ED RNs working in differently designed settings, such as EDs with adjacent acute or urgent care centers, may place a different emphasis upon the patient education process (ENA, 1993; Budassi & Barber, 1981).

There are four recommendations for further study. The first recommendation is to include different

elements of the collaborative practice model when examining the patient education process. In order to measure the impact of community referrals, collaborative health care providers such as COPC clinics must be included in the study process (Grumbach, et al., 1993; Nutting, 1990).

The second recommendation is to include the scope of nursing practice in educational presentations for RNs. The legal and professional scope of nursing practice requires the RN to provide patient education (ANA, 1985; Clarke, 1991; ENA, 1993; TNA, 1993). The third recommendation is to study the different educational pathways for RNs rather than the number of years in professional nursing. The varying educational backgrounds may correlate with RN ability to provide effective patient education (Bradamat & Chalmers, 1989; Tilley, et al., 1987).

The fourth recommendation is to examine the impact of liaison nurses or case managers in ED settings. Modern emphasis upon managed care has led to the creation of new roles in health care provision (Nutting, 1990). The varied ED settings and their integral relationship with the communities served are important arenas for innovations in health care provision such as managed care (ENA, 1993).

Emphasis upon patient education in the ED setting is essential for the provision of health care to the client discharged home. The RN role represents a focal point in the continuum of health care for the ED client. The development and implementation of presentations which enhance RN skills as provider of patient education are feasible in the urban ED setting.

References

American Nurses Association. (1985). Code of ethics with interpretive statements. Washington, DC: Author.

American Nurses Association. (1991). Nursing and the American Nurses Association. Kansas City, MO: Author.

Anderson, R.J. (1986). How to preserve ethical values, equal access while seeking new efficiency. Healthcare Marketing Quarterly, 3, 16-20.

Anderson, R.J. (1991). COPC adds life to community. Parkland Today, 10(2), 8.

Anderson, R.J. (1992). A primary care alternative. Parkland Memorial Hospital Highlights, 29(2), 10.

Bigelow, B. (1991). Ambulatory care centers: are they a competitive advantage? Hospital and Health Services Administration, 35(3), 351-364.

Board of Certification for Emergency Nursing. (1994). 1994 handbook: international certification examination for emergency nurses. Park Ridge, IL: Emergency Nurses Association.

Bradamat, I.J. & Chalmers, K. (1989). Nursing education in Canada: historical progress - contemporary issues. Journal of Advanced Nursing, 14, 719-726.

Breckon, D.J., Harvey, J.R., & Lancaster, R.B. (1989). Community Health Education. Rockville, MD: Aspen Publishers, Incorporated.

Bryant, J.H. (1990). Primary health care - what still needs to be done? World Health Forum, 11(4), 359-367.

Boumbulian, P.J., Day, M.W., Delbanco, T.L., Edgeman-Levitan, S., Smith, D,R,. & Anderson, R.J. (1991). Patient-centered, patient-valued care. Journal of Health Care for the Poor and Underserved, 2(3), 338-346.

Budassi, S.A. & Barber, J. (1981). Emergency nursing: principles and practice. St. Louis, MO: The C.V. Mosby Company.

Burns, J. (1992). Ambulatory facilities continue rise. Modern Healthcare, 22(20), 102-105.

Burns, J. (1993). Outpatient care's future hinges on managed care. Modern Healthcare, 23(1), 42-44.

Cassidy, J. (1993). Integrated delivery resource manual. Health Progress, 12, 38-39.

Clarke, A.C. (1991). Nurses as role models and health educators. Journal of Advanced Nursing, 16, 1178-1184.

Clinton, H.R. (1993). Nurses in the front lines. Nursing & Health Care, 14(6), 286-288.

Close, A. (1988). Patient education: a literature review. Journal of Advanced Nursing, 13, 203-213.

Curtin, L.L. (1990). Designing new roles: nursing in the nineties and beyond. Nursing Management, 21(2), 7-9.

Davis, C. & Davis, J. (1992). "Nurse": dynamic term for a dynamic relationship. Nursing Management, 23(3), 42-43.

Emergency Nurses Association. (1993). Emergency nursing scope of practice. Journal of Emergency Nursing, 15(4), 361-364.

Faherty, B. (1993). Now is the time to advocate. Nursing Outlook, 41(6), 248-249.

Flahault, D. & Roemer, M. (1986). Leadership for primary care. Geneva: World Health Organization.

Geiger, H.J. (1993). Why medical students don't choose primary care? American Journal of Public Health, 83(3), 315-316.

Green, L.W. & Kreuter, M.W. (1992). CDC's planned approach to community health as an application of PRECEED and an inspiration for PROCEED. Journal of Health Education, 23(3), 140-147.

Grumbach, K., Keane, D., & Bindman, A. (1993). Primary care and public emergency department overcrowding. American Journal of Public Health, 83(3), 372-378.

Hass, F., Kunst, O., Lerner, B., Hutson, H., Baker, D., Stevens, C., Brook, R., Bindman, A., Grumbach, K., Kellerman, A., & Newton, E. (1992). Patients leaving emergency departments without being seen by a physician. Journal of the American Medical Association, 267(4), 231.

Institute of Medicine Division of Health Care Services. (1982). Community-oriented primary care. Washington, DC: National Academy Press.

Joint Commission for the Accreditation of Hospitals Association. (1992). Study focuses on hospital emergency department overcrowding. Joint Perspectives, 4, 7.

Jowett, S. (1992). A health model for community nursing. Nursing Standard, 6(25), 33-35.

Kark, S.L. (1981). Community oriented primary health care. New York: Appleton-Century-Crofts, Incorporated.

McCarthy, M.I. (1991). Implementing a new clinical coordinator role to facilitate primary care: one emergency department's experience. Journal of Emergency Nursing, 17(4), 204-210.

Messner, R.L. (1993). What patients really want from their nurses. American Journal of Nursing, 93(8), 38-41.

Meyer, C. (1992). The emergency nurse's world: always changing, always challenging. American Journal of Nursing, 92(9), 67-72.

Middleton, E.L. & Whitney, F.W. (1993). Primary care in the emergency room: a collaborative model. Nursing Connections, 6(2), 29-39.

National Commission for Health Education Credentialing. (1985). A framework for the development of competency-based curricula for entry-level health educators. New York, NY: Author.

National Commission for Health Education Credentialing. (1991). Renewal and certification procedures for certified health education specialists. New York, NY: Author.

Noble, C. (1991). Are nurses good patient educators? Journal of Advanced Nursing, 16, 1185-1189.

Nutting P. (1990). Community-oriented primary care: from principle to practice. Albuquerque, NM: University of New Mexico Press.

Pallarito, K. (1992). Making primary care the primary concern. Modern Healthcare, 22(7), 24-30.

Prescott, P.A., Phillips, C.Y., Ryan, J.W., & Thompson, K.O. (1991). Changing how nurses spend their time. IMAGE Journal of Nursing Scholarship, 23(1), 23-28.

Rich, J. (1993). Caring for E.D. patients: thirteen ways to protect your practice. Nursing93, 23(2), 60-61.

Schutzenhofer, K. (1992). Essentials for nurses in the year 2000. Nursing Connections, 5(1), 15-26.

Shalala, D. (1993). Nursing and society: the unfinished agenda for the 21st century. Nursing and Health Care, 14(6), 289-291.

Smith, D., Anderson, R.J. & Boumbulian, P.J. (1991). Community-responsive medicine: defining an academic discipline. American Journal of Medical Sciences, 302(5), 313-318.

Steckler, A.B., Israel, B.A., Dawson, L., & Eng, E. (1993). Community health development: an anthology of the works of Guy W. Steuart. Health Education Quarterly, Supplement 1, S1-S146.

Stone, L. (1992). Cultural influences in community participation in health. Social Science Medicine, 35(4), 409-417.

Texas Nurses Association. (1993). Annotated Guide: Texas' Nurse Practice Act. Austin, TX: Author.

Tilley, J.D., Gregor, F.M., & Thiessen, V. (1987). The nurse's role in patient education: incongruent perceptions among nurses and patients. Journal of Advanced Nursing, 12, 291-301.

United States Department of Health and Human Services Public Health Service. (1990). Health People 2000. Washington, DC: Author.

Villaire, M. (1993). Marie Manthey on the evolution of primary nursing. Critical Care Nurse, 13(6), 100-107.

Wartmann, S.A., O'Sullivan, P.S. & Cyr. M.G. (1992). Ambulatory-based residency education improving the congruence of teaching, learning, and patient care. Annals of Internal Medicine, 116(12), 1071-1079.

Wilson-Barnett, J. (1988). Patient teaching or patient counselling? Journal of Advanced Nursing, 13, 215-222.

Zuckerman, A.M. (1993). Have focused strategy for ambulatory care. Modern Healthcare, 23(4), 33-34.

Appendices

Appendix A

Cover Letter

Appendix A

October 1, 1993

Dear ,

I am a graduate student in the College of Health Sciences at Texas Woman's University, currently completing the requirements for a Master of Science degree in Health Studies. I am collecting information on the client discharge teaching process provided by registered nurses in the Emergency Department. By participating in this research study, you may assist in the development of improved educational tools for the ED client.

After receiving approval from the Parkland Nursing Research committee and the Institutional Review Board, I will contact all registered nurses in your department. You are being asked to attend a presentation entitled the "Community Referral Presentation," which is about fifteen minutes in length. Participation is voluntary.

If you choose to participate, confidentiality will be maintained by coding the registered nurses and patient medical records. Only group data without names will be used Your participation in this project is very important. There is no risk or any compensation associated with this study. The impact of the client discharge teaching provided by the ED nursing staff is significant.

Please do not hesitate to contact me for any questions you may have. I can be reached weekdays at 590-8608(office) or 823-4237(home/answering machine). Thank you for your time and consideration in this matter.

Sincerely,

Maggi Gunnels, RN
5942 Velasco
Dallas, Texas 75206

Appendix B

Consent Form

Appendix B

SECTION D: Informed consent

TEXAS WOMAN'S UNIVERSITY
SUBJECT CONSENT TO PARTICIPATE IN RESEARCH

TITLE OF STUDY; The Community Referral Presentation: Its Impact upon the Client Discharge Teaching Provided by Registered Nurses in the Emergency Department of One Urban Public Hospital.

INVESTIGATOR: Mary D. Gunnels, RN (214)590-8608

This study involves research, particularly data collection on the client discharge teaching process in the emergency department. By participating in this research study, you may assist in the development of improved educational tools for the ED client.

You are being asked to attend a presentation entitled the "Community Referral Presentation," which is about fifteen minutes in length. There is no risk nor any compensation associated with this research study. Participation is voluntary.

If you choose to participate in this research study, confidentiality will be maintained by coding the names of the registered nurses as well as patient records. Only group data without names will be used.

If you have any concerns about way this research has been conducted, contact the Texas Woman's University Office of Research and Grants Administration at (817)898-2000.

I, _____, consent to participate in this research study. An offer to answer all of my questions regarding the study has been made and I have been given a copy of the dated and signed consent form. If alternative procedures are more advantageous to me, they have been explained. A description of the possible attendant discomfort and risks reasonable to expect has been discussed with me. I understand that I may terminate my participation in this study at any time.

_____
Name

_____
Date

Appendix C

Presentation Outline

Appendix C

The Community Health Education Program

1. Introduction.
2. Explanation of project.
   A. Thesis study.
   B. Duration < 8 weeks.
   C. Voluntary.
3. CHEP (5-8 minutes)
   A. Definition of community referral.
   B. How to document community referral on the ACI.
   C. Resources available in Discharge Area (i.e. Community Council Directory).
4. Distribution of consent letters with profile.

Appendix D

After-care Instruction Form

Appendix D

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

DEPARTMENT OF EMERGENCY SERVICES
AFTER CARE INSTRUCTIONS

IMPORTANT: We have examined and treated you today on an emergency basis only. This is not a substitute for, or an effort to provide complete medical care. In most cases you must let your private doctor check you again. If you have been referred to a clinic, we strongly recommend that you keep your appointment. If you have had special tests such as EKG's, X-rays or labs we will review them again. We will attempt to call you if there are any suggestions. After leaving, follow the instructions listed below.

DIAGNOSIS:

MEDICATION:

FOLLOW LABEL INSTRUCTIONS FOR ANY PRESCRIPTION GIVEN BY EMERGENCY PHYSICIAN

☐ TAKE ANTIBIOTICS UNTIL GONE

PREPRINTED INSTRUCTIONS GIVEN: ☐ YES ☐ N/A

IN SPANISH: ☐ YES ☐ N/A

☐ BACTRIM
☐ CLOTRIMAZOLE VAGINAL CREAM/TAB
☐ DOXYCYCLINE
☐ DILANTIN
☐ ERYTHROMYCIN
☐ IBUPROFEN/MOTRIN
☐ FLAGYL
☐ KEFLEX
☐ LASIX
☐ ROBAXIN
☐ PENICILLIN
☐ PHENOBARBITAL
☐ PREDNISONE
☐ TETRACYCLINE
☐ TYLENOL #3
☐ VERAPAMIL
☐ ZANTAC
☐ _____
☐ _____
☐ _____

DEMONSTRATED/PREPRINTED INSTRUCTIONS GIVEN

☐ ABDOMINAL WARNINGS
☐ BURN CARE
☐ CAST CARE
☐ CRUTCH TRAINING
☐ D&C FOLLOW-UP
☐ DRESSING CHANGE
☐ FOOT CARE
☐ HEAD INJURY
☐ SUTURE CARE
☐ WOUND CARE
☐ WET TO DRY DRESSING
☐ OTHER _____

OTHER RESOURCES

☐ DENTAL CLINIC REFERRAL
☐ HEALTH DEPT. REFERRAL
☐ HOMELESS REFERRAL
☐ SOCIAL SERVICES REFERRAL
☐ FAMILY PLANNING REFERRAL

SPECIAL INSTRUCTIONS: _____

FOLLOW-UP/CLINIC APPOINTMENT GIVEN ☐ YES ☐ N/A **PRESCRIPTION GIVEN:** ☐ YES ☐ N/A

I HAVE RECEIVED AND UNDERSTAND THE INSTRUCTIONS ABOVE. I UNDERSTAND THAT I HAVE HAD EMERGENCY TREATMENT ONLY. I WILL ARRANGE FOR FOLLOW-UP CARE AS INSTRUCTED AND I WILL CAREFULLY FOLLOW THE INSTRUCTIONS GIVEN.

TRANSLATOR USED: ☐ YES ☐ N/A

DISCHARGED: ☐ HOME ☐ OTHER _____ (X)_____
PATIENT/SIGNIFICANT OTHER SIGNATURE

☐ AMBULATORY ☐ WHEELCHAIR ☐ OTHER _____

RN/MD SIGNATURE: _____ DATE: _____ TIME: _____

UNAVAILABLE FOR DISCHARGE TEACHING: 1) _____ (TIME / INITIAL) 2) _____ (TIME / INITIAL) 3) _____ (TIME / INITIAL)

006A

PS 149 Revised 9/92 White Copy - Medical Record Yellow Copy - Patient's Copy

Appendix E

Agency Research Committee Permission Letter

Appendix E

Parkland
Nursing Research

October 4 1993

Mary D. Gunnels, RN
Emergency Services

Dear Maggi ,

Thank you for presenting your research proposal, "A Community Health Education Program, Its Impact Upon the Client Discharge Teaching Provided by Registered Nurses in the Emergency Department of an Urban Public Hospital" to our committee August 28th. As you know the Committee asked that you further define the methodology before approval is given.

Your revised proposal has been reviewed and looks much clearer. You have approval from the Nursing Research Committee to begin your project.

Please feel free to consult either of us should problems or questions arise. Good luck with your research. Please share your findings and research experience with us at a point convenient to you.

We applaud your enthusiasm for research and your willingness to advance nursing practice in this way.

Sincerely,

Paula Tosch

Paula Tosch RN MSN
Co-Chair, NRC

Paula A. Loftis

Paula A. Loftis MS, RN
Co-Chair, NRC

cc: Beth Mancini

Parkland Memorial Hospital • 5201 Harry Hines Boulevard • Dallas, Texas 75235 • (214) 590-8087

Appendix F

Human Subjects Review Letter

Appendix F

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
OFFICE OF RESEARCH AND GRANTS ADMINISTRATION
P.O. Box 22939, Denton, Texas 76204-0939 817/898-3375

HUMAN SUBJECTS REVIEW COMMITTEE

November 4, 1993

Mary D. Gunnels
5942 Velasco
Dallas, Tx 75206

Dear Mary D. Gunnels:

Your study entitled "The Community Health Education Program: Its Impact upon the Client Discharge Teaching Provided by Registered Nurses in the Emergency Department" has been reviewed by a committee of the Human Subjects Review Committee and appears to meet our requirements in regard to protection of individuals' rights.

Be reminded that both the University and the Department of Health and Human Services (HHS) regulations typically require that signatures indicating informed consent be obtained from all human subjects in your study. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to HHS regulations, another review by the Committee is required if your project changes.

Special provisions pertaining to your study are noted below:

_X_ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

_X_ Your study is exempt from further TWU Human Subjects Review.

___ No special provisions apply.

Sincerely,

Chairman
Human Subjects Review Committee

cc: Graduate School
Dr. Susan Ward, Health Studies
Dr. William Cissell, Health Studies