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The role of the hospital nurse and the public health nurse in the continuity of care for patients with hemiplagia due to a cerebral vascular accident.

THE ROLE OF THE HOSPITAL NURSE AND THE PUBLIC HEALTH NURSE IN THE CONTINUITY OF CARE FOR PATIENTS WITH HEMIPLEGIA DUE TO A CEREBRAL VASCULAR ACCIDENT

BY

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CHAPTER I

INTRODUCTION

Advances in medical research and management have resulted in a changing emphasis in the American health picture. The development of successful immunization programs has reduced communicable diseases to a minimum. The widespread use of antibiotics prevents certain complications of infections or acute conditions. These factors, coupled with a steady increase in the standards of living, have had a dramatic effect upon life expectancy. It has been estimated that 30.4 per cent of the population in the United States in 1960 were over 45 years of age.[1] In summary, infectious diseases and health problems of older people are becoming more of a problem than in the past.

Vascular lesions rank third as a cause of death in the population over 45 years of age in the United States.[2] Furthermore, there are one million Americans living today

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[1] C. V. Langton and C. L. Anderson, Health Principles and Practice (St. Louis: C. V. Mosby Co., 1957), 11.

[2] Ibid.

with hemiplegia due to a cerebral vascular accident.[3] Statistics such as these, present in a vivid manner the impact of the aging population on programs of medical care. Programs providing services for chronic illnesses demand the cooperation and continuous effort of all community health agencies. Many helping professions are included in the care of patients over 45 years of age who have hemiplegia due to a cerebral vascular disease.

Positioning, a progressive exercise program, anti-coagulant therapy, nutrition, management of the bowel and bladder are all necessary adjuncts to the care of these patients. It is often the nurse's responsibility to organize the treatments prescribed by the attending physician. A treatment schedule which is lacking in organization and continuity results in crippling deformities, debilitation and despair. For such organization, an adequate and efficient system of communication is essential within an agency and between agencies. The process of communication may range from no organized method to an elaborate system of forms and records which accurately describe the many personal details of patient care.

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[3]Michael Dacso, "Clinical Problems in Rehabilitation," Geriatrics, VIII (February, 1953), 179-180.

An understanding of one another's purpose and role is basic to successful communication. The contribution that a community nursing agency can make to the rehabilitation of the patient is strongly influenced by the care provided patients during hospitalization and by the information received from the staff of the hospital. Gilbert describes the importance of communication in her writings:

> Much of the continuing improvement in inter-agency relationships depends, as far as the public health nurse is concerned, on an understanding of her own function and the functions of the community agencies together with preparation for the means of communication with other agencies.[4]

It is important that the hospital staff not only provide a plan of optimum care for patients during the acute and convalescent stages of illness but also extend the plan to include continuation of patient care directed toward ultimate rehabilitation. The cooperation of many people, departments and health agencies is involved in the development of such a program. Progress has been made in some instances but every patient deserves the combined interest of the many disciplines for continued progress.

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[4]Ruth Gilbert, The Public Health Nurse and Her Patient (Cambridge: Harvard University Press, 1951), 327.

STATEMENT OF THE PROBLEM

This is a study of the expectations of nurses in the hospital and in public health concerning continuity of care with emphasis upon nursing activities pertinent to the care of a patient with hemiplegia due to a cerebral vascular accident.

Answers to the following specific questions are proposed in this study:

1. Is there agreement among the hospital nursing staff about their responsibility for care?

2. Is there agreement among the hospital nursing staff about the responsibility of the public health nurse for care of the patient in the home?

3. Is there agreement among public health nurses about their responsibility for care?

4. Is there agreement among public health nurses about the responsibility of the hospital nurse for care?

5. Is there satisfactory provision for communication between the nurses providing care in the

hospital and the nurses providing care in the home?

SCOPE AND LIMITATIONS

The study was conducted in three community health agencies offering care to patients with hemiplegia due to a cerebral vascular accident. All of the cooperating agencies use the Greater Boston Inter-Agency Referral Form as a means of communication. Twenty nurses participated in this study and had been employed in the cooperating agencies for a minimum of six months. Ten were staff nurses with a public health agency. Ten were hospital nurses from two general hospitals; two head nurses and three staff nurses from each hospital. None of the nurses was considered a rehabilitation specialist.

The conclusions drawn from the data apply only to nurses studied. However, the findings may suggest to others interested in the care of hemiplegia patients the advisability of conducting a similar study in their own agency.

JUSTIFICATION OF THE PROBLEM

Optimum care of the patient with hemiplegia due to a cerebral vascular accident requires coordination between

the nurses providing care in the hospital and the nurses providing care in the home. The success of the coordination is dependent upon the quality of communication between agencies which provide care and supervision to these patients. Understanding and agreement of philosophy and goals of care are basic to a productive system of communication. Studies have been conducted of patients with hemiplegia. No studies could be located that specifically studied continuity of nursing care for patients with hemiplegia.

The study will have particular interest for nurses in hospitals, public health agencies and also those concerned with the rehabilitation of these patients. To all interested in continuity of nursing care, the study represents on the one hand, commendation for progress made, and on the other, a challenge for continued emphasis and education.

PREVIEW OF METHODOLOGY

Records were reviewed of patients treated for a cerebral vascular accident in each of the three cooperating agencies during a stated period of time. The ten public health nurses were selected by the writer from the roster of the Visiting Nurse Association of Boston. The

ten hospital nurses were employed in two general hospitals in the Boston area. Two head nurses and three staff nurses were selected by nursing service in each hospital.

Data were collected by the writer by a three phased interview. Phase 1 of the interview was structured to obtain written information about the age, preparation, education and experience of the nurse. Each participant was asked two open-ended questions with reference to the responsibility of the hospital nurse and the public health nurse in care of patients with hemiplegia due to a cerebral vascular accident. Information was sought about the use of the Greater Boston Inter-Agency Referral Form.

In phase II, all participants were presented descriptions of five common chronic illness conditions. They were asked to rank the rehabilitation potential of each condition when present in a patient under 65 years and also in a patient over 65 years.

In phase III, a modified Q-sort technique was used. Forty items considered pertinent to the care of a patient with hemiplegia due to a cerebral vascular accident were constructed. Respondents were asked to sort the items into those considered to require a medical order, those considered to be nursing activities or those that did not qualify for the previous categories. Finally, these

nursing items described as commonly provided were sorted to reveal the method of recording available for the nurse in the agency. A concluding question was asked of each participant concerning her opinion of the record system provided by the agency as a means of evaluating patient progress and providing continuity of patient care.

Each phase of the interview guide was pre-tested with nurses who were graduates of diploma and degree programs and employed by hospitals and public health agencies. The actual interviews, with a short introduction to the purpose of the study, averaged 50 minutes.

SUMMARY OF THE PRESENTATION

The impact of the philosophy of rehabilitation and its current application to continuity of care for the aging population are reviewed in Chapter II. This presents highlights of writings in medical journals, published texts and unpublished theses during the years since World War II.

A detailed description of the process by which the information for the study has been collected is presented in Chapter III. This is followed by a presentation of the findings of the study in Chapter IV. Finally, Chapter V includes the recommendations, conclusions and summary of the study.

CHAPTER II

THEORETICAL FRAMEWORK OF THE STUDY

REVIEW OF THE LITERATURE

Rehabilitation, as a philosophy, is as old as humanity itself. As a medical specialty, rehabilitation is a by-product of World War II. Ironically, the practice of rehabilitation which proved so successful for the injured and wounded was not readily available to the non-veteran. Through the efforts of such dedicated men as Dr. Kessler and Dr. Rusk, the philosophy, facilities and far-sightedness of rehabilitation has been increasing in scope. There has been an ever-growing number of professional contributions to medical journals, texts and periodicals which emphasize the application of the principles of rehabilitation to a variety of disease entities. In a medical-surgical nursing text published in 1961 the entire fourth chapter has been devoted to the subject of rehabilitation.[1]

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[1]Kathleen Shafer et al., Medical-Surgical Nursing (St. Louis: C. V. Mosby Co., 1961), 35-46.

Nursing has fostered a number of expressions to describe its responsibilities in the field of rehabilitation. "Comprehensive care," "total patient care," or family-centered care" are a few of these descriptive phrases. The need for follow through into actual practice has been discussed by Patroski:

> The growing number of hospital-discharged persons with hemiplegia requiring prolonged training and corrective therapy for physical disabilities and emotional maladjustment, often incurred during the period of hospitalization, appear to indicate the serious need on the part of the nurse to better understand as well as put into practice the significant implications embodied in the term "total patient care."[2]

Patroski concluded there was a "need for the nurse to recognize the family as an extremely powerful factor in determining the degree of restoration in the patient."[3] Dunn and Gilbert have included a note of optimism in their writings:

> Despite progress, the family often remains in a medical vacuum, largely outside the scope of private practice and nearly neglected by public health. We say "nearly" because one public health practitioner, the public health nurse, has always focused her attention on the family unit.[4]

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[2]Regina Patroski, "Implications for Nursing Care of the Patient with Hemiplegia in the Acute and Early Convalescent Stages" (unpublished Master's thesis, School of Nursing, Boston University, 1956), 2.

[3]Ibid., 89.

[4]Halbert L. Dunn and Mort Gilbert, "Public Health Begins in the Family," Public Health Reports, LXXI (September, 1956), 1007.

Complexities of modern medical practice have resulted in an increase of specialization which predisposes to a fragmentation of care. But the family unit, a dynamic and changing center of concentration, is predisposed to problems, too. Rejection or isolation of the aged, linked in part to the modern family structure and functions, has contributed to a major health problem.[5] The advanced life expectancy has brought with it degenerative processes associated with longevity. Arteriosclerosis and hypertension are two such processes. The complications of these and other manifestations which plague the senior citizens represent major challenges to the medical team.

There has been an increasing concern for the care of an aging population which has been paralelled by an emphasis on rehabilitation. Unfortunately, the transference of the principles of rehabilitation to the treatment of the processes of the aged and their complications has been limited. Bonner, in a recent publication, decried the apathy expressed by the attending physician, young and old, toward the application of rehabilitation services to the patient with hemiplegia due to a cerebral vascular

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[5] Ibid., 1003.

accident.[6] This article, which drew upon the physician's personal experiences, supported the findings of a survey conducted by the Commission on Chronic Illness. In the published report of their national survey, the Commission indicated that apathy or indifference to the care of a patient with long-term illness was prevalent among the staff in many hospitals.[7]

Solutions to the problems of the aged and the patient with long-term illness are multiple and diverse. The team approach, which coordinates the services of specialists, is one attempt to improve the quality of patient care. There must however, be a cooperative effort by the physician and the nurse to include other members, professions and disciplines to the team. Pellegrino cautions, "Both physician and nurse must resist the temptation to assume that they, alone, can settle the problems of medical care."[8]

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[6]Charles D. Bonner, "Prognostic Evaluation for Rehabilitation of Patients with Strokes," Geriatrics, XIV (July, 1959), 424.

[7]Commission on Chronic Illness, Chronic Illness in the United States, II: Care of the Long-Term Patient (Cambridge: Harvard University Press, 1956), 13.

[8]E. D. Pellegrino, "The Nurse Must Know the Nurse Must Speak," American Journal of Nursing, LX (March, 1960), 361.

Johnson concurs:

> The health team cannot be a closed circle of in-facing initiates with their backs to the outside world; rather, it must be an open circle ready to welcome new workers and able to expand as new areas of useful cooperation are discovered.[9]

The needs of the patient must receive top priority and be the center of concern if any plan is to be successful. Rehabilitative care requires the cooperation of the patient, family and all members of the team. Nursing holds an important place in such a program of action. Maximum restoration of function almost certainly requires that the patient receive the profits of rehabilitative nursing care. Dr. Paul D. White speaking in Princeton, New Jersey, made the following point, "The first step in rehabilitation . . . and often the only step in the prevention of severe crippling is to return to the status of self-help."[10] There are, however, many obstacles to this important step. Oversolicitousness on the part of loved ones, feelings of rejection and despair experienced by the patient, and a reluctance by members of the nursing staff to encourage self-care represent a crippling combination which threatens the goals

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[9]Paul E. Johnson, "Religious Psychology and Health," Mental Hygiene, XXXI (October, 1947), 557.

[10]Paul D. White et al., Cardio-vascular Rehabilitation (Boston: McGraw-Hill Co., 1957), 60.

of rehabilitation. The nursing staff, by virtue of an extended contact with a person relegated by illness to a dependent state, maintains a particularly important position in the rehabilitation process. In many cases, it is nursing care which bridges the gap between debilitation and rehabilitation.

The Commission on Chronic Illness has made this challenge to the medical professions:

> By and large we apply only scantily the technical knowledge that is now available. This failure is partly the result of faulty thinking with regard to the real nature of rehabilitation. Surely, we would not do so poorly if there were general recognition that to neglect these skills is to fail in both prevention and care.[11]

This regrettable situation may apply to many patients with varied conditions or processes. Dr. Rusk described the plight of certain patients in this way:

> Unfortunately, in the past, the medical attitude toward hemiplegia has been one of hopelessness and helplessness. If a dynamic approach is used, however, the hemiplegic is not a lost cause. Spot checks have shown that 90% can be taught ambulation, self-care and urinary and fecal continence, and 40% can be taught to do gainful work.[12]

At another time Rusk stated, "It is our feeling (at Bellevue Rehabilitation Center) that 75% of the hemiplegics

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[11]Commission on Chronic Illness, II, 14-15.

[12]Howard Rusk, "Rehabilitation of the Hemiplegic," Postgraduate Medicine (April, 1954), 347.

could have an adequate program in the ordinary general hospital program."[13]

Nursing plays a vital part in the achievement of success for such programs. Contractures are but one of the limiting complications which could be prevented by the application of nursing measures. Positioning during the acute stage is of vital importance. Covalt[14] and Morrisey[15] stressed the value of purposeful change of the patient's position. Doody[16] and Sandin[17] in their studies have pointed out the value of range of motion exercises as well as proper positioning for the prevention of contractures. Gordon refers specifically in his writings to the

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[13] Ibid.

[14] Nila K. Covalt, "Preventive Techniques of Rehabilitation for Hemiplegic Patients," General Practitioner XVII (March, 1958), 131-143.

[15] Alice Morrisey, Rehabilitation Nursing (New York, G. B. Putnam's Sons, 1951), 59.

[16] Barbara J. Doody, "A Survey of the Affected Upper Extremities of Hemiplegic Patients after Discharge from Hospital (unpublished Master's thesis, School of Nursing, Boston University, 1959).

[17] Margaret S. Sandin, "Perceptions of Nurses, Physical Therapists, and Physicians Regarding the Performance of Range of Joint Motion as an Integral Part of Nursing Care" (unpublished Master's thesis, School of Nursing, Boston University, 1960).

contributions of nurses:

> The nurse can contribute enormously if she would adopt certain well-known rehabilitation procedures as her own: to be specific, preventive positioning against secondary deformity in the acute phase; modern procedures of bladder control training; early ambulation and early movement of parts to prevent thrombosis, deconditioning, and general deterioration; familiarity with self-help devices combined with alertness to provide them. And many others. The nurse will, therefore, be the backbone of the long-term care phase.[18]

Previously Gordon has written:

> That peripatetic nurse, who travels about the community to visit and minister to the sick at home, can become a powerful link in the chain of activities required for rehabilitation.[19]

Continuous, uninterrupted, goal-directed care is an essential quality of rehabilitation. W. Scott Allan in his writings has emphasized the need for communication between those providing patient care in the hospital and at home:

> Most of all, the hospital needs to link its efforts for the patient with the community rehabilitative programs and services, to the end that maximum restoration of function and adjustment to handicap

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[18]Edward E. Gordon, "More Training for Nurses in Rehabilitation," Rehabilitation Literature, XX (October, 1959), 290.

[19]Edward E. Gordon, "Chronic Disease and Disability: a Public Health Responsibility," Public Aid in Illinois (May, 1959), pp. 6, 12.

becomes not merely a possibility but a probability.[20]

A lack of awareness for the services which are available within the hospital as well as in the community represents a threat to the continuity of care. This has been pointed out by Gabig,[21] Weber,[22] and Patroski.[23] Patroski has recommended that "one of the best means for insuring continued care after hospital discharge is a concise and complete method of referral to the health agency assuming the care of the patient in the community."[24]

The development of acceptable referral plans has been an attempt to improve the strength in the link of communication between the hospital and the home. An efficient and successful referral plan requires cooperation,

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[20]W. Scott Allan, Rehabilitation a Community Challenge (New York: John Wiley and Sons, 1958), 44.

[21]Mary G. Gabig et al., "In-Service Education for General Duty Nurses," American Journal of Nursing, LIII (April, 1953), 452.

[22]Helen J. Weber, Improvement of Nursing through Good Administration, Report of a workshop held at University of Dayton, Ohio, (Dayton, Ohio, 1958), Lecture 2, 10.

[23]Patroski, 100.

[24]Ibid., 38.

based on understanding. Communication has been defined as "the art of developing understanding."[25] Lack of understanding, lack of awareness of services or inadequate familiarity with responsibilities and functions are indicative of poor communication. Poor communication interferes with continuity of care and impedes progress in the improvement of patient care.

BASIS FOR THE HYPOTHESIS

Ten years ago, Ruth Gilbert stated that "hospital nurses and public health nurses are becoming more clearly related professionally. The work of one is a continuation of the work of the other in a different community set-up."[26] Progress, indicative of improved communications, has been made in the continuity of care. Farrisey points out, however, that "daily one encounters patients and families who have fallen into the abyss which yawns between the hospital and the community agency."[27] Lack of familiarity

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[25]Hiram S. Hall, "Communications with Others," American Journal of Nursing, LIII (January, 1953), 63.

[26]Ruth Gilbert, The Public Health Nurse and Her Patient, (Cambridge: Harvard University Press, 1951), 8-9.

[27]Ruth M. Farrisey, "Referral in Practice," American Journal of Nursing, LII (June, 1952), 732.

with the responsibilities and functions of community agencies contributes to a lack of cooperation and communication of care which is so basic to the patient's rehabilitation.

STATEMENT OF THE HYPOTHESIS

There is a lack of agreement concerning the responsibility of the hospital nurse and the public health nurse in the continuity of care for patients with hemiplegia due to a cerebral vascular accident.

CHAPTER III

METHODOLOGY

SELECTION AND DESCRIPTION OF THE SAMPLE

Three community health agencies cooperated in the study. Each agency participates in teaching and research, is known to provide quality nursing care, and uses the Greater Boston Inter-Agency Referral form as a means of communication. Twenty nurses were included in the sample. They represented the staff of a public health agency and two general hospitals in the Boston area.

Ten public health nurses were selected for the sample. The agency roster was used as an official listing of the staff nurses available in each district. It was established that the nurse would be selected who was the third name listed alphabetically in each office, if she was a registered professional nurse who had been employed by the agency for at least six months. The fourth name was used only in case the nurse selected failed to meet this requirement. In the district office in which the second nurse was chosen, both the third and fourth nurse were selected. Since the decision to select the third nurse was made

arbitrarily by the writer rather than by use of a table of random numbers or similar device, the sample does not meet all the requirements of a random sample.

The ten hospital nurses were selected on the basis of their availability in two general hospitals. In hospital "A", the Director of Nurses arranged for five nurses to cooperate in the study. The group included two head nurses and three staff nurses from units providing care to patients with cerebral vascular accidents. In hospital "B", the Associate Director of Nurses presented the study to the Assistant Directors of Nursing Service. Individual appointments were made at which time the author and each Assistant Director selected as participants two head nurses and three staff nurses from units providing care to patients with cerebral vascular accidents.

The sample, then, was composed of sixteen staff nurses and four head nurses. Seven of the total sample had held their present position less than a year; two nurses had occupied it for more than five years. In terms of educational background, the sample contained ten graduates of a diploma program and ten graduates of a degree program. Seven of the ten hospital nurses were graduates of a diploma program and seven of the public health nurses were graduates of a degree program.

REVIEW OF RECORDS

Accurate information about the number of patients treated for cerebral vascular accidents who have been referred from hospital care to visiting nurse care was sought by means of a record review in each cooperating agency. In the Visiting Nurse Association of Boston the author reviewed the records of patients with the diagnosis of cerebral vascular accident active during February and March, 1961. Information concerning the following was obtained: The diagnosis as received by the agency, the source and date of the referral, age, sex and marital status of the patient, date and occupation at the onset of the illness, length of hospitalization, names of other agencies interested in the patient, the payment plan and the level of patient activity.

Through the cooperation of the Medical Librarians the author reviewed the records of patients with the diagnosis of cerebral vascular disease discharged from each hospital between January 1 and February 28, 1961. Information concerning the following was obtained: The diagnosis upon discharge, the age, sex, marital status and occupation of the patient at the onset of the illness, length of hospitalization, the payment plan, provision for continuity of care, other disciplines interested in the patient, condition of the patient on discharge and comments on the referral.

TOOLS USED TO COLLECT THE DATA

Work sheets were prepared for the purpose of recording information gleaned from the record review. The information was thus available in a manner which was concise and lent itself to ease of tabulation and analysis.

A structured interview was selected as the method of choice for obtaining information from the nursing sample. Each interview was based on a three-phased interview guide which is included in Appendix A. Questions in phase I focused upon the nurse's age range, educational background, work experience, familiarity with public health nursing and with the use of the greater Boston Inter-Agency Referral Form. Four questions were included for the hospital nurse sample only. These questions sought information about their recent participation in providing for continuity of nursing care for patients with hemiplegia due to a cerebral vascular accident. Phase I concluded with two open-ended questions presented to all participants. Respondents were asked to comment on the responsibility of the hospital nurse and the public health nurse in providing care to these patients.

Phase II consisted of descriptions of five common chronic illness conditions, one of which was a cerebral

vascular accident. The participants were asked to place the descriptions in rank order as to the potential for rehabilitation if the condition existed in a patient under 65 years; and to rank them again for patients over 65 years. This technique was included for two reasons. First, to determine the nurses opinion of the rehabilitation potential of a patient with hemiplegia due to a cerebral vascular accident. Second, to determine if age was a factor in the decision.

A modified form of the Q sort was utilized in phase III. Forty items considered pertinent to the care of a patient with hemiplegia due to a cerebral vascular accident were presented individually on forty 3 x 5 index cards. Each nurse was asked to sort the items into three major categories:

1. Medical Order--those items which require a written order from the attending physician to allow the nurse to provide the care.

2. Nursing Activities--those items which may be performed without a written order from the attending physician.

3. Undetermined--items which the participants felt, for various reasons, did not apply at all.

The cards classified as "undetermined" were so recorded. The respondents were then asked to sort the "medical items" according to how frequently the physicians had requested each item. The participants then sorted the "nursing items" as to how frequently each item had been provided by the nurse. A final sorting was concerned only with the nursing items sorted as "always provided" or "usually provided." The nurses were asked to sort these items to describe the method available for recording these items so as to provide for continuity of nursing care. The interview concluded with a question concerning the nurse's satisfaction with the record system provided in her particular agency. These data were recorded on work sheets which allowed for ease of tabulation and analysis.

PROCUREMENT OF DATA

Appointments were made with the directors of three community health agencies to discuss the purpose of the study, the method designed to study the problem, the assistance required of the agency, and the time required of each participant nurse for the interview. Permission was granted to review records and to interview a stated number of nurses in each cooperating agency.

The interviews were conducted privately with a minimum of distractions. Each interview averaged 50 minutes in length. The author was most appreciative for the cooperation of the participants in this study. The administration of each agency was most hospitable and helpful in the preparation and organization necessary for the study.

CHAPTER IV

FINDINGS

This chapter is concerned with the presentation, analysis and discussion of data obtained from structured interviews held with ten hospital nurses and ten public health nurses and from a record review of patients with the diagnosis of cerebral vascular accident. The record review covered thirty-four patients discharged from two general hospitals and eighty patients treated by the visiting nurses in the community.

CONCERNING THE PREPARATION OF THE NURSES

The total sample was composed of twenty nurses. Ten were graduates of a degree program; seven of these were concerned with care of the patient in the community, and three were employed in a hospital situation. Ten were graduates of a diploma program; seven of these were concerned with care of the patient in the hospital and three were employed by a public health agency. It was interesting to note that in their particular diploma programs only four of the ten nurses had opportunity to provide nursing

care to patients in the home. Six of the ten hospital nurses in the sample had only classroom instruction and a one day observation in a community agency during their educational program as a source of familiarity with public health nursing.

CONCERNING LONGEVITY OF SERVICE

Nine of the public health nurses and two of the hospital nurses had been associated with their agencies for one to five years. Only one hospital nurse and one public health nurse had been employed for more than five years by their agencies. The fact that seven of the ten hospital nurses were employed with the agencies for less than eleven months was probably a reflection of the current turnover rate in hospitals.

CONCERNING PUBLIC HEALTH EXPERIENCE

Three of the ten public health nurses reported their working experience had included association with a hospital for varying periods of time. Only one of the ten hospital nurses had been employed by a public health agency as a graduate nurse. The nine other hospital nurses made the following report of their contact with public

health nurses: five stated they had no contact with public health nurses, four indicated their contact was limited to committee work with public health nurses, association with friends or classmates who were employed by public health agencies, or having a friend or relative who had received care from a public health nurse.

CONCERNING CONTINUITY OF CARE

Each hospital nurse had been asked three questions regarding her opinion and recent use of the Greater Boston Inter-Agency referral form. Two said they had no opportunity to write a referral during the month prior to their interview. Four reported they had initiated and completed the written form. Discussion, during the preparation of the referral, included other interested persons and disciplines. Four nurses had discussed an intended referral with family members, and five also had discussed it with the patient; six nurses stated they discussed the referral with a social worker; four had included the dietitian in the discussion.

The nurses were then asked to reflect upon the patients with hemiplegia due to a cerebral vascular accident hospitalized on their units during the previous two months. Four nurses recalled two or three patients who

would have profited by a referral to a public health agency, but who were not referred. Three nurses could not recall patients whom they thought needed to be referred. One nurse would have recommended a referral for six patients, but could not accurately say whether or not any of these patients were actually referred. The nurses who provided explanations why no referral was written indicated for two cases that the doctor or the family refused referral. Only one patient refused to be referred. In the other instance no one had suggested a referral.

Record review figures contributed significant information relative to continuity of care. The review of the records of eighty patients with cerebral vascular accident active with the Visiting Nurse Association revealed that forty-eight had been hospitalized at some time during their treatment. Twenty-two patients were returning to the hospital clinics for care. Only eleven had direct referral from the hospital to the nursing agency which would provide uninterrupted continuity of care. The records of thirty-four patients with cerebral vascular accident discharged from two general hospitals revealed that in eleven cases care was to be continued either in a rehabilitation center, a nursing home or by the Visiting Nurse Association. In only five instances was a copy of the completed referral form included in the

patient's record. These data indicate that only one-seventh of the total of eighty patients were referred to a community nursing agency. Granting that not every patient required such care, it was noted that only half of the patients receiving continued care in a community agency had the benefit of a written referral from the hospital.

CONCERNING THE REFERRAL FORM

All participants were asked if they would like details added or omitted from the present referral form. Five respondents, consisting of four hospital nurses and one public health nurse, advocated changes. These nurses recommended enlarging the space for the nurse to comment on the front of the report, and replacing the space allowed for narrative comment with a recommended list to be checked. Other suggestions made were: (1) that information relative to the hospital (date of admission and discharge, and the patient's unit number) be separated from information relative to the home (address, floor and telephone number); (2) Space be provided on the form for the inclusion of plans for follow-up.

Fifteen approved of the style of the present form. However, many of the hospital and public health nurses commented that better information should be supplied on the

form. More than half of those commenting indicated the need for a more complete picture of a patient at the time of discharge from the hospital. More inclusive information relative to the patient's level of self care, activity and adjustment to the illness were other examples cited. Five respondents desired more information from the social worker familiar with the individual patient, and four would have appreciated comments from the dietitian involved in the particular patient situation.

CONCERNING THE HOSPITAL NURSES' RESPONSIBILITY

Nurses in the sample providing care to patients in the hospital had been prepared predominantly in diploma programs and had only minimal familiarity with public health nursing. The majority were under thirty years of age and had been employed in the particular hospital for less than a year. The public health nurses in the sample had been prepared predominantly in degree programs; a limited number have had experience in hospital nursing. The majority were also under thirty years of age but had been employed with the agency from one to five years.

The preparation and experience of the nurse had apparent influence upon the expectations she held regarding patient care. The hospital nurse emphasized the importance

of the physical aspects of patient care while the public health nurse stressed the importance of teaching as a part of family-centered care. This is illustrated in Table 1, which presents the opinions of the twenty nurses regarding the primary responsibility of the hospital nurse in the care of patients with hemiplegia due to a cerebral vascular accident.

The following facts in these data appear to have interest to the study: Hospital nurses and public health nurses mentioned that the prevention of contractures was a primary responsibility of the hospital nurse. However, only hospital nurses referred specifically to range of motion exercises as her responsibility. Public health nurses recommended the development of teaching programs for the patient and/or his family as the primary responsibility of the hospital nurse. However, this was mentioned by only one of the hospital nurses as a responsibility. Maintaining an adequate airway, assessing the patient's rehabilitative needs, and the use of physical therapy were also suggested by hospital nurses as primary responsibilities. Only two, one hospital and one public health nurse, mentioned the preparation of patients for home care as a major responsibility. There was a low agreement, but no marked disagreement as to the responsibilities of hospital nurses in the care of patients with cerebral vascular

TABLE 1

OPINIONS OF TEN HOSPITAL AND TEN PUBLIC HEALTH NURSES REGARDING THE PRIMARY RESPONSIBILITY OF THE HOSPITAL NURSE IN THE CARE OF PATIENTS WITH HEMIPLEGIA DUE TO A CEREBRAL VASCULAR ACCIDENT

Responsibility	Number of Replies	
	Hospital Nurses	Public Health Nurses
Prevent contractures . .	3	4
Provide range of motion exercises	4	
Develop a teaching program for the family .	1	3
Prevent decubitus ulcers	2	1
Provide general nursing care		3
Develop a teaching program for the patient .		2
Prepare the patient for home care	1	1
Assess the patient's rehabilitation potential	2	
Encourage physical therapy	2	
Maintain an adequate airway	2	

accidents. Since the responsibility most frequently mentioned was cited by less than half of each group, it may be concluded that there was no high level of shared understanding of responsibilities between hospital and public health nurses.

In response to a question about other responsibilities of hospital nurses the participants provided information which is presented in Table 2.

A majority of the nurses, both hospital and public health, indicated the need for the hospital nurse to provide emotional support and encouragement for the patient and/or his family. Eight nurses in the sample also thought that the hospital nurse had considerable responsibility in planning for long term follow-up for patients with hemiplegia. Only two hospital nurses and one public health nurse commented on the hospital nurses' responsibility for knowing the patient's background and his status in the family. However, such information would appear to be particularly necessary if the hospital nurse was to provide emotional support or understand the implication of long term treatment.

TABLE 2

OPINIONS OF TEN HOSPITAL AND TEN PUBLIC HEALTH NURSES REGARDING OTHER RESPONSIBILITIES OF THE HOSPITAL NURSE IN THE CARE OF PATIENTS WITH HEMIPLEGIA DUE TO A CEREBRAL VASCULAR ACCIDENT

Responsibilities	Number of Replies	
	Hospital Nurses	Public Health Nurses
Provide emotional support and encouragement for the patient and family	6	6
Consider long term follow-up	4	4
Maintain adequate nutritive level . .	3	4
Position the patient properly	4	2
Provide skin care to prevent decubiti	4	1
Allow for bowel and bladder management	2	2
Educate the family regarding patient care	2	2
Learn the background of the patient and family	2	1
Consider speech problems	1	2
Provide range of motion exercises . .	1	1
Protect the patient from injury . . .	1	1

CONCERNING THE PUBLIC HEALTH NURSES' RESPONSIBILITY

The respondents were then asked to turn their attention toward the responsibilities of the public health nurse in the care of patients with hemiplegia due to a cerebral vascular accident. Table 3 presents the information given by the participants as the primary responsibility of the public health nurse.

It appeared that the nurses generally agreed that the public health nurse should continue the nursing care activities started in the hospital. Although an equal number of hospital nurses and public health nurses mentioned it was the responsibility of the public health nurse to consider the family group in patient care, three public nurses, only, referred specifically to their responsibility for teaching the family about patient care. It is interesting to note some comments made only by hospital nurses. These included opinions that considered it was the public health nurses' responsibility to check medications and to continue the exercise program.

In regard to the amount of agreement, it can be said there was low agreement but no marked disagreement. Since the responsibility most frequently mentioned was cited by n o t over half of each group, it may be concluded

TABLE 3

OPINIONS OF TEN HOSPITAL AND TEN PUBLIC HEALTH NURSES REGARDING THE PRIMARY RESPONSIBILITY OF THE PUBLIC HEALTH NURSE IN THE CARE OF PATIENTS WITH HEMIPLEGIA DUE TO A CEREBRAL VASCULAR ACCIDENT

Responsibility	Number of Replies	
	Hospital Nurses	Public Health Nurses
Continue what the hospital staff started	4	5
Consider the family group in the care	2	2
Teach the family to care for the patient		3
Evaluate the patient and family adjustment	1	2
Continue the exercise program . . .	3	
Check the medications	2	
Check the patient's activity . . .	1	
Give good physical care	1	

that there was no high level of shared understanding of the responsibilities of the public health nurses in the care of patients with hemiplegia.

The participants then expressed their opinion about other responsibilities of public health nurses in the care of patients with hemiplegia due to a cerebral vascular accident. This information is presented in Table 4.

Nurses, both hospital and public health, indicated it was a responsibility of the public health nurse to be sure the family was able to care for the patient and also to refer the patient to other community agencies for care. Two public health nurses referred to their responsibility for reporting disease manifestations to the physician. Three more spoke of their responsibility to report patient progress to attending physicians. Two hospital nurses mentioned that public health nurses had a responsibility to provide emotional support to the patient and his family.

TABLE 4

OPINIONS OF TEN HOSPITAL AND TEN PUBLIC HEALTH NURSES REGARDING OTHER RESPONSIBILITIES OF THE PUBLIC HEALTH NURSE IN THE CARE OF PATIENTS WITH HEMIPLEGIA DUE TO A CEREBRAL VASCULAR ACCIDENT

Responsibilities	Number of Replies	
	Hospital Nurses	Public Health Nurses
Be sure the family is able to care for the patient	5	5
Refer the patient to other community agencies	2	2
Report progress to attending physician	1	3
Return the patient to as good a level as possible	2	2
Give bedside care	1	3
Consider hygiene	2	1
Supervise the nutrition	2	1
Appraise the work tolerance realistically	1	1
Report disease manifestations to the physician		2
Recommend self-help devices . . .	1	1
Provide emotional support to the patient and family	2	
Prevent deformities through good skin care	1	1

CONCERNING THE COMMUNICATION OF RESPONSIBILITIES

Information gleaned from the sorting of forty items considered pertinent to the care of patients with hemiplegia due to a cerebral vascular accident was compiled. The sorting process focused upon items frequently requested by the physicians and those items frequently provided by the nurses. Items of care classified as frequently provided as nursing care were then sorted to indicate the method by which these items were recorded in each agency. A chronological list of these items is included in Appendix A. These data are presented in Table 5.

It was interesting to note certain findings in these data. The hospital nurses indicated that positioning measures were nursing activities frequently provided during the patient's hospitalization. This trend of emphasis also extended to the public health nurses. The manner in which these items of care were recorded included the entire scope of possibilities. The majority of the nurses had limited association with positioning measures such as a cock-up splint and the use of a sling. They tended to prefer a doctor's order for such measures, but only five nurses gave evidence of actual experience with these procedures. While six nurses indicated they would

TABLE 5

ITEMS OF CARE FREQUENTLY ORDERED BY PHYSICIANS, ITEMS OF CARE FREQUENTLY PROVIDED BY NURSES, AND METHOD OF RECORDING THE LATTER, AS REPORTED BY TEN HOSPITAL AND TEN PUBLIC HEALTH NURSES

Items of Care	No.	Frequently Ordered by Physicians		Frequently Done by Nurses		Method of Recording				
						Public Health		Hospital		
		Hospital Nurses	Public Health Nurses	Hospital Nurses	Public Health Nurses	None	Noted	None	Kardex	Nursing Care Plan
PREVENTION OF CONTRACTURES										
Encourage use of uninvolved arm	10	1	--	8	9	3	6	4	1	3
Provide range of joint motion	7	1	1	7	7	--	7	--	3	4
Advise moving fingers	31	2	--	7	7	2	5	4		3
Teach quadriceps setting	13	5	2	2	4	1	3	1	--	1
Massage twice daily	20	4	5	3	--	--	--	--	3	
Have patient take 5 deep breaths	26	--	--	5	6	3	3	1	4	--
Provide a pulley apparatus	2	5	1	1	1	--	1	1	--	--
POSITIONING										
Support the legs	22	--	--	10	10	1	9	2	7	1
Equip bed with foot board	4	--	--	10	9	1	8	4	6	--
Recommended back-lying position	16	--	--	10	9	7	2	7	2	1
Recommended side-lying position	19	--	--	10	9	4	5	6	2	2
Change position every two hours	15	--	--	10	6		6	1	9	--

TABLE 5--Continued

Items of Care	No.	Frequently Ordered by Physicians		Frequently Done by Nurses		Method of Recording				
						Public Health		Hospital		
		Hospital Nurses	Public Health Nurses	Hospital Nurses	Public Health Nurses	None	Notes	None	Kardex	Nursing Care Plan
POSITIONING (Cont'd.)										
Support affected arm by sling	9	--	2	1	--	--	--	--	1	--
Apply a cock-up splint	1	2	1	1	--	--	--	--	1	--
TEACHING PROGRAM										
Explain reasons for care to family	12	--	--	9	10	3	7	6	1	2
Inquire about eating habits	21	--	--	9	9		9	2	2	5
Instruct in position change	17	--	--	8	10	2	8	6	1	1
Encourage the family to give care	25	--	--	6	10	4	6	2	2	2
Inquire about living habits	14	--	--	6	9	2	7	2	--	4
Discuss safety factors	27	--	--	4	9	2	7	3	--	1
Provide written instructions	35	3	2	2	5	2	3	--	--	2
Advise about self-care devices	36	1	--	3	5	--	5	2	--	1
ENCOURAGEMENT AND SUPPORT										
Explain reasons for care to patient	23	--	--	10	10	4	6	6	1	3
Allow time for expression	38	--	--	10	9	6	3	3	1	6

TABLE 5--Continued

Items of Care	No.	Frequently Ordered by Physicians		Frequently Done by Nurses		Method of Recording				
						Public Health		Hospital		
		Hospital Nurses	Public Health Nurses	Hospital Nurses	Public Health Nurses	None	Notes	None	Kardex	Nursing Care Plan
ENCOURAGEMENT AND SUPPORT (Cont'd.)										
Explain mood change to family	28	--	--	9	9	4	5	7	1	1
Provide opportunity for decisions	40	--	--	8	8	4	4	4	1	3
Say, "Everything will be O.K."	29	--	--	--	1	1	--	--	--	--
LONG-TERM PLANNING										
Arrange equipment	18	--	--	9	10	9	1	4	2	3
Encourage self-care	11	--	--	9	9	2	7	3	1	5
Ensure sitting balance	32	1	--	8	6	2	4	3	3	2
Supervise gait training	33	1	--	5	5	1	4	3	1	1
Provide short leg brace	30	5	2	--	--	--	--	--	--	--
Encourage writing practice	8	--	--	--	4	2	2	--	--	--
Assist progress in A.D.L.	24	--	--	4	6	2	4	1	1	2
MANAGEMENT OF BOWEL AND BLADDER										
Provide opportunity for urination at regular intervals	3	--	1	10	3	2	1	2	7	1
Regulate daily bowel elimination	6	--	--	6	7	4	3	1	2	3

TABLE 5--Continued

Items of Care	No.	Frequently Ordered by Physicians		Frequently Done by Nurses		Method of Recording				
						Public Health		Hospital		
		Hospital Nurses	Public Health Nurses	Hospital Nurses	Public Health Nurses	None	Notes	None	Kardex	Nursing Care Plan
MANAGEMENT OF BOWEL AND BLADDER (Cont'd.)										
Clamp off indwelling catheter	34	7	5	--	--	--	--	--	--	--
Inquire about past pattern of bowel elimination	5	--	--	4	7	1	6	3	--	1
ATTENTION TO SPEECH										
Anticipate the needs of the aphasic patient	39	--	--	6	8	7	1	2	1	3
Provide speech aids .	37	--	--	4	3	1	2	1	1	2

See Appendix A for chronological list of items presented in the study.

instruct the patient in the technique of quadriceps setting, and seven would do so if requested specifically by a physician, seven indicated this was a responsibility of another department. Although a majority of nurses indicated they would encourage the patient to use his uninvolved arm, less than half stated they would use a pulley apparatus which would be a means of encouraging a patient to use the uninvolved arm to exercise an affected extremity. While public health nurses indicated they recorded these items on the patient's record, the hospital nurses used a Kardex or nursing care plan as a method of recording.

In spite of a current emphasis for patient-centered care, the responses to items of care related to the patient's background and future did not always indicate an application of the principles involved. For example, only six hospital nurses indicated they frequently inquired about the patient's living habits and status in the family. Two stated this information was not recorded and four said it was included in the nursing care plans. While information was sought frequently about the patient's eating habits and food preferences less than half of the hospital nurses inquired about the patient's pattern of bowel elimination. In fact, of the four who indicated they did inquire, only one apparently recorded

this information. It may be speculated that the very nature of the duties of the public health nurse in the care of patients in the home contributed to their increased attention to these matters. This seemed to apply to the inclusion of the family in patient care, as well. Obviously it was more popular for the hospital nurses to explain reasons for care to family members than to allow them to participate in patient care. The nurses, both public and hospital, encouraged self care but less than half offered advice about the many self care devices which have aided patients to experience success in self care.

Although communication is vital to self-esteem and purposeful living, only four nurses, all public health, responded positively to the item relative to the practice of writing. The use of speech aids received note from less than half the respondents. Replies to items 38 and 39 in Table 5, indicated a lack of consistency as to the manner of approaching the care of the patient with aphasia.

Continence is an important factor in the treatment of these patients. The hospital nurses indicated that provision for urination at frequent, regular intervals was the preferred method of management. Twelve of the participants stated that it would require a written order to clamp

off an in-dwelling catheter. However, many commented they were assuming the doctors would order this done, but they had no specific recollections that they did.

The low level of agreement about some of these items, and obvious discrepancy in some areas combined with the variance in the recording of the items appeared to adversely affect the continuity of nursing care. Some nurses indicated they would institute certain items of care without a written order, while others would not. Many items of care considered to be nursing activities were not recorded at all. Even when the items or pertinent information were recorded inconsistency was in evidence. The public health nurses recorded visits by means of a narrative explanation of care which did not lend itself to quick review; the hospital nurse utilized nursing care plans and kardex systems which were not included in the permanent record of the patient.

In reply to the concluding question relative to the method of recording available, ten of the participants, five public health and five hospital nurses, expressed dissatisfaction with the system. The other ten nurses indicated satisfaction with the method of recording which the agency provided. They felt there was ample opportunity to record information necessary to insure continuity of nursing care.

CONCERNING REHABILITATION POTENTIAL

Phase II was concerned with the nurse's opinion of the rehabilitation potential of patients with cerebral vascular accident and four other common chronic disease conditions. Before presenting the findings it seems appropriate to comment on the descriptions of common chronic disease conditions. In some descriptions, particularly the diabetic, the information offered was meager. In other cases, such as the patient with a cerebral vascular accident, the disease manifestations were minimal. It was also interesting to observe during the interviews that "diagnosis-centered" statements such as these, appeared to be more difficult for public health nurses to rank. The findings are presented in Table 6.

The nurses, both hospital and public health, indicated that the patient with diabetes, regardless of age, represented a high degree of rehabilitation potential. This suggests decided optimism about this disease, since no details which could allow inference about the prognosis were given in the description, and it could easily be unfavorable. The greatest discrepancy in the rankings occurred about the description of the patient exhibiting symptoms of depression. The hospital nurses appeared to

TABLE 6

REHABILITATION POTENTIAL OF PATIENTS UNDER SIXTY-FIVE AND OVER SIXTY-FIVE YEARS OF AGE WITH FIVE COMMON CHRONIC ILLNESS CONDITIONS AS RANKED BY TEN HOSPITAL AND NINE PUBLIC HEALTH NURSES

Description of Conditions	Rehabilitation Potential Score*			
	Patient under 65 years of age		Patient over 65 years of age	
	Hospital Nurses	Public Health Nurses	Hospital Nurses	Public Health Nurses
The patient is under care for swollen, painful joints with limited activity . . .	3.9	4	3.3	3.5
The patient is under care for cardiac insufficiency with occasional dependent edema of the ankles .	2.9	3.4	2.7	3.2
The patient is under care for diabetes and will need insulin daily	1.1	1.4	1.9	1.2
The patient is under care for a weakness of the left arm and a functional but weak left leg due to cerebral thrombosis	2.9	2.9	2.9	2.6
The patient is under care for loss of weight, disinterest in personal appearance and prolonged bouts of crying	3.8	3.2	4.5	4.1

*Score is an average of ranks assigned by respondents to patients on the basis of the patient's potential for rehabilitation, with rank 1 indicating the highest potential.

be more optimistic for these patients than did the public health nurses. In three out of four instances the patients with cerebral vascular accidents, regardless of age, were ranked next to the patient with diabetes for rehabilitation. This, too, suggests an optimism perhaps due to the emphasis on the rehabilitation of cerebral accident patients in recent years. Since the majority of the nurses in the sample had recently graduated from schools of nursing where the rehabilitation of patients most likely received emphasis it may be inferred that some nurses appreciate the opportunity for rehabilitation of patients with chronic disease conditions.

The rehabilitation potential scores were correlated using the Spearman formula for rank order correlation. If these conditions existed in a patient under 65 years, the coefficient of correlation among ranks was .84. Then, if the condition existed in a patient over 65 years, the correlation among ranks was .90. The rankings of these conditions by public health nurses had a coefficient of correlation which was .70. Then, for hospital nurses the coefficient of correlation among ranks was .88.

All these correlations were high. This indicates high agreement between hospital and public health nurses

regarding the rehabilitation potential of patients with various chronic disease conditions, regardless of the age of the patient. This agreement could be described as a stereotyped reaction to diagnosis.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

The problem posed in this study is concerned with the expectations for continuity of nursing care for patients with hemiplegia due to a cerebral vascular accident as derived from data collected from public health and hospital nurses. The literature reviewed was concerned with continuity of care as an essential quality of rehabilitation. There were, however, no studies located which dealt with the continuity of care of the patient with hemiplegia due to a cerebral vascular accident.

Answers to the following questions were sought:

1. It there agreement among the hospital nursing staff about their responsibility for care?

2. Is there agreement among the hospital nursing staff about the responsibility of the public health nurse for care of the patient in the home?

3. Is there agreement among public health nurses about their responsibility for care?

4. Is there agreement among public health nurses about the responsibility of the hospital nurse for care?

5. Is there satisfactory provision for communication between the nurses providing care in the hospital and the nurse providing care in the home?

Two methods were used to answer these proposed questions. The first was a record review of patients with cerebral vascular accident discharged from two general hospitals as well as records of patients with cerebral vascular accident active for treatment with the Visiting Nurse Association of Boston. The second method was a structured interview with twenty nurses. Ten nurses from one voluntary public health nursing agency and ten nurses from two general hospitals were included in the sample.

Interviews conducted were based upon a three-phased interview guide. Phase I was concerned with the nurse's age, educational background, work experience, familiarity with public health nursing and the use of the Greater Boston Inter-Agency referral form. Phase II

was concerned with the nurses' opinion of the rehabilitation potential of patients under 65 years and over 65 years with a cerebral vascular accident or one of four other common chronic disease conditions. Phase III, through a sorting process of forty items considered pertinent to the care of a patient with hemiplegia due to a cerebral vascular accident, classified each item relative to its status as a medical order or nursing activity. Information about the frequency with which these items of care were provided and the method of recording those nursing items said to be provided frequently was also obtained in phase III.

The majority of hospital nurses were graduates of a diploma program and had been employed with the particular health agency for less than eleven months. The opportunity for these nurses to become acquainted with the responsibilities of a public health nurse had been minimal. The majority of public health nurses were graduates of a degree program and had been employed with the particular health agency from one to five years. Opportunity for experience with a public health nursing agency was provided in the nurse's educational program. A few had included work experience as a hospital nurse since graduation.

CONCLUSIONS

Based upon the findings and implications of the study it appears that the following conclusions may be made:

Concerning Agreement Among Hospital Nurses About Their Responsibility

There were many replies to the question about the hospital nurse's primary responsibility in the care of patients with hemiplegia due to a cerebral vascular accident. Although the prevention of contractures and the provision of range of joint motion exercises were most frequently mentioned, no one responsibility received mention by more than half of the hospital nurses. Granting that there was no marked disagreement, the low agreement evidenced by the varied replies indicated there was no high level of understanding among hospital nurses of their responsibilities.

Other interesting findings in the data included:

1. Other primary responsibilities mentioned by the hospital nurses were chiefly concerned with meeting the physical needs of patients.

2. More than half of the hospital nurses referred to the importance of providing emotional

support to the patient and family in reply to the probe question about other responsibilities.

3. A limited number expressed the importance of knowing the patient's background and status in the family.

4. Only one hospital nurse considered the preparation of the patient for home care a primary responsibility.

5. The hospital nurses associated rehabilitation potential with certain chronic disease conditions regardless of age.

6. Lack of agreement was strongly evident about the manner in which items of care were recorded.

7. Very little of the information received or the nursing activities provided was recorded in the patient's record for permanent use.

8. Half of the hospital nurses expressed dissatisfaction with the existing record system.

Concerning Agreement Among Hospital Nurses About the Responsibility of the Public Health Nurse

In reply to the question about the primary responsibility of the public health nurse in the care of patients with hemiplegia due to a cerebral vascular accident, the hospital nurses offered a variety of responses. No one responsibility was mentioned by more than half of the sample. In fact, some of the responsibilities mentioned by several hospital nurses were not suggested by public health nurses in reply to the same question. This apparent lack of consistency coupled with the low agreement allows the conclusion that there was no high level of understanding among hospital nurses of the responsibilities of public health nurses.

Concerning Agreement Among the Public Health Nurses About Their Responsibility

There were many replies to the question about the public health nurse's responsibility in the care of patients with hemiplegia due to a cerebral vascular accident. Replies emphasized the role of the family in patient care.

Exactly half of the public health nurses considered it was their primary responsibility to continue what was started by the hospital staff. The low agreement evident in the replies indicated there was no high level of understanding among public health nurses of their responsibilities.

Other interesting findings in the data included:

1. Coordination of care with other community agencies and with the physician was seen as another responsibility of the public health nurse.

2. There was little appreciation shown for speech aids with a tendency to anticipate needs rather than encourage speech re-education.

3. The public health nurses associate rehabilitation potential with certain chronic disease conditions regardless of the age of the patient.

4. Half of the nurses expressed dissatisfaction with the available record system.

Concerning Agreement Among Public Health Nurses About the Responsibility of the Hospital Nurse

In response to the question about the primary responsibility of the hospital nurse in the care of patients

with hemiplegia due to a cerebral vascular accident no reply was offered by more than half of the public health nurses. Prevention of contractures and the importance of developing a teaching program for the family represent examples of responsibilities frequently mentioned. Other replies suggested by several public health nurses were not mentioned by any of the hospital nurses in reply to the same question. It may be concluded from this lack of obvious agreement that there was no high level of understanding among public health nurses of responsibilities of hospital nurses.

Other interesting findings in the data included:

1. More than half of the public health nurses referred to the importance of providing emotional support to the patient and the family in reply to the probe question about other responsibilities of the hospital nurse.

2. The public health nurses seldom mentioned the responsibility of the hospital nurse for knowing about the patient's background and family status.

3. Only one public health nurse specifically indicated it was the responsibility of the hospital nurse to prepare the patient for

home care.

4. There was some indication that the public health nurses felt the development of teaching plans for the patient and family was a responsibility of the hospital nurse.

Concerning the Provision for Communication Between the Hospital Nurse and the Public Health Nurse

A small fraction of the patients with cerebral vascular accidents were referred directly from the hospital to the community nursing agency for care, as was shown by the record review. The interview data showed that there was evidence of inconsistency in the method of recording items of care by nurses in the cooperating agencies. Half the participants in the study expressed dissatisfaction with the agency record system. More than half of the respondents were satisfied with the style of the Greater Boston Inter-Agency referral form but requested the inclusion of more information from nurses and other professional personnel interested in the patient. It may be concluded that the inconsistency in recording, the inadequacy of the record system within the agencies, the small number of referrals and the need for more information on the inter-agency referral forms which are

sent indicates deficiencies in communication between agencies, which probably adversely affects continuity of care.

Other interesting findings in the data included:

1. The hospital nurses recorded little information in a manner which contributed to continuity of patient care.

2. The narrative record available for public health nurses apparently included information for permanent use but did not lend itself to quick review.

3. More detailed information on the inter-agency referral form from nursing and allied professions was generally recommended.

4. Some of the referrals provided by the hospital staff included meager information concerning the patient's progress and program during hospitalization.

On the basis of the findings, the hypothesis that there is a lack of agreement concerning the responsibility of the hospital nurse and the public health nurse in the continuity of care for patients with hemiplegia due to a

cerebral vascular accident was substantiated. The data apply only to the opinions of the twenty nurses representing three health agencies and the records reviewed in these agencies. No general conclusions can be made from this study.

RECOMMENDATIONS

On the basis of the findings, the following recommendations are made:

1. that schools of nursing reevaluate the opportunities for public health experience.

2. that public health agencies reevaluate the opportunities available for experience suitable for students of a diploma program.

3. that continuity of care receive the attention of in-service programs of hospitals and public health agencies.

4. that a study be made of the cooperation of the allied professions to the referral plan.

5. that a study be made of patients with a diagnosis of cerebral vascular accident discharged without a referral, as well as

with a referral to a community nursing agency.

6. that a study be made of the relation of the nurse's preparation to her appreciation and understanding of rehabilitation.

7. that a study be made of the accuracy, efficiency and value of the existing record systems in hospitals and public health agencies.

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APPENDIX

Code_____

Age Range 20-29___
30-39___
over 40___

Directions: I am interested in studying the role of the hospital nurse and the role of the public health nurse in the care of a patient who has had a cerebral vascular accident.

Kindly answer each question as it pertains to your personal experience.

1. Are you a graduate of

   Diploma program _____

   Associate degree program _____

   Collegiate degree program _____

   Practical Nurse program _____

   Other _____ (please specify)

2. Do you have additional educational preparation?

   Credits toward a B.S. _____ Other _____

   a B.S. _____

   Credits toward an M.S. _____

   an M.S. _____

3. What is your present position ?

   _____

4. How long have you been in your present position ?

   Number of years _____

   If less than a year, the number of months _____

Code _____

5. What have been your working experiences since the completion of your basic nursing program ?

Position Held	Number of Years
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. How did you become familiar with the duties of a public health nurse ?

During the basic nursing program:

Classroom teaching _____

Observation with an agency _____ How long _____
(visited with another nurse)

Working experience with an agency _____ How long _____
(you actually did patient care)

Other _____

Since the basic nursing program:

Working experience on above list _____

Association with public health nurses as committee members _____

Participation with public health nurses in patient conferences _____

Personal experiences as a friend or relative of a patient receiving care from a public health nurse _____

Association with friends or classmates who are in the field of public health _____

Other _____

None of the above _____

Code _____

7. How often have you contributed to a referral of a patient to a public health agency ?

   Never _____ A few times _____ Frequently _____ Many times _____

8. In what way do you usually (most of the time in the last month) contribute to a referral to a public health agency to provide continuity of patient care ?

   Not at all _____

   Initiated and completed it _____

   Discussed with other interested members of staff

      Physician _____

      Nursing staff _____

      Social worker _____

      Physical therapist _____

      Dietitian _____

   Discussed with the family _____

   Discussed with the patient _____

   Other _____

9. Think about the patients with hemiplegia due to a cerebral vascular accident you have cared for during the last two (2) months. How many do you think would have profitted by a referral to a public health agency, but were not referred ? Number _____

10. For what reason or reasons was this so ?

      the patient refused _____

      the family refused _____

      the doctor felt it was not necessary _____

      the patient could not afford it _____

      no one suggested it _____

Code _____

11. Did you raise the question of a referral to anyone else ?

Yes _____ No _____ To Whom _____

12. Since your agency uses the Greater Boston Inter-Agency referral form, are there details you would like added or retracted from the written referral form ?

Yes _____ No _____ Don't know _____

(If YES) What ?

_____

_____

_____

13. What do you consider the hospital nurses' primary responsibility in the care of the patient with hemiplegia due to a cerebral vascular accident ?

_____

(If a GENERAL STATEMENT) Could you explain what you mean ?

(If a SPECIFIC STATEMENT) In addition to this which other responsibilities would you consider important ?

_____

_____

_____

14. What do you consider the public health nurses' primary responsibility in the care of the patient with hemiplegia due to a cerebral vascular accident ?

_____

(If a GENERAL STATEMENT) Could you explain what you mean ?

(If a SPECIFIC STATEMENT) In addition to this which other responsibilities would you consider important ?

_____

_____

_____

Code _____

Directions to Phase II

Consider these five (5) descriptions of conditions you may encounter in your day to day nursing care.

Assume the descriptions apply to someone under 65 years of age.

Kindly rank the descriptions in the order which best describes YOUR PERSONAL response to the question: How likely is it that this person (under 65 years of age) can live as happy and useful a life, with the condition under care, as might be possible if the condition did not exist ?

1. Very likely 2. ... 3. ... 4. ... 5. Least likely

Description	Rank
A. The patient is under care for swollen, painful joints with limited motion in the extremities.	_____
B. The patient is under care for cardiac insufficiency with occasional dependent edema of the ankles.	_____
C. The patient is under care for diabetes and will need insulin daily.	_____
D. The patient is under care for a weakness of the left arm and a functional but weak left leg due to a cerebral thrombosis.	_____
E. The patient is under care for loss of weight, disinterest in personal appearance and prolonged bouts of crying.	_____

Code _____

Directions to Phase II

Assume the descriptions apply to someone over 65 years of age.

Kindly rank the description in the order which best describes YOUR PERSONAL response to the questions: How likely is it that this person (over 65 years of age) can live as happy and useful a life, with the condition under care, as might be possible if the condition did not exist ?

1. Very likely 2. ... 3. ... 4. ... 5. Least likely

Description	Rank
A. The patient is under care for swollen, painful joints with limited motion in the extremities.	_____
B. The patient is under care for cardiac insufficiency with occasional dependent edema of the ankles.	_____
C. The patient is under care for diabetes and will need unsulin daily.	_____
D. The patient is under care for a weakness of the left arm and a functional but weak left leg due to cerebral thrombosis.	_____
E. The patient is under care for loss of weight, disinterest in personal appearance and prolonged bouts of crying.	_____

Code_____

Directions to Phase III

On each card is an item of care that is considered pertinent to the care of a patient with hemiplegia due to a cerebral vascular accident.

Some items require a written order to allow the nurse to provide the care.

Others are considered nursing activities which may be performed without a written order from the attending physician.

Some others you may feel do not apply at all.

PLEASE SORT THESE CARDS INTO THOSE CATEGORIES

Medical Order Nursing Activity Undetermined

Now I will ask you to consider each item in terms of frequency (IN OTHER WORDS, "HOW OFTEN HAVE YOU ENCOUNTERED THIS IN YOUR DAY TO DAY NURSING OF PATIENTS ?")

Medical Order Cards: Have you found that the physicians

ALWAYS WRITE THIS ORDER

USUALLY WRITE THIS ORDER

SELDOM WRITE THIS ORDER, but never refuse it when suggested

NEVER WRITE THIS ORDER, and have refused to do so when suggested

Nursing Activity Cards: Have you found that this care is:

ALWAYS PROVIDED

USUALLY PROVIDED

SELDOM PROVIDED

NEVER PROVIDED

Usually and Always Cards: Consider just these activities. In your nursing situation, how is each item of care recorded to evaluate the patient's progress and provide continuity of care ?

NOT RECORDED

NURSES NOTES

NURSING CARE PLAN

KARDEX SYSTEM

ACTIVITIES LIST

OTHER (Describe)

Do you wish that any other system were available for this purpose ?

Yes _____ No _____ Don't know _____

Item	Content
1.	Frequent application of a cock-up splint for the affected hand to keep the hand and wrist in good position.
2.	Provide a pulley apparatus which will allow for active exercise of the affected extremities.
3.	Provide opportunity for urination every two hours during the day, every three hours at night.
4.	Equip the bed with a footboard to prevent the pressure of the bed clothes and to support the feet and allow for exercise of the extremities by keeping the feet supported.
5.	Inquire about the patient's pattern of elimination prior to the stroke did the patient have an established pattern and what was it.
6.	Allow time for elimination at the same time each day.
7.	Take care to carry the extremities through the entire range of motion during the bath and again later in the day.
8.	Provide opportunity for the patient whose dominant hand is affected to practice the skill of writing.
9.	Support the affected arm by a sling when the patient is in a sitting position or standing, to prevent undue strain on the shoulder.
10.	Encourage the patient to use the uninvolved arm freely.
11.	Encourage the patient to participate in hygiene. Combing hair and brushing teeth, for example.
12.	Explain the reasons for the care given the patient to interested family members.
13.	Instruct the patient in the technique of quadriceps setting of the uninvolved leg periodically and the value of same.
14.	Inquire about the patient's living accomodations prior to the stroke to include information about the level of activity and degree of independence.

15. Change the patient's position in bed every 2 hours. This should be from the back to the uninvolved side.

16. The recommended back-lying position:
Affected arm away from the body. Wrist and hand supported in neutral position. Elbow straight or slightly bent. Feet flat against a supporting footboard.

17. Instruct the patient in the method of turning in bed to change position.

18. Arrange the patient care equipment within reach of the unaffected arm to encourage self-care.

19. The recommended side-lying position:
On the uninvolved side with pillows to provide support to the back. Support the paralyzed arm with a pillow to prevent undue strain on the shoulder. Keep the hip angle reduced to allow stretching and prevent contractures.

20. Massage the affected extremities twice daily.

21. Inquire about the patient's eating habits. Ex. Likes, dislikes and special preparation.

22. Provide support for the affected leg to prevent the leg from turning out. (A blanket roll, trochanter roll or sandbag, for example.)

23. Explain to the patient the reason for nursing activities such as exercises and turning.

24. Suggest the patient practise skills such as tying shoes, zippers and buckles, buttons of various sizes during leisure time.

25. Encourage the family member to take part in the actual care.

26. Have the patient take five (5) deep breaths three (3) times daily.

27. Discuss safety factors with the patient and/or family. Scatter rugs and highly polished floors should be given special attention. Hand rails on the stairs for support is another.

28. Counsel the family members about the changes in patient's mood. The tendency to cry and laugh without apparent control, for example.

29. Encourage the patient regarding his present state by telling him, "everything will be alright in a few weeks."

30. The use of a short leg brace to support the affected leg.

31. Advise the patient to move the fingers and the wrist of the affected hand with the uninvolved hand.

32. Establish good sitting balance.

33. Appraise the patient's gait and offer recommendations to improve the method.

34. Clamp off the in-dwelling catheter for progressively increasing periods of time to encourage normal bladder functioning.

35. Provide written instructions for the patient and/or family regarding the recommended care and suggested program.

36. Advise the patient and/or family about equipment, adaptations and devices which would be useful for the patient.

37. Have a number of aids to encourage speech. A book with common objects, pictures of relatives etc. to allow for speech re-education.

38. Allow time and opportunity for the patient whose speech is affected to express himself. Commend him when successful and excuse the mistakes.

39. Make it easier for the patient who cannot speak by anticipating the needs and say what you think the patient is trying to communicate.

40. Provide the patient with frequent opportunity to make decisions of progressive importance. For example; food selection, clothes selection, certain activities.