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# The Effect of a Change Intervention Within the Framework of Organization Development on the Frequency of Use of Nursing Diagnosis

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The Effect of a Change Intervention  
Within the Framework of Organization Development  
on the Frequency of Use of Nursing Diagnosis

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June 1986

Submitted in partial fulfillment of the  
requirements for the degree of  
Master of Science in Nursing

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## Abstract

Although 64% of the 32 registered nurses who comprised the staff of a pediatric unit had been formally educated in the use of nursing diagnosis, only 27.4% of individualized additions to the nursing care plans were accepted nursing diagnoses. An intervention based on Change Theory as incorporated in an Organization Development framework was initiated to increase the addition of accepted nursing diagnoses to the standard nursing care plans. The effect of the process was followed through the audit of 229 nursing care plans over a thirteen month period using a time series design. Following the intervention, 74.4% of individualized entries to the standard nursing care plans were accepted nursing diagnoses, representing a 171.5% increase. The findings objectively demonstrate that an intervention based on Change Theory as incorporated in an Organization Development framework was an effective method of increasing the use of nursing diagnosis in the study population.

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## Chapter I

### Introduction and Problem Statement

Because nursing is an ever changing field, it is necessary to have available an effective method of updating the knowledge and clinical skills of practicing nurses. Continuing education programs have been the traditional method of providing for this need. For the purpose of this paper, the terms "continuing education," "staff development," and "inservice" will be used interchangeably, and will refer to programs on a nursing topic beyond basic nursing education for which college credit is not awarded.

If the purpose of continuing education is to update the knowledge and skills of practicing nurses, then the new knowledge gained from a program must be reflected in a change in behavior and in the practice habits of nurses attending the programs (Popiel, 1973). However, there is a paucity of literature available regarding objective evaluation of continuing education programs and their effect on the clinical behaviors of participating nurses. The purpose of the study is to evaluate the effect of an intervention based on Change Theory



as incorporated in an Organization Development Framework on the implementation of the use of nursing diagnosis in nursing care plans.

The term "nursing diagnosis" refers to those diagnoses accepted for clinical testing by the North American Nursing Diagnosis Association (Appendix A), and sub-defined by Carpenito (1983, p. 16) as being different from collaborative problems (Appendix B). The use of the term nursing diagnosis for this study, then, refers to those diagnostic categories (Appendix A) in which the nurse can order the primary intervention. The use of an accepted word or phrase as either the diagnosis or the etiology will be considered appropriate.

In the following examples, the underlined portion of the statement is an accepted word or phrase from the list of nursing diagnoses. In the first example, the accepted word or phrase is used in the first half of the statement as the diagnosis: "Potential for noncompliance related to limited financial resources and inability to purchase necessary medications." In this example, a nursing intervention might be to refer the patient to a community agency for assistance, a decision which does not require any physician consultation.

In the second example the accepted word or phrase from the list of nursing diagnoses is used as the cause or etiology and

appears in the second half of the statement: "Hypokalemia related to knowledge deficit of high potassium foods and the effects of diuretics." In this example, a nursing intervention would be to educate the patient regarding the medication and diet, an intervention based solely on the nursing model. For the purpose of this study, use of either form is considered acceptable.

In the facility in which the intervention was conducted, standard nursing care plans are provided for the most frequently seen medical problems (Appendix C). The items listed in the problem column of the standard nursing care plan are primarily of the type Carpenito (1983, p.15) referred to as "Interdependent" and "Clinical Problems," and more recently as "Collaborative Problems" (Carpenito, Personal Communication, May 7, 1985). For the purpose of this paper, the term "standard care plan" refers to the documents as shown in Appendix C. The terms standard care plan and nursing care plan will be used interchangeably.

Although many of the statements could be re-written using nursing diagnosis terminology, this was not the goal of the intervention. Standard care plans can be individualized through the addition of nursing diagnoses. The intervention was designed to increase the use of accepted nursing diagnoses when individualizing standard care plans.

### Research Question

The question to be investigated is:

Will an intervention based on Change Theory as incorporated in an Organization Development framework lead to an increased frequency of use of nursing diagnosis on standard nursing care plans?

To evaluate the intervention, a time series design will be used. This design provides a means for observing change over time.

## Chapter II

### Review of Literature and Conceptual Framework

Nursing care plans are not new, nor is the problem of motivating staff nurses to complete them. Price (1980) looked at reasons nurses were not completing care plans and identified three major themes: lack of continuity between the plan as written and what was actually being done by nurses; lack of time to complete the plans; and a discrepancy in what nurses see as "professional." Price (1980) found that nurses regard treatments and tasks as primary functions, with assessment, planning and evaluation as secondary. The emphasis seems to be on doing rather than thinking. Typical of the findings in the literature was the method chosen for handling the problem: Price would develop inservice programs. No criteria for a formal study were suggested and no results of the proposed intervention were presented.

Prose, Gianni, and Scharf (1983) also found that care plans were not being completed nor was nursing diagnosis being used. In a very ambitious intervention, the entire process of assessment, development of care plans, documentation, and report were changed. At the time the article was published, the authors were in a six month trial period prior to evaluation.

Personal correspondence regarding the outcome of the intervention was somewhat sketchy, but Ms. Scharf noted she has only one Head Nurse who monitors the use of nursing diagnosis (Scharf, Personal Communication, Sept. 23, 1985). This would suggest that Head Nurses are not committed to the change.

A concept addressed frequently in the last few years is that of nursing diagnosis, which can be viewed as a portion of the nursing process and, therefore, of nursing care plans. Gordon (1982, p. 2) proposed the following definition of nursing diagnosis: "Nursing diagnoses, or clinical diagnoses made by professional nurses, describe actual or potential health problems which nurses by virtue of their education and experience are capable and licensed to treat." Carpenito (1984, p. 4) enlarged upon and clarified Gordon's definition with the following:

Nursing diagnosis is a statement that describes a health state or an actual or potential altered interaction pattern of an individual, family, or group, to life processes (psychological, physiological, socio-cultural, developmental, and spiritual) for which legally, the nurse can identify and order the primary interventions to maintain the health state or to reduce, eliminate, or prevent client alterations.

A key difference in Carpenito's definition, which will be discussed in more detail, is the phrase, "for which legally, the nurse can identify and order the primary interventions." The criteria for being recognized as a profession includes the need for a specialized body of knowledge (Baer, 1984), which nursing diagnosis helps define.

Carpenito (1983, p.9) lists three significant reasons for the use of nursing diagnosis: "Define nursing in its present state, classify nursing's domain, and differentiate nursing from medicine." Warren (1983) enlarges on Carpenito's reasons, and includes improvement of communication, justification of third party payment, generation of a nursing research base, computerization of records based on nursing diagnosis, and documentation of nursing accountability and activity. The use of nursing diagnosis is important to nursing. Prior to 1973 there had been no organized, concentrated effort at developing a taxonomy for nursing. There are still schools of nursing that have not included the teaching of nursing diagnosis in their curricula. Therefore, there are many practicing nurses who have received no formal education regarding nursing diagnosis. As with most changes within the profession, nurses have had to learn about nursing diagnosis through informal means such as inservice programs.

If continuing education is the accepted method of updating knowledge and improving the practice of nurses, it is important to look at the effectiveness of the approach.

Understanding a concept does not insure its incorporation into practice (Oliver, 1984). If the rationale for continuing education programs is to initiate change in nursing practice, one should be able to evaluate if change does occur. The literature abounds with articles dealing with the need for inservice education and how to establish programs. However, there is little in the literature regarding the objective evaluation of behavior following continuing education programs. Stiles (1981) states, "by carefully identifying a problem, you can plan an appropriate education program. By adequate testing, you can determine if the program was successful." Stiles provides no statistical data for the statement, and, instead, concentrates on the construction of tests. She does not suggest that understanding the material guarantees its use.

Sovie (1981), a staff development educator, develops a framework for education of a nursing staff. Although she mentions the importance of program evaluation, she provides no suggestions as to how the evaluation should be done.

McBride (1981) suggests the use of the American Nurses Association Standards of Nursing Practice (1973) from which to

formulate objectives, thereby providing specific, measurable criteria against which continuing education programs can be evaluated. The article does not suggest that this method has been used. Furthermore, there is no suggestion as to how to evaluate the effects on the practice of the participants.

The only scientifically sound research article found in nursing literature in the last six years regarding evaluation of behavioral changes following a continuing education program was by Oliver (1984). A significant factor in the design was the effort to do an objective evaluation. Most continuing education programs have been subjectively evaluated on content alone by the participants. Oliver (1984) used a non-equivalent control group pretest-posttest design and objectively coded evaluation forms.

By way of record analysis, Oliver assessed the physical assessment skills of 153 community health nurses prior to the completion of an adult health screening workshop. Eighty seven of the total group voluntarily attended the workshop; the remaining 66 comprised the control group. Following the workshop, Oliver reviewed the charts again for evidence of use of skills taught during the program. In addition, she accompanied each participating nurse on a home visit to observe the use of physical assessment skills. She found that less than



ten percent of the assessment items were performed and documented both before and after the workshop. An analysis using one-way analysis of variance concluded, "The workshop experience did not affect the quality of documentation or the quality of performance" (Oliver, 1984, p. 133). However, the implications for planning future continuing education programs are significant. If continuing education programs are supposed to enable nurses to increase their knowledge and update their skills, educators and administrators need to take a serious look at measuring the effectiveness of the education process.

One need only look at the references in articles on continuing education to see that the authors rely almost exclusively on educational principles in planning programs. In the traditional, basic nursing education programs, beginning students start with little or no knowledge of nursing principles and practice, learning theory and ways to implement it. After graduation, practice habits become ingrained through experience. Often, in spite of new theoretical information, nursing actions and behaviors remain unchanged (Oliver, 1984). If the desired outcome of continuing education is not just the addition of new knowledge, but the change in behavior as well, it may be necessary to use a framework involving principles other than those of traditional education. Change Theory as

incorporated in an Organization Development framework is an alternative.

Change Theory was originally developed by the eminent social psychologist Kurt Lewin (1947) who described three phases of change: 1) the unfreezing phase; 2) the change phase; and, 3) the refreezing phase. Kreitner (1983, p. 430) states, "Unfreezing prepares the members of social systems for change and then helps neutralize initial resistance." Unfreezing activities may include announcements, meetings, and promotional campaigns. The second phase is the change phase itself, in which specific interventions are employed, such as team building activities, educational programs, and skill development. The third phase of Lewin's Change Theory is the refreezing phase, in which supportive measures and reinforcement are provided so that the new behavior becomes incorporated into practice.

Over time, and through the efforts of many theorists and researchers, the management framework of Organization Development (OD) has evolved, incorporating Change Theory. Additions, deletions, and changes in the methods employed have not altered the basic theoretical concept of Lewin, only embellished it (Kreitner, 1983).

Kreitner (1983) provides a model of OD, relating it to Lewin's three phases of change (Appendix D). The diagnostic

portion of OD corresponds to Lewin's unfreezing phase, but also includes assessment of the situation and planning of a change strategy. It includes promotional activities as outlined by Lewin as well as an assessment of "Where we are, where we want to go, and how we can get there" (Kreitner, 1983, p. 431). The four most widely used approaches in the diagnostic phase include review of records, interviews, survey questionnaires, and direct observation. Mager and Pipe (1970) have developed a flow chart which may assist in the diagnostic process (Appendix F).

The second portion of Organization Development corresponds to Lewin's change phase. Interventions can be directed at the individual, a group, or the entire organization depending on the desired outcome (Appendix H). A skill deficiency can be dealt with on an individual basis through education. If the goal is to change behavior of a group, members need to develop skills as individuals as well as recognize the significance of the change to the group. Within the group, the normative system regulates "the performance of a group as an organized unit, keeping it on the course of its objectives" (Napier and Gershenfeld, 1973, p. 80). As individual behaviors change, group norms will also change (Hersey and Blanchard, 1982).

The follow up period of the Organization Development Model corresponds to the refreezing phase of Lewin's Change Theory.

Kreitner (1983, p. 40) describes the two objectives of the refreezing phase as evaluation of the intervention and maintenance of the positive changes. Three major roles within the group are needed to effect a permanent change: a leader, a resource person, and a role model (Field, 1979).

It is important to elicit support from a leader who is committed to the change. The resource person must be a person who can provide support, assistance, and particularly guidance in making the change. A role model is an available person or group member who has already incorporated the desired behavior and uses it effectively. Field (1979) feels it is unusual to be able to find one person to fill all these roles. Without reinforcement and support over time, it is unlikely that behavioral change will occur within the group (Kreitner, 1983).

In addition to the phases of change, unfreezing, change, and refreezing, Hersey and Blanchard (1982) deal at length with levels of change. The first level of change results from the acquisition of new information causing a change in the level of knowledge. New information about a topic could be presented in an inservice program, increasing the knowledge of the participants, but not necessarily changing their behavior. The second level of change, a change in attitude, involves altering one's value system. A person needs to see the importance of the

new information. Change in individual behavior, the third level of change, involves taking the valued information and moving from belief to practice. At this point, strong support is necessary so the new behavior is used consistently (Young and Lucas, 1984). The fourth level of change identified by Hersey and Blanchard (1982) is the change in group performance. As individual group members begin to alter their patterns, group norms will also begin to change (Knowles, 1972; Napier and Gershenfeld, 1973). This is the most difficult level to achieve, but it is the goal of Organization Development.

Organization Development has been evolving for more than a quarter of a century (Bennis and Jamieson, 1981). By the 1960's Organization Development had moved from Lewin's laboratory based interventions with small groups of workers to activities within the organization itself. Typical of the description of Organization Development in the late 1960's and early 1970's was the statement by Schein (1970, p. 125) that Organization Development is "helping the organization to gain insight into its own processes, develop its own diagnostic and coping resources, and improve its own internal relationships." By the mid-1970's, White and Mitchell (1976) had begun to express concern about the ability to evaluate changes of this type. Clearly stated measurable objectives could be more easily

evaluated. Warren Bennis, author of 150 articles and 20 books about the theory and practice of management, in a joint paper with D. Jamieson, stated that the movement of Organization Development in the 1980's must be to integrate training and research with OD (1981, p. 24). They see the future of OD directed toward "educating, equipping, and empowering people" (Bennis and Jamieson, 1982, p. 24).

Although little is found in the literature regarding objective evaluation of continuing education programs, this is not true of programs based on Organization Development principles. Porras and Berg (1978, p. 250) defined Organization Development as "a set of specific change interventions focused on people and organizational processes."

Based on this definition, the authors proposed and conducted a research project which investigated the impact of Organization Development. An intense search of the literature between 1959 and mid-1975 yielded 160 assessments of planned organizational change projects. Of these, 135 met the criteria for research regarding interventions used and empirical evaluation techniques employed. An analysis taxonomy was prepared, and 308 variables were measured in two general areas of organizational life. The category labeled process variables included decision-making, motivation, attitudes and so forth; the category labeled outcome

variables included such things as performance, economic outcomes, and absenteeism.

Definitions, research methods, and results are thoroughly presented in the report by Porrás and Berg (1978), but are beyond the scope of this paper to present in detail. Methods of analysis included frequency counts and percentages. All information presented is descriptive, with no inferential statistical methods being used. Multiple figures and tables aid the reader in recognizing similarities, differences, and trends in variables following interventions based on Organization Development principles.

Of significance to this discussion is the finding that Organization Development interventions such as encounter groups and sensitivity training produced the lowest rate of change in both process and outcome variables (Porrás and Berg, 1978, p. 260). Training with task emphasis, survey feedback, and working with groups reported the largest change rate for outcome variables (Porrás and Berg, 1978, p. 255), although statistical analysis is not available. Based on their findings, the authors describe a potentially effective combination of factors on which to base OD activities as an intervention "which might typically consist of three interventions, with member participation encompassing a period of 16 to 20 days and consultant

involvement of 13 to 24 months" (p. 263). Although intensity of the activity does not appreciably affect process variable changes, it does impact on outcome variables. More intense intervention increases the percent of positive change in outcome variables (Porras and Berg, 1978, p. 263).

The study by Porras and Berg has had a significant impact on the business world. It is frequently cited in recent literature regarding management, Change Theory and OD. It may be responsible for the continued movement of OD interventions toward outcome oriented activities, which are more easily evaluated than process oriented activities. The focus of the interventions in either case is based on Change Theory.

Many phenomena of interest in nursing occur over time, but the use of a time series design is often overlooked by nursing researchers (Metzger and Schultz, 1982). The characteristic feature of a time series design is that observations occur in order, and it is possible to observe the relationship of the variables from one data point to the next. As used in the business literature of the seventies, the time series design uses descriptive statistics and graphs to demonstrate change. Harvey and Boettger (1971) used a modified time series design to demonstrate progressive improvement in the desired behavior of managers over a twelve month period.



Golembiewski and Carrigan (1970) also used a modified time series design in their research involving changes in interpersonal styles of twelve managers following an educational program included in an OD intervention. Provided in the report is a diagram demonstrating the value of the modified time series design over the one group pre-test post-test design. Descriptive statistics are provided, and tables comparing differences over four observations are also included. Again, no inferential data are provided in the report.

The time series design is a descriptive rather than an inferential design. Metzger and Schultz (1982) explain the difference between classical inferential statistics and time series data sets, and outline several complex analysis techniques being developed to strengthen the predictive aspects of time series studies. These authors point out, however, that "inferential statistics mute the importance of individual differences in predicting future behavior," and that "time series analysis techniques are basically idiographic." Their comments suggest that a time series design demonstrates trends, without the use of inferential statistical analysis.

A review of literature has indicated that many nursing leaders recognize the need for use of nursing diagnosis and encourage its use in the development of nursing care plans. It

has also been documented that programs used to encourage behavioral changes in nursing continue to be presented with no objective evaluation of their effectiveness. Only one objectively evaluated continuing education program for nurses was found in recent literature, and that study showed that the program, which was based on educational principles alone, produced no change in behavior in the nurses who attended. Non-nursing programs based on OD principles, however, have been studied and shown to be effective in producing change. Therefore, Change Theory, as incorporated into the Organization Development framework may add a new dimension to the development of continuing education programs. Finally, the use of the time series research design has received support from researchers in both health care and management, and can be used to demonstrate change over time.

The fact that nursing strongly identifies with the educational model, and that Change Theory and Organization Development are associated with management may explain why the concept has been overlooked in nursing interventions. It is, however, significant. If one wants only to impart information, a continuing education program may suffice. But, if one wants to move an individual to change the thoughts and activities that have been developed through an entire span of one's nursing

practice, there is a need for more than just an educational program. With most continuing education programs there is often no preliminary activity or follow-up. Freezing and unfreezing phases are important in establishing a permanent change in individual behavior and group norms. Therefore, Change Theory as incorporated into Organization Development has been selected as the framework on which to base this study.

#### Research Question

The question to be investigated is:

Will an intervention based on Change Theory as incorporated in an Organization Development framework lead to an increased frequency of use of nursing diagnosis on standard nursing care plans?

## Chapter III

### Methods

Because change takes place over time, the study is, by necessity, longitudinal. The Methods chapter attempts to describe in detail the change intervention and the rationale for each step. A time line depicting the activities of the change agent is included (Figure 1, page 33).

#### Study Site and Subjects

An intervention based on the OD model, to be described later, was instituted in a 410 bed midwestern teaching hospital located in a large metropolitan area. The intervention was directed toward the thirty-two registered nurses who comprised the staff of the pediatric floor. For the purpose of the study, a staff nurse is a registered nurse who works either full or part time as a regular member of the pediatric unit. Although there are also licensed practical nurses on the staff, their job description includes neither writing nursing care plans nor establishing nursing diagnoses. Therefore, the term staff nurse will be limited to registered nurses.

### Description of the Intervention

Preliminary data regarding the staff nurses were gathered using a six item questionnaire developed for the study (Appendix G). The questionnaire was presented to a group of nine nurses and then revised. The second draft was presented to a group of four nurses, after which a second revision was done. The final version was presented to 29 of the 32 pediatric staff nurses. Twenty-five completed questionnaires were returned, representing 78 percent of the staff.

Of the twenty five respondents, fourteen (56%) had graduated in 1980 or later. There were eleven (44%) diploma graduates, eight (32%) baccalaureate graduates, and six (24%) associate degree graduates. All but one of the graduates of 1980 or later had had formal education in the use of nursing diagnosis. Sixteen (64%) of the total pediatrics staff nurses had had nursing diagnosis as part of their formal education. In spite of the fact that the majority of the staff had been educated in the use of nursing diagnosis, its use was not evident in the nursing care plans. The possibility of initiating the use of nursing diagnosis among pediatrics staff nurses was discussed with the Head of the Maternal Child Health Department and the

two head nurses on the pediatric floor. Verbal approval and strong support were received regarding this effort.

Two factors still needed to be determined at this point. First, if 64% of the staff nurses had had formal education in the use of nursing diagnosis, what was the reason it was not being used? Second, what would be the best approach to implementing its use?

The multipurpose questionnaire (Appendix G) asked the nurses to "list six activities you do in your position which you consider important nursing activities." Of the twenty-five respondents, only six (24%) listed writing nursing care plans; one (4%) listed formulating nursing diagnoses. The findings are consistent with the findings of Price (1980): nurses regard treatments and tasks as primary functions, with assessment, planning, and evaluation as secondary. The emphasis among staff nurses is on doing rather than thinking.

Mager and Pipe (1970) provide a format for evaluating situations in which people are not performing as desired (Appendix F). Paramount in their discussion of performance discrepancies is the warning that not all problems can be handled with education: "One common occurrence that warns you a performance discrepancy may be lurking around is the

announcement that takes some form of 'We've got a training problem!'" (p. 3).

Lack of training may have been a portion of the problem, since 36% of the respondents to the questionnaire had had no formal education in the use of nursing diagnosis. Of the other 64%, some nurses may have never had a chance to perfect the skill of writing nursing diagnoses, thus extinguishing the behavior. More importantly, however, the staff nurses did not value writing nursing care plans or nursing diagnoses.

In determining the best approach to implementing the use of nursing diagnosis, Mager and Pipe's (1970) warning that not all problems can be corrected with education alone was considered. An intervention based on Change Theory as incorporated in an OD framework was planned.

Kreitner (1983, p. 432) outlines four widely used approaches in the unfreezing or diagnostic stage of an Organization Development intervention: review of records, interviews, questionnaires, and observation. In March, the questionnaire described previously was distributed.

Reviewing of records in the form of nursing care plans was increased to looking at all nursing care plans twice weekly. Informal discussions with staff nurses regarding the value of nursing care plans and the need for nurses to define their

practice were initiated. Also in March, the Staff Development Department began disseminating information on an upcoming program. Lynda Carpenito, the nationally known author and lecturer on nursing diagnosis had been scheduled to present a program in early May to the entire hospital. The program eliminated the availability of a control group, since the entire hospital would be involved. In addition, the scheduled date of the program shortened the time for preparation and unfreezing. It was anticipated, however, Carpenito's presentation would add excitement and credibility to the project.

In April, a formal paper addressing the lack of use of nursing diagnosis was prepared and presented to the head nurses and the head of the Maternal Child Health Department. Data from the questionnaires were compiled and presented to the staff nurses at a staff meeting. Copies of the results were posted at the nurses' stations as reinforcement and for nurses who were unable to attend the meeting. The head nurses began encouraging attendance at the Carpenito lecture.

March and April comprise the unfreezing period. The purpose of the activities during this period were two-fold: 1) to assess the situation and plan the appropriate change (Kreitner, 1983, p. 430); 2) to focus attention on the topics, prepare the



staff for change, and help reduce resistance (Hersey and Blanchard, 1982).

In planning the change phase or intervention, Kreitner's definition was used: "An intervention is a systematic attempt to correct an organizational deficiency uncovered through diagnosis" (Kreitner, 1983, p. 435). The diagnostic phase revealed there was little value placed on the use of nursing diagnosis, and there was a knowledge deficit regarding the writing of nursing diagnoses by at least 38% of the staff nurses.

During the change phase, multiple interventions can be applied. Porras and Berg (1978, p. 263) describe a combination of factors on which to base OD activities. The combination typically consists of three interventions, with member participation of 16 to 20 days and consultant involvement of 13 to 24 months. An effort was made to follow the guidelines (Figure 1).

Kreitner (1983, p. 436) discusses six interventions to be used in the change phase (Appendix H), however, not all were applicable in the study setting. Also, the use of education was felt to be necessary, although it was not outlined by Kreitner. The use of education in OD is consistent with Porras and Berg (1978, p. 251), who describe a category of Complimentary Techniques which includes cognitive training, although these

approaches are "seldom used alone in an OD program." The use of education is also consistent with Bennis and Jamieson (1981, p. 24) who propose that the trend in OD is to integrate OD principles with training and research.

Carpenito's lecture in early May, which addressed both the rationale for the move toward nursing diagnosis and information on how to write nursing diagnoses, initiated the actual change phase. Following Carpenito's lecture, the change agent was present twice weekly the remainder of the month on the pediatric unit, requesting feedback from staff nurses regarding the lecture, reinforcing Carpenito's efforts, and role modeling the use of nursing diagnosis on nursing care plans. This role is consistent with French and Bell (1973, p. 17-18) who note "the use of a 'change agent' or 'catalyst' ... (is) one of the distinguishing characteristics of OD ..." and "in the early phases, at least, the services of a third party ... are essential." Administrative support is essential in producing and maintaining positive changes (Kreitner, 1983). Toward the end of May, objective criteria for the staff were developed and a letter stating the objectives was written by the head nurses to the pediatric staff nurses (Appendix I).

During June, the bi-weekly visits to the pediatric unit were divided into two twenty minute sessions, providing four periods

per week for contact between the change agent and the staff nurses. The head nurses encouraged attendance, often covering the floor during these periods so staff nurses could attend. Attendance at a session was often put on the assignment sheets for the staff, and the head nurses also monitored the nursing care plans to see who most needed to attend. The strong support was essential in improving staff attendance and in their acceptance of nursing diagnosis.

The focus of the bi-weekly sessions was three-fold. First, nurses were encouraged to evaluate their roles and see how the use of nursing diagnosis would better enable them to describe what they do. Second, time was spent in describing a particular nursing diagnosis and applying it to patients on the pediatric unit. Third, time was used in developing skill in writing nursing diagnoses. In addition to the small group sessions, at each visit a review of the nursing care plans was done to assess progress, look for problems, and determine which nurses were using nursing diagnosis.

An effort was made to include the evening nurses by scheduling two sessions, in addition to those mentioned, during the three to eleven shift. In addition to the bi-weekly sessions, two identical inservice meetings were scheduled toward the end of June. The inservice meetings were longer, more

formal, and directed toward a larger group. A handout was given to each person attending which provided updated results of the questionnaire distributed in March, an exercise taken from Gordon (1985) involving recognition of nursing diagnoses, and a brief case study (Appendix E).

Handbooks by Carpenito regarding nursing diagnosis were purchased by the Maternal Child Health Department and distributed to each nursing station during June. Written definitions of nursing diagnoses and examples of nursing diagnoses were placed on bulletin boards and at nurses' stations. A list of accepted nursing diagnoses (Appendix A) was placed at each nurses' station.

Because of the nature of nursing activities and staffing patterns, not all nurses were able to attend on each contact day. Providing two sessions on each day was intended to increase attendance. On occasion, an exceptionally ill patient or heavy case load would make it impossible for a nurse to attend; on one occasion, none of the nurses working were able to find time to attend a session. This was an anticipated problem. A review of the nursing care plans was completed and new information was posted on the bulletin boards. It is believed the presence of the change agent on the unit served as a reinforcement for the project. The concentrated effort, the

combination of several activities, and working with groups are all consistent with the findings of Porras and Berg (1978), in increasing the rate of change in outcome variables.

By the end of June, a cursory review of nursing care plans revealed that over fifty percent contained nursing diagnoses, suggesting that the staff nurses were moving through the levels of change (Hersey and Blanchard, 1982). At least some nurses had moved from understanding and valuing the use of nursing diagnosis to the actual use of nursing diagnosis. At this point, strong support was needed to ensure the consistent use of the new behavior (Young and Lucas, 1984). Therefore, the refreezing or follow-up period was initiated the first of July. The refreezing period is designed to address unanswered questions and provide support so that the change will be maintained. Kreitner (1983, p. 440) describes the two objectives of the refreezing period as maintenance of positive change and evaluation of the intervention.

Field (1979) defined three major roles within the group which are needed to effect a permanent change: a leader, a resource person, and a role model. During July, staff nurses were identified who would serve as resource people and role models. Nurses who were asked to help were willing to assist other nurses in identifying and writing nursing diagnoses.

Staff nurses were encouraged to seek out the identified nurses for help. The leader role was filled by the head nurses who continued to support the efforts of the staff nurses in writing nursing diagnoses. In addition, staff nurses using nursing diagnosis were commended by the head nurses during formal evaluation meetings; nurses who were not using nursing diagnosis were encouraged to include this as a goal for professional growth. Kreitner (1983) views the formal reward and punishment system as a method of supporting change.

During July, the number of contact days was reduced from twice weekly to once weekly, with two twenty minute sessions held that day. The focus of the sessions was also changed. In June, sessions were spent taking specific diagnoses, looking at how to write them, and discussing to which patients the diagnoses would apply. In July, sessions were spent taking the nursing care plans of specific patients, discussing the case, and then selecting appropriate nursing diagnoses from the list of accepted nursing diagnoses. Group input and discussion were facilitated, and nurses identified as resource people and role models were encouraged to act in the appropriate roles. Also during July, review of nursing care plans and posting information on bulletin boards were continued.

During August, no contact with staff nurses or head nurses was made. It was anticipated that the mechanism of change was in action, with the staff nurses and leaders now controlling the process. It was further anticipated that, as individual group members continued to change, group norms would also change (Knowles, 1972; Napier and Gershenfeld, 1973), as evidenced by the increased use of nursing diagnosis in the care plans.

The second part of the follow-up or refreezing period is evaluation of the intervention (Kreitner, 1983, p. 440). The purpose of the study was to objectively evaluate the effect of the intervention based on Change Theory as incorporated in an Organization Development framework on the use of nursing diagnosis.

### Design

A time series design was selected for the study (Figure 1). Although inferior to the control-group design, the time series design does have significant advantages over the one group pretest-posttest design.

Observing change over time adds credibility to the hypothesis that behavioral change of the participants is due to the effect of the intervention rather than extraneous factors (Golembiewski and Carrigan, 1970). In the pretest-posttest design there is little control for change due to events external

Figure 1

Time Line Depicting Activities of the Change Agent

	Nov thru Feb	Mar	Apr	May	Jun	Jly	Aug thru Nov
<b>Phase of change</b>	Baseline	Unfreezing		Intervention		Refreezing	Post-evaluation
<b>Activities</b>	None	Assessment	Planning	Carpenito lecture	Bi-weekly meetings	Identification of leader, resource persons, and role models	none
		Questionnaire	Review of care plans	Review of care plans	Role modeling	Inclusion of use of nursing diagnosis as a goal for professional growth during staff evaluation by head nurses	
		Informal discussions with members of the staff		Letter to staff from head nurses			
		Information on Lynda Carpenito		Inservice meetings		Review of care plans	
		Formal paper to head nurses		Carpenito handbooks		Information on bulletin boards	
		Compilation of data from questionnaires		Information on bulletin boards		Weekly meetings	
				List of nursing diagnosis at nurses' stations			



to but concurrent with the intervention, and change may be attributed to maturational process. For example, the staff nurses may have been slowly moving toward use of nursing diagnosis without an intervention. Use of the time series design with pre-intervention data collection can detect this; if a question remains, additional pre-intervention data can be collected to clarify if a trend exists (Broyles and Lay, 1979; Golembiewski and Carrigan, 1970). Data collected from November\1, 1984, through February 28, 1985, provided a flat baseline, demonstrating no evidence of increased use of nursing diagnosis prior to the intervention.

There was concern that loss of staff nurses from the study population by normal attrition might threaten the validity of the study. The longer the total OD intervention continued, the greater the chance of staff changes. The length of the intervention was limited to help decrease the possible loss of subjects.

There were decreases in the staff in January; in February, two nurses left and three additional nurses were added to the staff. Because the changes occurred during the baseline data period, they will not impact on the overall OD intervention. On March first, there were 29 pediatric staff nurses, plus three regularly scheduled nurses from the float pool, totaling 32

nurses. During the change and post-evaluation periods, one nurse started April first; one left in July; one nurse began orientation in mid-August; another began in September. The remainder of the registered nursing staff on the pediatric floor did not change during the period from March first through November thirtieth. New staff starting after the period of the intervention were expected to be socialized into the group using the new group norms (Napier and Gershenfeld, 1973).

#### Procedure and Data Collection Process

Since data were collected ex post facto, no effort was made to discuss methodology or the data collection procedure with the study population. Knowledge of the design of the study may have influenced behavior regarding writing nursing care plans and using nursing diagnosis. A non-obtrusive means of observation was intended to limit reactivity of the subjects.

The data collection process involved an ex post facto audit of the nursing care plans, selecting every sixth chart from the discharge records. The first chart selected each month corresponded to the number rolled on a die. Every sixth chart from this point was selected for audit. The selection process provided between 14 and 21 records in each of the 13 data collection periods, for a total of 229 charts. Each data

collection period consisted of one calendar month beginning with November 1, 1984, and ending November 30, 1985.

The audit was used to determine if nursing diagnoses had been added to the standard care plans. If additions to the care plan which met the criteria outlined on page two were present, the number per care plan was recorded. The number of care plans which were individualized was divided by the number of charts in each data collection period, giving the percent of care plans which were individualized. The number of entries which were accepted nursing diagnoses was divided by the total number of entries on each care plan, giving the percent of additions which were accepted nursing diagnoses (Table 1).

The research design provided a random chart selection process and the use of only one primary auditor to help reduce bias in the study. An impartial second auditor was used to determine reliability. An experienced faculty person from a school of nursing randomly selected twenty charts from charts which had already been audited. The second auditor reviewed the nursing care plans to determine if nursing diagnosis had been added to the standard nursing care plans. If additions which met the criteria were present, the number per care plan was recorded. There was a 95 percent agreement between the findings of the primary auditor and the impartial second auditor.

Table 1

Percent of Total Care Plans Individualized and Percent of Entries in Accepted Nursing Diagnoses.

Phase of change	Data collection period	Number of charts audited	Number of care plans individualized	% of Care plans individualized	Number of individualized entries	Number of individualized entries in nursing diagnoses	% of Additions in accepted nursing diagnoses
Baseline	Nov '84	21	11	52%	24	7	29%
	Dec	19	9	47%	21	6	29%
	Jan '85	17	10	59%	17	5	29%
	Feb	17	10	59%	22	5	23%
Unfreezing	Mar	20	13	65%	27	8	30%
	Apr	19	11	58%	22	4	18%
Intervention	May	16	12	75%	25	13	52%
	June	19	12	63%	32	25	78%
Refreezing	Jly	16	7	44%	10	8	80%
Post-evaluation	Aug	18	12	67%	24	12	50%
	Sep	14	9	64%	23	19	83%
	Oct	18	11	61%	24	19	79%
	Nov	15	9	60%	15	14	93%

Because the standard care plans are based on the medical model, differentiating between medical diagnosis and nursing diagnosis was a fairly objective process.

The Methods chapter has attempted to describe in detail the change intervention and the rationale for each step. A time line depicting the activities of the Change Agent has been included to help clarify the relationship between the intervention and the conceptual framework (Figure 1).

## Chapter IV

### Results

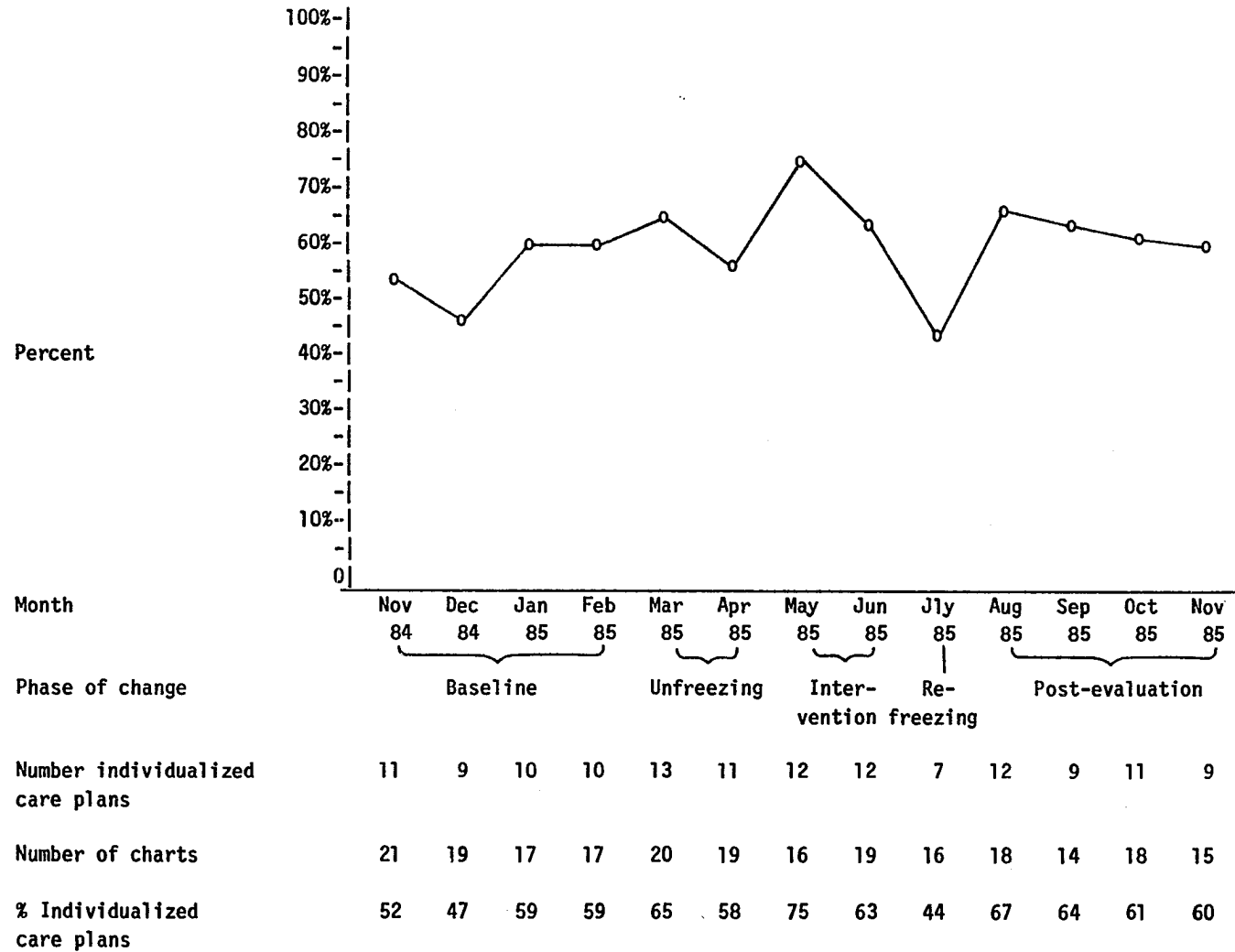
The purpose of the study was to demonstrate that an intervention based on Change Theory as incorporated in an Organization Development framework would lead to an increased frequency of addition of nursing diagnoses to standard nursing care plans. A total of 229 nursing care plans were audited over a 13 month period to determine if accepted nursing diagnoses were being used to individualize standard care plans.

Because change takes place over time, a time series design was selected for the study. Observing change over time adds credibility to the hypothesis that behavioral change of the participants is due to the effect of the intervention rather than extraneous factors (Golembiewski and Carrigan, 1970). "Time series analysis techniques are basically idiographic" therefore, the design does not provide for inferential statistical analysis (Metzger and Schultz, 1982). The results of the study are best displayed as graphs (Figures 2, 3 and 4).

With exception of a peak in May of 75% and a low in July of 44%, the percentage of total nursing care plans which were individualized appears fairly stable (Figure 2). However, the average percent of nursing care plans which were individualized

Figure 2

Percent of Total Care Plans Individualized



during the four baseline data collection periods is 54%. The average percent of nursing care plans which were individualized during the four post-evaluation data collection periods is 63%, demonstrating a 16.67% increase in number of nursing care plans which were individualized following the intervention.

The rise in May may be explained by the Hawthorne effect, as it was at this point the staff became aware that their nursing care plans were being monitored. The knowledge that they were being observed may have been sufficient to cause the staff nurses to increase their effort to individualize the standard care plans (Polit and Hungler, 1983). The drop in July, however, remains unexplained.

In contrast, data regarding the percentage of individualized entries which were accepted nursing diagnoses provides a more dramatic graph (Figure 3, Figure 4). Data collected during the four baseline data collection periods remains flat with 27.4% of entries being acceptable nursing diagnoses.

In May, at the beginning of the change intervention, there is a marked increase in the use of accepted nursing diagnoses (Figure 3). Because 64% (N=16) of the nurses had been educated in the use of nursing diagnosis prior to joining the pediatrics staff, the chance to use a skill previously learned and be recognized for it, may have been a factor in the rapid increase



Figure 3

Percent of Additions to Nursing Care Plans Which Were Accepted Nursing Diagnoses

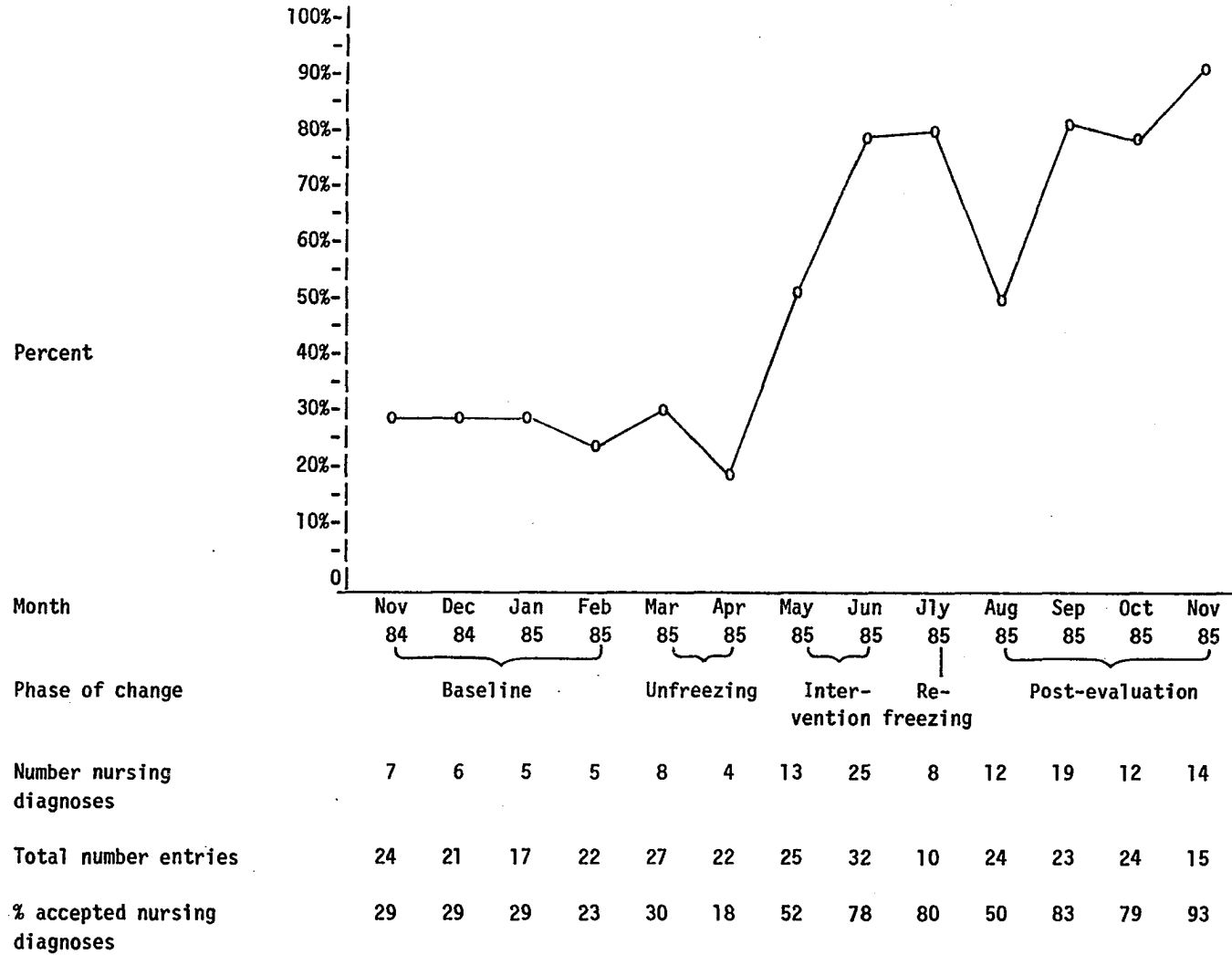
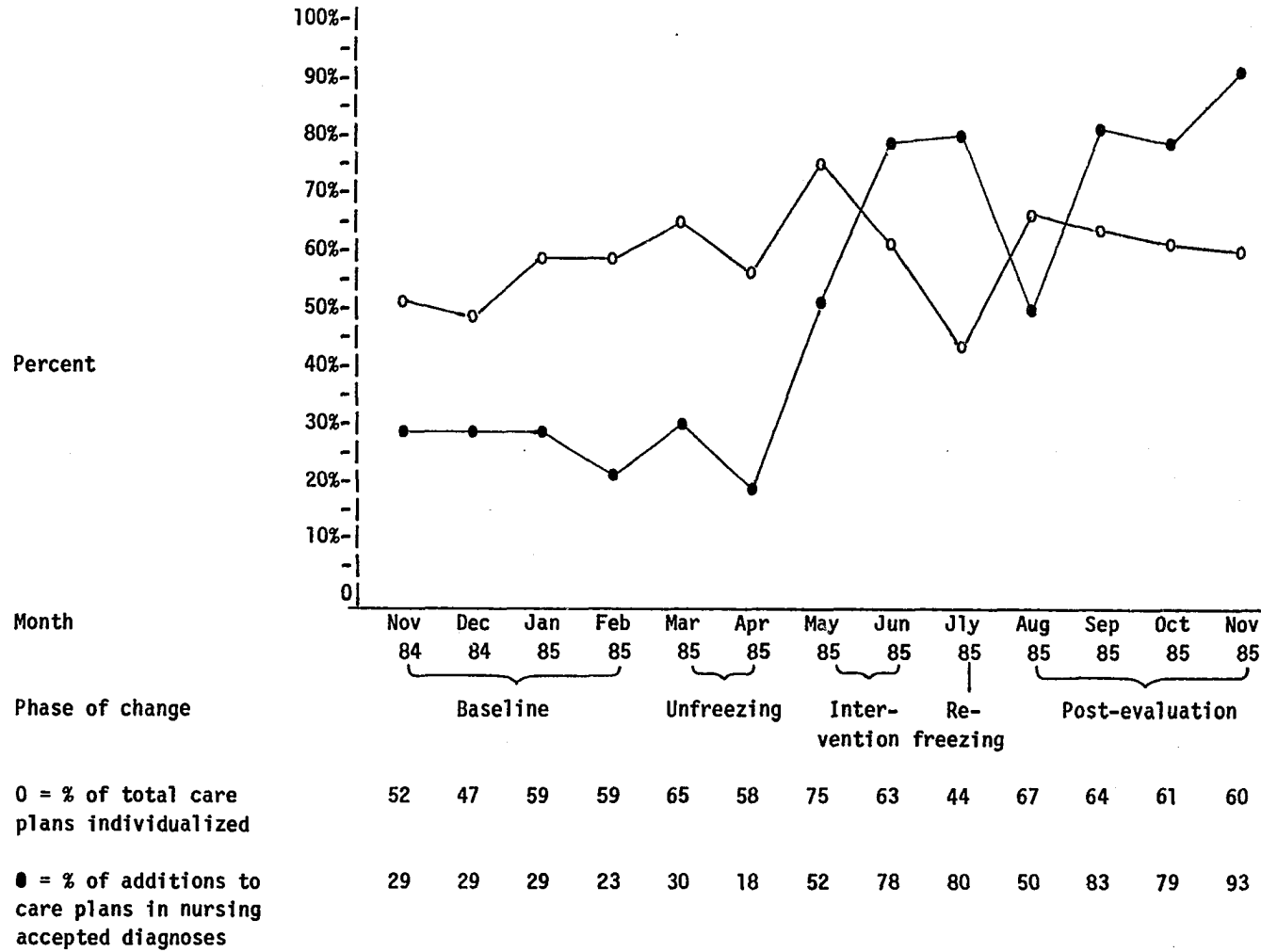


Figure 4

Percent of Total Care Plans Individualized and Percent of Additions in Accepted Nursing Diagnoses

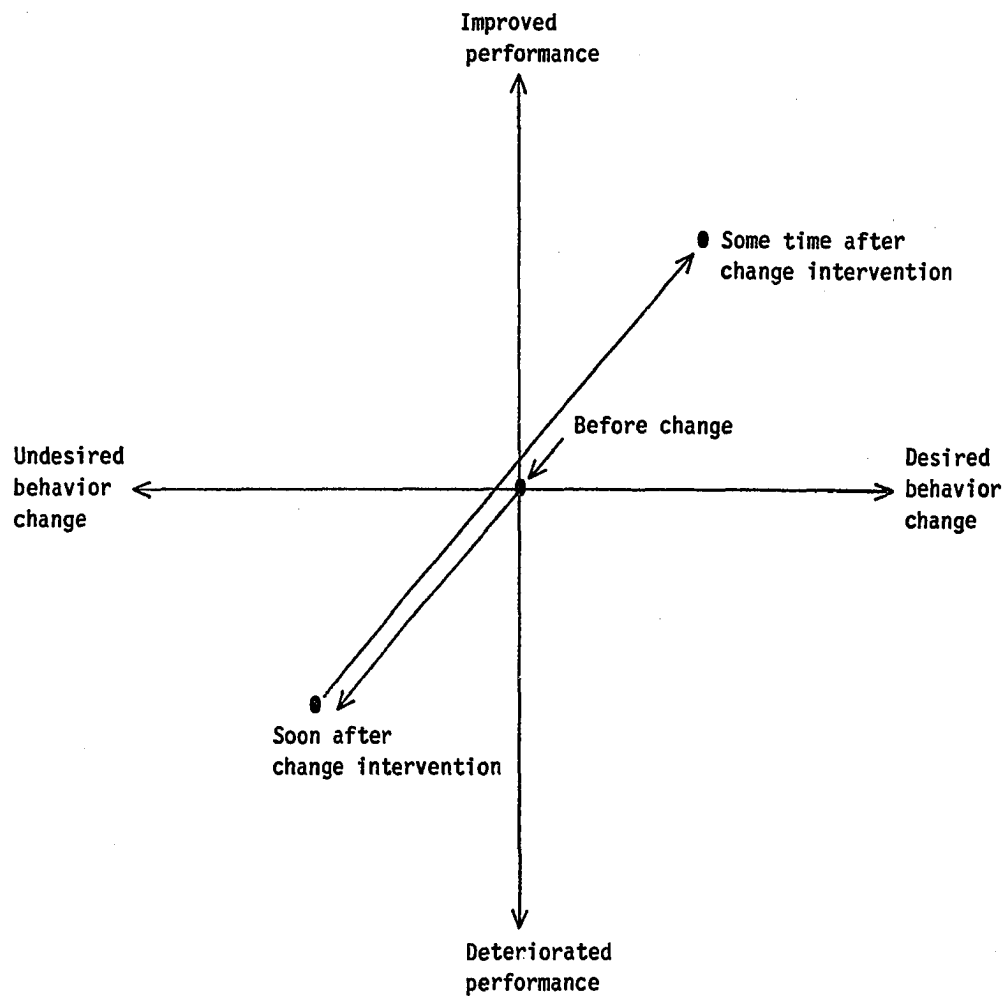


in the percentage of accepted nursing diagnoses found on individualized nursing care plans in May (Mager and Pipe, 1973).

In August there was a dramatic drop in the percentage of accepted nursing diagnoses on individualized care plans. August was a time of transition, away from the external influence of the change agent, toward internal control. The change may represent a period of movement toward undesired behavior and deteriorating performance which has been found to follow soon after a change intervention (J. Mishra, Personal Communication, Dec. 1985) (Figure 5).

The fact that the change agent was no longer on the unit may have suggested that performance did not matter (Mager and Pipe, 1973). Without strong support, group members who were still in the first and second levels of change may have temporarily reverted to former habits (Hersey and Blanchard, 1982). Three major roles within the group are needed to effect a permanent change: a leader, a resource person, and a role model (Field, 1979). During July, nurses to fill these roles had been identified and had been encouraged to begin functioning in the roles. By August, nurses filling the identified roles were in the third level of change having moved into the practice of writing nursing diagnoses when individualizing care plans (Hersey and Blanchard, 1982). Nurses filling the identified

Figure 5

Performance Following Change Intervention

J. Mishra, Ph.D.

roles were expected to become the internal mechanism for continued change of norms within the group. Norms will be changed more readily by nurses who have "achieved positions from which they can be listened to and who are perceived as striving to enhance the productivity and values" of the group (Napier and Gershenfeld, 1973, p 94). The transition from external influence to internal control may account for the decline in August.

In September, the percentage of accepted nursing diagnoses found on individualized care plans went back up and remained high during the last three data collection periods, suggesting that the fourth level of change, change in group performance, was occurring (Hersey and Blanchard, 1982). As individual group members began to alter their behavior regarding nursing care plans, group norms also began to change (Knowles, 1972; Napier and Gershenfeld, 1973). Individualization of nursing care plans through the use of accepted nursing diagnoses was becoming the group norm.

The average percent of individualized entries to standard nursing care plans which were acceptable nursing diagnoses during the four post-evaluation data collection periods is 74.4%. Compared with the average of 27.4% during the baseline period, this represents a 171.5% increase in individualized

entries to nursing care plans which were acceptable nursing diagnoses following the intervention. The findings demonstrate that an intervention based on Change Theory as incorporated in an Organization Development framework will lead to an increased frequency of use of nursing diagnosis on standard nursing care plans.

## Chapter V

### Discussion

The conceptual framework was ideal for the study. The melding of seminal work on Change Theory (Lewin, 1947) with current concepts regarding Organization Development (Kreitner, 1983) provided specific phases of change for data gathering as well as guidelines for activities during the individual phases. Information on levels of change (Hersey and Blanchard, 1982) provided specific behaviors to be observed.

The time line depicting activities of the change agent (Figure 1) provides information on what was done rather than a plan of what to do. A major activity on the time line over which the change agent had no control was the Carpenito lecture. Although Carpenito's presence added excitement and credibility to the project, the scheduling of the lecture rushed the unfreezing phase, making it difficult to complete unfreezing activities prior to the lecture date. Prior knowledge of the content and level of the Carpenito presentation may have allowed the change agent to better prepare the staff. Because the lecture was not presented at a beginning level, there was an increase in frustration, and subsequently the resistance, among

nurses who were not familiar with nursing diagnosis. Ideally, the unfreezing period should have prevented this.

The length of time allotted to the actual intervention phase was adequate and the activities were varied enough to maintain interest. There was initial concern that the refreezing phase was not long enough, and that some nurses may have benefitted from the support of a longer refreezing phase. However, because of the length and intensity of the entire change process, additional time may have led to burn-out of the staff and the change agent.

The change process cannot be rushed. Although an overall plan must act as the basis for an OD intervention, assessment and evaluation throughout the process may require deviation from the plan. Freedom and willingness to redirect activities based on group needs are essential.

The time series design could be considered both a strength and a weakness. Because statistical significance regarding the change is not demonstrated with a time series design, generalizations to other nursing populations cannot be made. With current emphasis in nursing literature on the use of inferential statistics, a study using descriptive statistics may seem elementary by comparison. But the design does permit continued observation of the study population by virtue of its



open-endedness. Reinforcement through additional inservice programs, increased use of resource people on the unit, and a presentation of the data from the study to the staff may stimulate renewed interest in individualizing care plans and using nursing diagnosis. Additional data can be gathered on the population and the graph extended at any time. The time series design is limited only by the time of the researcher.

Alternate designs were considered. A paired  $t$  test with one data collection point before the intervention and one following would yield inferential data but would not show change over time. Although Metzger and Schultz (1982) allude to a more sophisticated inferential analysis of a time series design, the method was not available. The descriptive time series design has been used frequently in business literature and was effective in presenting the data in this study.

Paramount to the success of the study was the freedom granted to the change agent by the head nurses on the pediatric unit and the Head of the Maternal Child Health Department as well as by the members of the Thesis Committee who supervised the research. Because the role of change agent requires continual assessment, evaluation and redirection of activities, adherence to a rigid plan would not be as effective.

### Implications for nursing

Review of the literature has not demonstrated the effectiveness of the traditional educational approach in establishing behavioral change in practicing nurses. Therefore, the demonstrated effectiveness of the intervention based on Change Theory as incorporated in an Organization Development framework has wide implications in nursing. It is often assumed that because people are not performing as desired, there is a need for further education (Mager and Pipe, 1970). The entire staff development and inservice education concept is based on this assumption. Particularly for nurses who have been in practice for a period of time, education may be only a part of what is needed.

The staff development department uses the same person or persons to carry out programs; Organization Development principles suggest the use of an outside change agent (French and Bell, 1973). Educators from the staff development department state they receive little administrative support; OD necessitates strong administrative support (Kreitner, 1983). A staff development program frequently consists of an educational program of one-half to one hour; OD interventions designed to cause change in behavior typically consist of three interventions with member participation of 16 to 20 encounters

and consultant involvement of 13 to 24 months (Porras and Berg, 1978). Finally, a staff development program is complete in itself; Change Theory necessitates the unfreezing, intervention, and refreezing phases (Lewin, 1947).

The use of continuing education or "cognitive training" is consistent with Porras and Berg (1978, p. 251), although this approach, alone, may not be sufficient. Because nursing is an ever changing field, it is necessary to provide an effective method of updating knowledge and clinical skills of practicing nurses. If the purpose of a continuing education program is only to impart knowledge, then an educational program may suffice. If the goal is to change behavior as well, education alone has not proven to be effective.

Change in behavior reflects a higher level of change than change in knowledge. A change in knowledge is not always reflected in a change in behavior. This study has demonstrated that an intervention based on Change Theory as incorporated in an Organization Development framework is an effective method of increasing the use of nursing diagnoses on standard nursing care plans.

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## Appendix A

## Nursing Diagnoses Accepted for Clinical Testing

Activity Intolerance	Mobility, Impaired Physical
Airway clearance, ineffective	Noncompliance (specify)
Anxiety	Nutrition, alterations in: less than body requirements
Bowel elimination: Constipation	Nutrition, alterations in: more than body requirements
Bowel elimination, alt.: Diarrhea	Nutrition, alterations in: potential for more than body requirements
Bowel elimination, alt.: Incontinence	Oral mucous membrane, alterations in
Breathing patterns, ineffective	Parenting, alterations in: actual
Cardiac output, alt in: decreased	Parenting, alterations in: potential
Comfort, alterations in: pain	Powerlessness
Communication, impaired verbal	Rape-trauma syndrome
Coping, ineffective individual	Self-care deficit (specify level: feeding, bathing/hygiene, dressing/grooming)
Coping, ineffective family: compromised	Self-concept, disturbance in
Coping, ineffective family: disabling	Sensory perceptual alterations
Coping, family: potential for growth	Sexual dysfunction
Diversional activity deficit	Skin integrity, impairment of: actual
Family processes, alteration	Skin integrity, impairment of: potential
Fear	Sleep pattern disturbance
Fluid volume, alt.: excess	Spiritual distress (distress of human spirit)
Fluid volume deficit, actual	Social isolation
Fluid volume deficit, potential	Thought processes, alterations in
Gas exchange, impaired	Tissue perfusion, alterations in
Grieving, anticipatory	Urinary elimination, alt. in patterns
Grieving, dysfunctional	Violence, potential for
Health maintenance alteration	
Home maintenance management, imp.	
Injury, potential for	
Knowledge deficit (specify)	

Guzetta, CE and Dossey, B. (1983). "Nursing Diagnosis; Framework, Process and Problems." Heart and Lung 12, 3, p 284.

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<u>Dimensions of Professional Nursing</u>	<u>57</u>
<u>A General Model of OD</u>	<u>59</u>
<u>Dimensions of Professional Nursing</u>	<u>63</u>
<u>Diagnostic Exercises</u>	<u>66-67</u>
<u>Analyzing Performance Problems</u>	<u>69</u>
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**INFECTION/  
INFLAMMATION**

- HEALTH** 1. Normal resp. rate and quality.
- 2. Clear chest.
- ACTIVITY** 3. Pt. able to do own ADL.
- KNOWLEDGE** 4. V. understanding and willingness to follow discharge instructions by pt. &/or S.O.

**STANDARD CARE PLAN**

Blodgett Memorial Medical Center

DATE	PROBLEMS	EXPECTED OUTCOMES	DEAD-LINES	CHECK-POINTS	RE-SOLVED	NURSING ORDERS	INIT
	1. <u>Congestion</u> , cough & dyspnea due to disease process.	1. a. Normal resp. rate, b. Clear breath sounds.	disch.	see N.O.		1. a. TPR q4° until afebrile x 24° (if temp $\downarrow$ 38.5, take q2°). b. C & DB q2° W/A x 2 at noc. c. $\downarrow$ HOB to comfort. d. V breath sounds q shift until clear. e. Notation re: character of resp., type & amt. of secretions, pt's color q shift. f. Cough meds & expectorants as ordered. g. Discourage smoking. h. Teach pt proper disposal of secretions.	
	2. <u>Dehydration</u> due to fever &/or inadequate intake.	2. a. 3000 cc/24° unless contraindicated. b. Good skin turgor. c. Moist mucous membranes. d. Afebrile.	afebrile for 24°	q8°		2. a. 1300-day; 1300-P.M.; 400-noc. b. I & O. c. Provide fids. of pt's choice. d. Antipyretics & hypothermia as ordered.	
	3. <u>Fatigue</u> due to disease process.	3. V. less fatigue.	disch.	daily		3. a. Arrange schedule to allow for rest periods Rest times at _____.	
	4. <u>Apprehension</u> due to SOB.	4. a. Relaxed facial expression. b. V. understanding of correlation between anxiety & SOB.	disch.	daily		4. a. Maintain calm unhurried appearance. b. Explore with pt coping mechanisms to alle 1. 2. c. Reassurance of continued observation & su 1. 2.	

Appendix C

## APPENDIX E

**Criteria for Being Acknowledged as a Profession**

1. Provide services vital to human and social welfare
2. Have specialized body of knowledge that serves as basis for skills and services
3. Engage in research and clinical investigations to expand knowledge
4. Provide services based essentially on intellectual operations accompanied  
by individual responsibility
5. Educate its clinicians in institutions of higher learning
6. Establish and control its own practice
7. Be composed of individuals who are service and career oriented rather  
than self-serving
8. Have a code of ethics which guides the conduct of its clinicians
9. Have an active, cohesive association that fosters and ensures the  
quality of practice

ref: Baer, Charold L., 1984, Topics in Clinical Nursing, 5, 4, p 90.

Kelly, L.Y., 1981, Dimensions of Professional Nursing, 4th ed.

Lysaught, J.P., 1981, Toward an Unambiguous profession of Nursing.

**Updated Results of Questionnaire to Staff**

**Number distributed: 29**

**Number returned: 25**

<u>Function</u>	<u>Number</u>	<u>Percent</u>
Assess, monitor, evaluate	12	48%
Write care plans; plan care	6	24%
Write nursing diagnosis	1	4%
Provide hands on care	15	60%
Follow doctors orders	3	12%
Team lead; supervise	3	12%
Chart; document	2	8%
Counsel; support (pt.&s.o.)	15	60%
Teach; role model (pt.& s.o.)	16	64%
Collaborate, coordinate, refer	10	40%
Learn; research	1	4%
Give meds, IV's, prescribed treatments	11	44%
Other	10	40%

**Definition: Nursing Diagnosis**

Nursing diagnosis is a statement that describes a health state or an actual or potential altered interaction pattern of an individual, family, or group, to life processes (psychological, physiological, socio-cultural, developmental, and spiritual) which legally, the nurse can identify and order the primary interventions to maintain the health state or to reduce, eliminate, or prevent client alterations.

L. Carpenito, 1984.



## Nursing Diagnoses Accepted for Clinical Testing

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Bowel elimination, alt.: Diarrhea	Nutrition, alterations in: potential for more than body requirements
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Breathing patterns, ineffective	Parenting, alterations in: actual
Cardiac output, alt in: decreased	Parenting, alterations in: potential
Comfort, alterations in: pain	Powerlessness
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Coping, ineffective individual	Self-care deficit (specify level: feeding, bathing/hygiene, dressing/grooming)
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Coping, family: potential for growth	Sexual dysfunction
Diversional activity deficit	Skin integrity, impairment of: actual
Family processes, alteration	Skin integrity, impairment of: potential
Fear	Sleep pattern disturbance
Fluid volume, alt.: excess	Spiritual distress (distress of human spirit)
Fluid volume deficit, actual	Social isolation
Fluid volume deficit, potential	Thought processes, alterations in
Gas exchange, impaired	Tissue perfusion, alterations in
Grieving, anticipatory	Urinary elimination, alt. in patterns
Grieving, dysfunctional	Violence, potential for
Health maintenance alteration	
Home maintenance management, imp.	
Injury, potential for	
Knowledge deficit (specify)	

Guzetta, CE and Dossey, B. (1983). "Nursing Diagnosis; Framework, Process and Problems." Heart and Lung 12, 3, p 284.

DISCHARGE CRITERIA:

LOWER JAW & OVERBITE, ORBITO 2  
 ONE YEAR OF (MAXILLO-FACIAL OSTEOPLASTY) TO  
 HEALTH ASSURE GOOD CONTROL OF DIABETIS - HISTORY REVEALS MUM STILL INSISTS ON GIVING ALL INSULIN  
 ACTIVITY INJECTING IN SPITE OF PATIENT'S DEMONSTRATED COMPETENCY - PATIENT EXPRESSES FEELINGS OF  
 KNOWLEDGE BEING "DIFFERENT" FROM MUM BECAUSE OF "BACK BITING" & DIABETIS.

PATIENT CARE PLAN

STANDARD CARE PLAN

Blodgett Memorial Medical Center

DATE	PROBLEMS	EXPECTED OUTCOMES	CHART-ING TIMES	RE-SOLVED	NURSING INTERVENTIONS	INIT.
6-1 (No. 2)	DIVERSIONAL ACTIVITY DEFICIT R/T MAINTAINANCE OF COMFORTMENT	1) RELATE METHODS OF CARING & CARE GIVING 2) ENGAGE IN DIVERSIONAL ACTIVITY			1) PLAY TRIVIAL PURSUIT, CHECKERS. 2) INVOLVE PATIENT IN ACTIVITIES WHICH ALLOW INTERACTIVE ASSES FOR STATES	
(No. 3) (No. 4)	FEAR R/T KNOWLEDGE DEFICIT RE: SURGERY	1) EXPRESS LESS FEAR OF SURG. 2) DESCRIBE POST-OP CHANGES, EQUIPMENT, & PROCEDURES 3) ACTIVELY PARTICIPATE IN POST-OP ACTIVITIES			TEACH, ACCORDING TO STANDARD TEACHING PLAN FOR MAXILLO-FACIAL OSTEOPLASTY	
(No. 5) (No. 6)	POTENTIAL FOR IMPAIRMENT IN SELF-CONCEPT R/T POSITIVE FEEDBACK ON BODY IMAGE CHANGES.	1) RELATES METHODS OF INCREASING SEX-REL CONTACTS 2) VERBALIZES REALISTIC IDEA OF SURGICAL OUTCOME			1) PROVIDE REALISTIC INFORMATION RE: OUTCOME OF SURGERY 2) DISCUSS PEEC INTERACTION.	
(No. 7) (No. 8)	ALTERATIONS IN PARENTING R/T UNREALISTIC EXPECTATIONS OF SELF BY MOTHER	1) MUM WILL VERBALIZE WAYS IN WHICH PATIENT CAN ASSUME MORE SELF-CARE RESPONSIBILITY 2) MUM WILL DEMONSTRATE REINFORCING BEHAVIOR TOWARD PATIENT'S SELF-CARE EFFORTS			1) PROVIDE GUIDANCE TO MUM RELATED TO NEED (DEVELOPMENTAL) OF PATIENT TO ASSUME SELF-CARE. 2) REFER FOR FAMILY COUNSELLING TO HELP 3) PROVIDE STRONG EMOTIONAL SUPPORT FOR MUM & PATIENT.	
(No. 9) (No. 10)	POTENTIAL FOR IMPAIRMENT IN HOME MAINTENANCE INHERENT R/T KNOWLEDGE DEFICIT OF POST-OP CARE.	1) Pt. & Mum WILL VERBALIZE & DEMONSTRATE SKILLS NECESSARY FOR HOME CARE. 2) Mum WILL VERBALIZE RESPONSIBLE FOR FOLLOWING			TEACH POST-OP PROCEDURES & REFERENCE TO STANDARD TEACHING PLAN FOR MAXILLO-FACIAL OSTEOPLASTY.	

This questionnaire is designed to help gather data for research on Nursing Diagnosis. It is important that you complete the items as an individual, without discussing the responses with your colleagues. Individual responses will be kept confidential; the results of the study will be available to the staff at the completion of the research. Thank you for your help.

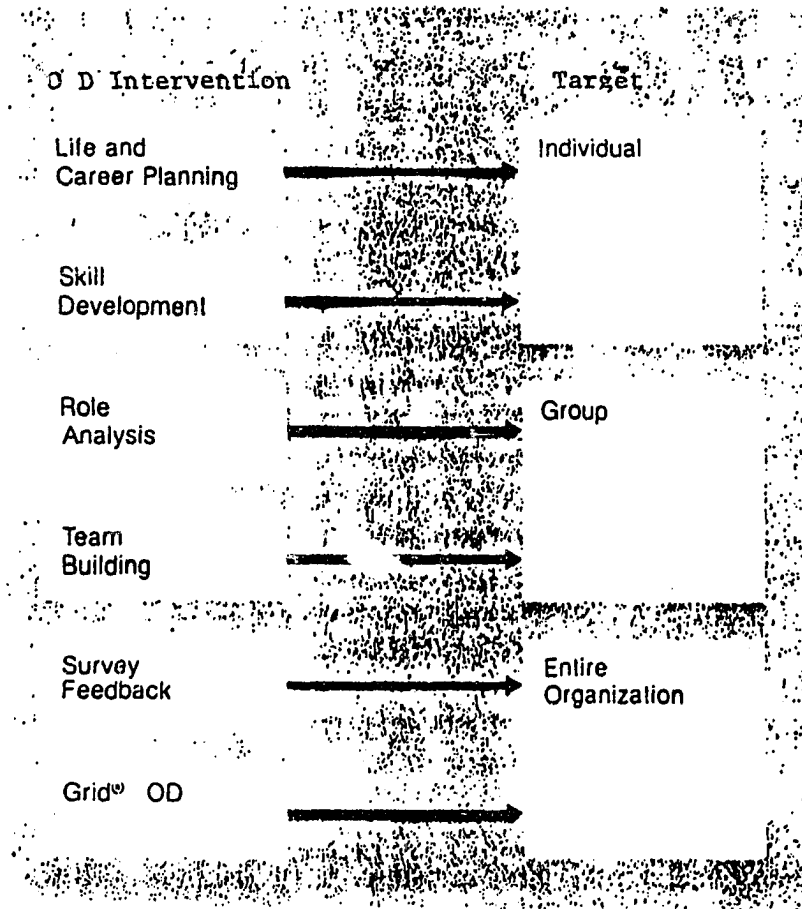
*Sandi Ellington, RN, GISC  
grad. si*

- 1) What year did you graduate from your nursing education? \_\_\_\_\_
- 2) Circle the response which indicates the highest level of nursing education you have completed.
  - a) LPN
  - b) ADN
  - c) Diploma
  - d) BSN or BS-N
  - e) MSN or MS-N
- 3) Did you receive instruction in Nursing Diagnosis during your education?    yes    no
- 4) Have you learned about the use of Nursing Diagnosis in informal ways, such as inservice programs or nursing journals?    yes    no
- 5) After reading the following responses, circle as many responses as you would consider appropriate Nursing Diagnosis. (If you select response a), please do not select any other responses.)
  - a) I do not have enough knowledge of Nursing Diagnosis to select any of the other responses.
  - b) Encourage verbalization.
  - c) Potential for dysreflexia due to spinal cord injury.
  - d) Knowledge deficit related to diabetes.
  - e) Heart murmur and prolapsed mitral valve.
  - f) Provide assistance with meals.
  - g) Sleep pattern disturbances related to pain.
- 6) List six activities you do in your position which you consider important nursing activities. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thanks again.



## Appendix H

**OD Interventions for Different Levels**

Kreitner, R. (1983)  
Management  
Houghton Mifflin Company  
pg. 436

**BLODGETT MEMORIAL MEDICAL CENTER  
NURSING SERVICE DIVISION  
MATERNAL CHILD HEALTH DEPARTMENT**

**M E M O**

**TO:** 3A, 3B, PSCU, RN's  
**FROM:** <sup>JA</sup>Sue Drenth and Pat <sup>Pue</sup>Cornell  
**DATE:** May 24, 1985  
**RE:** Nursing diagnosis

It is the goal to have nursing diagnosis as defined by Lynda Carpenito used in all patient care planning on Pediatrics by August 30, 1985. We are accelerating our efforts on Pediatrics, because through July, we have available to us Sandi Gladstone, a GVSC graduate student who is writing her thesis on the use of nursing diagnosis.

The first step in implementing this change was the Carpenito lecture. Those of you who did not attend, may obtain a copy of the materials from us.

The subsequent steps are:

1. Kathy Campbell and Sandi Gladstone will provide inservice programs to review and clarify information from Carpenito, and to help with the "how to" portion of writing nursing diagnosis.
2. Sandi Gladstone will be available Tuesdays from 10:00 am to 11:00 am and Fridays from 1:00 pm to 2:00 pm through June; and on Tuesdays only from 10:00 am to 11:00 am the month of July. She will work with small groups or individuals on writing nursing diagnosis for specific patients.
3. Head nurses will be available for consultation and questions at any time.
4. Current staff members with background in nursing diagnosis can be used as resource persons and role models.
5. Books on nursing diagnosis will be available on each unit for individual reference.

**Objectives:**

**By May 31 staff nurses will:**

1. Read and/or review information from Carpenito's lecture.
2. Define nursing diagnosis.
3. Explain the rationale for the use of nursing diagnosis.

**By June 30 nursing staff members will:**

1. List cues (signs and symptoms) which might lead to formulating nursing diagnosis.
2. Differentiate between actual, possible and potential nursing diagnosis.
3. Demonstrate the use of nursing diagnosis on three care plans.

**By July 30 nursing staff members will:**

1. Differentiate between nursing diagnosis and collaborative problems.
2. Interpret cues (signs and symptoms).
3. Use nursing diagnosis in 50% of care plans.

**By August 30 staff members will:**

1. Formulate nursing diagnoses based on assessment data in 75% of care plans.

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