ANNEX 2

A SUPPLEMENTARY RESOURCE FOR

“EVALUATING FAMILY HEALTH NURSING THROUGH EDUCATION AND PRACTICE”

Colin Macduff and Dr Bernice JM West
Centre for Nurse Practice Research and Development
School of Nursing and Midwifery
Faculty of Health and Social Care
The Robert Gordon University
Aberdeen AB10 7QG

This resource was published in March 2004 by The Robert Gordon University on CD Rom format (ISBN 1 901 085 775) in order to provide supplementary information about the research methods used during the SEHD-commissioned study “Evaluating Family Health Nursing through Education and Practice”.
INTRODUCTION

This CD Rom has been prepared by CeNPRaD as a supplementary resource to be used in conjunction with the document “Evaluating Family Health Nursing through Education and Practice” (Macduff and West 2003). The contents give further details of the research methods used.

Any large scale evaluation study generates a welter of paperwork such as introductory letters, draft schedules and contract arrangements. Rather than replicate this, the CD Rom seeks to include only material that will substantively inform understandings of the research that took place. In this regard there is a particular emphasis on presenting more detail of questionnaires and interview schedules used.

The format for presenting the selected material largely mirrors that used in the main report. Thus information on specific questionnaires used in the evaluation of the FHNs’ educational experiences will be found in one of the Part 2 folders of the CD Rom. An index to the major content of each folder is presented on the following pages.

For each substantive data collection method used we have adopted the following presentational format:

| Textual commentary explaining reasons for adopting this particular method and the process involved in applying it |
| Accompanying information for the data collection context (eg. explanatory letter/s where appropriate) |
| The data collection tool used |
| Other analyses carried out (beyond those detailed in the main report) |
| The research team’s reflections on the strengths and weaknesses of using this method |

We hope this CD Rom proves a useful adjunct to the main report. It is important to stress that copyright for several of the data collection tools presented within this CD Rom remains with the original authors whom we cite. As such they should be approached if permission is being sought to use their data collection tool. Copyright relating to all other material within this CD Rom rests with ourselves, unless where otherwise indicated.

Colin N Macduff, Research Fellow

Dr Bernice JM West, Director

Centre for Nurse Practice Research and Development
School of Nursing and Midwifery
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG

December 2003
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6.0 REFERENCES AND COPYRIGHT

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1.0 ESTABLISHING CONTEXT, ENABLING ENGAGEMENT

1.01 Administrative context of the evaluation

The research evaluation of the operation and impact of Family Health Nursing in specific remote and rural areas within Scotland was commissioned by The Scottish Executive Health Department following a process of competitive tendering. The evaluation was based on the following six proscribed objectives:

1 To evaluate the education programme curriculum and consider how well it fits into the Scottish context.

2 To evaluate the learning experience and preparation of FHNs and the support provided to them in placements, focusing in particular on the role of mentors and differentiating between the requirements of community nurses who undergo re-education on the short course and registered nurses who undertake the full FHN course.

3 To compare the coverage and extent of service provided by current primary health care nursing services and the subsequent coverage of service provided by the FHN.

4 To explore the operation of the FHN model, focusing on the nature of the services provided and drawing comparisons between the pilot sites.

5 To identify relevant stakeholders’ perceptions of the FHN model.

6 To draw out implications from the study’s findings for the future provision of education for FHNs and for the extension of service provision to other areas of Scotland, including urban areas.

Contractual arrangements for the conduct of the study were issued through The Scottish Executive Central Research Unit which managed the contract and acted in an internal brokerage capacity during the research. The Principal Research Officer from the Health and Community Care branch of this Unit convened a small Research Advisory Group which comprised the client (Scottish Executive Nursing Primary Care Division) and ourselves as the external contractor. This group met regularly during the study and acted as a forum for exchange of information relating to the conduct and progress of the research.

Thus, while the research was necessarily dependent on the existence of the Family Health Nurse pilot project and had to adapt to its unanticipated developments, it is important to emphasise that its conduct and administration was independent from the project’s National Steering Group, local Steering Groups, sites and ongoing implementation mechanisms.

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1 The Health and Community Care branch of this Unit were initially responsible for liaison with CeNPRaD. Following re-organisation within the Scottish Executive our contacts were with Scottish Executive Social Research.
1.0.2 Initial consultations and considerations

Indeed to enable initial engagement with these groups and processes, it was first necessary for the research team to embark on a round of sustained consultations in the Spring and Summer of 2001. This activity combined preliminary stakeholder consultation and reading of the overall situation with efforts to establish good inter-personal working relationships. Such activity is vital to the success of this type of study and tends to be underemphasised in nursing literature on evaluation research.

Although it was often necessary at this stage to communicate some information using paper-based methods and e-mail, we consciously maximised other methods involving personal contact. Thus we made several productive visits to each of the regions during this early stage of the research, made occasional use of videoconferencing and frequent use of the telephone.

It is also important to emphasise that the research team had previous personal knowledge of the geography of the remote and rural regions involved. Indeed between us we had previously visited at least two thirds of the site locations involved in the first year of FHN practice. While these previous visits were mostly built up over the years in a tourist capacity, nevertheless it meant that we came in to the research having had some sort of engagement with local culture and having had extensive experience of the logistics of travelling in these regions.

The latter aspect is a very important consideration that necessarily affects the design of a research study such as this. The 31 FHN sites involved in the pilot project included many that were at the outer limits of Scottish remoteness and rurality. If our base in Aberdeen is visualised as the handle of an opened lady’s fan, these sites would trace the arc of the outer edge. To use a more tangential analogy, they could be visualised as the tips of the displaying peacock’s feathers. Admittedly the peacock in question would have to be listing somewhat and, by extension, our base in Aberdeen would be proximal to its nether regions!

These challenges in visualisation are made in order to preface the more serious point that travelling in a relatively direct line to the outer arc was usually either time consuming or very expensive. Occasionally it was downright impossible. Moreover, travel between the sites on the outer arc was often characterised by similar difficulties. Given the confines of a finite research budget, this imposed some constraints on the overall design of the study so that site fieldwork was necessarily limited in frequency.

Nevertheless with guile, prior planning, and with the help of local knowledge and assistance, it often proved possible to combine many site visits so as to maximise contact time. This was a very explicit goal in that we always found that our understandings moved forward following site visits, even when wrestling with a range of data that could initially seem contradictory or paradoxical. In the process it also afforded more insights into the everyday problems faced by health and social care staff at each particular site, one of which was always the logistics of travel.

During the design phase of the study, and during its conduct, we reviewed literature on definitions of remoteness and rurality. This was driven to some extent by our felt need to sub-classify the sites. We also sought advice from recognised scholars in the field who informed us on a range of classification systems, each of which had limitations. In the end we found the Scottish Household Survey six-fold area definition was generally useful in that it clearly defined all the 31 FHN sites as remote and rural. Further sub-classification of these sites on the basis of remoteness and rurality alone proved to be fraught with difficulty and inconsistency. In any case we increasingly came to see this as inappropriate in that many other factors were relevant to the formation of sub-groupings in the context of our study. Thus, after much deliberation, we opted for our own pragmatic customised classification of the sites involved in the first year of practice (Table 3.5 in main report). This entailed categorising the sites primarily in terms of common
contextual features related to their geography, population density and organisation of primary care services.

What some of the above reflections on initial research design and subsequent experience illustrate is that at the start of evaluations of this nature (i.e. complex, evolving policy initiatives/practice developments) the potential researcher’s knowledge (and often those of the policy initiators and practice enactors) is necessarily limited. For example, on invitation to tender, it was not clear how many sites would be taking part and where they would be.

Moreover, on invitation to tender, one of the study’s six proscribed objectives referred to “differentiating between the requirements of community nurses who undergo re-education on the short course and registered nurses who undertake the full FHN course”. However, during the initial consultation phase of the research in Spring and Summer 2001, it became increasingly apparent that a formal short course would not run. This underlines the importance of building some scope for flexibility into initial research designs.

While we were at the centre of our own research design considerations, the hub of the project for the FHNs as students was the educational centre in Inverness. Despite this city being the transport hub of the Highlands and Islands, most of the FHNs faced substantial travelling distances and times.
1.0.3 Ethical considerations and approval processes

Subsequent to the research contract being awarded in February 2001, the process of seeking ethical approval for the proposed study began. At the same time the educational programme to prepare the first cohort of FHNs also began. Naturally this meant that it was not possible for us to collect study data during this time. However, in effect, this allowed the staff and students of this new course some time to establish practices before taking part in the evaluation.

Applications were made to the three relevant Regional Research Ethics Committees. Two of the Committees approved the application without need for further clarification/amendments, while the other requested clarification on a number of points and some minor amendments. These were achieved to the Committee’s satisfaction by the end of May 2001 at which time the research study formally commenced.

During the Summer of 2001, however, the research team became aware of the need to seek amendment to one particular part of the study design. Initially it was envisaged that stakeholder consultation with lay members of the general community at each site would be achieved by asking relevant professionals to identify community leaders, those active in the voluntary sector and those on local Health Councils. Thus as professional stakeholder identification progressed we also interviewed a number of interested lay people who had been suggested by local health and social care staff. While these interviews yielded valuable perspectives, both members of the research team felt that the views elicited were necessarily partial and often rather closely aligned with the views of those who had suggested them.

Accordingly we sought a method of more randomly sampling perceptions within local communities about to be served by an FHN. The resultant proposal to use the appropriate electoral roll as a basis for randomly identifying 20 members of each local community seemed a reasonable and feasible way of doing this. These local people would be mailed a brief stakeholder questionnaire (see Folder 3.1). While it was acknowledged that, in terms of representativeness, this would potentially provide proportionately greater coverage of lay opinion in FHN sites with small populations, it seemed to offer a useful snapshot of the extent to which local communities at each site had become informed through the public consultation processes that were taking place as part of the FHN project.

Approval for this amendment was sought from the Ethics Committees in August 2001. Again two of the Committees approved the application without need for further clarification/amendments, while the other requested clarification on a number of points and some amendments. Despite much consultation and work over the next six months, however, mutual understanding on the stipulated amendments could not be achieved. Consequently our application for amendment to the lay stakeholder aspect of the study was withdrawn from this Committee. This meant that in the three active FHN sites under the jurisdiction of this regional committee during 2001, stakeholder consultations were limited to the professionals involved in each site.
1.0.4 Literature review and expert consultations

Our literature searching and reviewing strategies are presented in the main report. It is important to note that literature review was ongoing throughout the evaluation research process. In this regard we found the ZETOC electronic update system useful in alerting us to new journal articles of potential interest. In some instances we approached authors in order to further explore their thinking.

Our various networking activities helped alert us to relevant new policy documents. In addition we made and took opportunities to consult with a range of recognised subject experts in order to inform our understandings during the research.
PART 2 EDUCATING FAMILY HEALTH NURSES
2.0 ACCESS AND EDUCATIONAL CURRICULA

2.0.1 Seeking the participation of the FHN students

In order to address Objective 2 it was firstly necessary to seek consent from the FHNs to participate in the research. The information letter given to the first cohort of students at the end of May 2001 is presented overleaf, followed by the consent form used. At the end of 2001 a very similar information letter was given to the four Trusts so that prospective FHN students for the 2002 cohort could have prior briefing in relation to the study.

All the students from both cohorts consented to participate in the study. Following receipt of their completed consent forms we forwarded these to Stirling University in order that they could provide us with their routinely collated data in relation to each student’s personal circumstances, professional experience, academic/professional qualifications and progress on the course. This arrangement had been previously agreed between the two Universities, with due consideration of data protection and ethical issues.
Evaluation of the operation and impact of the Family Health Nurse Pilot in Scotland

*Information for FHN students*  
May 2001

Following Dr West’s presentation of information about the proposed evaluation, and the subsequent discussion on 30\(^{th}\) March, we are writing to seek your participation in the evaluation. To recap, your involvement would comprise five main elements:

- giving the research team access to the information held about yourself by The University of Stirling. In particular we are interested in profiling each student’s personal circumstances, professional experience, academic/professional qualifications and progress on the course. All of this information will be treated in strict confidence by the research team and will be used only in anonymised format in any publications.
- completing a number of questionnaires during the evaluation, including your: self-assessment of competency (x3); experiences of placement (x1); stress and quality of working life (x3).
- assisting the research team to access the best sources of data on the nature and scope of local health needs and primary health care provision.
- facilitating the research team’s on-site visits (eg accompanying on limited observation of practice; assisting the research team to access health care records).
- facilitating the selection of families whose progress can be followed.

As researchers we are aware of the sensitivities of working on a new project in rural communities. We re-iterate that information shared with us will be treated in strict confidence and we will report the study in such a way as to avoid identifying individual FHN students. The proposed evaluation will be thoroughly scrutinised by the Local Research Ethics Committees in Highland, Western Isles and Orkney before proceeding. You are free to withdraw from participation in the evaluation at any time without giving a reason, although we would welcome dialogue in any such eventuality.

If you have any further questions please do not hesitate to ask us for clarification.

Dr Bernice West, Director, Centre for Nurse Practice Research and Development
Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development
CONSENT FORM FOR FHN STUDENTS

Title of Project: An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

please tick box

1. I confirm that I have read and understand the information letter for the above study, and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason

3. I give permission for the research team to access information about myself held by the University of Stirling. I understand that this information will be stored and treated in strict confidence and I will not be individually identified in any report

4. I agree to take part in the above study

Name (in capitals) .................................................................
Signed....................................................................................
Date..........................................................
Address........................................................................................
2.0.2 Review of other community nursing educational curricula in Scotland

In order to address Objectives 1 and 6, it was necessary to review curricula from the five Universities in Scotland offering community-based degree programmes with specialist practice qualifications.

The letter overleaf was sent to the appropriate person/s within each of these institutions. All the institutions kindly forwarded the desired documents. This support from academic colleagues throughout Scotland was very helpful and much appreciated.
Dear

Recent policy developments from the Scottish executive with regard to nursing have recognised the importance of public health and family centred nursing. As educationalists we have for many years attempted to incorporate some of these ideas into post-registration nursing programmes for health visitors and district nurses.

Earlier this year Colin Macduff and myself tendered for the evaluation of the Family Health Nurse Pilot (Scotland) and were successful. Six objectives were set by the Scottish Executive, one of which asks us to consider the educational programme for family health nursing in light of current existing educational provision across Scotland.

To meet this objective we would like to review current course documentation pertaining to the preparation of qualified nurses to work in the community or in Primary Care.

I believe that ********** University offers the following programmes:

**************
**************
**************

If possible I would like a copy of course documentation (Definitive Course Documents; curricula: student handbooks) pertaining to each of these programmes of study.

These documents will be reviewed by myself and reported upon anonymously in the final report to the Scottish Executive.

In the course of carrying out this part of the Evaluation I plan to devise a review document and process which may be of interest to you in reviewing your own courses. On completion of the entire evaluation I will ensure that a copy of the report is sent to you.

I plan to start this phase of the evaluation in October 2001 and would welcome copies of course documentation by the 30th September 2001. I enclose a batch of FREEPOST address labels for your convenience and look forward to receiving your course documents.

If you require any further information about this evaluation please contact me on 01224 262647 (work); e-mail b.west@rgu.ac.uk. Alternatively my colleague and co-researcher Colin Macduff can also be contacted on 01224 262647 or e-mail c.macduff@rgu.ac.uk.

Yours sincerely

Dr Bernice J. M. West
Director
CeNPRaD
2.1 STUDENT COMPETENCE, STRESS/SATISFACTION, QUALITY OF WORKING LIFE

2.1.1 Nursing Competencies Questionnaire (NCQ)

As external evaluators we were interested in profiling baseline competencies of the nurses who undertook this course. This would inform Objectives 1, 2 and 6 of the evaluation. Firstly it was important to ascertain whether the educational programme providers would be doing this themselves, as there was concern throughout the evaluation to avoid duplication of effort for all concerned.

As this was not being attempted by the educational programme providers, and as it seemed to potentially offer information that would be relevant to this and any subsequent family health nursing developments, we set about trying to find a suitable method. However, given the difficulties associated with clinical competence assessment in nursing (see Watson et al 2002), this was a tall order.

Essentially we were looking in a short space of time for a brief, “off-the-peg”, competency measurement tool that would be relatively “light on its feet” in providing a valid external gauge that would complement rather than interfere with subsequent internal educational course mechanisms. As such the aim was to gather relevant pre (and post) course contextual information rather than to use the tool as a basis for assessing individual students during the educational experience. The latter aspect was already being addressed by the educational programme providers.

Perhaps unsurprisingly a literature search found very few measurement instruments with many of the above properties. However the Nursing Competencies Questionnaire (NCQ; Bartlett et al 1998) seemed promising in this regard. This self-report questionnaire appeared practical and had proved the most valid and reliable in a detailed comparison of methods conducted by Norman et al (2000) with Scottish pre-registration nursing students. Moreover it had been used with post-registration nurses (Bartlett et al 2000), albeit with recently qualified ones. The questionnaire covers the constructs or domains of: leadership; professional development; assessment; planning; implementation; cognitive ability; social participation; and ego-strength. As such it also seemed broadly comparable to the five core family health nursing competencies indicated in the WHO Europe curriculum and the four specialist domains of practice advocated by the former UKCC.

Thus it was decided to try this approach with these very experienced community nurses. Permission to use the questionnaire was obtained from one of the authors. Early in the course\(^2\) students from both cohorts were asked to complete the questionnaire (see following pages) by considering their perceived levels of competency across eight domains immediately prior to coming on the course. Six months after completing the course, Cohort 1 nurses were sent the questionnaire again.

\(^2\) It was not possible to do this with the first cohort until the end of May 2001 when ethical approval had been obtained for the study.
This questionnaire presents you with a list of ideal attributes and skills, and asks you to rate how often you carry each of these out. The list is comprehensive and it is not expected that you will achieve the maximum level on all items. As such, it is important that you rate yourself as honestly as possible in each case. The information that you give will be used only for the evaluation study. It is not part of your assessment on the FHN course.

In answering the questionnaire we would like you to rate yourself in relation to your clinical practice during the four months prior to coming on the FHN course (ie. October 2001 - January 2002). Try to think of your typical working practices during that time.

In this way, answering:

ALWAYS indicates that you always achieved the level of competence during that period, with almost no exceptions (tick box under column 4)

USUALLY indicates that you usually achieved the level of competence during that period (tick box under column 3)

OCCASIONALLY indicates that you occasionally achieved the level of competence during that period (tick box under column 2)

NEVER indicates that you never achieved the level of competence during that period, with almost no exceptions (tick box under column 1)

Please tick an appropriate box for each item listed. Thank you.

1 give praise and recognition to colleagues for achievement
2 delegate duties to colleagues appropriately after assessing skill levels
3 guide and supervise less experienced colleagues in the provision of care to assigned clients
4 provide feedback to colleagues concerning appropriate or inappropriate clinical interventions
5 initiate changes to the organisation of care delivery when necessary
6 demonstrate responsiveness to colleagues by listening, providing support, or referring to appropriate source of help if indicated
7 resolve conflict between colleagues when appropriate
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<td><strong>4 ALWAYS</strong></td>
<td><strong>3 USUALLY</strong></td>
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<td><strong>1 NEVER</strong></td>
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<td>8 encourage educational and professional development of colleagues</td>
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<td>9 initiate changes in clinical practice</td>
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<td>10 contribute to an atmosphere of mutual trust, acceptance and respect amongst colleagues</td>
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<td>11 manage unexpected changes in work situations</td>
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<td>12 maintain accountability for own actions and those delegated to others</td>
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<td>13 participate actively in clinical meetings, committees and working groups</td>
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<td>14 participate in a professional organisation</td>
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<td>15 accept and use constructive criticism</td>
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<td>16 accept responsibility for own actions</td>
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<td>17 demonstrate self confidence</td>
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<td>18 adapt clinical practice in line with current trends</td>
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<td>19 assume new responsibilities appropriate to capabilities</td>
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<td>20 demonstrate a sense of independence and autonomy in work</td>
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<td>21 express opinions on clinical issues</td>
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<td>22 collect accurate client health data from available sources</td>
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<td>23 conduct accurate clinical assessment</td>
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<td>24 perform accurate and comprehensive psychosocial assessment skills</td>
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25 demonstrate knowledge about the condition of clients assigned to you

26 anticipate teaching needs of clients

27 consider psychosocial aspects of any illness or disability when planning care

28 make accurate clinical judgement based on assessment data

29 revise care as necessary, based on accurate evaluation of client’s condition and response to care

30 arrange therapeutic activities appropriate to interest and needs of various clients

31 address the clients preference when planning care

32 establish clinical priorities in relation to total patient needs

33 identify and use community resources in the delivery of care

34 identify and use resources within the hospital in the delivery of care where appropriate

35 adopt individualised approach in planning client care

36 seek advice from health care personnel within the organisational structure to manage client care when appropriate

37 practice safely at all times

38 carry out clinical activities consistent with local policies and procedures

39 use clinical procedures as an opportunity for interactions with clients

40 demonstrate a working knowledge of equipment

41 perform manual skills with dexterity
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<td>function competently in emergency situations</td>
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<td>use time and resources effectively and efficiently</td>
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<td>44</td>
<td>encourage family to participate in the care of clients</td>
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<td>45</td>
<td>strive for optimum standards of clinical care</td>
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<td>46</td>
<td>give emotional support to clients in need</td>
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<tr>
<td>47</td>
<td>give emotional support to family of clients in need</td>
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<tr>
<td>48</td>
<td>plan and implement health teaching for clients when necessary</td>
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<tr>
<td>49</td>
<td>plan and implement health teaching for families when necessary</td>
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<tr>
<td>50</td>
<td>use appropriate teaching methods and materials for different audiences</td>
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<tr>
<td>51</td>
<td>respond to family or client requests, explaining if wishes can not be achieved</td>
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<td>52</td>
<td>communicate concise and appropriate client information as necessary to members of the health care team</td>
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<tr>
<td>53</td>
<td>document clients care and progress accurately</td>
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<tr>
<td>54</td>
<td>encourage client to take responsibility for his/her care according to capabilities</td>
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<td>55</td>
<td>take an advocacy role for the client</td>
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<tr>
<td>56</td>
<td>uphold ethical principles in clinical practice</td>
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<td>57</td>
<td>recognise legal responsibilities in clinical practices</td>
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<td>58</td>
<td>identify rational for making clinical decision</td>
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<tr>
<td>4 ALWAYS</td>
<td>3 USUALLY</td>
<td>2 OCCASIONALLY</td>
<td>1 NEVER</td>
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<tr>
<td>59 provide rational for thoughts and behaviour when questioned</td>
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<tr>
<td>60 apply resources in a creative manner to solve clinical problems</td>
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<tr>
<td>61 utilise a problem solving process in planning care</td>
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<tr>
<td>62 identify and reflect upon own behaviour, feelings or beliefs</td>
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<tr>
<td>63 apply findings from research to clinical practice as appropriate</td>
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<tr>
<td>64 seek information to help resolve a clinical or health care issue</td>
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<tr>
<td>65 show insight into situations involving human relationships</td>
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<tr>
<td>66 discuss options expressed in the press or general media</td>
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<tr>
<td>67 engage in debate about a social or political issue</td>
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<tr>
<td>68 respond to social or health related policy issues through various channels</td>
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<tr>
<td>69 attempt to influence the stand of a professional organisation on a professional issue</td>
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<tr>
<td>70 display knowledge about current political and social issues</td>
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<tr>
<td>71 consult researchers appropriately to assist the investigation of clinical problems</td>
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<tr>
<td>72 initiate research studies and surveys on health related topics</td>
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<td>73 perform responsibilities competently despite strong emotional reaction to a situation</td>
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<tr>
<td>74 act assertively to defend a point of view</td>
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</tbody>
</table>
4 ALWAYS  3 USUALLY  2 OCCASIONALLY  1 NEVER

75 fulfil responsibility at the risk of disapproval of manager, client or peer

76 admit a weakness, mistake or lack of knowledge while recognising the importance of remedying it

77 recognise own limitations and seek help from appropriate sources when needed

78 take initiative at work when there is no external pressure to do so
Detailed analyses of the responses to this questionnaire are presented within the main report where the need for cautious inference in relation to before-and-after competence comparisons is also highlighted.

Norman et al (2000) suggest that the NCQ may comprise coverage of six domains/constructs (intervention; assessment; leadership; awareness; teaching; research/staff development) rather than the eight suggested by Bartlett et al (2000). After consultation with the former authors we also took the opportunity to analyse our data in terms of the six domains suggested. This analysis confirmed no statistically significant differences between the pre and post-course mean domain scores.

When the mean pre-course scores of Cohort 1 and Cohort 2 students were compared in this way, the latter group scored significantly lower in terms of leadership only (p=0.003). Our previous comparison using Bartlett et al’s eight domains had also found significant differences in professional development and assessment (see main report).

It is probably prudent not to read too much into our findings based on these factor analyses as both Bartlett et al and Norman et al’s published “solutions” were essentially exploratory. Given our relatively small sample of nurses, it was deemed inappropriate to attempt our own factor analysis (Watson 1998 cites Kline as recommending a required variable to subject ratio of between 1:5 and 1:10 to make factor analysis valid).

Moreover we would also counsel caution in regard to interpretation of our comparisons of mean scores, even in terms of baseline scores. The typically high mean scores across most domains tended at times to mask relatively large variations between the minimum and maximum scores of individual students (i.e. ranges and standard deviations were often large). Thus while one Cohort 2 student scored 12 out of a possible 24 points in relation to self-reported ego-strength (50%) another scored 23 points (96%). Normative statistics such as measures of central tendency tend to iron out such variations, but as evaluators working with a relatively small number of students such variations were noticeable and often noteworthy (e.g. our perceptions of the ego strength of known individuals at times were at odds with their own self-perceptions as reported via the questionnaire).

This highlights one of the limitations of our application in that the main data comprised only the student’s self-reported competency. Due to the constraints of the evaluation timescale it was not possible to identify colleagues who could have reported their perceptions of the students’ competency from a pre and/or post course perspective. Moreover such an undertaking would require considerable attention to matters of consistency and ethical understandings, especially in remote and rural community nursing where the chance to observe colleagues’ actual work may be limited. In this regard it could be easier when there is a defined, agreed supervisor-supervisee relationship such as during an educational course. Bartlett et al (2000) used this approach, asking the mentors/supervisors of graduates and diplomates to complete the NCQ. From the presentation of their results it is not entirely clear whether there were statistically significant differences between the perceptions of these nurses and their own mentors/supervisors. However it can be seen that the mentors/supervisors mean ratings were lower than the nurses in 81% of cases (i.e. they typically assessed the individual nurse’s competence as being at a lower level than the nurses’ self-reports).

The NCQ itself also has its limitations as a questionnaire. Some of these were apparent on initial scrutiny and were highlighted during its first administration in a classroom setting (e.g. Statement 75 actually contains three elements that are by no means resolvable through one answer). A small number of other similar anomalies were also apparent. Interestingly Watson et al (2002) have

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1 We are grateful to these authors for sharing details of the six factor solution they obtained by using Principal Components Analysis.
recently proposed a revised short NCQ comprising 18 of the statements from the original NCQ. However several of the more problematic statements from the original questionnaire are retained, notably “I use time and resources effectively and efficiently”. The latter statement is something of a tour-de-force in that it combines two aspects and a further two criteria in the space of eight words! When the multiple possibilities this raises are then considered in the light of the four different possibilities for responding, there is obvious scope for conceptual confusion and related doubt about the validity of what is being gauged.

As we indicated in the main report, our consistent findings of high mean scores across domains raised the possibility of the questionnaire showing a ceiling effect when used with very experienced staff. To our knowledge this was the first application of the NCQ with such an experienced group of nurses and, while our reflections have a number of caveats, we feel it yielded interesting data and experience. Many of the difficulties encountered are merely symptomatic of more general problems in the whole field of competency assessment that go beyond the profession of nursing. We hope to publish further reflections on this topic based on these experiences.
2.1.2 Stress and job satisfaction

In order to address Objective 2 we were interested in gaining insights into perceived stress and job satisfaction for this group of community nurses before they undertook the course, during the course and afterwards. Again it was important to ascertain whether the educational programme providers would be doing this themselves. Although a number of feedback mechanisms were built into the course, it turned out that the educational programme providers had no plans to formally assess the above aspects.

In considering the selection of a suitable method, an extensive range of literature was reviewed. Many tools exist to measure stress and job satisfaction but, on closer scrutiny, it was possible to eliminate several for being too general in nature (e.g. the General Health Questionnaire in its different formats; see Goldberg et al 1997) or too institution-orientated (e.g. the Nurse Stress Index which asks about “my department”; see Cooper and Mitchell 1990). A number of reports on community-orientated questionnaires were therefore reviewed including Fletcher et al (1991), Parry-Jones et al (1998), Snelgrove (1998) and Rout (2000). The latter two questionnaires seemed most promising in terms of content that would pertain to remote and rural contexts. It proved possible to contact Sherrill Snelgrove who kindly shared the full questionnaire with us and agreed that we could use it. On scrutiny the full questionnaire appeared very well matched to the context of our study. Although the questionnaire appeared to have been subject to limited psychometric testing based on its application to one mixed group of community nursing staff, it seemed sufficiently promising to merit using on this study.

The questionnaire was administered at different time points (see Table 2.13; main report) during the study in order to gain insight longitudinally. The version displayed on the following pages was amended very slightly for administrations where the students were being asked to answer in relation to the last 4 months as a student on the course (i.e. Time 2). The amendments consisted of adding two statements to the table in Section C. These read “Your fellow students” and “Overall quality of campus supervision”. The existing statement “Overall quality of supervision” was also modified to read “Overall quality of placement supervision”. In this way distinction between campus and placement aspects of job satisfaction was sought.

The latter amendments were agreed with students when they completed it between classes on campus. On later occasions the questionnaire was administered postally.
OCCUPATIONAL STRESS INDICATOR FOR COMMUNITY NURSES

Section A: Sources of stress

The statements below are concerned with the pressures arising in your work life during the 4 months prior to coming on the FHN course (ie. between October 2001 and January 2002)

Pressure is defined as a problem, something you find difficulty coping with, about which you’ve been feeling worried or anxious

Thinking back about your normal working life then, please indicate the degree to which each statement was a source of pressure to you. There are no right or wrong answers, but you are asked to tick an appropriate box for each statement.

<table>
<thead>
<tr>
<th>Amount of pressure this caused me in 4 months pre course</th>
<th>none</th>
<th>slight</th>
<th>moderate</th>
<th>considerable</th>
<th>extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time on a visit</td>
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<td>Work overload</td>
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<td>Organisation of caseload</td>
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<td>Getting cover</td>
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<tr>
<td>Unpredictable occurences</td>
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<td>Tedious routine work</td>
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<td>Inadequate office facilities</td>
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<tr>
<td>Work underload</td>
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<tr>
<td>Referring problems to other agencies</td>
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<td>Responsibilities for students</td>
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<td>Vicious dogs</td>
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<td>Driving/other drivers /car parking</td>
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<td>Breaking down in isolated spots</td>
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<td>Conflict with home/work problems</td>
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<td>Winding down</td>
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<td>Taking paperwork home</td>
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<td>Lack of emotional support at home</td>
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<td>Worry about childcare</td>
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<td>Superiors non appreciative of home pressures</td>
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<td>Lack of contact with supervisors</td>
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<td>Future of job</td>
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<tr>
<td>Relationships with other professionals</td>
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<td>Record keeping</td>
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<tr>
<td>Amount of pressure this caused me in 4 months pre course</td>
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<td>---------------------------------------------------------</td>
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<tr>
<td>None</td>
<td>Slight</td>
<td>Moderate</td>
<td>Considerable</td>
<td>Extreme</td>
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<td>---------------------------------------------------------</td>
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<tr>
<td>Attending meetings</td>
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<tr>
<td>Not liking a colleague</td>
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<td>Lack of involvement in decision making</td>
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<td>Not being notified of changes before they occur</td>
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<td>Uncertainty about role</td>
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<td>Lack of knowledge of role by other professionals</td>
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<td>Emotional involvement with clients</td>
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<tr>
<td>Dealing with death and dying</td>
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<td>Clients with on-going social problems</td>
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<td>Fear of physical attack</td>
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<td>Coping with sexual harassment</td>
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<td>Unreasonable demands from clients</td>
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<td>Unreasonable demands from relatives</td>
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<td>Poor social conditions of clients</td>
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<td>Emotional problems of clients</td>
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<td>Difficult cases: child cases</td>
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<td>Difficult cases: elderly focus</td>
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<td>Chronic cases</td>
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<td>Failed visits</td>
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<td>Worry over decision making</td>
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<tr>
<td>Feelings of isolation over decision making</td>
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<tr>
<td>Lack of resources for clients (physical aids, physical, social and emotional help)</td>
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<tr>
<td>Quantifying work</td>
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</table>
Section B: Feelings of stress

In the 4 months prior to coming on the course, did you have prolonged periods of the following?

<table>
<thead>
<tr>
<th></th>
<th>not at all</th>
<th>slightly</th>
<th>moderately</th>
<th>most of the time</th>
<th>all of the time</th>
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<tbody>
<tr>
<td>Physical exhaustion</td>
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<tr>
<td>Isolation</td>
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<td>Boredom</td>
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<tr>
<td>Emotional exhaustion</td>
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</table>

Section C: Job satisfaction

This section asks how satisfied/dissatisfied you felt with a number of aspects of your work life during the 4 months prior to coming on the course.

<table>
<thead>
<tr>
<th></th>
<th>very satisfied</th>
<th>satisfied</th>
<th>undecided</th>
<th>dissatisfied</th>
<th>very dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freedom to choose own method of work</td>
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<td>Your fellow workers</td>
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<td>Opportunity to use your abilities</td>
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<td>Rate of pay</td>
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<td>Career development opportunities</td>
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<td>In-services training received</td>
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<td>Hours of work</td>
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<td>Adequate training for job</td>
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<td>Support and guidance from superiors</td>
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<tr>
<td>Overall quality of supervision</td>
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</tbody>
</table>
Section D: Satisfaction with role before starting course

<table>
<thead>
<tr>
<th>To what extent were you satisfied with your work role during the 4 months prior to starting the course</th>
<th>very satisfied</th>
<th>satisfied</th>
<th>undecided</th>
<th>dissatisfied</th>
<th>very dissatisfied</th>
</tr>
</thead>
</table>

Section E: Social support

Thinking of your normal work life prior to coming on the course, if you had a work centred problem which of the following people would you talk to about it? (please circle as many as appropriate)

- MOTHER
- FATHER
- SON
- DAUGHTER
- PARTNER/SPOUSE
- FRIEND
- WORK COLLEAGUE
- SUPERVISOR
- MANAGER
- OTHER

Section F: Any other comments

Finally if there are any other comments that you would like to make about pre course work stress/satisfaction, please do so below:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Thank you very much for taking the time to complete the questionnaire
Our analyses of responses to this questionnaire started from basic review of frequencies and other descriptive statistics in order to identify the items that seemed to be most involved in determining stress and job satisfaction. We also calculated total scores for: sources of stress; feelings of stress and job satisfaction. Again the range of scores across individual students within each cohort was typically large, and this was found each time the questionnaires were administered. This indicates that amongst respondents there was often wide variation in perceived levels of stress and job satisfaction. This pertained during the course as well as prior to coming on the course.

The total scores derived were then used in order to compare scores within each cohort at different time points (see Table 2.13; main report) using the Wilcoxon test and between the two cohorts at the same relative time points using the Mann Whitney test. These are the comparisons reported in Section 2.5.2 of the main study.

Snelgrove (1998) reported a factor analysis that identified four dimensions linked to the largest areas of variance in the stress items. These were:

a) emotional pressures/difficult cases

b) unpredictable events at work

c) change and instability at work

d) work content

We had hoped to analyse our data in terms of these four dimensions but the original mapping of items to dimensions was not available to us. Again it was deemed inappropriate to attempt our own factor analysis in view of our relatively small sample of nurses.

Nevertheless the questionnaire was seen by the FHN students as being very relevant to their experiences and relatively quick and easy to answer. The quality of responses was generally good and overall the questionnaire yielded useful information on all occasions. It also included a number of items that were very comparable in content to items within the questionnaire that we devised for students’ summative evaluations of their learning experiences (i.e. that completed at the end of the course). This enabled cross checking of individual’s answers in order to study whether experiences were consistent across a number of time points. In this respect findings were generally very confirmatory.
2.1.3 Quality of Working Life (QOWL)

In addition to measuring stress and job satisfaction, we devised a further instrument to gauge the related, but broader, concept of quality of working life. While the questionnaire on stress and job satisfaction was based on the *standard needs* principles that characterise the majority of questionnaires (i.e. items of equal weighting are presented to the potential respondent on the basis that they have been found through previous research/review to embody the characteristic elements of the concept being investigated, such as quality of life; see Browne et al 1997) the new questionnaire was devised as a purely respondent generated tool (see Macduff 2000).

The respondent generated approach does not assume such consensus over item selection and weighting. Rather it attempts to give the respondents the scope to choose items that they see as constituting the concept in question, and the means by which to indicate the current relative importance of these items.

Our decision to complement our study of stress and job satisfaction with an exploration of quality of working life, stemmed from a perception that there may be some very particular and individual factors that impinge on the life and work of nurses in distinctive remote and rural communities. This emerges to some extent in the literature on remote and rural health care (e.g. see Farmer et al 2003), but we also felt this to be the case from our previous nursing and research work.

Thus we reasoned that a respondent generated approach would give participants the scope to raise their own issues. Review of existing respondent generated tools found several that addressed the broader concept of quality of life, but none that focused on the particular concept of quality of working life. Consequently we designed a new tool for exploratory use in this study. The design was substantially informed by the pioneering work of Ruta et al (1994) who developed the Patient Generated Index (PGI) and O’Boyle et al (1992) who developed the SEIQoL questionnaire. It was also informed by personal experience of using the PGI (Macduff and Russell 1998) and by review of Annells et al (1999)’s experiences of adapting the PGI for use by Australian district nurses with their patients.

The resultant tool is presented as a separate document within this folder of the CD Rom as it proved technically difficult to incorporate it within the main body of this word document. As will be seen the three parts of the questionnaire provide respondents with the opportunity to:

- identify areas of their current working life that they perceive as most important
- rate how good or bad they are at present
- indicate the relative importance of the areas chosen

The questionnaire was explained and given to the first cohort of FHN students in person in June 2001. They were asked to complete it in their own time based on their current perceptions of quality of working life as a student (rather than attempting to complete it retrospectively based on their perceptions of their working life prior to starting the course). All questionnaires were returned by July 2001 (see Table 2.2 in the main report). A similar procedure was followed for the Cohort 2 students at a similar point during their course. Finally the questionnaire was sent to Cohort 1 students approximately six months into their experience of working as a qualified FHN.
We found that the questionnaire was generally well completed in that the respondents clearly understood what was being asked of them. This is important as some respondent generated tools have had problems in this regard (see Macduff and Russell 1998). The one exception to this was the student who replicated the aspects given in the explanatory example at the foot of the questionnaire. Whether this was through misunderstanding or mischievousness was not clear, but we suspect the latter given that the ratings and weightings differed from the explanatory example. In view of the potentially sensitive nature of one of the replicated aspects we refrained from follow-up enquiry!

The questionnaire proved useful in eliciting issues about balancing their experience of being a full time student (e.g. study skills; isolation while on placement; travel to campus) with their own role as a family member (e.g. childcare; finance). This group of typically very experienced female community nurses were very often mothers and, by a long way, the major earner within their own families. The latter factor may be more prevalent amongst nurses within remote and rural communities than amongst their peers within large cities. These findings raise some questions about how feasible and/or desirable it is to attempt to separate quality of working life from more general quality of life issues.

Such a separation was rather more evident in the responses from the qualified FHNs from Cohort 1 in July 2002. These were characterised by a mixture of positive experiences when actually working with families, and difficulties related to the introduction of their new role (e.g. organisation of caseload; colleagues’ limited understanding of role; time pressures). These findings tended to confirm findings from the Stress and Job Satisfaction questionnaire completed at the same time.

In designing the questionnaire for the purpose of this study, our focus was primarily on the information that might be elicited through its three stages. It was, however, also possible to derive an overall score for perceived quality of working life on a scale of 0-10 (0 being the worst possible; 10 being the best possible). This was done for the purposes of some further, exploratory analysis.

For Cohort 1 at time 1 (i.e. while they were students) the average QOWL score was 4.27 (range 4.8). For Cohort 1 at time 2 (i.e. while working as FHNs) the average QOWL score was very slightly higher at 4.78 (range 6). Thus again we see relatively wide variation amongst the perceptions of individual members of each cohort. When total QOWL scores at time 1 and time 2 were compared using the Wilcoxon test no statistically significant difference was apparent4.

The latter comparison was essentially exploratory. As Macduff (2000) notes, respondent generated questionnaires tend to highlight some essential difficulties involved in comparing scores over time. In this case we were comparing QOWL where the respondent was occupied in two essentially different roles (i.e. that of student and qualified FHN). Thus one might expect some difference in perceptions of what is important in constituting quality of working life. Our questionnaire made this manifest in that respondents typically chose a number of different aspects to rate and weight at Time 2. By contrast a questionnaire based on the standard needs approach would present the respondent with the same pre-determined aspects as it did before, in the assumption that these would still have equal currency and weighting.

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4 In writing this our attention is drawn to an error in the main report (Page 35; last sentence of paragraph 5). This sentence implies that our statistical findings from analysis of the QOWL questionnaires confirm the finding from analysis of the job satisfaction questionnaires that Cohort 1 were significantly less dissatisfied with their jobs after the course than they were prior to undertaking the course. In fact our statistical findings from analysis of the QOWL questionnaires were comparing student experience with later work experience. We apologise for this error.
These reflections pertain to the notion of *intra-subject construct dynamism* (Allison et al 1997) referred to in the main report. In turn they highlight some of the assumptions we have made in interpreting findings from some of our more conventional questionnaires that were administered over a number of points in time. In mitigation we would merely say that we are definitely not alone in working on the basis of such assumptions! In fact it remains relatively unusual in published studies to explicitly recognise that some fundamental assumptions of this nature are being made (e.g. that sequential respondents are using consistent construct criteria as the basis of their replies).

Finally our exploratory analyses with this questionnaire compared the two cohorts’ perceived quality of working life as students on the course (i.e. comparison of the total scores of both cohorts at T1 using the Mann Whitney test). No significant statistical difference was evident, although for Cohort 2 at time 1 the mean QOWL score was slightly higher 4.76 (range 6.4). Again the large range of scores demonstrates the variation in perceived experience amongst members of the cohort.

Overall the new quality of working life questionnaire proved a useful adjunct to the more conventional questionnaires. As such there seems scope for its further development and application.
2.2 EXPERIENCES OF STUDENTS AND SUPERVISORS

2.2.1 The summative questionnaires for students and supervisors

In order primarily to address Objective 2, we reasoned that it would be useful to study students’ campus-based learning experiences and clinical placement experiences as perceived summatively at the end of the course. Such information would complement data that we were collecting during the course and data that the educational providers were collecting and making available to us. Firstly we ascertained the nature and extent of the latter “in-house” processes. In addition to asking regularly for students’ reflections on the course, the educational providers also collated student evaluations of each module and administered a brief end-of-course questionnaire. Accordingly our starting point was to minimise duplication with the latter, although a small amount proved inevitable.

We reviewed relevant literature in order to find out whether a suitable “off the peg” questionnaire might be available for this summative application. The broad concept of clinical supervision was firstly explored, including the work of Butterworth et al (1997) and Winstanley (2000). However we were more concerned with supervision in the context of the supervisor/mentor-student relationship. Within Scotland, the National Board for Nursing, Midwifery and Health Visiting (NBS; now NHS Education Scotland) has commissioned a number of research projects that have explored aspects of this topic in recent years. The work of Cameron-Jones et al (2000) in the field of pre-registration nursing was informative in this regard. Moreover Watson and Harris (1999) looked at supporting students in practice placements within Scotland, and included post registration students on specialist community practitioner courses within their study sample.

Neither of the questionnaires used in these studies appeared to offer a ready-made tool that would be ideally suited to the particular context of our study. However their approach of matching student and supervisor/mentor responses, and their coverage of content areas, informed the development of the questionnaire that we subsequently designed for the FHN study. Thus we acknowledge the usefulness of this previous scholarship.

The resultant questionnaire for students is presented on the following pages. As can be seen the first part seeks to gather mostly written data summarising campus based learning experiences. The second, more extensive part of the questionnaire makes more use of 5-point response scales to gauge experiences of clinical placement. This approach was also then used in a similarly designed, matched questionnaire for the supervisors of these students. The supervisor questionnaire is presented on the pages directly after the student one in order to facilitate comparison.

The questionnaire was firstly distributed to selected colleagues within our School of Nursing for review and revision. The revised questionnaire was then sent to four nurses who had recently completed a Community Specialist Practitioner nursing course at the Robert Gordon University. The explanatory letter asked them to complete the questionnaire and provide feedback on its clarity, length, topic coverage and any other comments. Two completed questionnaires and feedback forms were subsequently returned. Following this a small number of minor revisions were made. Due to time constraints it was not possible to pilot test the questionnaire designed for supervisors.

The final questionnaire was explained to the FHN students during the final week of their course when they were on campus. They then completed the questionnaire in their own time so as to facilitate reflection. The same process was followed with those supervisors who attended campus during this final week. The questionnaire was mailed, with an explanatory letter, to those supervisors who had been unable to attend.
QUESTIONNAIRE FOR FHN STUDENTS

ON

CAMPUS BASED LEARNING EXPERIENCES

AND

EXPERIENCES OF CLINICAL PLACEMENTS

This questionnaire asks you to reflect on your learning experiences during the past year. In the first section, you are asked about your learning experiences when you have been based on campus in Inverness. In the second, longer section, you are asked about your learning experiences when you have been on clinical placements. Please take some time to reflect on the questions before completion. We would be grateful if you could return the questionnaire in the FREEPOST envelope by 7th January 2002.

Thank you

Colin and Bernice

Code number:

Date:
PART 1: YOUR CAMPUS BASED LEARNING EXPERIENCES

1) Looking back over your learning experiences at Inverness campus this year, please write down the three aspects of the course that you found most valuable
(i)__________________________________________________________________________________
(ii)__________________________________________________________________________________
(iii)__________________________________________________________________________________

2) Looking back over your learning experiences at Inverness campus this year, please write down the three aspects of the course that you found least valuable
(i)__________________________________________________________________________________
(ii)__________________________________________________________________________________
(iii)__________________________________________________________________________________

3) Were there any topics that were not covered at all in the FHN course that you feel should have been covered?
   Yes  ☐   No ☐

   If you answered “yes”, please name the topics and say why they should have been covered
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

4) Were there any topics that were covered in the FHN course but were not covered well?
   Yes  ☐   No ☐

   If you answered “yes”, please name the topics and indicate how the coverage was poor
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

5) If you have any other comments about your campus based learning, please write them below
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
PART 2: YOUR EXPERIENCES OF CLINICAL PLACEMENTS

1) Looking back over your experiences of placement supervision on the FHN course, please give an overall rating to each of the following aspects (please tick appropriate box). Any explanatory comments would also be appreciated.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>excellent</th>
<th>good</th>
<th>fair</th>
<th>poor</th>
<th>very poor</th>
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</thead>
<tbody>
<tr>
<td>The process of matching you with an appropriate supervisor</td>
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<td><strong>Comments</strong></td>
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<tr>
<td>Your supervisor’s understanding of your pre-course level of knowledge &amp; skills</td>
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<td><strong>Comments</strong></td>
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<td>Your supervisor’s understanding of the FHN course and its learning outcomes</td>
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<td><strong>Comments</strong></td>
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<td>Your supervisor’s understanding of the FHN course assessment process</td>
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<td><strong>Comments</strong></td>
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<td>Your supervisor’s understanding of the FHN course documentation</td>
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<td><strong>Comments</strong></td>
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<td>The match between your supervisor’s knowledge &amp; skills and the knowledge &amp; skills appropriate for the FHN course</td>
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<td><strong>Comments</strong></td>
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<td>The attitude of your supervisor towards sharing appropriate knowledge &amp; skills with you</td>
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<td><strong>Comments</strong></td>
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<td>The level of rapport that you and your supervisor developed during the course</td>
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<td><strong>Comments</strong></td>
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<td>The overall attitude of your supervisor towards the FHN course</td>
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<td>The overall level of support that you received from your supervisor during placement</td>
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<td>The overall level of support that you received from University lecturers/teaching fellows during placement</td>
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<td><strong>Comments</strong></td>
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<td>Understanding of your placement circumstances shown by University lecturers/teaching fellows</td>
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<td><strong>Comments</strong></td>
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</tbody>
</table>
2) Thinking of contact between yourself and your placement supervisor *BY REMOTE MEANS* such as TELEPHONE OR E MAIL, please indicate the typical frequency with which the following kinds of dialogue occurred

<table>
<thead>
<tr>
<th></th>
<th>at least once a week</th>
<th>at least once a month</th>
<th>at least once every 3 months</th>
<th>at least once during the course</th>
<th>never</th>
</tr>
</thead>
<tbody>
<tr>
<td>General catching up on progress</td>
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<tr>
<td><strong>Comments</strong></td>
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<tr>
<td>Discussion of your clinical casework (eg. work with specific families)</td>
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<tr>
<td><strong>Comments</strong></td>
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<tr>
<td>Reflective discussion relating theory to practice</td>
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<td><strong>Comments</strong></td>
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<tr>
<td>Discussion of specific skills relevant to your FHN role</td>
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<td><strong>Comments</strong></td>
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<tr>
<td>Identification and review of specific goals to be achieved in your work with families</td>
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<tr>
<td><strong>Comments</strong></td>
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<tr>
<td>Discussion of interpersonal issues related to your placement (eg. teamwork)</td>
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<td><strong>Comments</strong></td>
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<tr>
<td>Discussion of personal issues related to your placement (eg. home/work conflict)</td>
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<td><strong>Comments</strong></td>
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</tbody>
</table>
3) Thinking of contact between yourself and your placement supervisor IN PERSON, please indicate the typical frequency with which the following kinds of interaction occurred

<table>
<thead>
<tr>
<th>Interaction Description</th>
<th>at least once a week</th>
<th>at least once a month</th>
<th>at least once every 3 months</th>
<th>at least once during the course</th>
<th>never</th>
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<tbody>
<tr>
<td>General catching up on progress</td>
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<tr>
<td>Discussion of your clinical casework (eg. work with specific families)</td>
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<td>Reflective discussion relating theory to practice</td>
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<td>Your supervisor being present when you were working with families</td>
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<td>Your supervisor teaching specific skills relevant to your FHN role</td>
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<tr>
<td>Identification and review of specific goals to be achieved in your work with families</td>
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<tr>
<td>Discussion of interpersonal issues related to your placement (eg. teamwork)</td>
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<tr>
<td>Discussion of personal issues related to your placement (eg. confidence)</td>
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</tbody>
</table>

Comments:

4) Other than your placement supervisor, was there anyone else who supervised your practice or taught you skills?

Yes ☐ No ☐

If you answered “yes”, please indicate the job title(s) of this person/these people and briefly indicate how they helped you

5) How many families have you worked with so far during your placements as an FHN student?

______________ families
6) Please write down the three most valuable skills that you have developed during your placement work with families

(i)__________________________________________________________________________________
(ii)__________________________________________________________________________________
(iii)__________________________________________________________________________________

7) Please give a brief description of any ways in which you feel these families have benefited from your input so far

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

7) Please give a brief description of any ways in which you feel your input has been problematic for these families

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

8) What difference do you feel that placement supervision has made to the quality of your work with these families?

□ a great deal □ quite alot □ very little □ none

Comments

__________________________________________________________________________________

9) Please write down any three aspects of placement supervision for FHNs that you think could be improved

(i)__________________________________________________________________________________
(ii)__________________________________________________________________________________
(iii)__________________________________________________________________________________

10) Finally, if you have any other comments about your placement supervision experiences, please write them below

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
QUESTIONNAIRE
FOR PLACEMENT SUPERVISORS
OF STUDENTS
ON THE
FAMILY HEALTH NURSE COURSE

This questionnaire asks you to reflect on your experiences of acting as a supervisor on the Family Health Nurse course during the past year. Your feedback will inform the evaluation of the pilot project. Please take some time to reflect on the questions before completion. We would be grateful if you could return the questionnaire in the FREEPOST envelope by 30th January 2002.

Thank you

Colin Macduff and Dr Bernice West

Code number:
1) Looking back over your experiences of supervising placements on the FHN course, please give an overall rating to each of the following aspects (please tick appropriate box). Any explanatory comments would also be appreciated.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>excellent</th>
<th>good</th>
<th>fair</th>
<th>poor</th>
<th>very poor</th>
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</thead>
<tbody>
<tr>
<td>The process of matching you with an FHN student</td>
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<td>Comments</td>
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<tr>
<td>The process of preparing you to undertake supervision on this course</td>
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<td>Comments</td>
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<tr>
<td>Your understanding of the student’s pre-course level of knowledge &amp; skills</td>
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<tr>
<td>Comments</td>
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<tr>
<td>The attitude of the student towards receiving supervision from you</td>
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<tr>
<td>Comments</td>
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<tr>
<td>The level of rapport that you and the student developed during the course</td>
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<tr>
<td>Comments</td>
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<tr>
<td>The overall level of support that you gave to the student during placement</td>
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<td>Comments</td>
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<tr>
<td>The overall level of support that you received from University staff during your supervision of placements</td>
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<td>Comments</td>
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<td>Understanding of your placement circumstances shown by University staff</td>
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<td>Comments</td>
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<td>Your present understanding of the FHN course and its learning outcomes</td>
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<td>Your present understanding of the FHN course assessment process</td>
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<td>Comments</td>
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<td>Your present understanding of the FHN course documentation</td>
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<td>Comments</td>
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<td>The match between your knowledge and skills and the knowledge and skills appropriate for the FHN course</td>
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2) **Thinking of contact between yourself and the student BY REMOTE MEANS such as TELEPHONE OR E MAIL, please indicate the typical frequency with which the following kinds of dialogue occured**

<table>
<thead>
<tr>
<th>Kind of Dialogue</th>
<th>At least once a week</th>
<th>At least once a month</th>
<th>At least once every 3 months</th>
<th>At least once during the course</th>
<th>Never</th>
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<tbody>
<tr>
<td>General catching up on progress</td>
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<tr>
<td>Discussion of clinical casework (eg. work with specific families)</td>
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<td>Reflective discussion relating theory to practice</td>
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<td>Discussion of specific skills relevant to the FHN role</td>
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<tr>
<td>Identification and review of specific goals to be achieved in the student’s work with families</td>
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<tr>
<td>Discussion of interpersonal issues related to the student’s placement (eg. teamwork)</td>
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<tr>
<td>Discussion of personal issues related to the student’s placement (eg. home/work conflict)</td>
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</table>

**Comments**
3) Thinking of contact between yourself and the student **IN PERSON**, please indicate the typical frequency with which the following kinds of interaction occured

<table>
<thead>
<tr>
<th>Interaction</th>
<th>At least once a week</th>
<th>At least once a month</th>
<th>At least once every 3 months</th>
<th>At least once during the course</th>
<th>Never</th>
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<tr>
<td>General catching up on progress</td>
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<td><strong>Comments</strong></td>
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<tr>
<td>Discussion of clinical casework (eg. work with specific families)</td>
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<td><strong>Comments</strong></td>
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<td>Reflective discussion relating theory to practice</td>
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<td><strong>Comments</strong></td>
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<tr>
<td>Being present in person when the student was working with families</td>
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<td><strong>Comments</strong></td>
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<td>Teaching the student specific skills relevant to the FHN role</td>
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<td><strong>Comments</strong></td>
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<td>Identification and review of specific goals to be achieved in the student’s work with families</td>
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<td><strong>Comments</strong></td>
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<tr>
<td>Discussion of interpersonal issues related to the student’s placement (eg. teamwork)</td>
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<td><strong>Comments</strong></td>
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<tr>
<td>Discussion of personal issues related to the student’s placement (eg. confidence)</td>
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<tr>
<td><strong>Comments</strong></td>
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4) Thinking of a normal week, how much time on average did you spend on supervision of the FHN student? _______________________ hours

5) During the time that you supervised the FHN student, were you involved in supervising any other students?  
Yes ☐  No ☐  ☐

*If you answered yes, please give brief details of the number of students and their courses*
6) During the total time that you supervised the FHN student, how many families did they work with?

____________________ families

7) Please give a brief description of any ways in which you feel these families have benefited from having input from the FHN student

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

8) Please give a brief description of any ways in which you feel the FHN student’s input has been problematic for these families

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

9) What difference do you feel that placement supervision has made to the quality of the FHN student’s work with these families?

a great deal quite alot very little none

☐ ☐ ☐ ☐

Comments

____________________________________________________________________________________

10) Please write down any three aspects relating to placement supervision that you think could be improved

(i)________________________________________________________________________________

(ii)________________________________________________________________________________

(iii)________________________________________________________________________________

11) If you have any other comments about experiences relating to placement supervision, please write them below

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Finally, we would be grateful if you could provide some details about your professional background and your preparation for supervisory roles.

12) Please give details of any professional qualifications that you hold and the year obtained.

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Year obtained</th>
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13) Apart from supervising the FHN student, have you been involved in supervising any other pre or post registration nursing students during the past five years?

Yes ☐ No ☐

If you answered yes, please indicate the course(s) involved and describe any specific preparation that you received in order that you could undertake the supervisory role.

<table>
<thead>
<tr>
<th>Course (e.g. Diploma in Nursing; BA Community Nursing HV Specialism etc)</th>
<th>Preparation given (e.g. formal 2 day preparatory course; informal briefing from colleague etc)</th>
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</table>

14) Please give details of any preparation that you received specifically to prepare you to undertake the role of supervisor to the FHN student.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

15) Finally, what aspects of your own professional experience have been most useful for supervising the FHN student?

(i)__________________________________________________________________________
(ii)__________________________________________________________________________
(iii)__________________________________________________________________________

Thank you very much for taking the time to complete this questionnaire. Please return it now in the FREEPOST envelope provided.
The student and supervisor questionnaires were generally well completed across the different subsections. Qualitative comments were collated using SPSS and analysed in terms of content frequency and broader thematic coverage.

Aggregate scores for perceived quality of placement supervision, frequency of supervisor contact by remote means, and frequency of in-person supervisor contact were subsequently derived from the students’ responses (the same procedure was followed with the responses from their supervisors). This facilitated subsequent comparison of scores between the two cohorts of students using the Mann Whitney test. As reported in the main study, Cohort 2’s perceived quality of clinical placement supervision was significantly better than that reported by Cohort 1 (p=0.004). This finding confirmed similar findings from a range of other quantitative and qualitative data.

Use of Cohen’s kappa statistic (measuring level of agreement) for comparison of students and their respective supervisors’ ratings of a subset of matched individual questions is described within the main report. The report also reflects on the findings of relatively poor agreement on many of the questions using this rigorous statistical index.

As alluded to in previous sections of this CD Rom, the student (and supervisor) sample was too small for the use of factor analysis based on their responses to the new questionnaire. However we were able to explore the reliability of sub-scales of both questionnaires using the alpha coefficient statistic. This reflects the internal consistency of the items which comprise these sub-scales. It is generally accepted that alpha scores of over 0.70 are satisfactory, especially if a relatively small number of items comprise the sub-scale (Streiner and Norman 1995). Scores of over 0.90 may indicate that a number of items are asking the same question in a slightly different way (i.e. there is some item redundancy; see Streiner and Norman 1995).

The table below presents alpha coefficients based on students’ and supervisors’ responses to the main sub-scales.

<table>
<thead>
<tr>
<th>Sub scale</th>
<th>Respondents</th>
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<tbody>
<tr>
<td></td>
<td>Cohort 1 students</td>
</tr>
<tr>
<td>quality of placement supervision</td>
<td>0.86</td>
</tr>
<tr>
<td>frequency of supervisor contact by remote means</td>
<td>0.97</td>
</tr>
<tr>
<td>frequency of in-person supervisor contact</td>
<td>0.88</td>
</tr>
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</table>

It can be seen that the student questionnaire’s sub-scales typically appear to be internally consistent and reliable, although there may be some scope for reducing the number of items within the “remote contact” sub-scale. The results for the supervisor questionnaire are more mixed. The “remote contact” and “in-person contact” sub-scales perform very differently when responded to by the Cohort 1 and Cohort 2 supervisors. Some further exploration of possible reasons for this is required in order to inform future applications of this questionnaire.
2.2.2 Methods of review of student course work and evaluations

In order to study the student experience it was necessary to scrutinise a range of documents that were used in the educational programme. The academic teaching team were very helpful in providing information and facilitating access to the required information.

Where assessment procedures for individual modules involved written assignments (e.g. initial case study; exam; community portraits; annotated case reports) we typically asked to see a cross-section of the work. This would span those receiving the highest marks, average marks and the lowest marks. This proved a useful way of gauging the level of the course and student performance on it. Both researchers were involved in scrutiny of these documents and there was regular discussion of our interpretations. In the case of the community portraits we asked for and received all the students’ work as these were particularly useful to our understandings of the sites involved.

The educational team encouraged the students to regularly produce written reflections on their experiences and progress. These were collated, anonymised through some editing, and circulated to the Project Steering Group and a number of other parties such as service managers and ourselves. These were another useful set of data that informed ongoing understandings.

Our scrutiny of student practice profile forms was most often conducted in context when we visited the students at their respective home base sites. Discussion of the profile documents would sometimes include input from supervisors. We generally took field notes recording specific details and summarising themes arising.

Finally the academic staff supplied us with the collated results from students’ final evaluations of each module.
2.2.3 Methods of review of teaching, assessment and external examination

In person observation of campus based teaching sessions was occasional rather than frequent, averaging around one session per semester. Our critical reflections on the curriculum and our knowledge of emerging issues gathered through site visits tended to influence our requests to sit in on certain sessions (e.g. when the students were involved in in-depth interviews with families towards the very start of the course we asked to sit in on the next ethics session). Detailed notes were taken during these sessions, recording strengths and weaknesses. These were then summarised by thematic analysis and sometimes augmented by means of a written reflective commentary.

The main report gives insight into our observations of the Objective Structured Clinical Examination (OSCE) assessment procedure. As indicated, we observed twelve of the twenty OSCEs for Cohort 2 students, and this involved detailed note taking and subsequent discussion of emergent themes within the research team. One of these OSCEs was observed by means of video-link.

The external examiner reports that informed course review were also shared with the research team. These tended to be limited in scope.
2.2.4 Group discussions with students on campus

Informal contacts and interviews with students were ongoing throughout the project, but periods on campus provided the opportunity for the research team to engage in group discussions with each cohort. These took place once every three months or so and usually lasted around one hour. Academic teaching staff would help arrange a time for this, but they were not present at the discussions. Dialogue was usually structured around some topical issues that the research team wished to explore and issues spontaneously raised by the students. Often a good deal of “ventilation” took place whereby students voiced current concerns. These discussions were useful in sustaining and developing the relationship between the research team and the student body, but the group interaction necessarily inhibited more reserved students and less popular views. The member(s) of the research team present took notes around the main themes discussed.
2.3 EXPERIENCES OF RESEARCHERS AND TEACHERS

2.3.1 Field notes and research journals

As indicated already field notes were an important way of recording descriptive data, emerging questions and ongoing reflections. This technique was used extensively during visits to campus and on visits to sites where FHN students or qualified FHNs were working. Usually these notes would be prefaced by a number of themes or questions which we took with us on our visits. Moreover, whenever possible, we subsequently discussed our experiences within the research team in order to help to make sense of what was often a complex and paradoxical unfolding of events. The challenge of attempting to describe and explain such fieldwork, and the challenge of jointly exploring different interpretations, was a vital part of explanation building. This process was iterative and highlights the need for good teamwork and mutual support in work of this nature, especially where there are pronounced political dimensions to the development under scrutiny.

Research journals were used in a less detailed way to log and explore themes at a “meta” level (i.e. to step back from the detailed experience and data, and pull out important elements and issues). Sometimes we also used these journals to summarise the content of the regular, informal, phone discussions that we had with a range of people involved in the project.
2.3.2 Interviews with teachers

As the main report indicates, a formal interview was held with each member of academic staff who had a key role to play in delivering the programme. These interviews took place towards the end of the pilot project (i.e. December 2002) in order to explore summative reflections on the experience. A key member of the academic staff informed colleagues about the nature of the intended interviews and the main thematic areas that we wished to cover. All the relevant staff kindly agreed to take part.

Specifically the interviews aimed to explore the strengths and weaknesses of the course and to identify the lessons learned and the areas for potential development. Enabling reflexivity was one of the challenges of these interviews as a certain amount of guarding took place. Like the students, the teachers had been in the shifting spotlight and part of a highly politicised process for the last two years.

Questioning began by asking about the strengths and weaknesses of the curriculum; before reflecting on its fit with regulatory learning outcomes; the parity and quality of student experiences and learning; the role of the FHN; and finally focusing on their own personal experiences of being involved in the initiative.

Apart from one interview that was conducted by e-mail due to time and geographic restrictions, the interviews were conducted in person and tape recorded. Typically the interviews lasted between 25 and 75 minutes. The tapes were listened to several times, initial indicative thematic areas were mapped to tape-counter locations, and selected sections of the interview were fully transcribed. For some interviews this entailed transcription of almost all the content. For others the transcription was more limited in scope. Through a process of qualitative content analysis, the main themes were then derived from the transcribed material. Full details of application of this method are given in Folder 3.2 of this CD Rom (section on case studies).
PART 3 THE PRACTICE OF FAMILY HEALTH NURSING
3.0 CONTEXTS OF SITES, CASELOADS AND FIELD NOTES

3.0.1 Contextual data for the FHN sites

During the evaluation we gathered a wide range of literature relating to the epidemiology and demography of each site location. Most often such information pertained to rather wider areas than the FHN sites themselves, but a few were completely co-terminus. These documents had typically been produced by the various regional Primary Health Care Trusts involved in the project, but these were supplemented by information available through national sources (e.g. Public Health Institute for Scotland).

One of the regions gave us access to some particularly useful health needs assessments which they had commissioned. These gave some insights into the way that health services in general, and nursing services in particular, were viewed by local communities. One Community Health Profile (Hope et al 1997) also surveyed health care staffs’ perceptions of current service and included analyses of district nursing caseloads in the area. This proved a very helpful and informative document which, unusually, gave at least a systematic research/audit basis on which to base further role development. For example one major finding was that, whilst health promotion and mental health issues were recognised as Health Board priorities and germane to the local population and health professionals, there was little evidence that these were currently being addressed as priorities in the work of district nurses.

As such this information gave a useful “frame” for closer investigation of conditions at the FHN sites. In addition to gathering any relevant epidemiological and demographic data that was available to us when we visited specific FHN sites, we also drew on the community portrait documents that the first cohort of FHN students constructed during 2001 as part of their coursework. Again the quality and quantity of data available within these documents were variable, but most of the community portraits also gave more information and insight about the coverage and extent of local health and social care provision.

Sometimes this included a listing of the numbers of staff and the roles in which they functioned. This proved useful, but it was only by visiting each individual FHN site that we could obtain and cross-check such information in detail. Sites were typically visited at least twice during 2001 so that such information could be compiled, along with more detailed information on working and referral practices. In this way a list of professional stakeholders was compiled for each FHN site. This comprised all health care staff in the core Primary Health Care Team, along with all other relevant health, community and social care staff involved closely with the PHCT. Identification of the latter, non-core, group of individuals involved checking and cross checking names with several members of staff at each site.
3.0.2 Caseload details

An important aspect of the site visits involved establishing the coverage and extent of district nursing, health visiting, midwifery, practice nursing and GP service provision. For the latter three groups it was usually sufficient to obtain fairly general data (e.g. typical number of live births per year; practice population numbers and demographics etc.) and supplement this through triangulated interview data on working practices. As the main predicted interface of the FHN role was with district nursing and health visiting care, however, it seemed important to achieve a detailed understanding of the work carried out by these groups at each site.

To this end we sought scrutiny of caseloads relevant to each site. This firstly involved studying the means through which relevant data was recorded. This varied across the regions, and sometimes within the regions, but usually a register (large book) was kept with each patient’s name, age, address, presenting problem, frequency of visiting and various other entries. Moreover daily diaries were used to log visits. Finally a monthly collation of statistics for contacts was usually returned to regional headquarters based on the information from the register.

The required content for these monthly collations varied across the regions. Some used a “kalamazoo” format whereby the number of contacts with patients in different age categories was recorded for each day of a particular month. Others had more sophisticated layouts involving an array of computer-friendly codes which represented discrete aspects of each individual patient contact. Accompanying documentation explained the codes which the nurse would then enter. Interestingly one of the regions had recently reverted to more simplified details of contact information before our study commenced. Apparently there had been difficulty in getting nursing staff to return and complete the new forms, and there was some debate about what the ensuing statistics were actually used for.

In order to try to extract meaningful primary data we decided to seek full details of district nursing caseloads for a typical month during autumn 2001. Typically we had already met each district nursing caseload holder during earlier visits when we had explained the nature of our study. This was also supplemented by more information given to them by the FHNs at each site. Usually we then phoned each district nursing caseload holder to give them more information about the details that we wanted, and arranged to meet them in order to extract the information from the register together. We found that by talking through individual cases and entering them on to our data extraction form, we gained great insight into the nature and scope of the work being carried out. Furthermore the process invariably elicited the district nurse’s more general worldview in relation to her work, her community and perceptions of the FHN role.

Due to logistics it was possible to do this in person with all but two of the district nursing caseload holders. Where an in-person meeting was not possible we sent them the letter presented on the following page along with the data extraction grid presented on the page thereafter. Through both of these approaches it was possible to extract data for nine of the ten FHN sites involved in the first year of practice. At the remaining site the district nursing caseload holder repeatedly said that she would collate the data but this never happened. Subsequent visits to the site revealed that basic data was often very difficult to find, even for the staff working there. In this case we drew on information from the FHN and other community nursing colleagues in order to construct a typical picture of caseload activity.

The letter and the second data extraction grid presented were sent to the Health Visitors who covered the FHN sites. Again we attempted to meet first with the HVs in person to explain the nature of our study. This was possible in six out of ten cases. One of the problems in this regard was that some of the HVs were based outwith the FHN site (i.e. the FHN site was only a part of their “patch”) and it was difficult to arrange our schedules to coincide. Where this was the case the phone was used for initial introductions and explanations. Six of the Health Visitors returned
completed data extraction sheets. One gave a summary of information by phone and the remaining three refused our request citing pressure of workload. Again in these cases we tried to compile a typical picture of caseload activity based on information from colleagues. However in these cases it was instructive to note how little detail each colleague within the core team could actually provide about the HV’s typical activities.
29th October 2001

Dear

As part of the evaluation of The Family Health Nurse (FHN) project, we are seeking to gather data about the usual work of the community nurses and health visitors who cover the pilot sites. This is important as it will provide a baseline picture which will inform our understanding of the future local development of the FHN role.

To this end we would be very grateful if you could complete the attached A3 grid form which is designed to capture a one-off picture of the part of your present caseload that covers the ........................................area. While we would welcome any details that you think relevant, we are mindful of the pressures on clinical staff and are really just looking for a summary of client need and your current input in each case. We would wish to avoid individual clients names being listed under the patient identifier column so if it is possible to use a CHISS number or other unique identifier, this would be ideal. If not, perhaps you could number them in such a way that you would be able to identify their case again to us next year. Alternatively, initials could be used.

If you feel that there are other aspects of your work that are relevant to the site and that cannot be entered on to the large grid form (eg. work with groups etc.), please give details on the enclosed yellow sheet.

The research is being conducted in co-operation with Highland Primary Care Trust, Orkney Health Board and The Western Isles Health Board, and is funded by The Scottish Executive. Approval for the research has been obtained from the Local Ethics Committees in the pilot regions and from the respective Directors of Nursing. Data will be treated in strict confidence by our team, all of whom are experienced nurses and researchers. We will take all steps to ensure that no individual is identified in written reports on the project.

We hope that you will support this research. It is very important that developments such as this are evaluated so that future decision making can proceed from an informed basis. Your support and participation will help to ensure this. If you have any questions please do not hesitate to contact us.

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development (CeNPRaD)

Dr Bernice West, Director, CeNPRaD
Date:..................................................Site:..................................................................
Person(s) responsible for this caseload at present (plus their role).......................................................... ...........................................................

<table>
<thead>
<tr>
<th>Patient identifier</th>
<th>Age</th>
<th>Sex</th>
<th>How often seen at present</th>
<th>Main health need/problem</th>
<th>Related nursing activity</th>
<th>Other health need/problem</th>
<th>Related nursing activity</th>
<th>Other professionals involved</th>
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<td>Patient identifier</td>
<td>Age</td>
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<td>How often seen at present</td>
<td>Main health need/problem</td>
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Date:.................................................................. Site:..................................................................

Person(s) responsible for this caseload at present *(plus their role)*:..................................................................................................................................................................................
Overall the information elicited through these processes proved very useful in providing baseline understandings of the nature, coverage and extent of service activities. However the processes also drew attention to wide variations in: what people would be visited for; frequency of visiting; and in criteria for entry to, and exit from, caseload listings. Such variation was evident across the three regions but was also found amongst individual sites within the same region.

In turn this highlighted similar variation in the matched monthly collations of community nursing contacts that we were able to obtain. It was clear that different nurses completed these forms using very different criteria for what constituted a contact. This resulted in some contrasting data for sites with ostensibly similar patient populations and levels of professional staffing.

Accordingly we have noted these caveats in the main report and detailed the proxy measures that we have used towards engaging in any sort of meaningful comparison. The issues about recording of activities that were raised during this study are similar to those we have encountered in previous experiences of evaluating community nursing. In effect they reflect more fundamental difficulties relating to how the qualitative and contextual aspects of intimate interpersonal work can be rendered through quantification.

The above issues are made manifest vividly in the following excerpt from an interview with an FHN:

FHN: “.......there is a man that I see occasionally on the road, or if he is in someone else’s house. Now if I see him on the road, I know he’s alive. If I go to his house I can’t find him-he’ll be on the wander. That’s one. There’s another one who’s very hard to find. He’s back to his own house which is uninhabitable. But he’s there. But I see him on the road or walking in heavy weather. I’ll stop and have a chat with them and find out how they are going if I can. Or if I see them somewhere, or if I see them in the clinic we go to the side and go to the side and have a wee chat to see how they are getting on.

That’s a visit. I don’t always write down the “co-op” ones. For some reason I don’t feel its valid, but it should actually be. It is a contact. Of course it can be on a Saturday and nothing to do with work, but it just happens.

Researcher: Yes, there’s just a difficulty with the nature of recording...

FHN: but they are very good in a way, because they know it isn’t just a kind of private interest in them. They know that I’m genuinely interested in how they are and how they are getting on. Therefore if I am talking with somebody there might be a line waiting! The DN’s have that problem. They’ll hover at the tinned peas until you’re free!.......”My chest is better............”
3.0.3 Field notes

The procedures for taking field notes on site visits were similar to those already outlined in relation to the evaluation of educational experiences (Folder 2.3 of this CD Rom). However it is worth stressing how valuable this technique was in terms of keeping track of large amounts of information and in terms of answering and generating questions. We had initially envisaged using a laptop computer for the majority of this work. Indeed we used one during a number of early site visits. However the difficulties of using it on sustained trips to remote and rural contexts soon became apparent, and we resorted to tried and tested traditional methods (i.e. pen and paper).

In this way we almost always took summary notes during “informal” discussions at sites. These had usually been prefaced by a number of questions or themes that we wanted to explore with staff or patients. These notes were then expanded, from memory, in the evenings in guest houses and, just occasionally, hotel bars! It was usual to conclude with a reflective summary on the themes covered and the emergent questions. Then it was time to prepare for the next day’s visits and to log the themes that were to be specifically explored in those contexts. In this way it usually proved possible to keep on top of the enquiry and avoid becoming too confused.

During field trips some improvisation in methodology was also useful when responding to a need for more insight into a situation. One example of this was that during our on-site work with FHNs in 2002 it was sometimes difficult to get a clear picture of their emergent new role in terms of both their activities and their understandings. Thus during a round of site visits we started to ask each FHN to list the typical types of work they were doing and to draw these freehand as a pie chart so as to indicate relative proportions for each. Explanatory examples were then elicited in order to give further insight. Although this data never attained enough consistency to be analysed in terms of measurement, it showed how the FHNs were thinking. Many spontaneously divided the pie into “district nursing type work”, “health visiting type work” etc. while a few insisted it was all FHN work before subdividing the pie along other lines. For almost all, however, there was some intra-role conflict and difficulty in representing their work to others.

Telephone calls to the staff at the sites (and to “tracer” families) were also summarised through note taking. Such calls were relatively frequent, particularly to the FHNs themselves. As such this provided a mechanism through which we could keep up with perceptions of progress.
3.1 STAKEHOLDERS

3.1.1 The professional stakeholder questionnaire(s)

In order to address Objective 5 we sought to obtain professional stakeholders’ perceptions in relation to the local implementation of family health nursing at two points in time. Firstly we wished to systematically seek these perceptions at the end of 2001 when the concept had been “in circulation” for around a year and the FHN students were on the verge of trying to put the concept into practice locally. As such we would be seeking perceptions of what was still a hypothetical concept for professional colleagues. Secondly we wished to follow up in order to assess perceptions later when local FHN practice had been in place for one year.

Our procedures for identifying professional stakeholders have already been described. Our preferred method for seeking their perceptions was through the use of a standardised questionnaire. Unsurprisingly we found no such tools that had looked specifically at the concept of family health nursing as promulgated by the Scottish Executive and WHO Europe. In designing our own tool we decided to incorporate use of semantic differential technique (Osgood et al 1957). This involves the use of rating scales (usually seven point) that are bipolar with each extreme usually defined adjectivally (Oppehmein 1992). One of the major advantages of this technique is that it can be used not only to explore perceptions of relatively “matter-of-fact” aspects, but also perceptions of abstract ideas (Anastasi and Urbina 1997). This seemed well matched to our aspiration to study what was essentially an abstract idea at Time 1 and a “matter-of-fact” reality at Time 2.

Within the wider context of our evaluation the questionnaire was designed primarily to inform our understandings of emergent context-process-outcome patterns at each individual FHN site. However the questionnaire also offered opportunity to aggregate data in order to study the perceptions of all professional stakeholders and distinct sub-groupings amongst them.

Design of the tool took place early on in the evolution of the pilot project. Our own selection of aspects for semantic differential rating took place in the context of what was known (essentially little) and projected (essentially a lot) about the future implementation of family health nursing practice. It was however clear that there was a need to gauge perceptions of what was happening and its impact. We were aware of a number of potentially important and influential factors through our initial fieldwork, but at the end of the day we decided on seven items to be rated. A premium was put on keeping the questionnaire brief to avoid burdening potential respondents and aid return rates. Moreover our previous experiences of using semantic differential technique (West, Wilcock and Phillmore 1997) suggested the value of including an explanatory example of rating.

There was no opportunity to pilot our first prototype questionnaire without intrusion on the only sample for whom the concept under study would be an imminent reality. Accordingly we circulated the prototype to selected colleagues within the School of Nursing and asked for comments/suggestions. These were mostly affirmative and supported the inclusion of a line below each rated item in order to give scope for explanatory comments. The latter were seen as being useful on a number of levels. In particular it was felt that these would help us better understand responses to a few of the items where positive polarity could not necessarily be assumed (e.g. for the item contrasting different and similar service it was not axiomatic that difference would/should necessarily be associated with improvement). Within the larger group of items whose polarity could more safely be assumed we followed Oppenheim’s advice to vary the location of the positive end in order to try to counteract any halo effect. This was done with two items. Feedback from colleagues also confirmed that the pairs of poles for each rated item could truly be considered as opposites (see Oppenheim 1992) and that the mixture of adjectival and verbal anchoring was satisfactory.
The resultant finalised questionnaire also invited free text responses relating to anticipated impact on different sub groups. This was sent to professional stakeholders in the latter part of 2001 along with an explanatory letter and information sheet (see following pages).
29th October 2001

Dear..................................

As you may be aware, a new type of nursing role called The Family Health Nurse is currently being developed in the Highlands and Islands of Scotland. The main aim of these nurses is to work with local families to identify and meet their health needs. As the development is currently getting underway in your area, we are writing to ask if you would be prepared to help with our research into its operation and impact. The research is being conducted in co-operation with Highland Primary Care Trust, Orkney Health Board and The Western Isles Health Board, and is funded by The Scottish Executive.

Your involvement would comprise the following:

• completing the attached questionnaire which aims to elicit your initial thoughts on the development (an information sheet summarising the Family Health Nurse concept is attached)
• completing a similar follow-up questionnaire later next year. This would elicit your thoughts on how the development has impacted so far
• possibly taking part in a short telephone interview later next year. This would explore your perceptions in greater detail

Any information that you share with us will be treated in strict confidence by our team, all of whom are experienced nurses and researchers. The questionnaire has a coding number so that there is no need to add your name to it. Telephone interviews will be tape recorded then destroyed after analysis. Similarly, we will take all steps to ensure that no individual is identified in written reports on the project.

We hope you will support this research. It is very important that our evaluation is based on the thoughts and feelings of those who are involved and/or affected by this development. In this way we can have a sound basis for studying the value of the emergent Family Health Nurse role. Please complete the attached questionnaire and return it by 23rd November using the FREEPOST envelope provided. If you have any questions, please do not hesitate to contact us.

Thank you

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development
Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

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Within recent years, the Family Health Nurse (FHN) model has been developed by the World Health Organisation (WHO). It is based on the following principles:

- a skilled generalist role encompassing a broad range of duties, dealing as the first point of contact with any issues that present themselves and referring on to specialists where a greater degree of expertise is required
- a model based on health rather than illness - the FHN would be expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care
- a role founded on the principle of caring for families rather than just the individuals within them
- a concept of the nurse as first point of contact

Within Scotland piloting of this model is currently getting underway in Highland region, Orkney and the Western Isles. The aim is to test the FHN model as a means of delivering community nursing services in remote, rural areas. Community nurses from selected sites within each region are undertaking a degree level education programme based on the WHO FHN model. This course (of approximately one year’s duration) is being delivered by The University of Stirling, based at their Highland campus in Inverness. In the first year (2001) eleven nurses are undertaking it.

These nurses are on placement locally during the course. They will be working with a number of local families to identify the aspects of health that individual family members see as important, and then work with them towards improvements. This may involve help with illness and disability; early detection of problems; or advising on lifestyle and risk factors. It may also involve helping to co-ordinate health services and making referrals. On qualification as Family Health Nurses at the end of this year, they will then seek to further develop and establish the role at their local sites.
FAMILY HEALTH NURSE QUESTIONNAIRE

SECTION A

The pairs of statements listed below present opposing views of the Family Health Nurse (FHN) development. For each pair, please circle a star on the seven point scale between them which most closely corresponds with your view. An example of how to complete this section is now given.

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<td>whereas if you thought that fuel prices just tended towards being fair, you might complete it thus:</td>
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<td>★ ★ ★ ★ ★ ★ ★</td>
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Now, thinking about your local context and the potential contribution of Family Health Nursing, please complete for the statements below. (Family Health Nurse has been abbreviated to FHN). Please add comments if you wish.

I think the FHN will deliver a different type of service to what is currently available  ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Comments ____________________________

I think the FHN will add to existing local services  ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Comments ____________________________

I think the FHN development will involve substantial change to the way that services are delivered to patients  ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Comments ____________________________

I think the FHN development will involve minimal change for professionals in the way they work together  ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Comments ____________________________
I think the FHN development is not well suited to our local context

Comments

I think the FHN development will lead to an improvement in local health service

Comments

I think the FHN development is likely to succeed locally

Comments

SECTION B

In this section we would like you to write down any initial thoughts you have about the likely impact of the Family Health Nurse development on each of the following groups:

Patients and families

Other health or social care professionals (please specify)

The Family Health Nurses themselves

Finally, if you have any other comments please add them below

Thank you very much for taking the time to complete this questionnaire. Please return it using the FREEPOST envelope provided.
Reminder letters were sent to those who did not respond within three weeks. Response to the first administration of the professional stakeholder questionnaire is detailed in the main report. We judged the overall response rate as satisfactory in terms of minimisation of response bias. There was no evidence that any particular sub-group of professionals was less likely to respond. The usable response rate was only marginally less and there was no evidence that any particular sub-group of professionals was more likely to fail to complete the questionnaire in an intelligible way. On the contrary, from responses to the semantic differential ratings, explanatory free text comments and the other free text responses it was clear that respondents had appreciated what was being asked of them. Free text responses were very useful in illuminating baseline attitudes and the breadth of range in these responses suggested that the questionnaire was performing well.

However a relatively large number of respondents added explanatory comments below individual scale items to the effect that, as they knew little/nothing about the FHN development at present, it was difficult to answer. Typically these respondents either opted for an “undifferentiated” point on the scale (i.e. the mid-range points 3, 4, or 5) or they left the item unmarked. While this reflected some of the fundamental difficulty relating to perceptions of an abstract concept, it was also very useful at this point in the evaluation to learn from these professional colleagues that they felt they knew so little. Some indicated that they had been given no information beyond what we had included with the questionnaire. The response behaviour of this sub-group was also helpful in informing our general procedures for interpretation of responses. Several approaches to this are possible with semantic differential technique, including classifying true mid-point (point 4) responses as the only undifferentiated ones (i.e. constituting the “unsure” category). In the context of our study, however, it seemed that more definitive focus would be achieved by categorising responses on the mid-range points 3, 4, or 5 as undifferentiated. In this way responses on points 1 or 2, and responses on points 6 or 7, were categorised as the respective opposite poles. This system was duly followed in our basic analyses throughout the study and is illustrated in the layout of results within Annex 5 of the main report. In order to check the implications of this interpretation on our analyses we later re-analysed Annex 5 using true mid-point (4) responses as the only ones in the “unsure” category. While this naturally decreased the proportion of responses within this category, it made little difference to the proportionate balance of positive and negative responses.

In addition to producing frequencies and other descriptive statistics based on the semantic differential part of the questionnaire, we also took the opportunity to gauge the reliability of this section in terms of internal consistency. The resultant alpha coefficient for our Time 1 administration of the professional stakeholder questionnaire was 0.79. As indicated previously, this suggests a satisfactory level of internal consistency.

We also took the opportunity to further explore the structure of the semantic differential part of the questionnaire through the use of exploratory factor analysis. This technique has previously been used extensively in this context (Oppenheim 1992). Our aim was to find out more about the underlying factors that our questionnaire was “tapping into”, and to find out which factors the seven items “mapped” or “loaded” on to.

In this case our variable to subject ratio seemed suited to the use of factor analysis (Watson 1998). Our sample comprised the usable responses from the ten sites subsequently studied (excluding responses from the FHNs themselves). This totalled 83 responses (see Table 3.2 in the main report; fourth column entitled “December 2001”). Thus we used Principal Components Analysis with subsequent Varimax rotation in order to explore factorial solutions where Eigenvalues were greater than 1 (unity).

We plan to publish full details of the factor analysis in due course, based on Watson (1998)’s guidelines. In summary we found two factors that explained a total of 70% of the variance in responses. The first factor, which explained 46% of variance, we entitled “(anticipated) nature of impact”. The second factor, which explained 24% of variance, we entitled “(anticipated) magnitude of practice change”. Four of the seven semantic differential items loaded on the first factor, and the resultant alpha coefficient for this factor was 0.84. The remaining three items loaded on to the second factor (although one of these items tended to “bridge” both factors), and the resultant alpha coefficient for this factor was 0.76.
These results were encouraging in that they suggested that the questionnaire was measuring two underlying factors that were fundamental to our study’s aim. Moreover they suggested little, if any, item redundancy within the questionnaire. Interestingly the two factors very clearly relate to the main factors that Osgood (1957) found to be typically elicited through the semantic differential technique i.e. in order of importance: evaluation, potency and activity. In this regard our “nature of impact” factor reflects evaluation and our “magnitude of practice change” factor reflects potency.

Thus the professional stakeholder questionnaire seemed to provide a very useful, valid, reliable and brief means through which to obtain perceptions about local family health nurse implementation. On this basis it was decided to leave all existing items in the questionnaire that would be sent as a follow up at the end of the first year of practice (November/December 2002). This offered the added advantage of facilitating matched comparisons in perceptions between Time 1 and Time 2. Minor changes in the wording of the semantic differential items were made so as to reflect the fact that respondents would now be basing their answers on experience of the enacted concept.

During our field trips and other data collection procedures in 2002 it became apparent that it would be useful to ask some other questions systematically through the professional stakeholder questionnaire. Thus we added in a section that asked for perceptions of consultation; referral behaviour; frequency of contact with FHN; and need for a distinct FHN role locally. The latter question reflected a theme that had emerged throughout the pilot project in that there seemed to be a wide range of opinion about this fundamental, underlying aspect.

As indicated in the main report a number of the stakeholders who had responded in 2001 subsequently changed employment and location. Moreover a number of new stakeholders were identified, often in relation to new activities started by the FHNs. Using our updated listings we sent out the revised questionnaire and explanatory letter in November 2002. These documents are presented on the following pages.
26th November 2002

Dear

It is now almost a year since Family Health Nurses began working at various pilot sites in the Highlands and Islands of Scotland. As our evaluation of the pilot project nears its conclusion, we are writing to ask if you would be willing to complete the enclosed questionnaire which seeks your thoughts on the operation and impact of family health nursing so far in your local area.

Any information that you share with us will be treated in strict confidence by our team, all of whom are experienced nurses and researchers. The questionnaire has a coding number so that there is no need to add your name to it. The research is being conducted in co-operation with Highland Primary Care Trust, Orkney Health Board and The Western Isles Health Board, and is funded by The Scottish Executive.

We hope that you will support this research. It is very important that our evaluation is privy to the thoughts and feelings of those who have been involved and/or affected by this development. Please complete the attached questionnaire and return it by 9th December using the FREEPOST envelope provided. If you have any questions, please do not hesitate to contact us.

Thank you very much

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development
FAMILY HEALTH NURSE QUESTIONNAIRE

SECTION A
The pairs of statements listed below present opposing views of the Family Health Nurse (FHN) development. For each pair, please circle a star on the seven point scale between them which most closely corresponds with your view. An example of how to complete this section is now given.

For example if you believed that fuel prices were very unfair, you might complete as below:

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<tr>
<th>Fuel pricing is generally fair</th>
<th>* * * * * * *</th>
<th>Fuel pricing is generally unfair</th>
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Now, thinking about your local context and the development of Family Health Nursing so far, please complete for the statements below. Please add comments if you wish.

I think the FHN delivers a different type of service to what was previously available

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Comments

I think the FHN development has taken away from pre-existing local services

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Comments

I think the FHN development has involved substantial change to the way that services are delivered to patients

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Comments

I think the FHN development has involved minimal change for professionals in the way they work together

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Comments
I think the FHN development is not well suited to our local context

Comments

I think the FHN development will lead to an improvement in local health service

Comments

I think the FHN development is succeeding locally

Comments

SECTION B

In this section we ask some questions about the evolution of the FHN role locally from your perspective.

(i) Do you feel that you have been adequately consulted in regard to the local introduction of family health nursing? (please tick most appropriate box)

Yes ☐ No ☐ Don’t Know ☐

Comments

(ii) Do you feel that consultations with the local public about the introduction of family health nursing have been adequate?

Yes ☐ No ☐ Don’t Know ☐

Comments

(iii) Over the past year, approximately how many referrals have you made to the FHN? (please write down a number in each box)

Individual patients ☐ Whole families ☐

Please indicate the main reason for making these referrals

(iv) Over the past year, approximately how many referrals have you received from the FHN? (please write down a number)

Please comment on the nature and appropriateness of these referrals
(v) Please tick the box which best describes how often you usually have work-related contact with your local FHN

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(vi) In your view is there a need for a distinct FHN role locally?

Yes    No    Don’t Know

Please give further comments to explain your answer

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

SECTION C

In this last section we would like you to write down any thoughts you have about the impact of the Family Health Nurse development so far on each of the following:

Your own work

_____________________________________________________________________________
_____________________________________________________________________________

Patients and families

_____________________________________________________________________________
_____________________________________________________________________________

Other health or social care professionals (please specify)

_____________________________________________________________________________
_____________________________________________________________________________

The Family Health Nurses themselves

_____________________________________________________________________________
_____________________________________________________________________________

Finally, if you have any other comments please add them below

_____________________________________________________________________________
_____________________________________________________________________________

Thank you very much for taking the time to complete this questionnaire. Please return it using the FREEPOST envelope provided
Again, reminder letters were sent to those who did not respond within three weeks. Response to this second administration of the professional stakeholder questionnaire is detailed in the main report. Although the overall and useable response rates were slightly lower than for Time 1, these were still generally satisfactory. Again there was no evidence that any particular sub-group of professionals was less likely to respond or be less likely to complete the questionnaire in an intelligible way.

The additional questions that had been incorporated for this follow-up administration were answered well, and the free text responses now illuminated perceptions of the FHN role in action. In general the findings were very confirmatory, in that they were consistent with interview material and other data that we had gathered on successive site visits.

Excluding replies from the FHNs themselves, there were 78 useable responses. These gave a basis for further checking of the questionnaire’s reliability in terms of internal consistency. In this regard the alpha coefficient at Time 2 was 0.87.

Exploratory factor analysis was repeated at Time 2. This time only one factor was identified and this explained 58% of variance in replies. However a further factor that explained a further 13% of the variance almost had an eigenvalue of 1. Some authors (e.g. Tripp Reimer et al 1996) explore solutions with factors that explain over 10% of variance, so we took the opportunity to also impose a two factor solution on our data from the 78 responses. In terms of item to factor mapping, this produced a similar two factor solution to that obtained at Time 1 (when respondents were anticipating the development rather than interpreting its actual enactment).

For the latter reason, and because the respective populations of stakeholders surveyed at Times 1 and 2 differed somewhat, it is perhaps not surprising that our initial exploratory analyses of the Time 2 data produced a slightly different factorial solution. We further explored this finding by conducting a factor analysis on the replies from the 53 Time 2 respondents who had also answered the Time 1 questionnaire. This confirmed that the same two factor solution was consistent on both occasions for this core group of respondents.

In order to further explore the difference between the perceptions of the group of 53 and the remainder of the T2 respondents (i.e. the 25 new respondents), we used the Mann Whitney test. This showed that the group of 25 new respondents were more likely to feel that the FHN was providing a different service and that substantial change in service delivery had occurred.

The influence of this new group of respondents was also seen to some extent when we adopted a less conservative approach to comparison of the consecutive semantic differential data than that taken in Annex 5 of the main report. This involved using the Wilcoxon test to compare before and after mean ranks for each of the seven items (i.e. using the Time 1 sample of 83 useable responses and the time 2 sample of 78 useable responses). This showed one statistically significant difference: that respondents at Time 2 were significantly more likely to see the development as resulting in improvement to local service (p= 0.22). However when the same test was done to compare responses from the core group of 53 consecutive responders there were no statistically significant differences. This confirms the main reports finding that the status quo had not been substantially altered after a year of FHN practice.

Indeed the above explorations are generally very helpful in confirming the reliability and validity of the methods used, and in turn confirming the validity of the interpretations that we have made. On this basis the professional stakeholder questionnaire would seem very suitable for further use and development through application in other studies.
3.1.2 The lay stakeholder questionnaires

An abbreviated and adapted version of the professional stakeholder questionnaire was designed for sending to the 20 lay people randomly selected at each of seven sites. Details of the rationale, procedures and ethical considerations related to our consultations with people living within the local FHN sites have already been given in Folder 1.0 of this CD Rom.

The questionnaire sent in November 2001 is presented on the following pages, prefaced by the accompanying letter and information sheet. One of the main purposes of this approach was to gauge what, if anything, local people had heard about this impending development of local service (and how they had heard of it). Accordingly this is addressed in Section 1 of the questionnaire. We were also interested in obtaining initial thoughts on the application of the concept locally, irrespective of whether those mailed had previously heard of the development or not. To this end we included the information sheet.

For Section 2, the number of semantic differential items was reduced to four, in view of our feeling that brevity and cogency were important and might encourage responses from those who had no prior knowledge of the development. The items that were retained were those judged most likely to be answerable by the general population. At this stage no space was offered below these items for explanatory comments. However a further section (3) offered opportunity for general reactions. Finally Section 4 asked for some basic personal data and sought to establish whether the respondent had recent experiential knowledge of community nursing services. This would allow for further contextualisation of responses.

Indeed contextualisation was the main goal for analysing and interpreting data from this questionnaire. As such the data was used primarily to inform our understandings of the context for development at each site.
26th November 2001

Dear Mr/Mrs/Ms...................................

A new type of nursing role called The Family Health Nurse is currently being developed in the Highlands and Islands of Scotland. The main aim of these nurses is to work with local families to identify and meet their health needs. As a qualified Family Health Nurse will soon be working in your area, we are writing to ask if you would be prepared to help with our research into this development. The research is being carried out independently for The Scottish Executive by The Centre for Nurse Practice Research and Development (CeNPRaD), The Robert Gordon University, Aberdeen.

Your participation would involve:

- completing the attached questionnaire which asks for your initial thoughts on the development (a sheet giving more information on Family Health Nursing is attached)
- completing a similar questionnaire late in 2002.

If you decide to take part, only our small team of researchers will be aware of this and any information that you share with us will be treated in strict confidence. The questionnaire has a coding number so that there is no need to add your name to it. We obtained your name and address by making a random selection from the electoral roll and you are under no obligation to take part in this research.

We hope, however, that you will choose to do so, as it is very important that our evaluation is based on the thoughts and feelings of those who may be affected by this development. Please complete the attached questionnaire and return it by 14th December using the FREEPOST envelope provided. If you have any questions, please do not hesitate to contact us.

Thank you

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development
INFORMATION SHEET ON THE FAMILY HEALTH NURSE

Within recent years, a new type of nursing role called the Family Health Nurse (FHN) has been developed by the World Health Organisation (WHO). The main aspects of the role are:

- the FHN is expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care. This is a model based on health rather than illness
- the FHN is expected to care for families rather than just the individuals within them
- the FHN will be a skilled generalist nurse doing a broad range of duties
- the FHN will act as a first point of contact and refer on to specialists where a greater degree of expertise is required

Within Scotland piloting of this model is currently getting underway in Highland region, Orkney and the Western Isles. The aim is to test the FHN model as a means of delivering community nursing services in remote, rural areas. Community nurses from selected sites within each region will undertake a degree level education programme based on the WHO FHN model. This course (of approximately one year’s duration) is being delivered by The University of Stirling, based at their Highland campus in Inverness. In the first year (2001) eleven nurses are undertaking it.

These nurses are currently on placement locally. They are working with a small number of families to identify the aspects of health that individual family members see as important, and then work with them towards improvements. This may involve help with illness and disability; early detection of problems; or advising on lifestyle and risk factors. It may also involve helping to co-ordinate health services and making referrals. On qualification as Family Health Nurses at the end of this year, they will seek to further develop and establish the role at their local sites.
SECTION 1

Prior to receiving this letter, how much had you heard about the Family Health Nurse development? (please tick one box)

nothing □  a little □  a lot □

If you answered “a little” or “a lot”, please indicate how you first heard about it

through a friend/relative □  through a health care professional (eg. nurse/doctor) □
through local publicity □  through attending a local meeting □
through another source □ (please describe......................................................................................)

SECTION 2

In this section we present opposing pairs of statements. For each pair, please circle a star on the scale which most closely corresponds with your view. An example of how to complete this type of question is now given, using the subject of fuel pricing.

For example if you believed that fuel prices were very unfair, you might complete as below:

Fuel pricing is generally fair * * * * * *  Fuel pricing is generally unfair
* * * * * * *  

whereas if you thought that fuel prices just tended towards being fair, you might complete it thus:

Fuel pricing is generally fair * *  ⊗  * * * *  Fuel pricing is generally unfair

The next four pairs of statements present opposing views of the Family Health Nurse (FHN) development. Thinking about your local situation and the potential contribution of family health nursing, please circle the most appropriate star between each of the statements. (Family Health Nurse has been abbreviated to FHN)

I think the FHN will deliver a different type of service to what is currently available

I think the FHN will add to existing local services

I think the FHN will deliver a similar service to what is currently available

I think the FHN will take away existing local services
I think the FHN development is not well suited to our local situation

I think the FHN development will lead to a deterioration in local health service

SECTION 3

If you have any initial thoughts about the FHN development that you would like to share, please write these in the space below.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

SECTION 4

Finally we would be grateful if you could provide some personal information:

Your age _________

Whether you are male or female (please circle as appropriate)

Have you received any community nursing services in the past two years? Yes ☐ No ☐

Have any other members of your family received any community nursing services in the past two years? Yes ☐ No ☐

Thank you very much for taking the time to complete this questionnaire. Please return it using the FREEPOST envelope provided.
Reminder letters were sent to those who did not respond within three weeks. Response to the initial lay stakeholder questionnaire is detailed in the main report. The overall and useable response rates (49% and 42% respectively) were reasonable for this type of “cold call” mailing of the general public. As the more detailed table in the main report (Table 3.4) shows, response rates varied quite widely amongst individual sites. Perhaps unsurprisingly, response tended to be better from FHN sites with numerically small populations who lived within a relatively small geographic area.

Due to constraints of space within the main report, the aggregated results from this questionnaire were relatively under-reported. Accordingly some further details are reported here. Almost 75% of respondents had heard nothing about the FHN development prior to receiving our letter. Most of the remainder had heard a little from a health professional and a few had heard a lot. Again those that had heard about the development tended to live within FHN sites with numerically small populations. Only a few of the respondents had personal experience of receiving community nursing within the past 2 years, and a few others had relatives in this position.

Aggregated perceptions were fairly balanced as to whether the new service would be different or similar. Most respondents well relatively well disposed to the development and felt that it was well suited to local context, would add to services and result in improvement.

The “any comments” section of the questionnaire was particularly useful as a means of gaining insight into respondents’ initial reactions to the FHN concept. Only a relatively small number of respondents (4) indicated that they couldn’t really comment as they hadn’t heard about it/found the questions meaningless. Rather a further 15 raised a range of interesting points. Again most were well disposed towards it but, for some, there was a strong feeling that this family care happened already and that the role would duplicate current service. As indicated in the main report there was general concern that the FHN role should be additional and not entail any withdrawal of existing service provision. Finally two respondents raised interesting points relating to access to patients and to the GP role:

The district nurse is currently in attendance following a planned course of treatment directed by a personal GP. That is why she is there. How does the FHN gain entry by referrals? Spontaneous visit possibly seen as intrusive. Trust?

On initial reading has little to commend it. The bullet points describe a meddling health care. How are the families contacted, or only the sick ones? It describes a doctor replacement. It should be a doctor who decides what expertise.

Thus the initial lay questionnaire was not only useful in informing our understandings of the context for the development at each site but was also useful in a more general way. While the data that we obtained on local perceptions was obviously limited in terms of depth and coverage, this overall method proved feasible and seemed sustainable for follow-up purposes.

On a technical note, the reliability of the semantic differential part of the questionnaire was tested in terms of internal consistency. The resultant alpha coefficient of 0.83 suggested a satisfactory level. Unsurprisingly an exploratory factor analysis on this part of the questionnaire yielded a one factor solution explaining 72% of variance.

The follow up questionnaire that was mailed approximately one year later is presented on the following pages (prefaced by the accompanying letter). The first section was adapted in order to explore the nature of any contacts that respondents might have had with the new FHN service. The other two sections were unchanged apart from the addition of space for explanatory comments below each semantic differential item.
29th November 2002

Dear

You may remember that last year we asked for your views on a new type of nursing role called The Family Health Nurse. During the past year a qualified Family Health Nurse has been working in your area. We are writing to ask if you would be prepared to help again. This would involve completing the attached questionnaire which asks for your thoughts on the development of the role locally. A sheet giving general background information on Family Health Nursing is also attached.

The research is being carried out independently for The Scottish Executive by The Centre for Nurse Practice Research and Development (CeNPRaD), The Robert Gordon University, Aberdeen. If you decide to take part, only our small team of researchers will be aware of this and any information that you share with us will be treated in strict confidence. The questionnaire has a coding number so that there is no need to add your name to it. We obtained your name and address by making a random selection from the electoral roll and you are under no obligation to take part in this research.

We hope, however, that you will choose to do so, as it is important that our evaluation is based on the thoughts and feelings of those who may be affected by this development. Please complete the attached questionnaire and return it by 19th December using the FREEPOST envelope provided. If you have any questions, please do not hesitate to contact us.

Thank you

Yours sincerely

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development
FAMILY HEALTH NURSE QUESTIONNAIRE

SECTION 1

During the past year have you had any contact with your local Family Health Nurse (FHN)? (please tick one box)

yes □  no □  don’t know □

If you answered “yes”, please indicate the nature of this contact. Tick any boxes that apply.

I have received health care/support/advice from the FHN □

Members of my family have received health care/support/advice from the FHN □

I have met the FHN through her involvement with local health activities/community matters □

I know the FHN as a friend/colleague/acquaintance □

Other contact □ (please describe..........................................................................................................................)

SECTION 2

In this section we present opposing pairs of statements. For each pair, please circle a star on the scale which most closely corresponds with your view. An example of how to complete this type of question is now given, using the subject of fuel pricing.

For example if you believed that fuel prices were very unfair, you might complete as below:

<table>
<thead>
<tr>
<th>Fuel pricing is generally fair</th>
<th>Fuel pricing is generally unfair</th>
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<tbody>
<tr>
<td>*    *    *    *    *    *    *</td>
<td>⊗</td>
</tr>
</tbody>
</table>

whereas if you thought that fuel prices just tended towards being fair, you might complete it thus:

<table>
<thead>
<tr>
<th>Fuel pricing is generally fair</th>
<th>Fuel pricing is generally unfair</th>
</tr>
</thead>
<tbody>
<tr>
<td>*    *    ⊗    *    *    *    *</td>
<td></td>
</tr>
</tbody>
</table>

The next four pairs of statements present opposing views of the Family Health Nurse (FHN) development. Based on what you know about the development of family health nursing locally, please circle the most appropriate star between each of the statements. Please also add comments if you wish.

I think the FHN delivers a different type of service to what was previously available

I think the FHN delivers a similar type of service to what was previously available

Comments  

Comments

86
<table>
<thead>
<tr>
<th>I think the FHN development has added on to pre-existing local services</th>
<th>I think the FHN development has taken away from pre-existing local services</th>
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* * * * * * *

Comments _____________________________________________________________________________

<table>
<thead>
<tr>
<th>I think the FHN development is not well suited to our local situation</th>
<th>I think the FHN development is well suited to our local situation</th>
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Comments _____________________________________________________________________________

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<tr>
<th>I think the FHN development will lead to an improvement in local health service</th>
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* * * * * * *

Comments _____________________________________________________________________________

**SECTION 3**

Finally, if you have any thoughts about the FHN development that you would like to share, please write these in the space below.

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

*Thank you very much for taking the time to complete this questionnaire. Please return it using the FREEPOST envelope provided.*
Once again, reminder letters were sent to those who did not respond within three weeks. Response to this second administration of the lay stakeholder questionnaire is detailed in the main report. The overall and useable response rates (39% and 35% respectively) were more disappointing. Again response rates varied quite widely amongst individual sites and tended to be better from FHN sites with numerically small populations.

Data from lay stakeholder follow up was mainly used to inform our site analyses within the main report. On aggregation of the 45 useable responses, the data showed that almost 75% had not had any contact with the FHN during the first year of practice. For the remainder, the nature of contacts with the local FHN were various and often bound up in social activities.

Relatively few respondents felt that the FHN development had actually taken away from service provision (9%) or resulted in deterioration (4%). Only 11% felt that the development was unsuited to local context, but only 16% felt that it was providing a different kind of service. The predominant response, however, was one of uncertainty about what actually had been going on in the past year. Many respondents felt that they just did not know enough about the role, and this was reflected in their explanatory comments. The general comments section again produced some interesting remarks and observations.

The reliability of the semantic differential part of the questionnaire was tested in terms of internal consistency. The resultant alpha coefficient of 0.76 again suggested a satisfactory level. Exploratory factor analysis on this part of the questionnaire again yielded a one factor solution which on this occasion explained 60% of variance.

Overall the administration of the lay questionnaire on consecutive occasions resulted in some useful data. This tended to confirm findings from the professional stakeholder questionnaires, interviews and site visits. Nevertheless our attempts to consult the local public on this development raised a number of broader questions about how this is best done. Without the constraints of time and geography we might have opted for a more in-depth approach where more time was spent with local communities. However this was not a realistic option in this evaluation study.
3.2 FAMILIES

3.2.1 The “Tracer” families

The process of identifying “tracer” families and following their progress occupied a major part of the research team’s time during 2002. The process involved the numerous letters and documents included on the following pages, but also many phone calls and site visits. The process was undertaken in parallel with our ongoing data gathering on the size and nature of FHN, District Nursing and Health Visiting caseloads. It also resulted in the selection of the 6 case study families who were subsequently approached for interview. An overview of the selection of tracer and case study families is presented in Annex 1 of the main report.

The numerous letters and documents included on the following pages are presented as they should provide detailed insight into the nature and scope of this work, if read sequentially. The method of extraction of data from case notes, and the criteria for family selection, are also made manifest within these documents. As such, further explanation seems unnecessary.

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5 The term tracer was used simply to mean that the care of particular families would be traced during the evolution of family health nursing practice. For the most part this involved following their care, but at times the FHN and researchers were involved in some joint projective discussions around whether these families would be likely to require sustained input.
28th March 2002

Dear ******* (FHN)

Thanks for updating me on your progress when I phoned recently. We now want to move further forward with the process of identifying two tracer families whose progress we can follow over the next six to nine months.

In order to do this we would like you now to complete the attached forms for 4 families with whom you think you will have some sustained contact over the next six months or so. From our telephone conversations with the FHN pioneer group we know that it is proving difficult for some of you to identify such families, so please be assured of the following:

- we are not looking for “perfect” families or “perfect” family health nursing
- rather, we are interested in the typical nursing that you are doing and that you anticipate doing i.e. the reality of the role for yourself and the families that you have on your caseload
- this is likely to include both strengths and weaknesses from the nursing point of view
- we understand that circumstances for families may change during the next six months and that anticipated involvement may not be sustained for a number of reasons

As such, we would like you to select four families whose circumstances and health needs/problems reflect the range on your existing/developing caseload. This can include families of any description or dynamic (e.g. ranging from large families with more complex dynamics to individuals living alone). Across the four families it would be good to include a mix of anticipated health needs or existing health problems. It is not necessary that you should have done a Family Health Nursing assessment on these families:- only that you have, or anticipate having, some involvement with them. Finally, we would ask that you include no more than one family that you worked with as an FHN student.
The idea of having a pool of four potential tracer families is that it will give us a basis for further discussion and selection. With your help we will then invite the individuals within the two selected families to take part. This would involve you letting the family know that we will be sending a letter to all individuals aged 12 years or over seeking their consent (children under 12 will only be included with consent from parents/guardians). Their participation will involve granting us access to their health care records as appropriate and occasional phone calls from ourselves to follow their progress. For a few families participation will involve personal interviews (as part of the more in-depth case studies we will conduct with a total of six families across the whole project).

We will only be able to follow the progress of consenting individuals within any family. This is another good reason to have an initial pool of four potential tracer families at each site (ie. selected families may refuse to participate).

Your own ongoing role in assisting us to follow the progress of the tracer families will mostly involve phone calls from ourselves, but also facilitating access to health care records (and occasionally to the families themselves) when we visit each site.

We hope that this letter is helpful in explaining what we are looking for, but please contact either of us if you have any questions or require further discussion. Please complete the attached forms as soon as you can. After we receive them we will be in touch to refine the selection process further.

Looking forward to getting out on the road again! Many thanks.

kind regards

Colin and Bernice
<table>
<thead>
<tr>
<th>Family member (initials)</th>
<th>Age</th>
<th>Sex m/f</th>
<th>Role relationship within family (eg. son)</th>
<th>How often seen at present</th>
<th>Main health need/problem (if any)</th>
<th>Related nursing activity</th>
<th>Other professionals involved</th>
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*Please put a “1” beside the initials of the family member whom you anticipate will require most input from yourself*

*Please put a “2” beside the initials of the family member who would be the key contact person for this family*

Please briefly describe any involvement that you have had with this family so far

____________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________

Please indicate what caseload (if any) this family was on before you became involved *(tick appropriate box)*

District nursing [ ]  Health Visiting [ ]  Other [ ] *(please specify)*

Comments

_________________________________________________________________________________________________________________________

Please indicate why you think following this family’s progress could be valuable

_________________________________________________________________________________________________________________________

Please indicate any difficulties that might be anticipated in following this family’s progress

_________________________________________________________________________________________________________________________
5th June 2002

Dear ******** (FHN)

Finally (!) we have compiled a list of the families that we would like to follow as “tracer families”. By the time you read this I will hopefully have spoken with you to get the full contact details for all the members of the 2 families selected from your area.

However before we send out letters to these individuals, we would ask for your help in 2 ways:

(i) by reading the enclosed material. This is what will be sent out to them, so it is important that you know what is in it. This should help you answer some questions that family members might have

(ii) by contacting the 2 families (by phone or in person) to tell them that we shall be sending these letters to all those aged 12 or over. Hopefully this should help prepare the way and you might be able to alleviate natural anxieties that arise at the prospect of contact from researchers!

However if you can’t answer particular questions please get in touch and we will try to do so: either by discussion with yourself or by us contacting them directly. In this regard it is worth noting that in most cases we will only be accessing community nursing notes. However we need to keep open the option of gaining access to medical notes, should this be appropriate. In a few cases a more specialist consent form will be required (eg. where the patient cannot sign due to physical infirmity or intellectual difficulties of understanding). However I will hopefully have discussed this already with you if there is an individual amongst your families who might need this sort of form).

Please get in touch if you have any questions. Thanks again for your help with this.

kind regards

Colin and Bernice

PS. Did anyone try eating their porage (porridge??) from the glass bowl?!!
6th June 2002

Mr Name
Address

Dear Mr

As you may be aware, ******** has recently started working as a Family Health Nurse in ********. Family Health Nursing is a new role and we are keen to find out if it is of value in meeting the needs of people living in********. For this reason we are writing to ask if you would be prepared to help with our research.

We would be grateful if you could read the attached information sheet which gives details of what would be involved. If you have any questions, please don’t hesitate to get in touch with us. **Will you please return either the blue or the green reply slip as appropriate by 21st June 2002.** A FREEPOST envelope is enclosed so there is no need to use a stamp. Many thanks.

Yours sincerely

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development
Information sheet about research into the new Family Health Nurse role

Family Health Nursing is currently being developed in the Highlands and Islands of Scotland. The main aim of Family Health nurses is to work with local families to identify the aspects of health that individual family members see as important, and then work with them towards improvements. This may involve help with illness and disability; early detection of problems; or advising on lifestyle and risk factors. It may also involve helping to co-ordinate health services and making referrals.

In order to find out how well this new role works in practice, our small team of nursing researchers from The Robert Gordon University, Aberdeen would like to follow the progress of individuals who have involvement with these nurses. For this reason we may also be writing to other members of your family to ask if they would be willing to take part in this research. This sheet is designed to give you information about what would be involved should you be willing to take part.

Our main aim is to find out how your health needs are being met by local services. In order to do this we would like to speak to you on the telephone at least once during the next six months. In addition, with your permission, we would like to be able to look at your health care records and those of any children you may have who are aged under 12 years. This will allow us to follow your progress through these documents. Finally, during Autumn 2002 we may ask to interview you about your recent experiences of health and health services. This would involve one of our researchers visiting you at home. The interview would be tape recorded and we would also ask you to complete a short questionnaire about your opinion of the Family Health Nursing service.

All information that you share with us will be treated in strict confidence by our team, all of whom are experienced nurses and researchers. Although your local GP and Family Health Nurse will be informed if you are taking part in our research, they will not have access to information that you share with us. The tape recordings of interviews will be destroyed after analysis and we will take all steps to ensure that no individual patient or family member is identified in written reports on the project. You are under no obligation to take part in the research. Should you decide to take part you may withdraw at any time without jeopardy to your treatment.

If you decide to participate we estimate that your involvement would not exceed 3 hours in total over the next six months. In most cases this is likely to be substantially less. Should you have any questions, or wish to discuss any particular points, please do not hesitate to contact us.
The research is being carried out in co-operation with local health service staff and is funded by The Scottish Executive. We hope that you will be willing to help in this research as it will help to inform the future development of health services. As such, we would be very grateful if you could return either the blue or the green reply slip as appropriate by 21st June 2002 using the FREEPOST envelope (no stamp required). Thank you for taking the time to read this.

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development
CONSENT FORM

Title of Project: An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

Name of Researchers: Dr Bernice West, The Robert Gordon University
Colin Macduff, The Robert Gordon University

please tick box

1. I confirm that I have read and understand the information sheet for the above study, and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected

3. I understand that sections of any of my health care notes may be looked at by responsible individuals from The Centre for Nurse Practice Research and Development, The Robert Gordon University, Aberdeen, where it is relevant to my taking part in research. I give permission for these individuals to have access to my records

4. I agree to take part in the above study

Name (in capitals) ...........................................................................
Signed............................................................................................
Date........................................
Address.........................................................................................................................................

(If applicable)
As the legal parent/guardian of ..........................................................
..........................................................
..........................................................

(please insert names of children under 12),
I give the researchers permission to access the health records of the above named.

Signed..............................................................................................................

Date........................................

__________________________________
Title of Project: An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

Name of Researchers: Dr Bernice West, The Robert Gordon University
                   Colin Macduff, The Robert Gordon University

I do not wish to take part in the above study

Name (in capitals) .................................................................
Signed......................................................................................
Date..............................................................
Address....................................................................................
CONSENT FORM (to be used where consent is being given on behalf of another due to the other’s physical infirmity, or intellectual/cultural difficulties in understanding)

Title of Project: An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

Name of Researcher: Dr Bernice West, The Robert Gordon University

Please read the following two statements and complete the one which applies.

1. As the next of kin/legal guardian/advocate* (please delete as necessary) of ........................................................................................................................................(insert name)
   I confirm that I have explained to him/her what would be involved in taking part in this research study. He/she understands that the researchers will access his/her health records and may ask to talk to him/her about health and health services. I am satisfied that he/she is willing to take part.

   Name (in capitals) ........................................................................................................................................
   Signed........................................................................................................................................
   Date........................................
   Address........................................................................................................................................

   Name of witness (in capitals) ........................................................................................................................................
   Signature of witness........................................................................................................................................
   Date........................................
   Address........................................................................................................................................

2. As the next of kin/legal guardian/advocate* (please delete as necessary) of ........................................................................................................................................(insert name)
   I confirm that he/she is unable to give informed consent to take part in this research study. On his/her behalf, I agree that the research team can have access to his/her health records.

   Name (in capitals) ........................................................................................................................................
   Signed........................................................................................................................................
   Date........................................
   Address........................................................................................................................................
Dear Dr. ******(GP)

I am writing to inform you that the patients on the attached list have agreed to take part in our research evaluating the role of the Family Health Nurse. The attached information sheet describes the nature of patient participation in the study.

As you will see this involves granting our study team access to relevant health care records. We anticipate that this will mainly involve community nursing and health visiting records. However it is possible that in the next six months we will contact you again in regard to the possibility of accessing medical records. As such, please find enclosed a copy of the appropriate consent forms.

Approval for the study has been granted by the respective Research Ethics Committees within Highland, Western Isles and Orkney. However, if you have any questions about the research, please do not hesitate to contact us.

Yours sincerely

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development
FHN TRACER FAMILY DATA:
Form for researcher’s abstraction and analysis of nursing case note documentation

FHN site:

Name of family:

Key contact family member:

Family member receiving most input:

Composition of family (eg. single person; 2 generations and 2 families etc)

Distribution of presenting needs/problems within family (eg. single person problem; multiple problems for several family members etc)

Frequency of FHN visiting

Involvements on other professionals’ caseloads (eg. on existing caseload of d/n; h/v; m/w; new to area etc.)

Nature of initial referral to FHN ie. Origin (eg. inherited from previous caseload; active referral by h/v etc)

Nature of current dominant need in family (eg. Chronic; acute)

Dominant domain for intervention (eg. environmental and community; physiological etc)
PRIMARY ABRACTION FROM DOCUMENTATION

1) Describe format of notes for each family member

IF “TRADITIONAL NOTES”,
(i) Summarise the story told for index family member

(ii) Summarise the story told for other family members

(iii) Summarise the story told re involvement of other professionals

(iv) Summarise the story told re relationship to wider community
IF FHN NOTES

(v) Summarise the story told for index family member

(vi) Summarise the story told for other family members

(vii) Summarise the story told re involvement of other professionals

(viii) Summarise the story told re relationship to wider community
ANALYSIS OF DOCUMENTATION
Prompts: consider both the forms themselves and the way they have been filled in; Also, before and after comparisons; ethics; legal; research base etc.

(i) Nature and scope of assessment (eg. model; emphasis; breadth and depth)

(ii) How is assessment acted on? (eg. action plan; goals; interventions; outcomes; evaluations etc)

(iii) Quality and quantity of evidence in relation to other family members and to any health focus

(iv) Quality and quantity of evidence in relation to involvement with other health professionals

(v) Overall strengths of documentation (eg. omissions)

(vi) Overall weaknesses of documentation (eg. serious omissions)
FINAL CONSIDERATIONS

(i) Who uses the notes and where kept normally?

(ii) Who appears to be the other key professional (if any) involved with this family?

(iii) Are there any sensitivities that might be anticipated in following up this family in greater depth?

(iv) Phone number for key contact family member
12th September 2002

Dear ***** (FHN)

Thanks for your recent help in regard to a) completing the questionnaire on competencies, and b) getting tracer family notes to us so that we could abstract data. The latter process is now almost complete and by the end of the month we hope to have selected six families for more in-depth study.

To make this possible we need you to complete the final part of the tracer jigsaw: ie. the attached questionnaire! Not only that, but we would ask you to complete and return it as soon as possible and by Monday 23rd Sept at the latest. You may find some of the questions quite challenging, but it is important that we get your own thoughts and judgements about how work has progressed with these particular families. Your responses will be an important factor influencing the selection of six families for more in-depth study (alongside other data that we have collected and our own perceptions of potential to learn from particular cases).

We will be in touch again soon if one of your families is selected for more in-depth study. Obviously this will involve a visit from one of us, and we would be aiming to interview family members and another key professional (as well as yourself!). If one of your families is not selected, please be assured that it is not a reflection on the perceived quality of your work. We are hoping to learn from a range of cases with different characteristics, rather than to pick the six “best” family health nursed cases. Moreover the focus on these particular families is balanced by the bigger picture of casework at each site which has been built up during this year.

Kind regards

Colin and Bernice
FHN EVALUATION OF WORK WITH TRACER FAMILIES

Family:

1) To what extent have you used family health nursing knowledge and skills in working with this family? (please tick appropriate box)

- [ ] very extensively
- [ ] extensively
- [ ] a fair amount
- [ ] a little
- [ ] not at all

Please indicate the main fhn knowledge/skills that you used

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

2) In what ways, if any, has your involvement with this family differed from other possible community nursing service approaches? (eg. from district nursing and/or health visiting)

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

3) Other than yourself, who do you consider to be the health/social care professional who has had most involvement recently with this family? (eg. other nurse, GP, social worker, midwife etc). Please give name and contact details below

______________________________________________________________________________________
______________________________________________________________________________________

4) What factors have enabled your own involvement with this family?

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

5) What factors have hindered your own involvement with this family?

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
6) Thinking critically of the impact of the family health nursing approach so far within the family, please briefly describe the nature of any benefits and disadvantages for individual family members.

<table>
<thead>
<tr>
<th>Family member’s name</th>
<th>Benefits</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

7) How would you rate the overall success of the family health nursing approach so far in addressing the needs of this family?

<table>
<thead>
<tr>
<th>very successful</th>
<th>mostly successful</th>
<th>uncertain</th>
<th>mostly unsuccessful</th>
<th>very unsuccessful</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Any other comments
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

8) Finally, do you think in-depth study of this family’s experience of the family health nursing approach could be valuable? (and if so, why?)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Thank you very much for completing this questionnaire. Please return it in FREEPOST envelope.
Overall, these processes for identifying and following the progress of tracer families worked well. However our processes had to adapt somewhat to the rate of progress of the development of practice itself. During the first six months of 2002 most of the new FHNs felt that their progress with family work was slow and accordingly several felt that it was difficult to suggest suitable tracer families. In this regard reassurance was needed that we were interested primarily in their typical daily work rather than only their “best” family cases.

The details of the 4 families obtained from each of the 10 sites were mapped on to a giant matrix sheet. This presented a summary of their details in relation to the seven key parameters listed in Annex 1 of the main report. In this way the distribution pattern of typical and non-typical cases could be readily visualised. Our goal was to select 20 tracer families from this (2 per site) so that an optimum permutation of typical and non-typical cases could be achieved. This would ensure coverage of the sort of families and health/illness needs that the FHNs were dealing with most frequently. However it would ensure that we could also follow the progress of families with more unusual circumstances and/or needs (e.g. large, compound families where some of the children have come into the family through one, or both, parents previous relationship/s).

As mentioned in Annex 1 of the main report, following our invitations to take part, 42 individuals accepted (79%). This figure includes five persons aged between 12 and 18 who gave their own consent. The figure does not include a further ten children aged under 12 for whom consent had been given by their parent/guardian. One adult also gave consent on behalf of another adult due to the other’s physical infirmity and intellectual difficulty in understanding.

Eleven people (21%) refused to take part. This figure included an eleven year old and a thirteen year old. Where a person refused to take part we did not seek a reason. However it was interesting that 7 of the 11 refusals were from individuals who had contact with one particular FHN.

Where one family member refused to take part and the remainder consented, we made a judgement about the wisdom of continuing to follow that family’s progress. This was influenced by such factors as whether the member who had refused was a key contact of the FHNs and/or was in receipt of direct care. If the latter factors were the case we would not proceed. However if the member who refused was essentially on the periphery of FHN contact and input with the family, we sometimes decided to continue to follow the progress of the other members on the explicit understanding that no data would be sought in relation to the member who had refused. Where more than one member of the family refused to participate we would not follow the family’s progress.

Where we could not follow the progress of one, or even both, of the selected families at a particular site due to refusal, we looked amongst the four initially suggested for another family whose characteristics would fit into the desired overall matrix of 20. If the family seemed to fit, we then approached the individual members with a view to their participation. If none of the remaining families seemed to fit with the desired overall matrix we then asked the site’s FHN for details of one or two other families whom we might consider. The latter process was also sometimes necessary when the circumstances of participating tracer families changed (e.g. when they moved from the area).

The detailed considerations described above are all very much part of the nature of research where the family is the main “unit of analysis”, but the rights of the individuals within it are paramount. This tension for the researchers mirrors a similar tension faced by the clinicians.

This did not necessarily reflect on the approach of the particular FHN, who in fact became quite embarrassed after a series of patients from different families refused. Interestingly she felt that one of the reasons that they refused was that there was a general feeling in the area that the pre-existing services were satisfactory and they didn’t want to take part in anything (i.e. the research) that might be seen to threaten this in any way.
3.2.2 The Case Studies

Annex 1 in the main report also summarises the process involved in gathering data on the twenty tracer families in order to facilitate the subsequent selection of six families for more in-depth case study. The selection process involved detailed consideration and discussion of a number of factors. The overall goal was to select the six cases that seemed to offer most potential insight and learning in relation to the nature and range of FHN work.

The latter phrase requires further explanation. The initial mapping of 40 families onto a giant matrix sheet, and the subsequent selection of 20 tracer families, had given ostensibly equal weighting to seven key parameters (i.e. composition of family; distribution of presenting needs/problems within family; frequency of FHN visiting; involvement/s on other health care professional caseload/s; nature of initial referral to FHN; nature of current dominant need in family; dominant domain for intervention). This ensured range of coverage. In following the progress of the 20 tracer families it became clear that some of these parameters would, and should, be more important than others in influencing our consideration of which six family cases to study in more depth. For example the frequency of FHN visiting varied fairly widely over the 20 tracer families and seemed, in itself, relatively less important. In contrast, the distribution of presenting needs/problems within each family seemed more important as a basis for in-depth study of how the FHNs were tackling their new role.

In effect our considerations were guided by re-focusing on what the FHN role was trying to achieve (i.e. in the Scottish Executive's interpretation: to be a skilled generalist; to use a model based on health rather than illness; to care for families rather than just the individuals within them; and to act as first point of contact). This led us to further mapping of all twenty cases in relation to the following parameters: Primary/secondary/tertiary intervention; perceived extent and success of FHN skills used so far; composition of family; distribution of presenting needs/problems within family; region; involvement/s on other health care professional caseload/s.

Moreover, during our fieldwork, we had also generated a number of related questions that it seemed might be fruitfully addressed through more in-depth study. Many of these were in a simple what happens? format (e.g. what happens when an FHN consciously expands from the care of an individual who was already on the D/N caseload to addressing the needs of all family members?; what happens when an FHN offers care to a family who have had minimal/no previous contact with local primary care services?; what difference, if any, does the FHN approach bring to the care of patients with chronic illness who are visited daily?). However they also seemed to predispose to the investigation of a number of underlying why? questions if further explored through case selection and interviews.

During the process of this further mapping, we were informed that one of the twenty families was no longer able to take part in the research. Thus we were left to select using mapped data on 19 families. We set about the selection process by systematically interrogating our data using each of the parameters in turn. Thus we asked which six cases would give best insight into FHN work with: families of different compositional types; families with differing distributions of presenting needs/problems; families who had involvement with other health and social care professionals and those who didn’t. This process was also informed by the type of fieldwork questions mentioned above.
We also interrogated our data by using the other three more recently generated parameters. In this way we asked which six cases would give best insight into: the range of primary/secondary and tertiary interventions; the varying extent of FHN skills used; the range of success achieved, as perceived by the FHNs themselves\(^7\).

The outcome of this process of interrogation can be likened to overlaying the original matrix with successive sheets of tracing paper on which the six “best” cases for each parameter have been sequentially marked. In this way it was soon evident and clear that a particular set of six families offered the best potential for more in-depth case study using in-person interview methods.

Summary details of the six families selected are given in Annex 1 of the main report. Our approach to arranging interviews with these families, their FHNs, and one or more key professionals also involved in their care, was influenced by our previous experiences of piloting the case study methods.

The piloting took place in Spring 2002 in one of the regions involved in the study. In 2001 two FHN students from this region had carried out their practice placements in areas to which they would not subsequently be returning. As such this meant that there were several families who had been involved relatively briefly with FHN students, but who would not be receiving continuing care from a qualified FHN. Through the former FHN students we approached two of these families (one elderly couple with chronic illness problems; one more “complex” family with five young children\(^8\), one of whom had previous health problems).

This offered potential opportunity to test our approach to families; consent procedures; access arrangements; interview formats, schedules and recording; the consultation questionnaire; and our methods of analysis.

In this way we piloted the consent forms that were subsequently used with the tracer families. On this occasion both individuals in the elderly family declined the offer to participate. We did not seek a reason, but the FHN who had been involved thought that they were both very much preoccupied with coping with their respective health problems and that interviews might be seen as too onerous.

Within the other family, both of the parents consented to take part and gave consent on behalf of their three children who were under 12. However, the two children who were over 12 both declined to take part.

While the relatively high rate of declining to participate raised some concerns for us in relation to future conduct of the main case studies, it did affirm that individuals within families could, and would, exercise choice. This was useful experience as it proved that the consent forms worked and it made us think more about how we would address this eventuality through our methods and future working processes.

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\(^7\) In mapping the 19 cases using WHO-derived understandings of primary, secondary and tertiary intervention it was usually difficult to assign a case to one discrete category, as interventions were mixed. Thus 5 family cases were deemed “primary/secondary”, 3 “secondary” and 11 “secondary/tertiary”. Four FHNs reported using their new skills extensively with particular families, 12 reported using them “a fair amount” and 3 “a little”. Two FHNs judged their approach with particular families as “very successful” in meeting needs, 13 judged their approach as “mostly successful” and 4 were “uncertain”. None judged their input “unsuccessful”.

\(^8\) The children of the household comprised those from the parents’ current relationship, those from the father’s previous relationship, and those from the mother’s previous relationship.
In view of restraints of time and access it was decided to pilot our interview methods with the consenting individuals from this one family, and with the other health care professional who had most involvement. The latter individual had been identified by the FHN in response to our questionnaire, which had asked her to evaluate her work as a student with this family (we used the opportunity to test this questionnaire and subsequently made some minor revisions and additions to it). The FHN herself was not at the time able to meet with us for in-person interview due to family commitments so we decided to confine piloting of the FHN interview schedule to a subsequent, informal telephone interview.

We reasoned that our sequence of interviewing should start with the other professional with whom the family had most current involvement. This might forewarn us of any potentially difficult or sensitive issues in regard to the family’s health and health care. This arrangement proved possible and we then arranged, by telephone, to visit the family in their home the following day.

We interviewed the other health professional in her own home too as this was most convenient for her. The semi-structured interview schedule that we piloted aimed to explore: the nature of the health care needs of the individuals who had consented to take part; their contact with health services in general in the past two years, and in particular with community nursing services; the rationale for FHN involvement and its subsequent nature and scope; the impact and outcome of this for these family members; the relationship between FHN involvement and ongoing service provision by other community health and social care professionals. It also aimed to elicit more general reflections on: pre-existing service provision in general; the fit of the FHN role to this framework; future development of the FHN role.

The other health professional involved had accessed the community nursing records of those who had consented. This informed her responses during the initial part of an interview that was conducted jointly by both members of the research team. The process was hindered somewhat by the fact that the interviewee only had sporadic contact with the family (her colleague who had recently left the area had been most involved during the past two years). Moreover the interviewee had little direct knowledge of the FHN student’s involvement with the family and had to rely on the minimal information that was available in the community nursing notes.

Consequently a major part of the interview involved trying to establish what had actually been taking place in terms of health care needs and service involvement. Even with the community nursing notes available, this was not easily accomplished. The latter part of the interview was more productive in that the interviewee was much more able to furnish us with general reflections on local service provision and perceptions of the FHN role.

The interview lasted around 70 minutes and was tape recorded. It was subsequently transcribed in full. The data was analysed firstly by qualitative content analysis involving grouping content in relation to the factors italicised above (i.e. the nature of the health care needs of the individuals who had consented to take part, etc). This framing provided a basis for subsequent thematic analysis. Amongst the themes to emerge were:

- Possible lack of clarity about what the FHN students were doing
- Related lack of clarity about the future role of qualified FHNs
- Health Visitors’ ambivalence about whether their own role should be generalist or specialist
- Good pre-existing relations between DNs and HVs in terms of liaison and role flexibility, especially where very geographically isolated areas involved
- A danger of FHNs over-reaching their limitations
- GPs’ general lack of engagement with the project
Our interview schedule for the family members was designed so as to cover a core of similar factors to those covered in the interview with professionals (and the FHNs themselves). However we were also particularly interested in eliciting perceptions of what the FHN was doing and why she was doing it. In turn we were interested in eliciting comparison between this and the role of any other health and social care staff who had input with family members.

There was also the important and very practical issue of whether to conduct separate interviews with the different family members who had consented (i.e. the male and female partners and the three children under 12), or to interview them all together (or in sub-groups). Astedt-Kurki et al (2001) review some of the methodological issues involved in interviewing families and conclude that the choice of methods is completely dependent on the nature of the particular study.

In the context of our study it was possible to advance arguments for individual or group interviewing. The primary purpose of our interviews would be to explore experiential understandings of the new Family Health Nurse role and this could be valuable from both the individual point of view and from the point of view of the whole family-as-client. The latter perspective was seen as the ultimate goal for the FHN service, but at the time that piloting took place it was not entirely clear to what extent this might be achieved in the reality of practice.

Moreover the pilot interview was somewhat different as we were asking the family members to consider the FHN student’s input to the family. We had also decided that both members of the research team should take part in the interview. Although both members of the research team had extensive experience of conducting individual and group interviews, it seemed a valuable opportunity for each to take the lead with different parts of the schedule so that we could share feedback and reflections afterwards.

After much consideration we decided that it might be useful to try to interview the two adults individually (i.e. sequentially) if this was possible. The male partner had said that he would be available if work commitments permitted, and it seemed an opportunity to explore his own perspective on health services and FHN input. Astedt-Kurki et al (2001) cite Backett who states that “too often the views of men and husbands have been ignored, inferred, or developed from women’s accounts”, and this is a deficiency that has also been noted in relation to health visiting practice with families (Baggeley and Kean 1999).

Moreover we wanted to explore whether it would be feasible to involve the three youngest children in some discussion of health and recent contacts with health care workers. We decided to be flexible in our approach and to explore when and how this might be best achieved in situ.

Neither of the research team had any substantive experience of conducting research interviews with young children, but there was a shared awareness of many potential difficulties (e.g. being seen as strangers; winning their confidence even at a basic level; the logistics of orchestrating a non-threatening interaction).

On arrival in this busy household we were received warmly. After some general social conversation we took the opportunity to recap on the aims of our visit and to check whether they were happy with this. Although the main living room was obviously the hub of the household the adults thought it would be feasible for us to interview them sequentially in this room, and possibly to involve two of the children later on.

Our interview with the male adult was very interesting and gave us food for thought. He had no particular health concerns of his own, but was able to say a little about the health visiting services that the family had been in receipt of in the past few years. Again he’d had no personal involvement in terms of consulting the HV about his own health needs, but he felt it was useful that the HV would actually come out to the house to see the children. When asked why the HV might be doing this he supposed that it was to do with checking up to see that the children were
being looked after. When this theme was further explored he said that he felt this was ok and that they had nothing to hide, but he did know some people who wouldn’t like someone coming in and asking questions.

He hadn’t seen much of the FHN student, but couldn’t distinguish her role from that of the Health Visitor. He did feel, however, that the idea of a nurse who would look after the whole family was a good one, so that they could keep an eye on things and save bothering a doctor.

Throughout the interview there was a sense of the interviewee’s good-natured bemusement as to why we might be trying to tease out so much about this new nursing role. He felt that it was basically a good idea but there wasn’t much more he could say about it. As interviewers we were both conscious of the disparity between our in-depth probing and his benevolent humouring of us. After 10-15 minutes we mutually agreed, with some amusement, that there was no more to say and he went to bring through his female partner.

This interview was conducted with the mother cuddling the youngest child who was generally placid and quiet throughout. This interviewee was much more voluble and it became clear that she had been at the centre of all recent contacts from primary care professionals. She had received a great deal of help from the health visiting service in supporting her to care for the child who had experienced serious health problems in the past. Interestingly she felt that she could not always burden her own family with her worries, and the HV had been a great source of support in listening to her and suggesting practical ways of coping. The HV had always given her time and had formed a close and fruitful relationship with the children.

This detailed narrative was accompanied by a quiet conviction that gave it a heartfelt quality. Perhaps unsurprisingly, she was able to clearly distinguish this HV input from the more recent input of the student FHN. She had been happy to help the student FHN to learn through involvement with her family, and was able to recall some of the detailed assessment processes involved (e.g. “she does sheets of family members with different things and lifestyle of each of the family members and personalities and different things”). The genogram was also alluded to and she was able to recall some specific advice from the FHN that she had tried to act on. She understood the FHN student to have more time with the whole family as a unit, but that the student would go to the HV supervisor if there was a problem that she needed help with.

She felt the FHN was a good idea and that this type of nurse might be flexible and have more time. She felt that the HV might usually focus more on one subject and on routine assessment checks on the children. However she also felt that the HV had always given her time and been available when she needed her.

Following some more general reflections on local health services, and her relatives’ predominantly positive experiences of these, we concluded the interview. The duration was around 40 minutes and the interviewee had needed little prompting to answer questions fully.

By this time the two older children had joined us and the mother suggested that they talk with us alone for a short time. However they were rather shy and reluctant to talk without their Mum there and it became clear that it would be better not to push on this. As so often happens once the tape recorder is switched off and once the “formal” interview is over, there was some interesting discussion which covered a mix of topics. The mother outlined a little about the contact that the children had with the FHN and this encouraged a little disclosure from them. She also volunteered that she had helped the FHN student with her OSCE exam and had been very concerned to “do the right thing for her”.

Prior to leaving we explained the nature of the Consultation Satisfaction questionnaire (Poulton 1996) that we wanted each of the two adults to separately complete. We felt that it might be useful for them to be able to reflect and complete this in their own time before sending it to us.
This detailed recounting of one pilot situation has been undertaken in order to give the reader insight into some of the issues encountered in trying to conduct interviews in a family household. Moreover our learning was not confined to that immediate situation, as it later became clear that sections of the tape recording were unable to be completely transcribed due to a combination of factors (high ambient background noise; softly spoken interviewees; dialect; poor positioning of recording equipment). Accordingly a more restricted analysis was undertaken and was this informed by notes we had taken in a debriefing session following the interview. The process of sharing impressions and reflections was vital in helping us develop mutual understandings that in turn would inform our future approach to the case study interviews.

In effect the pilot interviews with this family had demonstrated that it would be important to try to achieve as much mutual understanding by phone prior to meeting in person (e.g. in regard to the practicalities of what might be possible). However it especially underlined the need to respond flexibly to the situation encountered. In this regard we reasoned that it might be best in future to give family members the choice as to whether they would prefer to be interviewed sequentially or together. The former option seemed to demand more of the family in terms of time commitment and orchestration.

We later received the two completed Consultation Satisfaction questionnaires. The “tick box” replies to the eighteen statements were consistent in nature with the perceptions expressed at interview, and were also internally consistent (this particular questionnaire often asks the same question in a number of different ways; please see the following section). Neither of the respondents had used the space below each item to expand on their answers through comments, but perhaps they felt that they had already done so at interview.

Prior to selecting this questionnaire for use we had looked at a number of other patient satisfaction instruments. While the conceptualisation and measurement of patient satisfaction is associated with a number of well documented difficulties (Fitzpatrick 1983), we thought it might be useful to supplement our much more wide-ranging interviews with a questionnaire focusing specifically on satisfaction with interactions with the FHN.

The Consultation Satisfaction Questionnaire was originally developed and used with General Practitioners, but Poulton (1996) adapted it for concurrent use with community nurses. As such it seemed generally well suited to our purpose, although several statements required the respondent to delete text so as to distinguish between individual and family consultations (i.e. they required careful reading by the respondent). The only adaptations that we made to Poulton’s version were to replace the “doctor/nurse/health visitor” options with “Family Health Nurse”, and to add space for comments below each statement. Permission to use the questionnaire was obtained.

After the pilot interviewing in Spring 2002, we selected the tracer families and followed their progress for approximately six months. Through this process we became aware of more issues and questions, some of which were “general” and would be of relevance to the interview questioning across all six family case studies (e.g. do the family member/s have a copy of the genogram and/or ecomap in the house?) while others were related to very specific circumstances within one particular family case (e.g. what happens when there are very many health and social care services involved simultaneously with a family receiving family health nursing?). Accordingly our interview schedules for the family, FHN, and other professional(s) evolved so that there was a core set of questions that were common across all the cases and also some very specific questions that had been generated through prior reflection on a particular case. This is evident in the schedules presented on the following pages. The interview schedules are prefaced by an example of the letter of invitation that was sent to the other relevant professional(s). Invitations to family members and the FHNs themselves were usually made by telephone. The Consultation Satisfaction Questionnaire was left with participating family members at the end of the interview, unless they preferred our help in completing it.
5th November 2002

Dear *********** (other health care professional with substantial direct involvement)

As you are aware, Family Health Nursing is currently being developed as part of a pilot project in the Highlands and Islands of Scotland. In order to find out how well this new role works in practice, our small team of nursing researchers would like to get the views of other health and social care professionals who have involvement with specific families.

As such, we are writing to ask if you might be prepared to take part in a short interview focusing mostly on the care of Mrs *************************

The interview would take place at a place and time convenient for you, and would typically last around 20-30 minutes. Where it is not possible to meet in person we can arrange an interview by telephone. We would hope to cover the following areas:

1) The nature of your own work with this family
2) The Family Health Nurse’s input with this family
3) Any impact on your own role and/or that of other colleagues
4) Reflections on the Family Health Nurse role in general

All information that you share with us will be treated in strict confidence. The interview would be tape recorded and the tape will be destroyed after analysis. We will take all steps to ensure that no individual patient, family member, or health care professional is identified in any subsequent written reports. The research study has been approved by the Research Ethics Committee within your region and we enclose copies of relevant consent forms completed by the family members taking part in the study. Please also find enclosed a sheet giving more information on the Family Health Nurse pilot and its evaluation.

Please complete the attached form indicating whether you would be willing to participate and, if so, what dates might be suitable to you. A FREEPOST envelope is included for your reply.

Many thanks.

Yours sincerely

Dr Bernice JM West, Director, Centre for Nurse Practice Research and Development

Colin Macduff, Research Fellow, Centre for Nurse Practice Research and Development
An evaluation of the operation and impact of the Family Health Nurse pilot in Scotland

Please tick as appropriate

I am willing to take part in a short interview as part of the above study

I do not wish to take part in an interview as part of the above study

Name .................................................................

If willing to participate, please circle any dates that would be suitable for you, giving an indication of suitable times of the day in the space below

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INTERVIEW SCHEDULE FOR OTHER CARE PROFESSIONALS INVOLVED IN THE FAMILY’S CARE

CORE QUESTIONS

Thinking of the specific family,

Can you tell me more about the contact/s you have had with the .......... family during the past year? (elicit which members of family involved; nature and frequency; when last seen)

How have these contacts come about? (initiated by self/family or other health care professional? If the latter, who?)

Can you tell me a bit more about what went on/what happened then and the outcome/s?

Thinking of what you know about the FHN’s contacts with this family,

What do you think the FHN was/is doing? What are they trying to achieve? (communication with other team members; use of nursing notes; shared goals?)

Is this similar to their previous ways of working or is it different? (in what way?)

Do you feel that the FHN’s work has been successful so far? (strengths and weaknesses)

Thinking about your own role and the work of your colleagues

Has the FHN’s involvement with this patient/family had any impact on your own role/working practices or those of colleagues? (if so, what, how, why?)

How do feel this role fits in with current local service provision (similar or different?)

Who do you think this family/this particular family member would contact first if they had a health problem?

Thinking about this new role in general,

What do you understand by the term Family Health Nurse?

Is it useful? Acceptable to patients?

What do you think about the emphasis on family?

What do you think about the emphasis on health?

CASE SPECIFIC QUESTIONS

A few examples:

1) If she’d been brought back in a supernumerary capacity would you have seen the need?
2) Is there still concern about a possible two-tier service at this site?
3) When you made the referral, what FHN input did you think was needed? How did you make the referral (formal or verbal)?
INTERVIEW SCHEDULE FOR PATIENTS/OTHER FAMILY MEMBERS

CORE QUESTIONS

Yourself and your family

Can you tell me about your own health during the past year?

Can you tell me about any contact/s with health care/social care services in this period (who initiated contact; what happened? how did you feel about the help you received? outcome for yourself and/or other family members?)

Can you tell me about the health of other (consenting) family members during the past year?

Can you tell me about their contact/s with health care/social care services in this period (who initiated contact; what happened? how did you feel about the help you received? outcome for yourself and/or other family members?)

Contacts with the FHN specifically

Can you tell me more specifically about contacts with the Family Health Nurse (what did they do with you and/or others in the family? why were they doing this? what did you think of it? what did you think of genogram/ecomap? what did it mean to you? copy of any records in the house? do you use them?)

Was there any plan, or any goals, that you or the FHN spoke about?

What progress has been made?

How do you feel about the help you received? (useful? acceptable or delving too deep?)

Relationship to other services

Is the FHN service similar to previous contact you have had with any health care staff locally, or is it different? (in what way?)

Have you noticed any particular change in local health services? (if so, what?)

If you have a health problem in the future, who would you contact first?

Thinking about this new role

What do you understand by the term Family Health Nurse/ What does it mean to you?

Is it a useful title?

CASE SPECIFIC QUESTIONS

A few examples:

1) Do you have any contact with the FHN that doesn’t involve her visiting you here at home?

2) You have a number of different people providing services to you: do you feel that there is any duplication?
INTERVIEW SCHEDULE FOR THE FHN INVOLVED IN THE FAMILY’S CARE

CORE QUESTIONS

Your contacts with this family

Can you tell me a bit more about the nature of the contacts you have had with family members? (initial contact/s; establishing relationships)

What have you been trying to achieve with this family? (plan; goals?)

Why? What work has this involved?

Is this similar to your previous ways of working or is it different? (in what way?)

Are there any features of the Family Health Nursing model that have proved particularly helpful or unhelpful in this case? (in what way; why?)

To what extent do you feel the nursing case notes reflect the input you have had with this family?

What do you think the impact has been for the family members with whom you have had contact?

In the context of your overall caseload, what makes this particular family a “family health” case?

Relationship to other services

Does your input differ from pre-existing community nursing services at this site? (in what way?)

Has your involvement with this patient/family affected the role/working practices of other colleagues? (if so, who, what, how, why?)

How does this new role fit within the framework of primary care service provision at this site?

Do you think you are the first point of contact for the members of this family?

General reflections

If you could change one thing about your current role, what would it be?

Which is more important in your FHN work- the focus on family or the focus on health? (ie. if you had to choose one what would it be?)

CASE SPECIFIC QUESTIONS

A few examples:

1) How does your role as midwife for this family fit with your role as FHN?

2) How many “family health cases” like this could feasibly be dealt with by one FHN?

3) Would you see yourself doing these child development checks alone and unsupervised in the future?

4) Is your input with Mrs.…… primary, secondary or tertiary in nature?
The following statements explore your satisfaction in regard to contacts with the Family Health Nurse. Please delete any of the words in italics that may not apply in your case, then put a tick in one box for each statement. There is space beneath each statement should you wish to add any comments.

<table>
<thead>
<tr>
<th>Statement</th>
<th>strongly agree</th>
<th>agree</th>
<th>neither agree nor disagree</th>
<th>disagree</th>
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<tbody>
<tr>
<td>1. I am totally satisfied with my visits to/from the Family Health Nurse</td>
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<td>2. The Family Health Nurse was very careful to check everything when examining me/carrying out my care/discussing my family's health</td>
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<td>3. I will follow the Family Health Nurse's advice because I think he/she is absolutely right</td>
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<td>4. I felt able to tell the Family Health Nurse about very personal things</td>
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<td>5. The time I was able to spend with the the Family Health Nurse was a bit too short</td>
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<td>6. The Family Health Nurse told me everything about my treatment/care/explained the reasons for advice given</td>
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<td>7. Some things about the consultations with the Family Health Nurse could have been better</td>
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<td>8. There are some things the Family Health Nurse does not know about me</td>
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<td>9. The Family Health Nurse listened very carefully to what I had to say</td>
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<td>10. I thought the Family Health Nurse took notice of me as a person</td>
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128
11. The time I was able to spend with the Family Health Nurse was not long enough to deal with everything I wanted

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<th>strongly agree</th>
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Comments

12. I understand *my illness/about my family's health* much better after seeing the Family Health Nurse

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<th>disagree</th>
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Comments

13. The Family Health Nurse was *interested in me as a person not just my illness/interested in the health of my whole family*

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<th>disagree</th>
<th>strongly disagree</th>
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Comments

14. The Family Health Nurse knows all about me

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<th>neither agree nor disagree</th>
<th>disagree</th>
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Comments

15. I felt the Family Health Nurse really knew what I was thinking

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<th>agree</th>
<th>neither agree nor disagree</th>
<th>disagree</th>
<th>strongly disagree</th>
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Comments
16. I wish it had been possible to spend a little longer with the Family Health Nurse

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Comments

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17. I am not completely satisfied with my visits to/from the Family Health Nurse

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Comments

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18. I would find it difficult to tell the Family Health Nurse about some private things

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Comments

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Thank you very much for taking the time to complete this questionnaire. Please return it now using the FREEPOST envelope.
The practical arrangements for the case study interviews generally worked out well, but the need to fit around family commitments and professional schedules was always a prominent consideration. One member of the research team carried out all the interviews. The sequencing of the interviews at each of the six FHN sites tended to be determined by transport logistics and availability rather than our original idea of interviewing the family last. The latter idea had arisen from the piloting situation where we knew relatively little about the family’s needs and dynamics. In the main study, however, we had been following each family’s care and progress for approximately six months and consequently there was less concern about unanticipated problems.

Three of the family interviews were conducted with one person alone. In two of these cases this was because that person lived alone and effectively was the family case in terms of FHN input. In the third case the husband had previously declined to take part in the study, and the daughter of the household had recently moved away and was unavailable for interview. Thus the 58 year old lady was the only person interviewed within that family.

The remaining three family interviews were each conducted concurrently with two participants. In all cases this was the mode that they preferred. In two cases this involved mothers and adult daughters. In the last case this involved an adult male and female who saw the concurrent format as expedient given that their young infant daughter was having a brief midday nap. Unfortunately the plan to interview the two girls within this household (aged 12 and 9 respectively) had to be abandoned as they had gone to see friends.

The interviews with family members ranged from 20 minutes to 50 minutes in length. These were all conducted within the family home, apart from one instance where the mother and daughter found it more convenient to combine the interview with their scheduled trip to the local town (a quiet room in the local health centre was used).

The interview recordings were of reasonable quality and there were very few instances where the transcription of particular passages of speech was not subsequently possible. Where the interview involved two concurrent interviewees there were occasional instances where the interviewer failed to direct questions specifically to individuals, but on the whole the understandings and inter-personal dynamics were good. The pairs of interviewees tended to contribute fairly equally, apart from one instance where an elderly lady preferred that her daughter take the lead role.

The interviews with other health care professionals ranged from 20 to 50 minutes in length. These usually took place in a Health Centre or GP surgery, but one took place in the professional’s home and one had to be conducted by telephone. As Annex 2 in the main report indicates, a total of seven other health professionals were interviewed. In one of the family cases it was not possible to interview any other professional who had significant involvement. This was because the family member had little contact with the GP and in any case that GP was unavailable for interview. In two of the other family cases we interviewed two professionals from each site. This was because the family member/s had significant concurrent involvement with several professionals. Some of these professionals had been interviewed more informally on a number of previous site visits.

The interviews with the Family Health Nurses ranged from 30 to 90 minutes in length. These usually took place in a Health Centre or GP surgery, but one had to be conducted by telephone. The greater length of these interviews reflects a number of factors. Firstly, given that FHN practice was the main focus of our study, there was a great deal of material to explore. Secondly each individual FHN was well known to the researcher, and the FHNs were used to being interviewed. Finally the FHNs were usually interested in exploring and explaining their role through discussion, and would make time to do this.
Within the main report, Annex 2 indicates how the outcomes of the analysis of the family case studies (at micro level) subsequently informed the construction of knowledge at the macro level (i.e. so that CPO patterns could be produced for each site, and so that distinct themes could be aggregated, where appropriate, across all sites). However the process of analysis of the case study interviews requires further explanation.

All the interviews relating to family case studies were subsequently fully transcribed. One researcher listened to each tape several times and read the transcripts in full. A memo was written for each interview summarising its characteristics and quality. The first stage of detailed textual analysis comprised qualitative content analysis (Bryman 2001; Priest et al 2002). This differs from more traditional understandings of content analysis that are predicated on consistency of detailed coding and subsequent quantification (Silverman 1993). Rather we used the common conceptual structure across our interviews as a framework for mapping the emergent themes within each case.

This common conceptual structure can be summarised as:

- Family context, health needs and health care contacts
- FHN input (what; why; how; impact on family)
- Comparison with: the FHN’s previous role; the coverage and extent of previous community nursing services; concurrent health and social care inputs
- The nature of impact on the FHN, other professionals; local services; the community
- General reflections on the role and what it means for the future

It should be noted, in the passing, that the three core elements within this structure reflect the factors that were examined (in less detail) through the professional stakeholder questionnaire (i.e. magnitude of practice change and nature of impact). This demonstrates how the study design was consciously layered so that the Family Health Nurse development could be studied in terms of both depth and breadth (again, see Annex 2 of the main study for visual representation).

Thus this common conceptual structure was used as a template (Crabtree and Miller 1992) for subsequent mapping of emergent themes. A data matrix similar to that suggested by Miles and Huberman (1994; page 183) was drawn up for each family case and the themes that emerged from analysis of the family, FHN and other professional interviews were mapped on to each of these six matrices. In order to illustrate this process an example of some of the themes from one family case is presented on the following page. This particular case study was used to illustrate the Slow/No go pattern in Annex 4 of the main report. Common themes are presented in coloured print while distinct themes are presented in standard black print.
<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Family’s health and contacts with services</th>
<th>FHN work &amp; impact on this family</th>
<th>Comparison with pre-existing &amp; current roles/services</th>
<th>Nature of impact on colleagues/ services/ wider community</th>
<th>General reflections on the FHN role and development</th>
<th>Other</th>
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<td><strong>Family member(s)</strong></td>
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<td>(Mother = M, Daughter = D)</td>
<td>Nurses visit regularly for varicose ulcer (M)</td>
<td>FHN has good relationship with M</td>
<td>FHN “takes more time” and “you could talk better to her” (M)</td>
<td>FHN not necessarily seen as first point of contact</td>
<td>FHN title doesn’t mean anything in particular to the family</td>
<td>M doesn’t really see a problem with her diet</td>
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<td>Nurses helped treat cyst but little FHN input now (D)</td>
<td>FHN gave leaflets: not used yet</td>
<td>The other nurses still come &amp; do what they did before: no change</td>
<td>Generally happy with services as they are</td>
<td></td>
<td>Usually all 3 eat together, same food</td>
</tr>
<tr>
<td><strong>Family Health Nurse</strong></td>
<td>Longstanding health problems (M)</td>
<td>Development of family care thwarted due to lack of time</td>
<td>FHN service not substantially different yet</td>
<td>FHN not necessarily first point of contact for this family: others still involved</td>
<td>Existing PHCT care good but FHN needed</td>
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<td></td>
<td>Daughter and son both have needs but sporadic contact with services</td>
<td>Successful referral of M to vascular clinic</td>
<td>Still has a lot of heavy DN cases: few family cases developed so far</td>
<td>Very few referrals from colleagues: PHCT working practices unchanged</td>
<td>FHN still part-time: needs more hours</td>
<td>Could be easier to take on new families where no previous DN contact</td>
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<tr>
<td></td>
<td>Need to tie all family care together</td>
<td>Did genogram with M only</td>
<td>As an FHN visits more flexibly</td>
<td>Able to develop some FHN work in local school but sporadic</td>
<td>Role not working, as its super-imposed: needs to be supernumerary, over a wider geographic area, should target young, less general nursing care</td>
<td>Often does split shifts: PHCT still 1 short</td>
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<tr>
<td></td>
<td>Family are passive users</td>
<td>Hasn’t had a chance to do dietary goals yet</td>
<td>DN service does address families’ needs if apparent i.e. it’s legitimate activity</td>
<td>Existing notes could be kept and added to by FHN</td>
<td>Not viable for FHN to be team leader here yet</td>
<td>Has kept some families that she saw as a student</td>
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<td></td>
<td>Dominant domain for input is physiological</td>
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<td>Community dev role under-developed: ?level of public understanding of role</td>
<td>Interested in history of local community and why health-related behaviours have arisen e.g. dietary habits</td>
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<td>Rest of team’s care giving is unchanged</td>
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<tr>
<td><strong>Other professional</strong></td>
<td>Rest of team cover FHN for input with M</td>
<td>Doesn’t know a lot re. FHN input beyond what is in the notes</td>
<td>FHN service not substantially different</td>
<td>Has had to cover the DN caseload in patch</td>
<td>Role not working, as its super-imposed: needs to be supernumerary</td>
<td>FHN has developed as an individual and professional</td>
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<td></td>
<td>Input from rest of team is unchanged: any other care input from team would be opportunistic</td>
<td>Don’t know if M has had anything extra from FHN beyond what is written in the notes</td>
<td>DN service does pick up family issues but more informally</td>
<td>FHN development has made for uncertainty within the team</td>
<td>However can’t really see a gap in the service: no real need for FHN?</td>
<td>“We all want it to work for her”</td>
</tr>
<tr>
<td></td>
<td>Son goes to diabetic clinic at GPs</td>
<td>Not sure about FHN’s dietary advice and its impact</td>
<td>Inherited heavy DN caseload: “DN by different title”</td>
<td></td>
<td>Could you just enhance DN training instead of training FHNs?</td>
<td>Would it have been better if an unqualified community SN had been given the opportunity?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Public don’t know what FHN is</td>
<td>Can NHS afford more health promotion?</td>
</tr>
</tbody>
</table>
Some of the themes that emerged from this qualitative content analysis are expressed in respondents’ actual words (“manifest content”) but more often they are derived from the interpretation and judgement of participants’ responses (“latent content”; Wood, cited in Priest et al 2002).

As can be seen, this analysis method gives a clear overview of differences in thematic coverage arising from the family, FHN and other professional interviews respectively. In turn this facilitated the research team’s own reflexive analysis of the strengths and weaknesses of the interview schedule and the way each interview was conducted. In this regard the interviewer was aware of missing some opportunities to ask probing questions or seek clarification in some of the earlier interviews. By the time the final (19th) interview was undertaken this was not the case. In short, technique improved through intensive practice.

The main advantage of this method, however, was that it made it easier to identify which themes were common within a family case, and which were distinct to one interviewee. Thus it can be seen from the matrix on the previous page that there was a common perception that the rest of the team’s process of care delivery was essentially unchanged. This perception was shared by all three interviewees.

Common themes that emerged like this were often driven by the core questions in the interview structure that sought to find out:

- what FHN practice was
- how, and to what extent, it worked
- and under what circumstances

In this way they became central to informing the development of the Context-Process-Outcome patterns that would come to constitute the practice typology. The convergence of perceptions in the above example strongly suggested that the introduction of FHN practice had not so far resulted in any substantive change to context or process at the site. Thus, in terms of analytical processing, this theme fed into the central column of rising arrows depicted in Annex 2 of the main report. It was then checked for fit against other site data such as: the family members’ case notes; data from the other tracer family; caseload data; stakeholder perceptions; and data from the wider study of practice within the PHCT. As it was affirmed, it gained substance and momentum and flowed upwards to directly inform the CPO pattern. If it had not been supported by other data we would have explored plausible alternative explanations.

Sometimes during the study we succeeded in eliciting respondents’ own theories as to why the development was working or not working. The matrix on the previous page summarises a good example (see also main report, Annex 4 pp 113-116) where both the FHN and the other professional agree that the FHN role is not working locally because it has been super-imposed on district nursing. They both advance an argument for supernumerary status but, when challenged, the other professional doubts the need for the FHN role itself.

These sort of “micro-theories” are seen by Pawson and Tilley (1997) as the essential generative mechanisms that explain why and how a program worked (or did not work). In turn this builds theory that can be tested in further realistic evaluation research studies. The theory of the key ally is another example that manifested at the macro level of our practice typology.

The purpose of triangulating interview data at the family case study level was not solely to look for corroboration or convergence (Silverman 1993), but also to recognise and explore divergence. In the above case there was a common theme in that the FHN and the other professional both saw the role as not working (and they also agreed why). The interviewed family were supportive of
the FHN in terms of their personal experiences but also generally found pre-existing services satisfactory, and the interview did not elicit a substantive theme in regard to the success or failure of the FHN role within the wider context of primary health care services and community health. Accordingly the theme of “role not working” fed to the right and upwards into the stream in Annex 2 with the double headed arrows. Again the theme was checked for fit against all the other relevant site data and it went on to inform the eventual CPO pattern.

At a more fundamental level, however, the FHN and the other professional had differing perceptions as to whether there was really a need for an FHN role locally. In this case the distinct themes of “need for FHN” and “no need for FHN” were both fed to the right and upwards into the stream in Annex 2 with the double headed arrows. This time these different interpretations were checked for fit against all the other relevant site data. The one interpretation that strongly prevailed locally (i.e. no real need seen for the FHN role) went on to inform CPO pattern development as a persistent factor underlying context and outcome. This quality of inherence also meant that it retained potential for aggregation as a distinct theme across most, or all, sites (i.e. it could flow upwards to the diagonal rightwards arrow at the top of Annex 2).

In the case of the perception that diverged from other local site data (i.e. there is a distinct need for FHN role) we explored plausible alternative explanations (downwards arrow direction in Annex 2). In this example we concluded that belief in the value of a distinct FHN role was bound up in this postholder’s new professional identity. As such this was handled as a distinct theme which filtered into the upwards stream on the right hand side of the page in Annex 2. This belief was found to be characteristic for the practising FHNs, and consequently the theme gathered upwards momentum to become a uni-professional aggregated theme.

A further example where there was both commonality and divergence emerged through elicited comparisons of the FHN service with the District Nursing service. The FHN and the other professional (who tended to speak on behalf of a core group of colleagues who had discussed their perceptions as a group prior to interview) again shared a common perception that the enacted FHN role was not so far substantially different from the District Nursing service. While both of the interviewed family members felt that all the nurses were good, the mother said that the FHN “takes more time” and “you could talk better to her”. This example is interesting as the mother had received community nursing over many years and was currently receiving regular input from both the DN team and the FHN.

Thus it seemed important to check both interpretations against other relevant site data (via the double headed arrow pathway in Annex 2). While the professionals’ interpretation prevailed in terms of informing the CPO pattern, it was apparent that we had little other comparative data from families at this site who had experienced both services. In a sense this highlights a more general limitation of our study i.e. that due to the wide scope and difficult logistics of the study we were only able to obtain in-depth data from a relatively small number of families. It is important to note, however, that the objectives of the study did not include comparison of respective community nursing services in terms of quality of service or the achievement of patient outcomes. Such a research goal would have been very difficult to address adequately and systematically in the context of this policy initiative. Rather the goal was to evaluate family health nursing operation and impact, comparing its coverage and extent with pre-existing services.

Consequently the mother’s perceptions were handled as two distinct themes which filtered into the upwards stream on the right hand side of the page in Annex 2. This recognised their validity. Although the themes were supported by interview material from one other site (Site I), they were not clearly supported in the other family interview where there was scope for concurrent comparison of community nursing services (Site C). As such there was insufficient momentum for aggregation of the “FHN takes more time” or the “FHN listens better” themes from family interviews across sites. However these themes do suggest a challenge (!) for further research,
given that FHN input in practice did seem to involve substantial time input and that the educational course was found to be strong in its teaching of communication skills.

These rather detailed examples are presented in order to show how data analysis of the interviews worked and how it fitted into the bigger picture. The presentation of qualitative data from in-depth interviews always presents challenges. Our approach to this in the Annex 4 case studies seeks to give the reader some insights into the wider context by presenting sufficient dialogue from interactions. This approach recognises Silverman (1993)’s criticism of qualitative research that selectively reports only very anecdotal snippets. Rather we have sought to use dialogue that illustrates particular themes that are characteristic of certain patterns (i.e. we are considering the issue of representativeness by using indicative material). Nevertheless there is a sense in which the inclusion of particular chunks of text, rather than others, is necessarily selective and we stand by this.

Indeed the confines and the evaluative focus of the main report meant that it was not possible to include some very rich data that was representative of themes that commonly emerged under the “other” category in the core interview framework. A major theme in this category related to the experience of living and working as a nurse/health professional in a remote and rural area. The following excerpt from an interview with an FHN gets to the heart of this matter:

**FHN:** “........You can’t be a person who really wants their privacy. You are in a goldfish bowl. You have to be able to cope with people’s interests. You also have to recognise, or to know, to have lived in an area, to be brought up in a country area, to know that this is how country areas live. Remote and rural areas. People do feel they own you. If you’ve lived in an area all your life there are people who see you as a baby. They maybe fed you a bottle, or changed your nappy, and from that they feel an ownership of you. And they feel it isn’t just curiosity or nosiness. They want to know how you’re getting on. They feel they’ve had a hand in bringing you up..............................and this is how country people feel if you are part of a community and living there. And it also depends on the experiences you’ve been through with them. If you’ve been through a bereavement with them, either their bereavement or yours, these all make big connections in a remote and rural area, and its part of the trust that builds up between Family Health Nurse and the community”.

The outcomes from the Consultation Satisfaction Questionnaire (Poulton 1996) were only briefly summarised within the main report. An individual questionnaire was given to each of the nine family members who were interviewed. This was done at the end of the interview, and only one person preferred that the researcher assist in its completion. The remaining eight family members subsequently returned completed questionnaires by post.

We also left a total of three questionnaires for completion by family members who hadn’t been able to be present at the interviews (e.g. the two children who had gone off to friends). These were all subsequently returned, but one of the children and one adult male had not completed the questionnaire. The child (9 years old) did not know how to answer the questions and the adult male felt that he had not consulted the FHN on his own behalf.

Thus there were a total of ten completed Consultation Satisfaction Questionnaires. As indicated in the main report, these were very affirmative of the contacts with the FHNs. Typically respondents were well satisfied with the inter-personal skills of the FHNs and with the thoroughness of their assessments. There was almost no dissatisfaction with the consultations (one respondent felt that a little more time could have been spent). However, only a few respondents added written comments and overall these questionnaires added little to our understanding of the experience of family health nursing. This was probably a case of the researchers going for a “belt and braces” approach where in fact only the interviews were necessary.
The Consultation Satisfaction Questionnaires itself is more suited for large surveys. In passing it is also worth mentioning that we have doubts about the inherent meaning and value of some of the statements in the questionnaire. While we understand that internal consistency checking can be useful, it is difficult to see the inherent informational value in Statement 8 (“There are some things the FHN does not know about me”) and Statement 14 (“The FHN knows all about me”). These statements would seem to relate to the “depth of relationship” factor identified by Poulton (1996) and previous developers of the questionnaire. However it would seem odd to suggest that “knowing everything” about a client (if such a thing were possible) directly correlates with depth of relationship. Interestingly several of the FHNs told us that they knew of core data related to family history that clients had either decided not to share during the genogram assessments or had themselves not been aware of. The following example from an interview with an FHN illustrates this vividly:

FHN: ".....you’re living in an area for a long time and you have a lot of information also, a lot of which perhaps you cannot write down its that sensitive. But you make connections in your head and you know how the whole community intermingles and you have got a picture of that. Its like the community portrait but its in your head. But there are some things you can’t write down.

Researcher: Yes, you see that interests me

FHN: See, I know some people who are not who they think they are

Researcher: Right, even that fundamental?

FHN: I know it but they don’t

Researcher: You know that? You’ve lived in the area a while, and that’s hearing from other people?

FHN: Yes

Thus for small remote and rural communities it seems unsafe to assume that any perceived professional omniscience is necessarily synonymous with a deep personal relationship.
PART 4 THE WIDER CONTEXT
4.0 THE WIDER SCOTTISH CONTEXT

4.0.1 Contemporary understandings of community nursing and the FHN

In Chapter 4 of the main report analysis of contemporary policy issues is followed by analysis of the effectiveness, deficiencies and requirements of community-based nursing, midwifery and health visiting services across the Scottish primary care sector. The methods relating to the telephone interviews and the subsequent approach to analysis are described in the main report. The following pages present the documents relating to these interviews, namely: the letter of invitation; planning and nomination documents; an information document about Family Health Nursing; and the advanced organiser which was used to guide the interview.
Evaluation of Family Health Nurse Pilot Project

As you know I have been working on the evaluation of the Family Health Nurse Pilot Project currently underway in Orkney, Highland and the Western Isles, with my co-researcher Colin Macduff. Over the last year we have been examining the education and practice of family health nurses in their usual working localities.

As part of the evaluation we have been asked to consider how family health nursing may be relevant to other areas of Scotland including urban contexts. To this end we intend to interview (by telephone) key people from various NHS Trusts that provide primary care. Hence this letter asking if you would be prepared to be interviewed on the telephone by myself. I am also seeking your help in identifying two other people to participate likewise: a lead nurse from an LHCC and the chairman of an LHCC (preferably two different LHCC’s). If you will provide names and contact addresses I will write to them asking if they are willing to participate.

I appreciate that I am asking a lot given your busy and demanding schedule but I want to be sure that I understand key issues surrounding nursing, health visiting and midwifery care in the community.

The interviews will be recorded (with your permission) and should last between 20-30 minutes. I will telephone at your convenience.

If you are agreeable I will check out my analysis of key issues with you and the other two colleagues. In the final report no mention will be made to you or your organisation by name. I will however recognise your help in the acknowledgements and send you copies of the final report.

I hope that my requests are not too onerous and that you are able to participate. I have attached two brief forms for completion. If you have any queries about the project, please contact me on 01224 262647 (W) or 01224 632840 (H) or e-mail b.west@rgu.ac.uk. Please return the forms to me by 16th July 2002.

With kindest regards.

Yours sincerely

Dr Bernice J. M. West
Director
CeNPRaD

Colin Macduff
Research Fellow
CeNPRaD
Family Health Nurse Pilot Project Evaluation
Telephone Interviews with Directors of Nursing

Name

Contact Address

Are you willing to be interviewed on the telephone?
Yes [ ] No [ ]

Optimum date/s for interview (please circle)

July 2002
S M T W T F S
17 18 19 20
21 22 23 24 25 26 27
31

August
4  5  6  7  8  9  10

Optimum Time

Telephone Number

Please return this form to me in the Freepost envelope provided. If you have any queries please contact me directly on 01224 262647(W) or 01224 682840 (H) or e-mail b.west@rgu.ac.uk.

Dr Bernice J.M. West
June 2002
Family Health Nurse Pilot Project - Evaluation

Suggestions for participants

Please complete this form giving details of a lead nurse of an LHCC and the chairman of an LHCC who could be approached to participate in this part of the evaluation.

LEAD NURSE
Name: ________________________________
LHCC

Contact Address: ________________________________
__________________________________________
__________________________________________

Chairman LHCC
Name: ________________________________

Contact Address: ________________________________
__________________________________________
__________________________________________

On receipt I will write to each of them individually.

Please return this completed form in the FREEPOST envelope provided.

Dr Bernice J.M. West
June 2002
INFORMATION SHEET ON THE FAMILY HEALTH NURSE

Within recent years, a new type of nursing role called the Family Health Nurse (FHN) has been developed by the World Health Organisation (WHO). The main aspects of the role are:

- the FHN is expected to take a lead role in preventing illness and promoting health as well as caring for those members of the community who are ill and require nursing care. This is a model based on health rather than illness
- the FHN is expected to care for families rather than just the individuals within them
- the FHN will be a skilled generalist nurse doing a broad range of duties
- the FHN will act as a first point of contact and refer on to specialists where a greater degree of expertise is required

Within Scotland piloting of this model is currently underway in Highland region, Orkney and the Western Isles. The aim is to test the FHN model as a means of delivering community nursing services in remote, rural areas. Community nurses from selected sites within each region are involved in undertaking a degree level education programme based on the WHO FHN model. This course (of approximately one year’s duration) is being delivered by The University of Stirling, based at their Highland campus in Inverness. In the first year (2001) eleven nurses undertook the course.

Having recently qualified, these nurses are now seeking to further develop and establish the FHN role at their local sites. This role involves identifying aspects of health that individual family members see as important, and then working with them towards improvements. This can include help with illness and disability; early detection of problems; or advising on lifestyle and risk factors. It may also involve helping to co-ordinate health services and making referrals. A further twenty nurses commenced the FHN course in early 2002 and are due to finish at the end of the year.

Further information on the pilot project is available at: http://www.show.scot.nhs.uk/familyhealthnurseproject/HomePage.htm
EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

Interviews with Directors of Nursing: main themes for exploration

Thinking about the current *nature, provision and delivery of community nursing services to the population of*......*(your Trust)*, what are the main strengths and weaknesses?

Thinking about current *provision of education for community nurses* within Scotland, what do you see as the main strengths and weaknesses?

What are your thoughts in general on Family Health Nursing?

Thinking of the future nature, provision and delivery of community nursing services within your Trust, do you see the Family Health Nurse role as being potentially useful and/or viable? *(if so, how?........)*
Evaluation of Family Health Nurse Pilot Project

Dear

I am writing on the recommendation of *********************, to ask if you would be willing to help with our research.

To explain further, the Family Health Nurse Pilot Project is currently underway in Orkney, Highland and the Western Isles. The project involves the development of a new type of nursing role, as described in the accompanying information sheet. Along with my co-researcher Colin Macduff, I am currently working on an independent evaluation of this new role. As part of the evaluation we have been asked to consider how family health nursing may be relevant to other areas of Scotland including urban contexts. To this end we intend to interview (by telephone) key people from various NHS Trusts that provide primary care. Hence this letter asking if you would be prepared to be interviewed on the telephone by myself.

I appreciate that I am asking a lot given your busy and demanding schedule but I want to be sure that I understand key issues surrounding nursing, health visiting and midwifery care in the community.

The interviews will be recorded (with your permission) and should last between 20-30 minutes. I will telephone at your convenience.

If you are agreeable I will check out my analysis of key issues with you. In the final report no mention will be made to you or your organisation by name. I will however recognise your help in the acknowledgements and send you copies of the final report.

I hope that my requests are not too onerous and that you are able to participate. I have attached a brief form for completion. If you have any queries about the project, please contact me on 01224 262647 (W) or e-mail b.west@rgu.ac.uk. Please return the form to me by 12th July 2002.

With kindest regards.

Yours sincerely

Dr Bernice J. M. West
Director
CeNPRaD

Colin Macduff
Research Fellow
CeNPRaD
Family Health Nurse Pilot Project Evaluation
Telephone Interviews with Key Representatives
from Local Health Care Co-operatives

Name ____________________________________________

Contact Address __________________________________
___________________________________________________
___________________________________________________

Are you willing to be interviewed on the telephone?

Yes ☐ No ☐

Optimum date/s for interview (please circle)

July 2002
S M T W T F S
14 15  17 18 19 20
21 22 23 24 25 26 27
31

August
1 2 3
4 5 6 7 8 9 10

Optimum Time __________________________

Telephone Number __________________________

Please return this form to me in the Freepost envelope provided. If you have any
queries please contact me directly on 01224 262647(W) or e-mail b.west@rgu.ac.uk.

Dr Bernice J.M.West
June 2002
EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

Interviews with LHCC Lead Nurses: main themes for exploration

Thinking about the current *nature, provision and delivery of community nursing services to the population of.......(your LHCC)*, what are the main strengths and weaknesses?

Thinking about current *provision of education for community nurses* within Scotland, what do you see as the main strengths and weaknesses?

What are your thoughts in general on Family Health Nursing?

Thinking of the future nature, provision and delivery of community nursing services within your LHCC, do you see the Family Health Nurse role as being potentially useful and/or viable? (*if so, how?*)
Thinking about the current *nature, provision and delivery of community nursing services to the population of......(your LHCC)*, what are the main strengths and weaknesses?

What are your thoughts in general on Family Health Nursing?

Thinking of the future nature, provision and delivery of primary care services within your LHCC, do you see the Family Health Nurse role as being potentially useful and/or viable? *(if so, how?)*
EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

Interviews with Local Health Council Chairpersons: main themes for exploration

Thinking about the current nature, provision and delivery of community nursing services to the population of......(your LHC), what are the main strengths and weaknesses?

What are your thoughts in general on Family Health Nursing?

Thinking of the future nature, provision and delivery of primary care services within your LHC, do you see the Family Health Nurse role as being potentially useful and/or viable? (if so, how?)
One member of the research team carried out all of the telephone interviews. These interviews with key informants were an attempt to elicit a range of relevant contemporary understandings of community nursing and family health nursing in Scotland. As Table 4.1 and Annex 6 in the main report illustrate, these telephone interviews were successful in this regard. While we were able to identify themes where there was relatively widespread agreement (e.g. experience of the workforce; duplication of effort), the sheer diversity of perspectives was often striking. Perhaps unsurprisingly this was particularly marked in relation to family health nursing.

A few interviewees had obviously considered the FHN role in some depth, but more often there was very little prior knowledge of the concept. In the latter circumstance the interviewees often looked to the interviewer for more information and interpretation of the role. This was quite understandable in as much as the researcher was often the interviewee’s sole point of engagement in regard to this concept. In these circumstances the researcher would provide some further contextual detail in regard to the pilot project, but the core representation of the project remained consistent with the information sheet that had already been sent to the interviewee. These sort of interactions gave the researcher more insight into the various ways that this information sheet was perceived, and also highlighted the practical difficulties that the project steering group and others had in explaining the FHN initiative.

A number of contextual factors will influence reciprocal interaction within any one telephone interview (Chapple 1999). In approximately one third of these telephone interviews the interviewer and the interviewee were already known to one another through previous work-related contacts. This immediately brings a different social dimension to the interaction and must also be acknowledged as a possible influence on the process and content of the interview (e.g. prior mutual knowledge of values and beliefs may influence the interviewee to respond in a way that they think the interviewer might expect/want). Annex 6 attempts to accommodate such concerns by making manifest subsequent judgements made about perspective, knowledge and personal stance, and quality of interview.
4.0.2 Steering Group meeting data collection

During the course of the study we had ongoing contact with members of the Advisory Group and occasional contacts with members of the Steering Group. Towards the end of the study we undertook more formal data collection from both of these sources.

Firstly we were invited to a Steering Group meeting in September 2002 which was considering “exit strategy” for the pilot project. While we had been sent the minutes of previous Steering Group meetings, we were not part of the Group and had only previously been present at two meetings for the short time that it took to present an outline of our work. On this occasion it was agreed that there would be mutual benefit in the research team being privy to the particular part of the meeting that involved discussion of future options.

These discussions were structured by the Steering Group so that three sub-groups would each address the same four possible outcome scenarios. These were:

1) That the FHN role is not an appropriate model to meet the health needs of remote and rural communities

2) That the FHN role will be further developed within the four NHS Boards already involved in the pilot

3) That there will be exploration of the FHN role within other remote and rural NHS Boards

4) That further investigation of the role will be carried out in other areas such as urban settings and/or with specific client groups

These concurrent sessions were scheduled to last for 75 minutes and were followed by feedback from each of the groups in turn and a general discussion. It was agreed in advance that the researchers’ role would be non-participatory and that the discussions would be recorded on audio tape for research analysis purposes only.

Accordingly the study team were joined by a research colleague, Dr Mike Lyon, so that each of the three group discussions could be observed in person and audio taped. All three researchers were then present at the subsequent feedback and discussion session.

After the event the three researchers had a meeting to discuss initial perceptions of the data. Each researcher then listened several times to the recording from their group and produced a detailed written summary of the themes that emerged, the group dynamics and underlying issues. These were then shared and discussed in depth at a subsequent meeting which also involved similar consideration of the feedback and discussion session.

This data informed our thinking at a number of levels. At a primary level it afforded much insight into the thoughts of individual Steering Group members. A total of 19 Steering Group members attended and they represented a fairly wide range of interests (e.g. service management; professional organisations; professional groups such as doctors and district nurses; a lay representative; education; the European project). Interestingly there was less diversity of perspective on the future than might have been anticipated with this sort of mixed group (e.g. all quickly rejected Scenario 1). There were differences on future emphasis but these seemed to relate mainly to the shared feeling that a project of this sort necessarily generated as many questions as answers.

At a secondary, analytical level there was insight into the differential power of various voices, professed values, tacit/embedded understandings and shared aspirations. In this regard it was clear that the Steering Group functioned through an affirmative, action-orientated, policy making
ethos. Three tentative explanatory models (derived primarily from a sociological perspective) were generated by Dr Lyon in order to inform the researchers’ analysis of the meeting. These related to: embeddedness; consensualisation and centre-periphery relations. By building this sort of interpretative reflection into our analytical processes we were able to step back from the immediate personal contexts of the evaluation and be refreshed by wider perspectives. This seems a very necessary part of research teamwork.
4.0.3 Advisory Group interviews

The second element in our collection of formal data from those involved in driving the project involved interviews with two members of the Advisory Group. These took place at the end of 2002 with a view to eliciting overall reflections on the project. The basic thematic framework used to interview the 19 key informants from Primary Care was supplemented with a number of further questions (please see the next page).
EVALUATION OF FAMILY HEALTH NURSE PILOT PROJECT

*Interviews with Advisory Group members 26/11/02: main themes for exploration*

(i) Thinking about community nursing in Scotland at present, what do you see as the main strengths and weaknesses?

(ii) Thinking about current provision of education for community nurses within Scotland, what do you see as the main strengths and weaknesses?

(iii) How might Family Health Nursing make a difference?

(iv) How do you see Family Health Nursing fitting with existing primary care structures?

(v) Thinking of the development of the FHN pilot project in Scotland, what do you see as the main strengths and weaknesses?

(vi) What, if anything, would you do differently if managing a similar project in the future?
Again these interviews were useful in informing our thinking about the origins, evolution and future of the initiative as perceived by those near to the centre of policy making. The timing of the interviews facilitated reflection on a number of the wider issues that emerged during the project. These included the rationale for the FHN pilot project, indicators of success, and the actual experience of acting as a driving force within the project.
PART 5  FINAL REFLECTIONS
5.0 FINAL REFLECTIONS

5.0.1 Design and conduct of the study

In concluding this supplement to the main report, it is timely to reflect briefly on the overall design of the study and our approach to evaluation research.

It is useful to start by reflecting on what we knew when we designed the evaluation in response to the invitation to tender for this work. Some contextual information was provided along with the aim of the evaluation and the six proscribed objectives. Design was made difficult, however, due to the following factors:

- Little was known about the nature of the educational course
- Very little was known about the students who might undertake it (e.g. how many would undertake the course and what would their backgrounds and motivations be?)
- The FHN role was hypothetical but the hypotheses were general and sketchy
- Consequently there was very little known about the actual role that they would undertake in practice
- The participating regions were known but the geographic locations where FHNs would practice were not known

In effect it was clear that many of these questions would be addressed and clarified as the project progressed. Accordingly it seemed important to build a fair amount of flexibility into the study design. Initially we had considered whether it might be possible to design the study of practice so that there was a major comparative element (e.g. by studying “control” sites with similar characteristics where family health nursing was not being implemented). This notion was not seriously entertained for long. Firstly it was clear that the “intervention” (i.e. family health nursing itself) was evolutionary, diffuse and therefore difficult to operationally define. In turn this meant that it would be very difficult to hypothesise which outcomes might be sensitive to this intervention so that rigorous comparison might be made. Thirdly the distinctive characteristics of many of the remote and rural locations meant that in-depth knowledge of context would be necessary before one could confidently “pair-off” intervention and control sites.

In short we believe that an attempt to design and conduct the evaluation within this sort of quasi-experimental framework would have been a methodological and logistical nightmare. This conviction grew as the reality of applying our own design to practice unfolded. It seems likely that a control group design would have involved so much attention to the validity of possible comparisons (and matters of research method) that the researchers’ eyes would be diverted from the job in hand (i.e. studying the operation and impact of the FHN role as it was actually enacted). The analogy that a quasi-experimental design repeatedly evoked was that of trying to fit the FHN octopus into a pair of starched, dress trousers: an uncomfortable experience all round, with the ever-present danger of getting snagged in the tentacles!

All this is not to suggest, however, that our own design was perfect. From the main report and the CD Rom it should be clear that we believe that the particular needs of an evaluation study such as this are seldom met sufficiently by one exclusive methodological approach. That is to say we do not believe in a recipe book approach to evaluation research. Rather there is a need to creatively customise designs in order to address complex problems. Most of the progress in evaluation research over the past 50 years has occurred through such need (for instance, see the journey of discovery undertaken by Guba and Lincoln 1989).

Nevertheless a study design informed by Pawson and Tilley (1997), Guba and Lincoln (1989) and Yin (1994) is necessarily a complex mix. In this regard we recognise that Pawson and Tilley’s approach usually involves the prior generation of theory for testing. While it would perhaps have been possible at the start of the project to set up a very generalised change theory similar to that
posited by Redfern et al (2000) for their multi-site evaluation, it is debatable whether this would have been of value or a distraction. So many factors were unknown at the start of this project.

One of our main baseline aspirations was simply to produce clear description of the FHN phenomenon as it evolved. However we also aspired to explanation and the production of a typology has gone some way to generating “micro-theory” that can be further interrogated. Similarly our use of multiple case study methodology has been influenced by Yin’s explanatory methods, but we were not in a position to overtly test theory at the start of the study. Our incorporation of design elements from Guba and Lincoln recognises the value of incorporating stakeholder perspectives but decidedly makes no attempt to broker consensus amongst them. Moreover, while we broadly endorse Guba and Lincoln’s views on the importance of context, we share Pawson and Tilley’s basic premise that some generalisation across contexts is possible and indeed desirable.

This demonstrates some of the underlying complexities of drawing on a number of methodological perspectives that are not necessary compatible if adopted in their entirety. However it also demonstrates that it is most unlikely within the paradigm wars, that one methodological perspective has a monopoly on the truth. We hope to publish further on these issues in due course.
5.0.2 Seen through a whisky glass

Within the main report and this CD Rom we have sought to make our methods as explicit as possible. We believe that this work comprises a sound body of evidence that lays a foundation for further family health nursing research. However this is something that only the individual reader can decide. At the end of the day, the proof of the pudding is in the eating. If you have managed to stay with us through the considerable methodological menu that we have presented, we hope that you feel replete and satisfied. It remains only to suggest that you now partake of one of the excellent range of malt whiskies that are produced in the regions that participated in the Family Health Nurse project (unfortunately not downloadable yet through the CD Rom format!).

In concluding on this theme, we wish to use the principle of the whisky tasting wheel/star to illustrate and summarise the character of our evaluation study. Firstly, on the next page we present a tasting star that visually represents the key characteristics of one of the finest whiskies to be found in the regions involved in the FHN project. As researchers we do not make this assertion lightly. Rather we have come to this conclusion on the basis of systematic study, based again on mixed methods employed when on field trips. Thus the first phase of this research involved an ethnographic element where we immersed ourselves in local culture. Thereafter we adopted a purposive sampling strategy where a case study was made of each malt. Initially the principle unit of analysis was standardised at ¼ gill, but we often found that single case study methods were inadequate and that multiple units of analysis were necessary. After extensive research we can confidently corroborate Yin (1994)’s assertion that multiple units of analysis are synonymous with embedding!

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TASTE CHARACTERISTICS OF A FINE MALT WHISKY EVALUATED DURING FAMILY HEALTH NURSE RESEARCH

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Having illustrated the tasting star, and having explained our painstaking endeavours in the name of research, it remains only to apply the principle to give a final, reflexive overview of the characteristics and coverage of our own evaluation study.

Slainte!

Colin N Macduff

Dr Bernice JM West

Aberdeen

December 2003
PART 6 REFERENCES AND COPYRIGHT
6.0 REFERENCES AND COPYRIGHT

6.0.1 References


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