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BERGER, MARY SUZANNE

CONGRUENCY BETWEEN AMBULATORY NURSING CARE REQUIRED AND  
DELIVERED; THE PATIENT'S PERSPECTIVE

THE UNIVERSITY OF ARIZONA

M.S. 1983

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CONGRUENCY BETWEEN AMBULATORY NURSING CARE  
REQUIRED AND DELIVERED; THE PATIENT'S PERSPECTIVE

by

Mary Suzanne Berger

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A Thesis Submitted to the Faculty of the  
COLLEGE OF NURSING  
In Partial Fulfillment of the Requirements  
For the Degree of  
MASTER OF SCIENCE  
In the Graduate College  
THE UNIVERSITY OF ARIZONA

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November 22, 1983  
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## ABSTRACT

An exploratory, descriptive study was conducted to ascertain whether there is congruency between ambulatory nursing care the outpatient believes is provided and nursing care the outpatient expects. The study also looked at the importance of a series of nursing activities from the patient's perspective.

The Activities of Ambulatory Care Nurses-Patient Questionnaire was developed by the author using literature and research derived ambulatory care nursing responsibility areas and activity categories. The instrument was administered to thirty medical-surgical outpatients. Analysis of patient responses indicated a fairly high level of congruency between nursing care expected and experienced. Of particular significance is the finding that the patients in this study expected yet did not receive adequate patient teaching. Likewise, patients expected to be transported to other clinic areas by the nurse and this care was not provided.

Patient-ranked importance of the 44 nursing activity items reflected a slight trend in priority toward traditional, technical and direct aspects of care. Lower priorities were assigned to decision making, planning, and supportive nursing activities.

## CHAPTER 1

### INTRODUCTION

The purpose of this research was to ascertain whether there is congruency between the outpatient's view of care he should receive and care that is delivered by the ambulatory care nurse. This study also looked at the importance of a series of nursing activities from the patient's perspective. This chapter provides an overview of the trend in health care toward the ambulatory setting. The evolving role of the ambulatory care nurse is demonstrated by an overview of the literature. The problem to be studied, its significance and an approach toward resolution are presented.

#### Ambulatory Care--An Alternative to Hospitalization

The current trend toward ambulatory health care indicates that this modality is more cost effective and appropriate for many health problems. Consumers are increasing their use of this alternative to hospitalization. Primary and preventive care, diagnostic treatments and procedures are accessible, convenient and less expensive in time and money (Eigsti and Vallone, 1983).

The literature abounds with the concern of consumers, health care providers, the government and third-party payers, regarding soaring health care costs. These groups are actively instituting means to decrease and control health care expenditures. A primary means to

such reduction is to shift health care to the ambulatory setting, which can provide more service and long-term treatment at a lower cost to clients (Curtin, 1983; Young and Saltman, 1983; Walker, 1983).

At the same time, the government and consumers are attempting to control ambulatory care cost escalation. Outpatient Diagnostic Related Groups (Ambulatory Patient Related Groups) have been developed to enhance cost effective health care planning and management within the ambulatory care setting (Fetter, 1980). Knapp has professed that the use of the Ambulatory Patient Related Groups can assist in "identifying and monitoring efficient or inefficient use of resources within ambulatory care practice" (Knapp, 1983, pp. 2-11).

The ambulatory health care consumer is gaining leverage in health care decision-making through legislation enacted for public protection (Grimaldi, 1983). In addition, membership on governing boards such as the Joint Commission on Accreditation of Hospitals compels the ambulatory care manager to consider consumer preferences in planning and delivering ambulatory care (Accreditation Manual for Ambulatory Health Care, 1982; Kovner and Smits, 1978).

Within the context of the consumer and associated legislation, attention to quality and cost effective health care, accountability, particularly in ambulatory care is expected to be a major thrust in the 1980's. It is anticipated that private and federal mandates will include the review of nursing care (Brosnan, 1981). The implication of increased utilization of ambulatory care and the concern about costs for the practice of ambulatory care nursing is the need to critically examine the role of the nurse. The activities encompassed in this role

must meet the needs and demands of the expanding outpatient population. It has been estimated that 89.9 percent of all illnesses are being treated in outpatient facilities. The expectation is that this figure will continue to rise (Rinaldi and Kelly, 1977).

#### Role of the Ambulatory Care Nurse

According to Roemer (1975), the first outpatient clinic in the United States was established in 1786. Nurses have been involved in the care of clinic patients since that time (Roemer, 1975). Yet, documentation that demonstrates the slow but steady progression from traffic-directing and technical duties to the present era of specialization is limited. During the past twenty years, ambulatory care nurses have been attempting to define, promote and expand their responsibilities (Buchanan, 1977). From the early to middle 1970's, many ambulatory care nurses began to function as primary care givers. This was a beginning indication that these nurses were being regarded by administration, physicians, and themselves as professionally capable, academically prepared, and competent independent patient care decision-makers (Schulman and Wood, 1972).

In attempts to define and delineate ambulatory care nursing practice and activities, nurses have consulted with other outpatient nurses and with members of the multidisciplinary health care team. Time studies to analyze outpatient nursing activities and staff utilization reviews have been instituted (Berger and Wesley, in press).

Ambulatory care nurse job descriptions have been reviewed and revised (Hooks et al., 1980). Protocols and standards of practice have

been developed (Lindenberg, Stuart and Baich, 1980; Bigham, 1973). Patient classification systems have been used to clarify the role of the professional nurse in varied outpatient settings (Stevenson, Brunner and Larabee, 1978; Simmons, 1980).

Quality assurance and audit criteria for ambulatory nursing have been developed based on standards set forth by the American Nurses' Association, the Joint Commission on Accreditation of Hospitals, Standards for Outpatient Services, and the American Nurses' Association Code for Nurses (Eigsti and Vallone, 1983; Hanson, 1975). Outpatient nurses have developed clinic-specific Ambulatory Care Quality Assurance Programs (Gruenwald and Artz, 1980; Ridle, 1977).

Task analysis has been utilized for clinic nurse role definition (Jacoby and Kindig, 1975), and direct observation of nursing activities has been implemented (Smale, 1971). Additionally, clinic nurses have defined their role through the use of patient assessment and screening procedures (Bigham, 1973; Weydert, Soper and Collins, 1974; Black, 1979; Kucha, 1974; Hain, 1976) and by applying the concept of self care (Allison, 1973; Backscheider, 1974).

Verran (1981), in an exploratory research project, extrapolated responsibility areas of ambulatory care nursing from the literature. These areas provided the framework for the development of non-overlapping activity categories to provide an inclusive systematically derived definition of the domain of overall ambulatory care nursing practice. The Delphi research technique was used to query ambulatory care nurse-experts about the activities they perform within the responsibility areas. The domain was delineated and defined as "the

full range of nursing practice that may be called into use to serve outpatients" (Verran, 1981). The domain is composed of responsibility areas that are defined as the accountability for the performance of categories of tasks and duties. Responsibility is determined by administrative direction and support as well as the health care disciplines working within the ambulatory care setting (Verran, 1981). The responsibility areas under the domain of direct patient care include: (1) patient counseling, (2) health care maintenance, (3) primary care, (4) patient education, (5) therapeutic care, and (6) normative care. The responsibility areas and the 42 underlying activity categories provide a taxonomy of nursing care activities in the ambulatory care setting. This taxonomy of ambulatory care nursing practice provides the most concrete and useful contribution to date in delineating and defining ambulatory care nursing activities. The taxonomy which incorporates literature-based definitions, empirically based operational definitions, and clinical examples is illustrated in Appendix A.

#### Research Problem

The preceding overview of the state of the art reflects the efforts of ambulatory care nurses to clarify their role and practice. These endeavors, however, have been confined to the professional frame of reference. To thoroughly assess the effectiveness of nursing activities, it is essential to scrutinize not only what the nurse believes to be necessary and helpful for the delivery of quality patient care. According to Roberts (1982), the outpatient's opinion regarding required nursing activities pertaining to his welfare must

also be considered. Roberts (1982) has elaborated that client and nurse shared decision-making is imperative because the patient's perception of his status is a vital factor in his understanding of as well as his cooperative participation in these regimes. The nurse's perception of the patient's condition/situation influences the full range of quality patient care planning. The input and responses of both parties determine health outcomes. Conway-Rutkowski (1982) and Chang (1980) have noted that a common understanding of the patient's needs and values provide the basis for optimal nursing care and positive client health outcomes.

Swansburg (1981) has suggested that differences may exist between patient and nurse perspectives regarding nursing activities that are deemed relevant and necessary for the patient. Inpatient settings have implemented measures to identify these differences to facilitate change and improve patient care. Patient surveys within the hospital setting that elicit patient opinion of services and nursing care are relatively common (Taylor et al., 1981; Houston and Pasanen, 1972). For example, a Midwestern hospital utilizes a fifty-four item survey questionnaire that is mailed to patients shortly after discharge. The return rate is between 55-60%. Computer data analysis has demonstrated that "nursing care is the single most crucial aspect in determining the overall rating of the hospital" (Carey and Posavac, 1982, pp. 44-46).

Patient expectations and views regarding health care, particularly nursing activities, remain nebulous and unexplored within the realm of ambulatory care (Roberts, 1982). Re-examination with

reformulation of the role of the ambulatory care nurse must include the patient's viewpoint (Bryant, 1975). The focus on cost effective health care, resourceful nursing staff utilization and consumer and legislative demand for accountable, quality care obligates ambulatory care nursing to re-examine and redefine tasks and responsibilities (Kissinger, 1973).

It is logically sound and professionally imperative that nursing activities not be formulated upon untested nursing assumptions. Client/consumer expectations of necessary and important nursing activities must be incorporated (Swansburg, 1981). The urgent need to bridge the gap between patient and nurse perspectives regarding congruency in ambulatory nursing requirements has provided the impetus for the present study.

#### Statement of the Problem

This study was designed to ascertain whether there is congruency between patient views of care he should have received and care actually delivered by the nurse in the ambulatory care setting. The study also investigated the importance of a series of nursing care activities from the patient's viewpoint.

#### Significance of the Problem

This problem is significant to the welfare of all clients receiving ambulatory nursing care. It is significant for the reformulation and refinement of ambulatory care nursing practice. Many attempts to identify and define ambulatory nursing activities and responsibilities have been made. Yet, those to whom these efforts,

care and concern have been directed, have not been consulted. Nursing has historically viewed itself as a patient-oriented and service-centered profession; however, there is negligible scientifically formulated data to support this view within the ambulatory care setting. In addition to delineating and defining the ambulatory nursing role from a nursing perspective there is a crucial need to study the nurse's role from the patient's position (Roberts, 1982).

Boettcher (1978) has described the collaborative nurse-patient relationship as a means through which the client is afforded dignity and respect. The client's right to participate in the planning and implementation of his health care regime is promoted. This modality ensures provision of patient information about health status. Furthermore, the nurse demonstrates care and concern by eliciting patient input so that mutually agreed upon health goals can be formulated.

Congruency between patient and nurse beliefs about priorities for care has been suggested to promote an increased sense of patient personal control. Involvement in health care decisions increases a patient's willingness to follow the plan of care he has participated in developing. The ultimate patient outcome is an increased state of physical and psychological well being (Dracup and Meleis, 1981).

Neuman (1980) has supported the importance of considering client expectations when planning health care interventions. This author stated that "goals for care could be inappropriate if not based on clarification of how the client perceives his situation or condition" (Neuman, 1980, p. 128). Neuman also elaborated that the patient's perceptions and experience comprise the foundation for

decision-making. Beliefs, values and attitudes influence perception. Therefore, the most carefully nurse-planned programs may be rejected by the patient if in his opinion the information provided is irrelevant. Stratman (1975) has substantiated the necessity of considering the attitudes, beliefs and values of the consumer. A study of ambulatory care patient satisfaction demonstrated that the consumer knows what he wants in regard to health care, based on personal goals and values. Stratman's study also revealed that the patient's values and beliefs about what is right for him may differ markedly from care the health care provider believes should be given.

#### Purpose of the Study

The following questions were examined in this study.

- Is there congruence between ambulatory nursing care that the outpatient believes is provided and the nursing care that the patient expects and experiences?
- How does the outpatient rank the importance of a series of nursing activities?

#### Summary

This chapter has addressed the trend in health care toward the ambulatory care setting. Issues related to the role of the ambulatory care nurse have been presented. The important matter of considering the outpatient's opinion regarding nursing care requirements has been discussed. This research addressed the need to examine congruence between the outpatient's opinion of ambulatory nursing care believed to be provided and care expected and received. The importance of a series

of nursing activities were investigated from the outpatient's point of view.

## CHAPTER 2

### CONCEPTUAL ORIENTATION

Two assumptions about the nature of man are recognized in the development of the proposed conceptual orientation for this study: (1) Man is an open system, and (2) Man is a social being. The first assumption, that man is an open system, means that he responds to his environment in an active manner. Man creates his world through such processes as learning, perception, cognition and language (Roberts, 1976). Roy (1980) has maintained that man must be viewed as a unified whole in constant interaction with the changing environment.

The second assumption, that man is a social being, is a premise that has been described by Rogers (1971). Rogers professed that through language, man communicates his thoughts, actions, customs and beliefs. Furthermore, man reacts to the environment in terms of his perceptions, expectancies, and needs at any given moment.

Principles of systems theory, communication theory, and social learning theory are viewed as impacting on the nurse-patient relationship and on the assumptions presented regarding the nature of man. For the purpose of this research, these elements are considered as being interrelated and directly associated with the concept of congruence.

Boettcher (1978) has recommended that the nurse-client relationship be viewed as an open system. The patient and nurse subsystems are interdependent, interrelated, and interpenetrable.

"When patient goals of health care and associated nursing activities are mutually agreed upon, an increase in nursing care effectiveness and positive client outcome would be expected" (Boettcher, 1978, p. 15). This idea, reflecting congruency, has been supported by King (1971) and Hazzard (1971).

Communication theory has allowed that interpersonal systems may be considered as information feedback loops. The behavior of each person is influenced and affected by the other (Watzlawick, 1967). The core of the classic nursing theory of Peplau (1952) is the interpersonal process. According to Peplau, the patient and nurse enter a relationship with preconceived ideas that influence perception. Through communication, an understanding of one another's roles and factors surrounding the patient's problem, increase until both are mutually sharing information that promotes problem resolution (Belcher and Fish, 1980). Brown (1965) and Sullivan (1953) have professed that effective communication depends on a shared common frame of reference. The importance of effective communication in the outpatient setting has been emphasized by Starr, Ellis and Oka (1980). These authors maintain that client input is essential for providing care that patients feel is necessary. Again, the concept of congruency between patient and health care provider is supported.

The expectancy construct derived from social learning theory is also viewed as impacting on congruency between nurse and patient opinions about care requirements. According to Rotter (1954), the expectancy construct constitutes a major influence on a person's interpretation of events and choice of corresponding behavior. The

reinforcement of the event is related to individual needs and past experiences. Weinberger, Greene and Mamlin (1981) contend that expectations influence the outpatient's opinions about care he thinks he will receive and care he considers necessary. In order for care to be considered effective, agreement on the value of the care must be established between the health care provider and the patient.

This research proposes that an interwoven relationship exists among: (1) the assumptions that man is an open system and a social being; (2) principles of systems theory, communication theory and social learning theory; and (3) the ambulatory care nurse-patient relationship. The concept of congruence is viewed as the essential link among the elements within the aforementioned relationship.

#### Congruence Model

The remainder of this chapter describes the delineation of the congruency concept used in this study. This research recognizes the importance of the concept of congruence between ambulatory nursing care that the outpatient believes is required and the nursing care the patient believes is delivered. The congruency concept represents the focus of analysis. The Delineation of the Congruency Concept is shown in Figure 1.

On the conceptual level, the model indicates that a positive, equal relationship between patient judgement of nursing care required and nursing care delivered will lead to congruency between expected and received nursing care. The two aspects of congruency--patient judgement of nursing care required and patient judgement of care

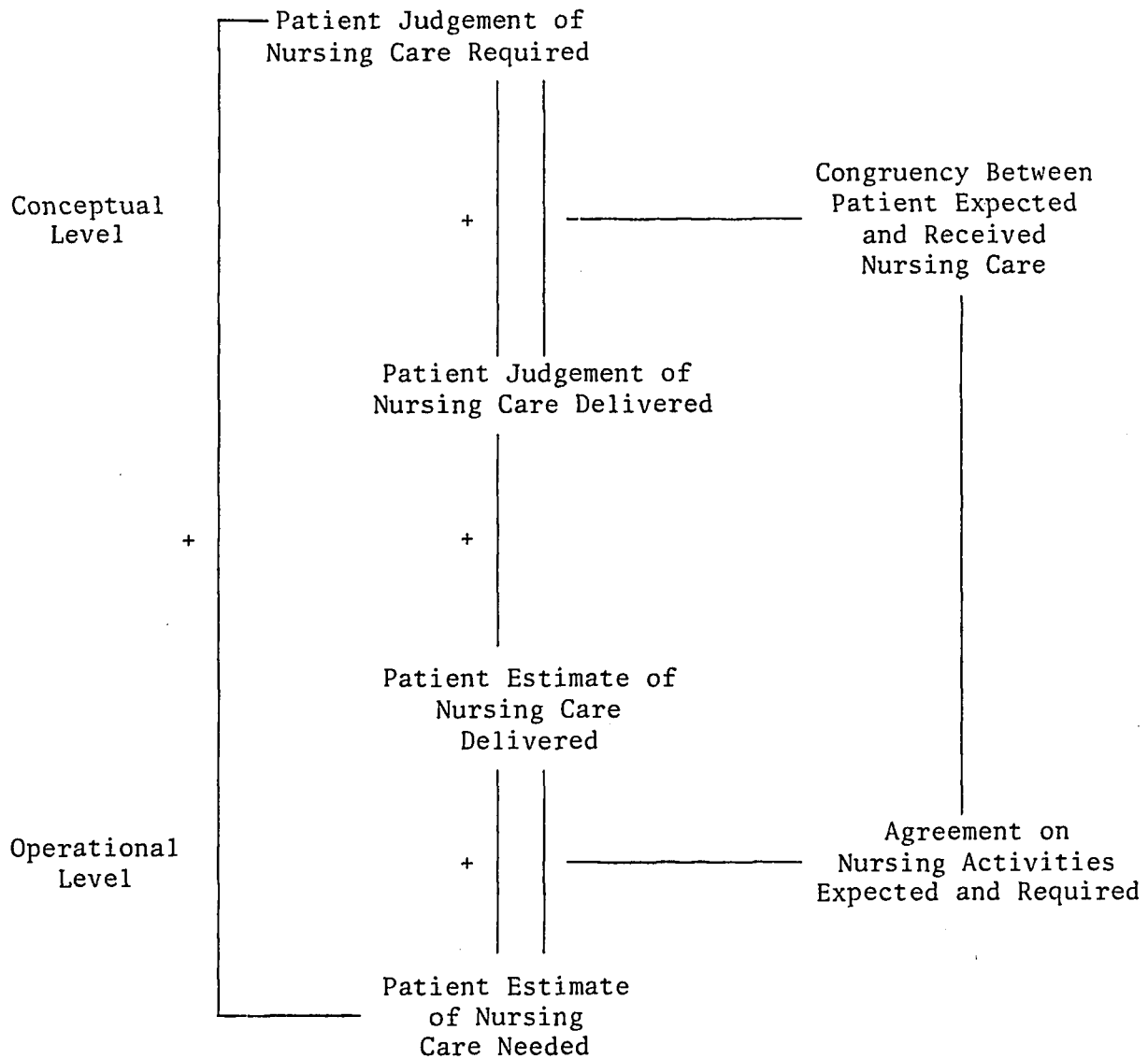


Figure 1. Delineation of the congruency concept.

delivered--are operationalized as patient estimate of nursing care delivered and patient estimate of nursing care needed. Both of these operational variables are seen as positive indicators of the higher-level concepts. The following sections will describe the Delineation of Congruency and the operationalization of the proposed Congruence Model.

#### Delineation of Congruency

The proposed Delineation of the Congruency Concept purports that congruency between what the patient expects and what he receives in nursing care occurs when there is a positive equal relationship between patient judgement of nursing care required and patient judgement of care delivered. Congruence has been described as matching experience, awareness, and communication. Incongruence has been defined as a discrepancy between experience, awareness, and communication (Lindell, 1979). Congruence is an important aspect of the nurse-patient relationship. The patient's opinion about what is important in meeting his needs and his view about the value of care will influence the amount of benefit he derives from the plan of care. The importance of clarifying the patient's perception so that appropriate nursing interventions may be instituted has been recognized by many, including Peplau (1952), King (1971), Neuman (1980), Chang (1980), Swansburg (1981), and Conway-Rutkowski (1982). Roberts (1982) and Bryant (1975) have supported the congruency concept specifically within ambulatory care nursing practice.

One study was found in the literature to scientifically support congruency in the ambulatory care setting. Anderson (1980) conducted a study at a university-based ambulatory care facility to test the concurrent validity of a psychosocial screening tool and to assess the relationship among the scale, health status, and nursing needs. Three psychosocial screening tools and a health perception scale were used to interview forty ambulatory care clients. Two questions were added to the health perception scale to tap patient perception of helpful nursing activities: (1) "How much help would you like from a nurse?" and (2) "How can a nurse be helpful to you today?" Patient responses to perceived helpful nursing care were categorized. Fifteen clients wanted some type of physical care such as their blood pressure taken or their weight recorded; five wanted the nurse to talk to them; four requested explanation of aspects of care; four wanted the nurse to be pleasant and kind; three expected advice; and one wanted the nurse to baby sit while the patient saw the doctor. Three expressed no need for a nurse, and five were not sure if they needed nursing care. Further testing was deemed necessary to replicate findings. It was stated that eliciting patient opinion could assist nurses with identifying specific patient needs and nursing care requirements, so that appropriate action could ensue. Anderson (1980) has maintained that establishing agreement between patient-perceived needs and relevant nursing care is important. Thus, congruence between care provided and care that is expressed by the patient as needed, has been recognized and advocated.

### Operationalization of the Congruency Model

For the purposes of this model and the proposed study, the unit of analysis shall be the ambulatory care patient. The model shows that patient estimate of nursing care that is needed is a positive indicator of patient judgement of nursing care required. Literature has supported that patients are able to recognize their health care needs and formulate opinions and decisions about nursing care that is necessary to meet their needs (Kirchhoff, 1976; Gehring and Geach, 1973; Neuman, 1980, Dracup and Meleis, 1981).

The concept of patient estimate of nursing care delivered is also described as a positive indicator of patient judgement of nursing care delivered. Operationalization of this model makes the assumption that the patient is capable of identifying nursing care that is delivered. Support for this assumption has been well substantiated in the literature (Houston and Pasanen, 1972; Stratman, 1975; Boettcher, 1978; Starr, Ellis and Oka, 1980; Weinberger, Green and Mamlin, 1981; Carey and Pasovac, 1982). Based on this assumption, the final operational aspect purported by the Congruence Model is that if there is a positive, equal relationship between patient estimate of nursing care delivered and patient estimate of nursing care needed, there will be agreement on nursing activities expected and required. This relationship is viewed as a positive indicator of congruency between nursing care expected and nursing care received by the patient.

A second assumption made in the operationalization of this model is that if care is delivered to the outpatient, the ambulatory care nurse obviously thinks it is important and required. Nurse-

determined ambulatory care nursing requirements have been identified in the literature (Verran, 1981).

Drawing from the author's ambulatory care nursing experience, this research recognizes that the nurse may acknowledge care needed by the patient. Yet, nursing judgements and situational factors may result in altering or not providing this care. Several explanations are postulated regarding interference with what the nurse believes is required patient care and care that the patient actually receives. The nurse may be working under time constraints due to inadequate staffing or administrative requirements for meeting and inservice attendance. A clinic emergency may require the nurse's immediate attention. A backlog in clinic patient flow may necessitate that minimal care be given to each patient. In addition, triage may indicate that one aspect of care warrants priority over another nurse-acknowledged care need, based on the patient's presenting health status. It would be expected that the nurse would explain such circumstances to the patient in order to enhance his ability to formulate an estimate of nursing care actually delivered and care that he needs.

It is further suggested that the outpatient may receive care that the nurse does not think is really necessary. Care may be given uniformly to all patients according to clinic protocol or procedure. Examples of routine care include weight, temperature and blood pressure measurement.

Operational variables described from the investigator's experience have been included in this conceptual orientation. The variables are viewed as having direct impact on ambulatory nursing care

that is provided. Furthermore, the importance that the nurse explain omissions, alterations and routines in care to the patient is emphasized. These factors are considered pertinent to the congruency concept.

### Summary

Congruence, as an important concept for promoting patient welfare, has been well supported in the literature. Scientific studies to substantiate this importance in ambulatory care nursing could not be found, with the exception of one investigation. The present study addressed the need to systematically examine congruency in ambulatory care nursing practice.

This chapter has described a proposed interwoven relationship among two assumptions about the nature of man, principles of systems theory, communication theory, social learning theory, and the ambulatory care nurse-patient relationship. The concept of congruence has been viewed as the essential link among the elements of this relationship. The conceptual orientation presented has addressed the importance of congruency between ambulatory nursing care the outpatient believes is delivered and care the patient expects and receives. The proposed Congruence Model and the Delineation of the Congruency Concept have been presented. Operationalization of the model has been explained.

## CHAPTER 3

### METHODOLOGY

The following topics are presented in this chapter: design of the study, setting and sample, protection of human subjects, data collection instrument, method of data collection, method of data analysis, and the operational definitions for the study. This was an exploratory, descriptive study to determine whether there is agreement between ambulatory nursing care that the outpatient believes is provided and the nursing care that the patient expects and receives. Ambulatory care nursing activities were derived from the literature to develop a patient opinion questionnaire.

#### Setting and Sample

The study was conducted in a university hospital based ambulatory care center located in the Southwest. The Activities of Ambulatory Care Nurses-Patient Questionnaire was administered to patients who had sought care at the clinic at least twice before participating in the study.

A purposive sample of thirty outpatients was selected by using the clinic appointment schedule. Fifteen patients with medical diagnoses of diabetes, cardiovascular disease, chronic obstructive lung disease or arthritis were included in the study. Fifteen patients with a surgical diagnosis, specifically those who had undergone abdominal,

orthopedic, genito-urinary or cardiovascular surgical procedures within the past four months prior to the investigation, were included in the study. These diagnostic categories were selected because they represent typical health care needs managed on an outpatient basis. The decision for selection was based on the investigator's ambulatory care nursing experience. Medical diagnosis and type of surgery were obtained from the patient record and recorded on the patient's questionnaire.

Patients participating in the study were required to be alert and oriented, not distracted by severe pain or excessive emotional distress, able to speak and read English, and willing to participate in the research project. Patients excluded from the study were those visiting the clinic for the first time. These patients would not have had the opportunity to become sufficiently familiar with the clinic or the activities of the nursing staff. They may have been unable to appraise the activities as requested by the study.

In summary, criteria for patient inclusion in the study were:

1. Two clinic appointments prior to the date of the study.
2. A medical diagnosis of diabetes, cardiovascular disease, chronic obstructive lung disease, or arthritis; or
3. A surgical diagnosis; specifically, that the patient had undergone an abdominal, orthopedic, genito-urinary or cardiovascular surgical procedure within the past four months prior to the date of investigation.
4. Mental alertness and orientation.

5. Absence of distractability due to severe pain or excessive emotional distress.
6. The ability to speak and read English.
7. Agreement to participate in the study.
8. Review of the study disclaimer prior to participation.

#### Protection of Human Subjects

The study proposal was approved by the Ethical Review Committee of the University of Arizona College of Nursing and the research director of the study facility. The approval forms are shown in Appendices B and C. The disclaimer explained the purpose of the study and the right not to participate in the study without risk of untoward consequences. The disclaimer explained anonymity and stated that there were no known risks for participation. Availability of the investigator to answer questions was also assured. Subjects were required to read the disclaimer before they were accepted for participation in the investigation. Confidentiality of the informants was upheld by the investigator through assignment of an identification number to each questionnaire.

#### Data Collection Instrument

The 44 item instrument used in this study was developed by the investigator. The taxonomy of ambulatory nursing care activity categories delineated and defined by Verran (1981) provided the foundation for tool development. Verran extracted literature-based ambulatory care nursing responsibility areas and used these to query 15 ambulatory care nurse-experts about activities performed under the responsibility

areas. The Delphi research technique used in Verran's exploratory study resulted in the formulation of 42 non-overlapping direct nursing care activity categories. The activity categories were abstracted from ambulatory care nursing tasks identified by the Delphi panel members.

The items comprising the Activities of Ambulatory Care Nurses-Patient Questionnaire developed for this study were derived from clinical examples of the activity categories delineated and defined by Verran (1981). Clinical examples were converted into activity statements. For instance, making the patient aware of his rights, both physically and financially, empirically represents the ambulatory care nursing activity category, Client Advocacy (Verran, 1981). This clinical example was converted into a nursing activity statement to become item number 1 of the questionnaire, i.e., "Explains your rights about health care and service." Another activity clinical example is counseling related to coping with terminal illness or assisting a family to cope with a terminally ill family member. The nursing activity category empirically represented is Terminal/Chronic Illness (Verran, 1981). This clinical example was converted into a nursing activity statement, i.e., "Provides support and guidance for you or your family if you have a long term or life threatening illness." This activity statement became questionnaire item number 5.

The questionnaire statements elicited patient response to questions directly related to the conceptual orientation. The questions were: (1) Has the nurse performed this activity for you? and (2) Whether or not the nurse performed the activity, do you feel you should have received the care described? These questions reflect and

were intended to measure the operational variables of Patient Estimate of Nursing Care Delivered and Patient Estimate of Nursing Care Needed. The instrument was formulated upon two assumptions of the proposed congruency orientation: (1) If care is given to the outpatient, the nurse obviously thinks it is important and/or required; and (2) The outpatient is capable of identifying care that is received.

Instrument items were phrased as statements that elicited three patient responses. The two responses reflecting the conceptual orientation were presented as dichotomous scales. A Likert-type format was used to tap the aspect of patient-perceived importance of the nursing activities described. Respondents were asked to rank the items from little importance to great importance on a scale from one to six. Six choices eliminated a central midpoint so that response sets would be avoided.

The disclaimer, instructions for questionnaire use and request for demographic data were incorporated within the first page of the instrument. In order to describe the sample, demographic data requested included: age, occupation, perceived health status, sex, education in years, marital status, length of time attending the clinic, and the section of the clinic attended. Space was provided at the end of the questionnaire for the patient to write any nursing care received that was not included in the instrument items or care that the patient believed should have been provided. The instrument is shown in Appendix D. The Instrument Key which presents literature-based ambulatory care nursing responsibility areas, research-derived activity categories, and corresponding instrument items is shown in Appendix E.

Validity is generally defined as the extent to which a tool measures what it is intended to measure (Rezler and Stevens, 1978). Content validity was of particular significance in the development of this instrument because it refers to how adequately the tool covers the area under examination. Content validity of the questionnaire items was assumed by the investigator based on the inclusive, non-overlapping Taxonomy of Ambulatory Care Nursing Practice (Verran, 1981), which provided the foundation for the development of the tool. An instrument's construct validity is concerned with the major dimensions of the framework underlying the tool. The nurse-expert systematically derived activity categories developed by Verran (1981) demonstrate construct validity. Because those activity categories underlie the questionnaire statements, construct validity of the instrument was assumed by the investigator.

There are three types of instrument reliability: internal consistency, stability, and equivalence. "Internal consistency is an index measuring the extent to which different subparts of an instrument are equivalent in terms of measuring the critical attribute" (Polit and Hungler, 1978, p. 428). Stability of an instrument refers to the extent that like results are obtained upon repeated administration of the tool. Equivalent reliability may be attained by using two parallel instruments to measure the same object of study (Polit and Hungler, 1978).

The use of any of these reliability measures could not be applied to the tool developed for this study. Items cover several dimensions of nursing care, therefore internal consistency was not

relevant. Stability was not appropriate to the instrument, as patient perception of care would be expected to change from one clinic visit to another clinic visit. Equivalent measures could not be found in the literature. Consistency of ratings among patients was, however, assured by adequate explanation of questionnaire items. This insured subject understanding of information requested, and was expected to produce results that were comparable across the study subjects.

A pilot test of the instrument was conducted at a university-based ambulatory care center in the Southwest, to determine the adequacy of the measurement instrument. The questionnaire was administered to three medical outpatients and three surgical outpatients to determine whether the respondents understood the directions and questions. The investigator also questioned the subjects concerning their reactions to and overall impression of the project. The criteria for the full study were used for the pilot study. The data from the pilot test was not included in the final analysis.

#### Method of Data Collection

The investigator remained in the clinic setting daily during clinic hours (8 AM - 5 PM) until thirty patients who met the criteria volunteered to participate in the study. The clinic appointment schedule was used as an initial screening device to determine diagnoses that met study criteria. Following their clinic appointments, patients were approached by the investigator to assess additional selection criteria and to explain the study and questionnaire directions. The Activities of Ambulatory Care Nurses-Patient Questionnaire was then

administered to those patients meeting all requirements for participation.

The investigator remained with the subjects while they completed the questionnaire to answer questions and provide additional direction if needed. Upon completion, the questionnaires were returned to the investigator. The forms were then number coded and diagnoses were written on the forms. The 44 items of the questionnaire were intended to elicit patient opinion about ambulatory care nursing activities that the patient believes are provided and needed. The patients were asked to express their opinion regarding the importance of these activities in order to answer the second research question which was, how does the patient rank the importance of a series of nursing activities.

#### Data Analysis

Descriptive statistics were used to analyze data pertaining to the sample demographic characteristics. The patient-rated importance of nursing activities was also analyzed using descriptive statistics. In addition, the set of activities were rank ordered by patient-perceived importance.

In order to answer the initial research question of the study, a congruency score was developed for each patient. For each activity statement, a score of one was given if the patient responded similarly to both questions relating to care delivered and care required. A score of zero was given if responses were dissimilar. These values were then summated to form a total congruency score. A value of 44

would indicate total congruency, while a score of zero indicated incongruency. Data on agreement between care delivered and required were further analyzed by each activity statement and by total instrument using descriptive statistics.

### Operational Definitions

For the purpose of this study, the definitions of the major terms used are as follow:

Outpatient: An adult over the age of eighteen who is currently being treated for a medical or surgical health care problem at an ambulatory care facility.

Outpatient Perspective: The viewpoint of the outpatient, particularly his/her conceptualization of the importance of ambulatory care nursing activities.

Ambulatory Care: Health care services provided in settings that do not require overnight stays. Multidisciplinary care is directed toward disease prevention, health maintenance, and diagnosis and treatment.

Ambulatory Care Nurse: A licensed Registered Nurse who provides care for the outpatient.

Ambulatory Care Nurse Perspective: The viewpoint of the ambulatory care nurse; particularly his or her conceptualization of the importance of ambulatory care nursing activities.

Ambulatory Care Nursing Activities: The comprehensive domain of activities performed by the ambulatory care nurse on the outpatient's behalf.

Congruency: Match between nursing care the patient believes is delivered and nursing care the patient expects.

## CHAPTER 4

### PRESENTATION OF DATA

This chapter presents the findings and statistical analysis of data collected regarding congruence between the outpatient's view of ambulatory nursing care he expects and care that he actually receives. The outpatient's point of view regarding ranked importance of selected ambulatory care nursing activities is presented. The subjects of this exploratory, descriptive study were a purposive sample of 30 medical-surgical outpatients. Sample characteristics will be described initially.

#### Characteristics of the Outpatient Sample

Thirty questionnaires were completed by outpatients meeting all criteria for study participation. The patients were screened initially by using the clinic appointment schedule. The sample population was predetermined by the investigator to include fifteen medical patients and fifteen surgical patients. Following their clinic appointments, the investigator approached the patients to further assess additional criterion fulfillment and to explain the study and questionnaire directions. The investigator remained in the clinic setting daily until thirty patients were selected who met study requirements and voluntarily agreed to participate. Participants were required to read the disclaimer attached to the questionnaire prior to completing the

instrument. The investigator remained with the outpatients while they completed the questionnaire to provide direction and to answer questions. Completed questionnaires were returned immediately to the investigator.

The sample consisted of 15 medical patients with diagnoses that are commonly treated on an outpatient basis such as diabetes, cardiovascular disease, chronic obstructive lung disease and arthritis. The remainder of the sample consisted of 15 surgical patients with diagnoses frequently treated on an outpatient basis, such as post-abdominal, orthopedic, genito-urinary or cardiovascular surgical procedures. All patients had attended the clinic at least twice prior to the study. For the purposes of this study, the two subpopulations of medical and surgical patients were treated as one sample, and will be referred to as one sample in the remainder of this report.

Sample characteristics on continuous demographic variables are shown in Table 1. Patient ages ranged from 24-83 years. Time attending the clinic facility ranged from 2-1/2 months to 10 years. Years of education ranged from 7-17 years, with a mean educational level of 12.77 years.

Sample characteristics on categorical demographic variables are shown in Table 2. Thirteen of the respondents were males and seventeen were females. Nineteen were married, three were single, four divorced and four widowed. Patient-perceived health status was categorized as good, fair or poor. Most patients in the sample considered themselves to be in good health. Sample occupational characteristics were

Table 1. Sample characteristics for age, time attending the clinic, and education (all variables given in years; N = 30).

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	Mean	Standard Deviation	Minimum	Maximum
Age	55.37	15.08	24.00	83.00
Time Attending Clinic	2.38	3.18	.21	10.00
Education	12.77	2.64	7.00	17.00

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Table 2. Sample characteristics for sex, marital status, perceived health status, and occupation (frequency and percent; N = 30).

	Frequency	Percent
<u>Sex</u>		
Male	13	43.00
Female	17	57.00
<u>Marital Status</u>		
Married	19	63.34
Single	3	10.00
Divorced	4	13.33
Widowed	4	13.33
<u>Health Status</u>		
Good	17	57.00
Fair	9	30.00
Poor	4	13.00
<u>Occupation</u>		
Professional	7	23.50
Technical	3	10.00
Laborer	10	33.50
Homemaker	4	13.00
Retired	6	20.00

classified as professional, technical, laborer, homemaker and retired. The technical classification had the lowest frequency and the laborer classification had the highest frequency.

Patient Perceived Importance of Selected  
Ambulatory Care Nursing Activities

One purpose of this study was to investigate how outpatients ranked the importance of a series of selected ambulatory care nursing activities. A Likert-type scale of one to six was incorporated into the Activities of Ambulatory Care Nurses-Patient Questionnaire so that nursing activities could be rated by the outpatient. Number one on the scale represented little importance, number six denoted great importance, and numbers two through five provided the patient the opportunity to select choices between the extreme ratings. Table 3 demonstrates patient-ranked importance of the 44 selected direct ambulatory nursing care activities derived from the Taxonomy of Ambulatory Care Nursing Practice shown in Appendix A. The means of the patient ratings were used to order the items from most important to least important. The results of this analysis demonstrated that the outpatient ranked the organization and preparation of documents such as the patient record, X-ray, laboratory and other reports as the most important perceived nursing activity pertaining to the outpatient's clinic visit. This activity item was derived from the activity category of Documents which is under the ambulatory care nursing responsibility area of Normative Care. Normative Care encompasses traditional and generally technical aspects of nursing care. The lowest ranked nursing activity item was Physical Examination. This

Table 3. Patient-perceived importance of activities.

Activity Item (1-44)	Rank	Mean
41 Documents	1	5.867
7 * General Assessment (patient understanding of illness)	2	5.800
40 Preparation	3	5.567
34 Specimens	4	5.533
39 Physician Assisting	5	5.433
1 Client Advocacy	5	5.433
5 Terminal Chronic Illness	6	5.367
23 Applications	6	5.367
8 Follow-up Assessment	6	5.367
44 Coordination	7	5.345
4 Clinical Procedures	8	5.333
35 Directing	8	5.333
42 System	8	5.333
17* Home Care (individualized instruction)	9	5.267
30 Medications	9	5.267
20 Surgical Preparations	10	5.233
43 Comfort	10	5.233
18* Home Care (general instruction)	11	5.200
24 Measurement	12	5.133
29 Dressings	12	5.133
37 Communication	13	5.100
33 I.V. Therapy	13	5.100
9 Provides Information	13	5.100
19 Plan of Care	14	5.017
10 Preventive Care Instruction	15	5.000
31 I.V. Medications	16	4.967
36 Transporting	17	4.933
16 Illness/Condition	17	4.933
26 Recovery	17	4.933
27 Invasive	17	4.933
11 Referrals	18	4.900
14 History	19	4.833
32 Blood Therapy	20	4.800
28 Non-Invasive	21	4.767
2 * General Support (encouragement to discuss concerns and worries about health problems)	22	4.667
3 * General Support (assistance with decision making about health care)	22	4.667
15 Health Care Maintenance	23	4.500

Table 3. -- Continued

Activity Item (1-44)	Rank	Mean
6 * General Assessment (evaluation of health care needs)	24	4.467
22 Irrigations	25	4.367
21 Respiratory Treatments	26	4.233
38 Chaperoning	27	4.167
25 Appliances	28	4.100
12 Triage	29	3.767
13 Physical Examination	30	2.833

\* Items number 7 and 6 were questions pertaining to the same activity category of General Assessment.  
 Items number 17 and 18 were questions pertaining to the same activity category of Home Care.  
 Items number 2 and 3 were questions pertaining to the same activity category of General Support.

activity item was derived from the category, Physical Examination which is under the nursing responsibility area of Primary Care. Primary Care encompasses professional aspects of care such as physical assessment and follow-up of medical and broader health care needs.

Patient rated importance of the 44 nursing activity items reflect a slight trend in priority toward activities which represent traditional technical and direct aspects of care. There were eight of this type of activities which fell within the top one-quarter of ranking. Seven of these activities fell within the second ranked quarter, six were within the third quarter, and four were ranked in the last quarter.

The patients in this study ranked the importance of more complex decision making, planning and supportive nursing activities slightly lower. A review of the ranking for these activities demonstrates that five activities fell within the top quarter, five were within the second quarter, four fell in the third quarter, and four were ranked in the last quarter.

There were three activity categories that were addressed by two questionnaire items. Item 17 pertained to individual Home Care instruction and item 18 considered general Home Care instruction. The two aspects of this activity category received different patient rankings. The subjects ranked individualized instructions to be of greater importance than general instructions. Items 6 and 7 related to the nursing activity of General Assessment. Item 6 described nursing evaluation of patient health care needs and item 7 considered whether the nurse questioned the patient regarding his understanding of his

illness or condition. Item 7 had a higher rank than item 6. General Support was the third activity category to which two questionnaire items were directed. Item 2 considered whether the nurse encouraged patient discussion of worries or concerns about health problems. Item 3 referred to the nurses's provision of assistance for helping the patient make decisions about appropriate health care. Both items had the same mean and were ranked lowest in the third quarter.

Results of this analysis suggest that the outpatients in this study considered nursing activities that are basically technical and traditional, and representative of direct physical care to be of slightly greater importance than other aspects of care. Activities that encompass professional decision making, planning, support and instruction were also considered to be important; however, this type of care was rated slightly lower. Although the difference is marginal, it may have substantive significance and important implications for ambulatory care nursing. The patient's perspective regarding activity importance indicates that higher priorities were assigned to aspects of care that may be considered less complex in nature. Traditional clinic operational duties and the provision of many direct activities care require minimal nursing educational preparation. In-depth nursing knowledge and skill are generally less essential for providing this type of care. In marked contrast, those activities deemed by the patient to be of less importance are far more complex from the nursing standpoint. Decision making, care planning, counseling, assessment and instructional activities require considerable nursing educational

preparation, judgement, skill and acceptance of professional responsibility.

Examination of the outpatient's opinion regarding the importance of ambulatory care nursing activities has been suggested to be an effective method for evaluating and reformulating nursing practice. Results of this study have demonstrated patient-perceived importance of nursing care activities. The patient's perspective has generated pertinent implications for impact on clinical ambulatory care nursing practice.

#### Congruency Between Patient Expected and Experienced Nursing Care

In order to answer the research question regarding the congruency between ambulatory nursing care the outpatient expects and experiences, a congruency score was developed for each outpatient participating in the study. For each nursing activity statement, a score of one was given if the patient responded similarly to both questions relating to care expected and care experienced. A score of zero was assigned if responses were dissimilar. These values were then summated to form a total congruency score. A value of 44 indicated total congruency, while a score of zero indicated incongruency. Data on agreement between care expected and experienced were further analyzed by each activity statement and by total instrument using descriptive statistics. Items with agreement at 80% and lower were considered incongruent, while scores with agreement above 80% were considered congruent. This criterion was arbitrarily determined after data was collected. Table 4 shows the number of items in each

Table 4. Congruency between patient-expected and experienced ambulatory nursing activities.

Agreement Range	Number of Items	Specific Items
90-94%	3	17, 19, 41
85-89%	13	1, 4, 11, 20, 26, 28, 30, 34, 35, 38, 39, 40, 42
80-84%	17	3, 5, 6, 7, 8, 14, 15, 16, 18, 21, 22, 23, 24, 25, 27, 29, 43
75-79%	3	12, 31, 36
70-74%	8	2, 9, 10, 13, 32, 33, 37, 44

agreement range as well as the specific items in each range. Analysis suggests a fairly high level of congruency, with 33 items falling at or above 80% agreement. Most of the congruent items fell within the 80-89% range. There were 11 incongruent items in the 70-79% range. The total scale had a mean score of 35.97, with a standard deviation of 7.963. Scores ranged from 16-44.

Scrutiny of the 33 congruent items shows that 22 items were in agreement regarding nursing activities expected and received. These activities fell mainly under two broad areas of nursing care. The first area involves professional decision making and counseling aspects of care. Examples of this type of care include patient assessment, patient teaching, care plan development and provision of emotional support. The second broad area of care incorporates those activities that are traditional clinic operational and patient preparatory functions. Examples of this type of care include preparation of the chart and reports, transporting patients, and the physical preparation of the patient for examination.

The remaining 11 congruent items demonstrated agreement between care that was not expected and not received. Most of these items fell under the general area of direct standardized patient care. Specific activities encompassed within this category are the administration of irrigations such as enemas, applications such as ice packs, appliances including splints and braces, respiratory treatments and medications given by all routes other than intravenously. Other direct activities included the performance of catheterization and suture removal, dressing care and obtaining specimens. Two items that pertained to

indirect aspects of care, i.e., directing patients to other clinic areas and chaperoning during physical examinations by a physician of the opposite sex, were also incorporated within the not expected, not received congruency classification.

#### Analysis of Incongruent Items

The study data suggest that the outpatients questioned in this study generally believed that they received the nursing care they expected. It was, however, demonstrated that this was not true for 25% or 11 of the total 44 nursing activity items addressed. Questionnaire items were designated as incongruent because they fell within the last two ranges for congruency between patient-expected and experienced nursing activities. Results demonstrated that there were activities that the patient received and did not expect. Likewise, there were activities that were expected and not received. Incongruent items by type of incongruency are shown in Table 5.

Examination of the 11 incongruent activity items indicates that three items (36, 37, 44) pertained to indirect aspects of nursing care and involve clinic operational duties. For example, five patients expected the nurse to assist them in getting to health care service areas outside the medical or surgical clinics. These patients felt that the nurse should either walk with them or transport them by wheelchair or cart; however, this care was not received. Two patients did not expect this type of assistance and had received it. Eight patients indicated that they would expect the nurse to secure a translator if English was not spoken; however, they did not receive

Table 5. Incongruent items by type of incongruency.

Item	Nursing Care Expected--Not Received (frequency)	Nursing Care Not Expected-- Received (frequency)
2. Encourages expression of worries or concerns about health problems	4	4
9. Provides general information about normal body functions	6	3
10. Teaches signs and symptoms of illness or complications	9	0
12. Pinpoints and solves problems with assistance from other health care providers when necessary	4	3
13. Performs physical examination	4	4
31. Gives intravenous medication	6	1
32. Gives blood transfusion	8	0
33. Gives intravenous feedings	7	1
36. Takes patients to other clinic areas	5	2
37. Gets a translator when necessary	8	0
44. Coordinates appointments to avoid long waiting periods	5	3

this help. There were no patients indicating that they had received this care and not expected it. Item 44 described nursing coordination of timing when a patient had more than one appointment during a clinic visit. Outpatients frequently need to visit more than one clinic and/or the laboratory, X-ray department or other areas, and coordination of timing by the nurse is important in minimizing long waiting periods between appointments. Five patients expected this care and did not receive it, three patients did not expect the care and received it.

Three items (31, 32, 33) demonstrating incongruity were related to direct professional responsibility activities involving intravenous therapy. Six patients indicated that they expected intravenous medications to be given by the nurse but had not received this care. One patient related that this care was not expected and received. Seven patients indicated that they expected the administration of intravenous feedings by the nurse and the care was not received. One patient did not expect this care and received it. Eight patients related the expectation of receiving blood transfusions from the nurse without receiving the care, while there were no patients that had received this care without expecting it.

Four questionnaire items (9, 10, 12, 13) that demonstrated incongruity pertained to activities requiring nursing assessment, decision making and care planning responsibilities. Physical examination by the nurse was expected and received by four patients and received but not expected by four patients. Triage, which was described as pinpointing and solving problems with assistance from

other health care providers as necessary, was an expected nursing care according to four patients. Although expected, this care was not received by these four patients. In parallel, three patients did not expect this nursing care and indicated that they had received it from the nurse. Item 9 referred to nursing provision of general information about normal body functions. Six respondents felt that they should have received this care and did not, three patients received this care and had not expected it. Item 10 described teaching signs and symptoms of illness or complications. Nine patients provided a remarkably high response rate, indicating that this expected nursing activity had not been received. Likewise, there were no patients that received this care unexpectedly.

The final incongruent item (2) related to the provision of emotional support, reflecting nurse counseling responsibilities. This item was phrased as "encourages expression of worries or concerns about health problems." Incongruity was demonstrated in this case by four patients responding that this care was expected and not received. Conversely, four patients indicated that this care was received without expectation.

#### Type of Incongruency

The highest degree of incongruency related to nursing care expected and not received. Particular significance was demonstrated by patient response to items 9 and 10 which pertain to patient teaching. Item 9 describes the provision of general information about normal body functions. Item 10 describes nurse teaching of signs and symptoms of

illness or complications. The patients in this study obviously expected the nurse to provide this kind of care, and yet they did not receive it. Another significant outcome of this study was that these outpatients expected the ambulatory care nurse to take them to other clinic areas. This aspect of care represents a traditional clinic operational function which was not performed. This activity is described by item 36.

Incongruency regarding care that was not expected by the patients and received was demonstrated at a low level. This type of incongruency pertained to item 9, which describes the provision of general information about normal body functions. Three patients did not expect this care and received it. Item 12, which describes triage activities, was not expected but received by three patients, and item 44 regarding the coordination of clinic appointments was not expected but received by three patients.

Four items demonstrated a split between both types of incongruency. Item 2 pertaining to nursing encouragement to discuss worries or concerns about health problems had four responses for each category of incongruency. Item 12 pertaining to triage nursing activities had 4 responses for care expected and not received and 3 responses for care not expected and received. Item 13 which describes physical examination by the nurse had four respondents expecting this care and not receiving it and four respondents not expecting the care yet receiving it. Item 44, referring to appointment coordination had five patients that expected this type of care who did not receive it and three patients who received the care without expecting it.

Four items must be considered from another perspective in that definite questions are raised by patient responses. Three items, i.e., 31, 32 and 33, all relate to the nurse's administration of intravenous infusions including blood transfusions. Several patients indicated that they had expected but did not receive intravenous medication, intravenous feeding, and blood transfusions. One patient indicated that he received intravenous medication without expecting it. One patient indicated that he had received intravenous feeding and had not expected it. None of the patients responded that they had received blood transfusions without expecting this care. Item 37 which describes obtaining a translator when English is not spoken by the patient also raises questions about patient response. Eight subjects responded that they expected this care and did not receive it. There were no patients who indicated that obtaining a translator was received as care when this care was not expected. The items and responses in this final category of incongruence obviously represent error in item presentation, explanation by the investigator and patient response. It is unreasonable that several patients would expect and not receive intravenous therapy. It is also not feasible that several of the outpatients indicated that they expected a translator and did not receive this care. All patients participating in this study were able to understand and read English.

It appears that these items were misinterpreted by study respondents and that the responses reflected opinions based on outpatients as a group rather than on the respondent's personal needs. These responses may indicate that the entire instrument or all responses for other

questions may not have been valid. If the outpatient misunderstood these four questions he may have responded in the same manner for other questions. There is some evidence for questionnaire validity, however, in the 11 congruent items of care not expected and not received. For example, it may be assumed that enemas and other aspects of care that are infrequently administered in the outpatient setting would not be expected and also not received. Patient responses support this assumption.

#### Summary

In conclusion, this research demonstrated a relatively high level of congruency between ambulatory nursing care the outpatient expected and experienced. Of the 44 items used in the patient questionnaire to tap the concept of congruency, 33 demonstrated congruent scores and 11 demonstrated incongruent scores. Items falling within the range of incongruency reflected patient opinion of nursing care expected and not received and care that was unexpected and received.

Examination of patient-perceived importance of selected direct ambulatory care nursing activities reflected a marginal overall trend in importance priorities toward nursing activities that are technical, traditional and representative of direct physical care. Activities that encompass decision making, planning, emotional support and instruction were ranked slightly lower. The patients in this study indicated that nursing activities that are generally less complex from a nursing standpoint are somewhat more important to them than nursing care that would be considered more complex. Specific significance is attributed

to two items that related to patient teaching in that the patients in this study expected this care and did not receive it. Another outstanding finding was that the patients expected to be transported to other clinic areas by the nurse and this care was not provided.

## CHAPTER 5

### CONCLUSIONS

This chapter discusses the findings and the implications of this study for ambulatory care nursing practice. Recommendations for future research and conclusions are also addressed.

#### Discussion of Findings

This research was conducted to ascertain whether there is congruence between ambulatory nursing care the outpatient expects and receives. The study also looked at the importance of a series of ambulatory care nursing activities from the patient's perspective. The need to consider patient opinion regarding ambulatory care nursing activities has been recognized as an important aspect of promoting outpatient welfare (Roberts, 1982; Bryant, 1975; Stratman, 1975; Kissinger, 1973). Neuman (1980) and others have emphasized the importance of considering client expectations, opinions, and experience when planning health care interventions. It has been stressed that lack of patient input may result in care that is deemed unimportant and inappropriate by the client.

The significance of congruence to patient welfare is emphasized in the conceptual orientation of this study. Congruence has been described as the essential link among a proposed interwoven relationship among two assumptions about the nature of man, principles of systems theory, communication theory, social learning theory, and

the ambulatory care nurse-patient relationship. Lindell (1979) has described congruence as matching experience, awareness and communication. Incongruence refers to discrepancy between experience, awareness and communication.

Statistical analysis of ambulatory care nursing activities expected and experienced by the outpatient demonstrated a fairly high level of congruency. The outpatients in this study indicated that 75% of the 44 items of the Activities of Ambulatory Care Nurses-Patient Questionnaire were expected and received or unexpected and not received. Study findings suggest that the patients in this study believed for the most part that appropriate nursing interventions had been implemented by the ambulatory care nurses. These results reflect the concept of congruency described in the proposed conceptual orientation. It may be inferred that in general, nursing interventions were based on clarification of patient needs so that patient-perceived appropriate care was instituted.

Twenty-five percent, or 11 items of the questionnaire, demonstrated statistical incongruency between care expected and received. The incongruent items represent diverse ambulatory care nursing responsibility areas and allow for a large margin of speculation and interpretation. Substantive significance becomes consequential in lieu of these findings, as this aspect of analysis pertains to the impact of research on clinical practice.

The type of incongruency most frequently demonstrated in this study involved nursing care the patient expected and did not receive. Many factors may be considered as attributing to the demonstrated

incongruency. For example, the matter of individual differences could be expected to influence the patient's perception of needs and associated care. In a study designed to tap patient needs and nurses' perception of those needs, Williamson (1978) noted that every person has a cluster of human needs that are special and important to him. These needs are determined by cultural background, personality and social class. External events such as personal crises may also affect the manner in which a person perceives his needs. Williamson (1978) also stated that illness is an event that alters one's perception of needs and causes need priorities to shift.

Age, marital status, sex, length of time attending the facility, the specific clinic attended, education and occupation may have affected incongruent patient responses. Because the demographic study variables were not specifically analyzed regarding incongruency, it is difficult to draw any firm conclusions regarding these factors. The heterogeneity of the sample restricts generalization, particularly pertaining to age, length of time attending the facility, and specific clinic attended. cursory review of these factors indicates that those patients attending the surgical clinic were generally younger and had attended the clinic for a shorter period of time than those patients visiting the medical clinic. The study design did not allow for analysis of diagnosis, thus eliminating the possibility for making specific inferences about illness needs pertaining to acuity or chronicity.

When considering individual differences among patients, it becomes apparent that individual differences also exist among the

nursing staff. These differences may have influenced care that was provided by the nurses, depending on their beliefs, values and backgrounds. The nurses' demeanor and attitudes may have influenced the patient's expectation of care, and care that he actually received. This consideration supports the assumption made in Chapter 2 that if care is provided, the nurse obviously believes it is important and required. Likewise, care that was not provided may have been viewed by the nurse as unnecessary or at least not a priority. It has been found that health care providers tend to become socialized into the institutional culture. This culture promotes an orientation that is not commonly shared with the patient so that values and beliefs and response to patient needs may be very different from those of the client (Skipper and Leonard, 1965).

It may be possible that the patients attending the surgical clinic may have had less opportunity to develop a collaborative relationship with the nursing staff. It is also possible that nurse-patient relationships in both medical and surgical clinics did not promote open communication between nurse and patient, thus minimizing collaborative decisions about health care and need resolution. Boettcher (1978) has emphasized the importance of nurse-client collaboration in determining patient needs and formulating appropriate and necessary nursing interventions. This idea reflecting the concept of congruency has been supported by Peplau (1952) and King (1971).

The common practice of maintaining clinic flow tends to minimize nursing time spent with each patient other than for direct care provision. This historical focus does not emphasize the promo-

tion of in-depth nurse-patient communication and relationship development. The preceding factors that may have affected incongruency relate directly to principles of systems theory, communication theory, social learning theory and the nurse patient relationship described in the conceptual orientation of this study.

Examination of the 11 incongruent items demonstrated findings that are specific and pertinent to ambulatory care nursing practice. For example, the patients in this study expected the nurse to transport them to other clinic areas when necessary. This care was not received. The patients may have felt that the need to receive care in another clinic area indicated that their physical condition warranted this type of nurse assistance. Another possibility underlying this expectation may be that the patients were unable to find their way to other service areas and depended on the nurse to assist them. Finally, these patients may have viewed the nurse as the primary care giver and viewed transporting as an essential continuation of the nurses' care and concern for them.

The nurses may not have provided transporting-type care because they believed it was unwarranted by illness or condition. They may not have been aware that the care was expected, or perhaps other clinic responsibilities did not allow for leaving the assigned duty area.

Another item demonstrating incongruency pertained to the patients' expectation that the nurse would coordinate multiple clinic appointments so that long waiting periods during the clinic visit would be avoided. This care was not received. Patients may have viewed this type of care as an advocative responsibility of their nurse. The

nurses may have been unable to provide this care due to other clinic responsibilities or perhaps did not view the care as a priority.

Four items demonstrated questionable incongruency. All three questionnaire items pertaining to patient-expected nurse administration of intravenous fluids and blood indicated that the patients expected this care and did not receive it. In addition, the item pertaining to securing a translator if English was not spoken was rated by the patients in this study as being an expected but not received aspect of nursing care. As discussed in Chapter 4, the only logical assessment of these items is that the patients were responding on the basis of care all outpatients should receive rather than from the perspective of individual needs.

Three items (12, 13, 2) demonstrated a split between incongruency related to care expected and not received and care received and not expected. For item 12, which related to nurse triage activities, responses indicated that some patients expected and did not receive and received but did not expect the nurse to pinpoint and solve problems by advice or by seeking help from other health care providers. It is possible that this care was provided by the nurse and not recognized by the patient. It is also possible that the patient's health problem was initially identified by another health care provider. The ambulatory care physician often performs this activity; however, this activity also falls within the domain of nursing care. It may be possible that the nurse-patient relationship, the clinic philosophy of care, the staffing pattern, the nurse's knowledge and/or values and beliefs about this type of care did not foster the provision

of this nursing care. Item 13 pertaining to physical examination by the nurse also demonstrated a split in patient congruency responses. Explanations for this finding are considered to be consistent with those provided for the item describing triage.

The third split congruency item pertained to the nurse's encouragement for the patient to express worries or concerns about health problems. This example relates to questionnaire item 2 and reflects the nursing responsibility area of Patient Counseling. Perceived need of emotional assistance for dealing with health problems may be related to individual differences of both patient and nurse. Another possibility is that the nurse-patient relationship and the clinic routine did not promote open communication for expression of patient emotional need and problem resolution.

The final two incongruent items were within the realm of patient teaching and were addressed by questionnaire items 9 and 10. Study results indicated that: (1) the patients in this study expected the nurse to provide general information about normal body functions, and (2) the patients expected the nurse to teach them about signs and symptoms that indicate illness or complications. For both of these items, patients stated that they did not receive this expected and important type of nursing care.

Literature substantiates that patients are becoming increasingly more knowledgeable regarding accountable care, and that they are able to identify specific care that they expect and need (Kovner and Smits, 1978; Stratman, 1975). Viewing the client as a knowledgeable consumer of health care has become a major focus within recent years

(Grimaldi, 1983). The emphasis on patient education has been described throughout nursing literature. The need to teach patients how to achieve optimal wellness, how to avoid illness and how to adapt to illness has been well documented (Redman, 1981; Berger and Wesley, in press; Redman, 1980; Narrow, 1979; Zander et al, 1978; DuGas, 1972).

The results of this study that nurses did not provide patient education as expected by the outpatients were remarkable. It is difficult to establish possible explanations for why this care was not provided. One may surmise that the maintenance of clinic flow could have been a deterrent. It is further possible that patient education was not a priority care in this particular setting. Yet, it has been documented that ambulatory care nurses make time for aspects of care that are considered important, and that allocation of time for patient education is contingent upon the recognition of patient teaching as a primary nursing function (Berger and Wesley, in press).

Patient-perceived importance of ambulatory nursing care activities was also examined in this study. Each patient in this study completed the entire portion of the questionnaire that tapped perceived activity importance.

In general, the outpatients indicated that nursing activities of greatest importance would be considered by nurses to be less complex in nature. In parallel, more complex nursing activities were considered by these patients to be somewhat less important. For example, organization and preparation of the patient record, laboratory and other reports were ranked highest on the list of 44 nursing activities described. Overall, traditional, technical and direct aspects of

care were rated slightly higher than decision making, planning and supportive functions. The lowest ranked item in importance was physical examination.

The top quarter of patient-rated important nursing activities included six items from the responsibility area of Normative Care. These included the preparation of documents, physical preparation for examination by the physician, providing assistance to the physician, providing direction to other clinic areas, coordinating clinic appointments, and explaining the ambulatory care system. Within the top quarter, there were three activity items derived from the responsibility area of Patient Counseling. Explaining rights about health care and services, providing support and guidance when faced with a life-threatening illness, and promotion of relaxation to alleviate nervousness and worry about a clinic procedure were encompassed by Patient Counseling. Two items in the top quarter reflected the responsibility area of Therapeutic Care. These were: (1) asks the patient to provide specimens, and (2) applies ice packs and other skin applications to reduce discomfort and promote healing. There were also two items ranked in the top quarter denoting perceived importance that pertained to the responsibility area of Health Care Maintenance. These items described the nurse action of asking how much the patient understood about his illness, and the nurse action of asking the patient how he was getting along between clinic appointments.

In considering these ratings of importance, it may be possible that outpatients may not be completely aware of the full range of ambulatory care nursing activities and responsibilities. The more

traditional activities may be more visible and readily identifiable. On the other hand, specific aspects of counseling were certainly considered important, as were assessment functions and the specific direct physical care duties.

It is acknowledged that the findings demonstrated by this study pertaining to congruency and importance regarding ambulatory care nursing activities may have been affected by the specific clinic attended by the patient. The medical clinic used for this study was more philosophically oriented to the principles of nurse-directed operation. The medical nurses provided more primary total patient care, and in general seemed to be fairly autonomous and self-directed in their practice. The surgical clinic reflected an atmosphere that was more typical of physician-directed care. The nurses in this clinic were less autonomous in decision-making activities.

#### Implications for Nursing

This study, which considered patient opinion regarding congruency between nursing care expected and received, and which looked at patient-perceived importance of nursing activities, has produced several important implications for ambulatory care nursing practice. The current trend toward ambulatory care and widespread public concern about quality care mandates that professional ambulatory care nurses re-examine and consider reformulation of aspects of care provided based on client input. The results of this study support the idea of providing nursing care on the basis of patient opinion. Study results also suggest that further research be directed toward patient opinion in the

area of ambulatory care. This notion has been supported in nursing literature (Bryant, 1975; Stratman, 1975; Roberts, 1982; Conway-Rutkowski, 1982). As discussed in Chapter 1, research within the area of ambulatory care nursing is limited.

The information provided by the outpatients in this study indicated that in general most aspects of care provided by the ambulatory care nurse were both expected and received. The patients identified aspects of care that were of greatest importance to them. Nursing care was also identified that was expected and not received. Data regarding congruency and importance suggest that consideration to patient input with subsequent reformulation of nursing practice warrants serious nursing attention. The need to balance interpersonal skills and technical-physical aspects of care in ambulatory care nursing is viewed as a relevant implication of this study's findings. Furthermore, attention to individual differences from both patient and nurse perspectives has been implicated and the need to align these perspectives has been suggested. The need to consider nurse and patient priorities of care is also viewed as an equally important study outcome.

The nature of ambulatory care nursing has historically been that of maintaining clinic flow, which tends to decrease the establishment of nurse-patient relationships. This focus may also reflect a disruption in continuity of patient care. It is possible that altering scheduling practices that minimize nurse-patient time could promote a more collaborative and mutual relationship. The importance of nurse-patient collaboration has been emphasized by Boettcher (1978).

Peplau (1952) professed that as the nurse-patient relationship develops, an understanding of one another's role is enhanced and that beneficial patient outcomes are promoted. The results of this study suggest that patients may not be aware of the full range of activities that are encompassed within the ambulatory nursing care domain. The patients in this study, for example, may not have been aware that such activities as triage, emotional support and physical examinations are a part of nursing practice. Likewise, these nurses may not have viewed these aspects of care as essential to their practice.

The matter of public image of the nurse may be an important consideration for ambulatory care nursing practice. It may be that patients have a stereotyped view of the nurse. The nursing role is commonly portrayed in the media as subservient to the physician and other health care providers. Very little, if any attention is directed toward reflecting the decision making, professional and knowledge-based expertise of the nurse.

Beletz (1974) conducted a study to assess nursing's public image. It was found that respondents perceived nurses as traditional, functional "doers." Study participants did not see nurses as performing cognitive or intellectual processes. Furthermore, the respondents saw the nurse's role in the community as limited to traditional duties performed in community health, doctor's offices or in a company health service.

It has been further demonstrated that nurses themselves have a blurred professional image in that there is ambivalence between nurses who view their role as basically technical in nature, and those who

perceive their functions and abilities as being professional, accountable and autonomous (Anderson, 1981). One implication of these possible nurse perceptions is that nurses must clarify and unify their sense of direction. The second implication is that nurses in the ambulatory care setting need to demonstrate and explain the nature of professional nursing activities in order to be recognized by the patient and others as a primary care provider. This notion has been substantiated in nursing literature (Lewis and Resnik, 1967; Alexander, 1979; Anderson, 1981).

Patient needs that reflected expected and not received traditional ambulatory nursing care in this study also present implications for clinical practice. It may have been that nurse priorities for providing patient-perceived important activities such as transporting patients and coordinating clinic appointments may have been negated by other nurse-perceived important activities. Awareness of the importance relegated to these two study items could assist the nurses to reformulate the manner in which care is valued and provided. It is possible that nurse assignment practices need to be adjusted to accommodate specific needs identified in this study. Allotment of time and acceptance of nursing responsibility for these patient-expressed needs may be in order.

The importance of providing patient education has been addressed extensively in general nursing literature. The findings of this study in ambulatory care indicate that these outpatients expected this care and did not receive it. A search of ambulatory nursing care literature produced no information specifically pertaining to patient

education in the outpatient setting. However, Berger and Wesley (in press) outline a format for providing patient education by means of a nursing exit interview by the nurse following the patient's clinic visit with the physician. The authors note that finding time for patient teaching depends on the nurse's recognition of this activity as an essential component of practice. The lack of ambulatory care nursing attention to patient education in the literature and the findings of this study may be indicative that outpatient nurses may not view patient teaching to be as important in comparison with other activities. Recognition of this possible deficit in care would be expected to prompt ambulatory care nurses to develop clinic-specific strategies for alleviating this suggested problem.

In summary, this study emphasizes the importance of considering the patient's perspectives regarding congruency and importance of ambulatory care nursing activities. Improvement and reformulation of care provided by the nurse must incorporate the patient's opinion in order for care to be totally effective and patient-oriented. The important interwoven relationship proposed in the conceptual orientation among two assumptions about the nature of man, principles of systems theory, communication theory, social learning theory and the ambulatory care nurse-patient relationship has been demonstrated.

#### Recommendations for Further Study

This study should be replicated using a larger sample to provide greater generalizability. A more heterogeneous patient sample should be used. For example, the study might focus on only medical

patients or surgical patients. A group of similar patients according to diagnosis would be more likely to produce more specific results for generalization.

Revision and clarification of the questionnaire items pertaining to intravenous infusion and securing a translator would be necessary. Increased sensitivity of these items would be expected to produce more meaningful findings and enhance the validity of the tool. Repeated use of the Activities of Ambulatory Care Nurses-Patient Questionnaire would be expected to increase instrument stability, thus enhancing reliability.

Using a group of outpatients as the unit of analysis rather than the outpatient as an individual should be considered. Likewise, attention should be directed toward analysis of sample demographic data. Participants should also be asked to answer the questions based on the experience of the present clinic visit rather than for overall evaluation of clinic appointments. This is important, because the patient's opinion would be expected to change from one clinic visit to another.

Future studies might also be improved by addressing only the congruency concept or the aspect of patient-perceived importance of nursing activities. In addition, future research should be directed specifically toward or at least include the nurse's perceptions of care required.

### Summary

This research was conducted to determine whether there is congruency between outpatient views of care he should have received and care actually delivered by the ambulatory care nurses. The study also looked at the importance of a series of nursing care activities from the patient's perspective.

According to this study, there was a high degree of congruency between outpatient nursing care expected and received. There was, however, an appreciable degree of incongruency which provided significant implications for ambulatory care nursing practice. Areas of particular concern pertained to the provision of traditional clinic duties of outpatient transportation and coordination of clinic appointments. The patients in this study related that these nursing activities were expected but not received. Incongruency was also demonstrated within the nontraditional care areas of providing emotional support and performing triage and physical examination. The study participants provided a split type of incongruency related to these activities in that the activities were viewed as both expected and not received and not expected and received. Study results further indicated that aspects of patient education were expected but not provided by the nurse. Specific activities for this type of care included providing general information about normal body functions and the teaching of signs and symptoms that indicate illness or complications.

Patient response to four items which pertained to the nurse's administration of intravenous infusions and the securing of a translator indicated that the patients were considering these aspects of

care on the basis of outpatients as a group rather than personally. These items were obviously unclear and reflected incongruency that may be avoided by rewording the statements.

Regarding patient-perceived importance of selected nursing activities, the patients in this study were able to rank the activity items according to their importance. This capability was addressed in the conceptual orientation of this study. Overall, these patients indicated that nursing activities that would be considered as less complex were rated higher than more complex activities. It was, however, demonstrated that items that pertained to nurse counseling, the provision of direct physical care and assessment practices were considered to be highly important.

This research has demonstrated the importance of considering patient opinion regarding congruency in care expected and received. Likewise, the patient's opinion regarding the importance of nursing activities was demonstrated as an indicator of nursing effectiveness in care provision and care explanation. Despite the problematic questionnaire items, the patient information obtained through this study is believed to have provided significant substantive findings for the practice of ambulatory care nursing.

APPENDIX A

TAXONOMY OF AMBULATORY CARE NURSING PRACTICE--  
DIRECT PATIENT CARE NURSING ACTIVITIES

## RESPONSIBILITY AREA

Patient Counseling

The provision of professional guidance and support to clients in regard to general reassurance on health status or disease state and support during clinic visit.

1. CLIENT ADVOCACY: Protection of client's right to care and attention to complaints regarding care or service.

Examples:

- 1) Make patient aware of rights both physically and financially.
- 2) Intervene if care is deemed inappropriate.

2. GENERAL SUPPORT: Attention to concerns and verbalizations regarding health status and reinforcement of positive aspects of health practice.

Examples:

- 1) Allow parent to ventilate about health status or disease state of child.
- 2) Encourage patient to make independent decisions according to their needs.
- 3) Reinforcing what parent has done at home or their promptness in seeking medical attention as being appropriate.
- 4) Listen to patients needing to verbalize.
- 5) Help patient identify alternatives relating to any needs.
- 6) Listening to parent/child regarding their concerns and reassure it is normal for that age.

3. CLINIC PROCEDURE: Provision of emotional support before and during clinic procedures.

Examples:

- 1) Be present during procedures and offer emotional support.
- 2) Reassurance to parents and child about clinic procedures such as ear irrigations and catheterizations.

4. TERMINAL/CHRONIC ILLNESS: Provision of support/guidance to clients and families of clients who are terminally or chronically ill.

Examples:

- 1) Counseling related to coping with terminal illness or assisting family cope with terminal family member.
- 2) Counseling of parents of dying children who are at home.

#### Health Care Maintenance

Nursing assessment directed toward continuing a state of wellness, including follow-up monitoring of status and instruction on general health care needs.

5. GENERAL ASSESSMENT: Assessment of client health and knowledge of health maintenance including socio-economic status and emotional status.

Examples:

- 1) Assess patient's self-image, financial situation.

- 2) Assess growth and development while child is in for regular visit.
  - 3) Assess patient's understanding of disease, drugs, body functions, and body mechanisms.
  - 4) Assessment of immunization status.
  - 5) Evaluate parent/child interactions for individuals of emotional and/or physical neglect and/or abuse which may need to be referred to Medical Social Worker.
6. FOLLOW-UP ASSESSMENT: Assessment of client's status as it relates to compliance with plan of care and progress of a condition or disease.

Examples:

- 1) On-going check-up on understanding of patient as to proper use of inhalers, and regularly used medication.
  - 2) Assess patient's mental responses to disease and drugs.
  - 3) Taking time to sit down and talk to the patient to determine state of improvement or otherwise.
  - 4) Monitoring of untoward effects of medical/surgical plan of care.
7. PROVIDE INFORMATION: Provision of information regarding general health maintenance and normal body functioning.

Examples:

- 1) Advise on diet appropriate for age.
- 2) Give suggestions for age-appropriate safety precautions.
- 3) Instructions on body functions such as menstrual cycle, menopause.

- 4) Instructions on personal hygiene.
  - 5) Answer questions on discipline for age.
8. PREVENTIVE CARE INSTRUCTION: Instructions regarding preventive aspects of health care and avoidance of disease development and complications.

Examples:

- 1) Instruct parents on poison prevention.
- 2) Instruct parents on immunization schedule.
- 3) Teaching self-examination of breasts.
- 4) Discuss common signs and symptoms in your children that need medical attention, e.g., pulling ears, fever, diarrhea, vomiting.
- 5) Giving general information on routine exams and why they should be done on a regular basis, e.g., Pap, breast exam.

#### Primary Care

The responsibility for physical assessment and follow-up of medical and broader health care needs, including general screening for specialized referral, physical diagnosis and treatment.

9. REFERRAL: Evaluation of needs for actual referral to other agencies/health care providers.

Examples:

- 1) Make referral to social service, public health or other needed referral.

- 2) Evaluate patient for possible referral to public health or social workers or other agencies involved with patient care.
10. TRIAGE: Screening of patient problems, either in person or by phone, with resolution of that problem either by advice or referral. Involves first patient contact with a health care provider during a specific clinic visit or call.
- Examples:
- 1) Screening nursing calls.
  - 2) Screening patients who appear acutely ill and referring to appropriate source for care.
11. PROTOCOL CARE: Provision of medical therapy or the monitoring of that therapy following multiple-decision protocols.
- Examples:
- 1) Giving chemotherapy to patient on basis of nurse-assessed laboratory results.
12. PHYSICAL: Performance of a complete physical exam and/or developmental assessment.
13. HISTORY: Procurement of a complete health and social history.

#### Patient Education

Planned education given to an individual or a group of clients regarding specific health self-care and/or health deviation self-care.

14. HEALTH CARE MAINTENANCE PROGRAM: Provision of a planned educa-

tional program related to prevention and/or health care maintenance.

Examples:

- 1) Birth control information, with films, pamphlets and specific instruction for chosen method.
- 2) Teach patient self-responsibility for health care, current trends in health care, and awareness of their own state of health.
- 3) Teaching that is concerned with health maintenance such as proper exercise, sleep and oral hygiene; using several teaching sessions on a planned basis.
- 4) Teach general information on child care: bathing, care of simple pediatric illnesses, care of skin, treatment of fever, etc.

15. ILLNESS/CONDITION PROGRAM: Provision of a planned educational program related to a specific condition or disease state.

Examples:

- 1) Teaching self-care program for hemophilia patients.
- 2) Teaching on hypertension, i.e., cause, treatment, low-sodium diet, weight reduction, and end organ damage.
- 3) Diabetic teaching: What is diabetes, goal of management, prevention of end organ damage, etc.
- 4) Educational program about ostomy care.
- 5) Peri-natal education: What things are normal for pregnancy and what are abnormal, etc.

16. HOME CARE: Instructions and/or demonstrations on procedures for home self-care.

a. GENERAL INSTRUCTIONS: Instructions that are routine and standardized and do not require the skill of a licensed practitioner.

Examples:

- 1) Teaching parent how to read a thermometer.
- 2) Counseling, regarding home care of sutures.
- 3) Provide post-procedure patients with adequate instructions to avoid complications.

b. STANDARDIZED INSTRUCTIONS: Instructions that are standardized but require the skill of a licensed practitioner.

Examples:

- 1) Teaching parent how to keep heparin lock patent at home.
- 2) Instructions on side effects of medications.
- 3) Instructions on how to give medication at home.
- 4) Advise regarding side effects of immunizations.

c. INDIVIDUALIZED INSTRUCTIONS: Instructions designed for a specific patient problem, and are unstandardized and nonroutine.

Examples:

- 1) Teaching parent how to do percussion and drainage.
- 2) Teaching the giving of insulin.
- 3) Teach patient what physical responses to report.

- 4) Teaching patient how to do self-cath, with demonstration.
- 5) Counseling related to diet for obesity, hypertension, diabetes, and chemotherapy patients.

17. PLAN OF CARE: Explanation and planned reinforcement of plan of care and physician instructions.

Examples:

- 1) Sit down with patient to review, reinforce and explain physician's plan of care and his/her instructions.
- 2) Counseling/teaching patients about the plan of care set up by the physician.

#### Therapeutic Care

The delivery of direct physical care to clients following the direction of a health care team member, and the observation and/or measurement of the results of that care or the care of others.

18. SURGICAL PREPARATION: Provision of physical care for surgical procedure to be done in clinic, or outpatient surgery.

Examples:

- 1) Abdominal skin preparation for a procedure.

19. RESPIRATORY TREATMENTS: Administration of any therapeutic treatment related to the respiratory tract.

Examples:

- 1) Give percussion and drainage.

20. IRRIGATIONS: Administration of irrigations, including enemas and

removal of impactions.

Examples:

- 1) Ear irrigations.
- 2) Enemas.

21. APPLICATIONS: Administration of any therapeutic applications to body surface, including dermatology treatments and treatments to reduce fever or injury.

Examples:

- 1) Applying ice packs to injuries.
- 2) Dermatology treatments.
- 3) Sponge child for temperature reduction.

22. MEASUREMENT: Measurement and recording of physiological and growth indices.

Examples:

- 1) Plotting height, weight and head circumference on growth curves.
- 2) Spirometry.
- 3) Measuring auditory acuity.
- 4) Measuring hemoglobin and hematocrit.
- 5) Measure height and weight.

23. APPLIANCES: Application and removal of casts and other appliances, if performed by a member of the nursing staff.

Examples:

- 1) Application of splints, slings.
- 2) Application of unna boot.

24. RECOVERY: Care given while patient is recovering from surgical or other clinic procedure.

Examples

1) Measuring vital signs, post-op or post-procedure.

2) Caring for outpatient surgeries.

25. INVASIVE: Performance of invasive procedures such as catheterizations.

26. NON-INVASIVE: Performance of non-invasive procedures such as removal of sutures.

27. DRESSINGS: Application of dressings and wraps.

28. MEDICATION: Administration of medication by any route except I.V.

29. I.V. MEDICATIONS: Administration of medications by I.V. route.

30. BLOOD THERAPY: Administration of blood and blood products.

31. I.V. THERAPY: Administration of I.V. fluids, either plain or with medications added.

32. SPECIMENS: Collection of all specimens, including cultures.

Examples:

1) Drawing blood for laboratory work.

2) Collecting various urine specimens.

Normative Care

The delivery of services received by most clinic clients, involving traditional entry and exit procedures, provision of assistance in the preparation for and during a primary care visit, and general direction or transportation to another care provider.

33. DIRECTING: Provision of directions to clients regarding location of other services.

34. TRANSPORTING: Transportation of clients to other services.

35. COMMUNICATION: Provision or procurement of special communication assistance.

Examples:

1) Obtain translator for non-English-speaking patient.

36. CHAPERONING: Assistance not necessary, but physical presence is required for legal reasons.

37. ASSISTING: Provision of assistance to physician for procedures, including preparation of equipment and clean-up.

38. PREPARATION: Preparation of client for physician visit.

Examples:

1) Provide gown for patient.

2) Help patient dress and undress.

39. DOCUMENTS: Organization of documents for client's visit.

Examples:

1) Ordering X-rays, getting lab results, checking for outside records or X-rays before patient sees physician.

40. SYSTEM: Explanation of ambulatory care system and related services.

Examples:

1) Explanation of agency system of physicians.

2) Explanation of billing, insurance, etc. (only if done by nursing).

41. COMFORT: Attention given to client comfort in regard to hunger, thirst, elimination, and information on reasons for delays, etc.

Examples:

1) Getting lunches or snacks for patients.

2) Helping patients up and down hallway, in and out of bathroom.

42. COORDINATION: Coordination and timing of client needs with the physician, lab, etc. .

Adapted from  
J. Verran, Journal  
of Ambulatory Care, 1981.

APPENDIX B

HUMAN SUBJECTS APPROVAL

## THE UNIVERSITY OF ARIZONA COLLEGE OF NURSING

## MEMORANDUM

TO: Mary Suzanne Berger  
55 North Cherry Avenue - Apt. #109  
Tucson, Arizona 85719

FROM: Ada Sue Hinshaw, R.N., Ph.D. *ASH/SW*  
 Director of Research

Katherine J. Young, R.N., Ph.D.  
 Chairman, Research Committee

DATE: August 4, 1983

RE: Human Subjects Review: Congruency Between Ambulatory Nursing Care  
Required and Delivered; The Patient's Perspective

Your project has been reviewed and approved as exempt from University review by the College of Nursing Ethical Review Sub-committee of the Research Committee, and the Director of Research. A consent form with subject signature is not required for projects exempt from full University review. Please use only a disclaimer format for subjects to read before giving their oral consent to the research. The Human Subjects Project Approval Form is filed in the office of the Director of Research, if you need access to it.

We wish you a valuable and stimulating experience with your research.

ASH:des  
 4/83

APPENDIX C

APPROVAL FOR RESEARCH



THE UNIVERSITY OF ARIZONA

HEALTH SCIENCES CENTER  
TUCSON, ARIZONA 85724

UNIVERSITY HOSPITAL

August 8, 1983

Mary Suzanne Berger, R.N., B.S.N.  
55 North Cherry Avenue  
Apartment 109  
Tucson, Arizona 85719

Dear Mary:

It is a pleasure to provide final approval for your thesis research, "Congruency Between Ambulatory Nursing Care Required and Delivered; The Patient's Perspective." You have made your contacts in the clinic through the Head Nurses. If you have any other questions or I can be of assistance, please contact me.

Sincerely,

A handwritten signature in cursive script, appearing to read "Ada Sue".

Ada Sue Hinshaw, R.N., Ph.D., F.A.A.N.  
Associate Director of Nursing  
Research  
Nursing Department  
University Hospital

ASH/myk

APPENDIX D

ACTIVITIES OF AMBULATORY CARE NURSES--  
PATIENT QUESTIONNAIRE

**ACTIVITIES OF AMBULATORY CARE NURSES--PATIENT QUESTIONNAIRE**

You are being asked to voluntarily give your opinion on the questions in this questionnaire. By responding to the questionnaire, you will be giving your consent to participate in a study. The purpose of the study is to identify what outpatient nursing activities are most helpful to patients. You are being asked to indicate what outpatient nursing activities you consider to be important and whether or not they have been done specifically for you. Your name is not on the questionnaire. You may choose not to answer some or all of the questions if you desire. Whatever you decide, your care will not be affected in any way. There are no known risks to this study. The information you provide will never be associated with your name, and will be available only to the investigator. The investigator will be available to answer questions you may have.

**Directions:**

For each of the questions, you are asked to give three responses. The responses are:

**1. How important is it that the nurse does this activity?**

Please circle the number that most closely shows how important the activity is to you. The scale is (1 - 2 - 3 - 4 - 5 - 6).

1 = Little importance

6 = Great importance

2-5 Allow choices between the extreme numbers of 1 and 6.

**2. Has the nurse performed this activity for you? Please check "Yes" or "No".**

**3. Whether or not the nurse performed the activity, do you feel you should have received the care described? Please check "Yes" or "No".**

There is space provided at the end of the questionnaire, if you wish to list other care you have received or care you believe you should have received. Thank you for your participation.

---

Before answering the questions on the following pages, would you please provide some information about yourself?

Age: \_\_\_\_\_ Length of time attending Health Condition: Good Fair Poor  
the clinic facility: \_\_\_\_\_ (Please circle one)

Marital Status: \_\_\_\_\_ Which section of the clinic do you attend? \_\_\_\_\_ Education in years: \_\_\_\_\_  
(For example, medical, (For example, 1 year of college =  
clinic or surgical clinic) 13 years of education)

Sex: \_\_\_\_\_ Occupation: \_\_\_\_\_

Identification  
Number \_\_\_\_\_

**Activities**

How important is it that the nurse does this?

Has the nurse performed this activity for you?

Whether or not the nurse has performed this activity, do you feel you should have received the care described?

Number one indicates little importance - Number 6 indicates great importance. Numbers 2, 3, 4, 5 provide degrees of importance between numbers 1 and 6. Please circle the number that best reflects your feelings about the importance of the nursing activity.

Please Check Yes or No

Please check Yes or No

1. Explains your rights about health care and service.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
2. Encourages you to express worries or concerns about health problems.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
3. Explains the choices you have about health care to help you decide what care is best for you.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
4. Helps you to relax if you are feeling nervous or worried about a clinic procedure.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
5. Provides support and guidance for you and your family if you have a long-term or life-threatening illness.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
6. Evaluates your health problems and needs.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
7. Asks how much you understand about your illness or condition.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
8. Asks how you are getting along between clinic visits.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
9. Provides general information about normal body functions (for example, proper diet and rest).	1	2	3	4	5	6	Yes___	No___	Yes___	No___

<u>Activities</u>	<u>How important is it that the nurse does this?</u>						<u>Has the nurse performed this activity for you?</u>		<u>Whether or not the nurse has performed this activity, do you feel you should have received the care described?</u>	
	1	2	3	4	5	6	Please Check Yes or No		Please check Yes or No	
10. Teaches you signs and symptoms that indicate illness or complications.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
11. Arranges appointments with other health care providers and/or services to meet your special needs.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
12. Initially pinpoints your problems and solves them by advice, or by seeking help from other health care providers.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
13. Performs your physical examination.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
14. Asks about your past health history and life circumstances.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
15. Provides general information about how to stay healthy.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
16. Teaches you about your special illness such as diabetes or high blood pressure.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
17. Provides information and demonstrates procedures that you will use at home.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
18. Provides information about general practices to be done at home to avoid health problems.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
19. Explains medical instructions and why it is important for you to follow instructions.	1	2	3	4	5	6	Yes___	No___	Yes___	No___

Activities	How important is it that the nurse does this?						Has the nurse performed this activity for you?		Whether or not the nurse has performed this activity, do you feel you should have received the care described?	
	1	2	3	4	5	6	Please Check Yes or No		Please check Yes or No	
20. Prepares you physically for clinic surgical procedures (cleanse skin, position on bed).	1	2	3	4	5	6	Yes	No	Yes	No
21. Does treatments to help you with breathing problems, such as using a breathing machine.	1	2	3	4	5	6	Yes	No	Yes	No
22. Uses irrigation treatments such as removing ear wax or giving enemas.	1	2	3	4	5	6	Yes	No	Yes	No
23. Applies ice packs to reduce fever or injury or uses other applications for skin problems.	1	2	3	4	5	6	Yes	No	Yes	No
24. Measures your height, weight, hearing, blood pressure.	1	2	3	4	5	6	Yes	No	Yes	No
25. Applies and removes casts, braces, splints and slings.	1	2	3	4	5	6	Yes	No	Yes	No
26. Stays with you and cares for you while you are recovering from a clinic surgical procedure.	1	2	3	4	5	6	Yes	No	Yes	No
27. Catheterizes, to remove urine from the bladder.	1	2	3	4	5	6	Yes	No	Yes	No
28. Removes stitches.	1	2	3	4	5	6	Yes	No	Yes	No
29. Applies dressings and ace bandages.	1	2	3	4	5	6	Yes	No	Yes	No
30. Gives medications to you (pills, shots, ointments).	1	2	3	4	5	6	Yes	No	Yes	No
31. Gives medication by vein.	1	2	3	4	5	6	Yes	No	Yes	No
32. Gives blood transfusions.	1	2	3	4	5	6	Yes	No	Yes	No

Activities	How important is it that the nurse does this?						Has the nurse performed this activity for you?		Whether or not the nurse has performed this activity, do you feel you should have received the care described?	
	1	2	3	4	5	6	Please Check Yes or No		Please check Yes or No	
33. Gives fluids for feeding purposes by vein.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
34. Asks you to give urine, stool, sputum and blood samples.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
35. Gives you directions to get to other areas in the clinic (X-ray, laboratory).	1	2	3	4	5	6	Yes___	No___	Yes___	No___
36. Takes you to other clinic areas by walking with you or using a wheel chair or stretcher if necessary.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
37. Gets a translator if English is not spoken.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
38. Stays with you if you are being physically examined by a physician of the opposite sex.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
39. Assists the doctor with procedures and examinations.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
40. Helps you get ready for examinations by the doctor (helps get undressed, provides with gown).	1	2	3	4	5	6	Yes___	No___	Yes___	No___
41. Has your record ready and up to date with laboratory and X-ray reports when you come for your clinic appointment.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
42. Explains clinic hours, routines and services.	1	2	3	4	5	6	Yes___	No___	Yes___	No___
43. Tries to make your clinic visit comfortable with attention to hunger, thirst, use of bathroom.	1	2	3	4	5	6	Yes___	No___	Yes___	No___

Activities

How important is it that the nurse does this?

Has the nurse performed this activity for you?

Whether or not the nurse has performed this activity, do you feel you should have received the care described?  
Please check Yes or No

Please Check Yes or No

44. Coordinates timing if you have to visit more than one service at the clinic, so that long waiting periods are minimized.

1 2 3 4 5 6

Yes\_\_\_

No\_\_\_

Yes\_\_\_

No\_\_\_

Is there any care that is not listed that was given to you or that you believe you should have received from the nurse? (Please write in the space below.)

M. S. Berger, R. N., B. S. N. 1983  
Adapted from J. Verran,  
Journal of Ambulatory Care, 1981.

APPENDIX E

KEY TO QUESTIONNAIRE

## KEY TO QUESTIONNAIRE

Patient Counseling\*

1. Client advocacy (Question 1)
2. General support (Questions 2 and 3)
3. Clinical procedures (Question 4)
4. Terminal/chronic illness (Question 5)

Health Care Maintenance\*

5. General assessment (Questions 6 and 7)
6. Follow-up assessment (Question 8)
7. Provide information (Question 9)
8. Preventive care instruction (Question 10)

Primary Care\*

8. Referrals (Question 11)
10. Triage (Question 12)
11. Physical examination (Question 13)
12. History (Question 14)

Patient Education\*

13. Health care maintenance (Question 15)
14. Illness/condition (Question 16)
15. Home care (Questions 17 and 18)
16. Plan of care (Question 19)

Therapeutic Care\*

17. Surgical preparation (Question 20)
18. Respiratory treatments (Question 21)
19. Irrigations (Questions 22)
20. Applications (Question 23)
21. Measurement (Question 24)
22. Appliances (Question 25)
23. Recovery (Question 26)
24. Invasive (Question 27)
25. Non-invasive (Question 28)
26. Dressings (Question 29)
27. Medications (Question 30)
28. I.V. Medications (Question 31)
29. Blood therapy (Question 32)
30. I.V. Therapy (Question 33)
31. Specimens (Question 34)

Normative Care\*

32. Directing (Question 35)
  33. Transporting (Question 36)
  34. Communication (Question 37)
  35. Chaperoning (Question 38)
  36. Assisting (Question 39)
  37. Preparation (Question 40)
  38. Documents (Question 41)
  39. System (Question 42)
  40. Comfort (Question 43)
  41. Coordination (Question 44)
- 

Note: \* Indicates literature-based responsibility areas of ambulatory care nursing activities. All items under these categories indicate research-derived ambulatory care nursing activity categories.

Adapted from  
J. Verran, Journal  
of Ambulatory Care, 1981.

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