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PRIMARY CARE FAMILY NURSE PRACTITIONERS' PRACTICES OF ASSESSMENT FOR THE STATE Of THRIVING AMONG COMMUNITY-BASED ELDERS

by

JUDY LABONTE

A Thesis
Submitted in Partial Fulfillment of the Requirements
For the Degree of Master of Science in Nursing
in the Division of Nursing
Mississippi University for Women

COLUMBUS, MISSISSIPPI

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Primary Care Family Nurse Practitioners'
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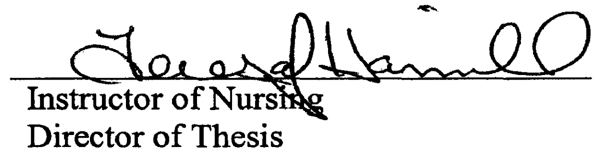
by

Judy LaBonte



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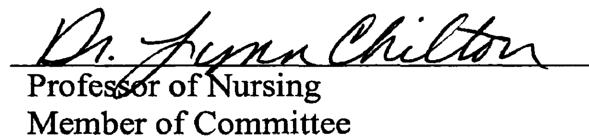

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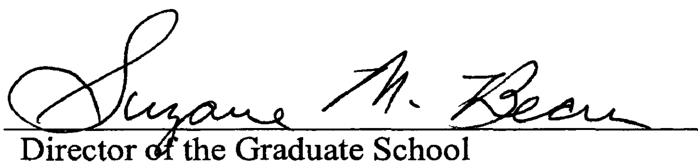

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Abstract

The increasing life span of people within the developed world may produce major health problems for the elder. These health problems lead to premature declines in function and cognition. Many healthcare professionals do not recognize these declines until the need for institutionalized care is urgent. Research has demonstrated that healthcare professionals either fail to recognize or address these declines, contributing to poor outcomes for the elder and the exponential rise in healthcare expenses of the Medicare and Medicaid funds. This exploratory, descriptive study was designed to examine the level of assessment by primary care family nurse practitioners (FNPs) for the state of thriving among community-based elders. The theoretical framework for this research was based on the Thriving Model: A Life Span theory developed by nurse researchers out of the University of North Carolina at Greensboro (Haight et al., 2002). The research question that guided this study was as follows: To what level do primary care family nurse practitioners assess for the state of thriving among community-based elders? The setting for this study was a southeastern state. A sample of 150 family nurse practitioners were surveyed using a researcher-designed tool, titled the LaBonte Questionnaire. The surveyed FNPs adequately assessed for routine primary care assessment such as laboratory data and review of immunizations. However, the data analysis revealed that the majority of primary care FNPs failed to adequately assess community-based elders

for the state of thriving as it related to activities of daily living and at-risk assessments, such as depression screening. Numerous implications for nursing practice, education, research, and administration were created by this study. Further research utilizing this new theory of thriving was recommended to further develop and define the critical concepts of thriving as it relates to the community-based elder.

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Chapter I

The Research Problem

The ability to remain independent within an individual's life span and postpone the inevitable physical and/or cognitive decline is the desire of most people (Gill, Baker, Gottschalk, et al., 2002; Griffith, 2002). The majority of elders wish to remain in their personal home, continuing to "thrive" within that environment (Aminzadeh, Amos, Byszewski, et al., 2002; Grando, Mehr, Popejoy, et al., 2002; Haight, Barba, Tesh, & Courts, 2002). Thriving can be described as a state of being by which an elder is able to flourish within his/her own environment, aging in place (Haight et al.). However, with the aging process, many elders experience an acute decline in functional or cognitive abilities that necessitates moving into a more supervised living arrangement (Aminzadeh et al., Gill et al.; Grando et al.; Griffith).

The consequences of aging can bring about illnesses that are of a chronic nature and require the aging elder to make numerous modifications to his/her life style (Aminzadeh et al., 2002; Gill et al., 2002; Griffith, 2002). Oftentimes, aging elders do not have accurate or pertinent knowledge on how to manage these illnesses or cope with the ever-increasing technological world (Gill et al., Griffith, Rosswurm, 2001). There are often prolonged illnesses that gradually progress, robbing the individual of a thriving

state (Newbern & Krowchuk, 1994). The morbidities and functional declines may cause an untimely or premature death (Newbern & Krowchuk).

The ability to remain independent and self-sufficient is a state that elders in the community wish to maintain (Aminzadeh et al., 2002; Gill et al., 2002; Griffith, 2002). Family nurse practitioners (FNPs) are prepared through holistic educational and clinical experience to assist these aging individuals to remain independent by assessing and managing their health problems (Sheehy & McCarthy, 1998).

With the findings from a holistic assessment of an elder's physical, cognitive, and functional strengths, and deficits, FNPs can implement critical interventions that will support the strengths and minimize deficits (Aminzadeh et al., 2002; Gill et al., 2002; Griffith, 2002). An assessment of thriving is very detailed in that it encompasses not only the physical elements, but also the psychosocial, cognitive, and psychological components of an elder's life (Haight et al., 2002).

The timely assessment and implementation of critical interventions could prolong the elder's ability to thrive and remain in a familiar environment (Haight et al., 2002; Gill et al., 2002; Griffith, 2002). The purpose of this study was to explore and describe the level of assessment by primary care family nurse practitioners for the state of thriving among community-based elders.

Establishment of the Problem

The life expectancy of Americans is increasing each decade (Urban & Rural Health Chartbook, 2001). Advanced age can bring about chronic illnesses such as hypertension, diabetes mellitus, neurological disorders, and arthritis that impair the

community-based elder's ability to live independently (Rosswurm, 2001). The care that these varied health problems require contributes to the exponential growth of healthcare expense.

Most of the elderly poor in this country live in non-urban areas (Urban & Rural Health Chartbook, 2001). Additionally, the poorer, rural elder tends to be less educated; have less dependable transportation and fewer support services to maintain a state of thriving (Burggraf & Barry, 1998; Rosswurm, 2001; Urban & Rural Health Chartbook). In less urbanized areas, the opportunities for the rural elder to obtain optimum healthcare are limited (Burggraf & Barry; Rosswurm).

This dearth of available healthcare services causes severe distress to elders and their families (Aminzadeh et al., 2002; Griffith, 2002; Rosswurm, 2001). Whenever there is a major health event, such as a stroke or a hip fracture, rural nursing homes are the predominant provider of extended care for rural elders (Rosswurm). Long-term care is cost prohibitive for most elders, leading to reliance upon federal and state reimbursement through the Medicaid programs (Rosswurm; Urban & Rural Health Chartbook, 2001).

In 1996, ninety-six percent of elders reported medical expenses averaging $5600 per person, an increase of healthcare expenses per individual of forty-six percent since 1987 (Rosswurm, 2001; Urban & Rural Health Chartbook, 2001). In 1999, the average monthly cost of long-term care was $3891. On a national level, the average Medicaid payment to nursing homes was 22% of the annual budget (Rosswurm; Urban & Rural Health Chartbook). Every year since 1965 when Medicare was introduced to this country, the cost related to eldercare has steadily risen to the point where in 1999,

Medicare had thirty-nine million enrollees with expenditures of $213 billion (Urban & Rural Health Chartbook).

The largest concentrations of the poor, rural elders live in the Midwest and the South (Urban & Rural Health Chartbook, 2001). The Southern region of the United States has a high population of poor, rural elders attempting to thrive within their own homes and communities (Urban & Rural Health Chartbook). With limited financial resources, elders living within their communities have few choices when seeking appropriate and timely healthcare interventions (Burggraf & Barry, 1998; Rosswurm, 2001).

In one southeastern state, one sixth of the total population is over the age of 60, the exact number being 448,137 according to the 1999 census. The old-old, aged 85 years and older number 41,119 (State of Mississippi Division of Aging & Adult Services, 2002). This southeastern state is considered a rural state where many elders are living in areas with limited services to support the state of thriving (State of Mississippi Division of Aging & Adult Services). They are culturally bound to their personal homes/properties and usually live within a twenty-five mile radius of close family members (Rosswurm, 2001; Urban & Rural Health Chartbook, 2001).

Cultural influences particular to the Southern region promote community cohesiveness, but sometimes minimize the willingness of the rural elder to seek or rely upon available health services (Rosswurm, 2001). Burggraf & Barry (1998) & Evans & Yurkow (1999) propose that healthcare providers, particularly nurse practitioners should locate their practices within underserved areas such as those in the rural southeast.

Affordable and accessible healthcare is necessary for the thriving elder who lives in less-urbanized areas (Grando et al., 2002; Haight et al., 2002; Rosswurm).

Burggraf & Barry (1998) encouraged the advanced practice nurse (APN) to venture out of the clinic setting, thus expanding the influence of the APN within the elder community by involving themselves in special interest groups such as churches, senior meetings, and community functions. Primary care FNPs' assessment of elders for the need of functional-based interventions could help the elder to remain as independent as long as possible and promote thriving within communities (Aminzadeh et al., 2002; Gill et al., 2002; Haight et al., 2002). With this early intervention, elders could function longer within their own environment, ultimately reducing the overall cost of healthcare by delaying the admission to nursing homes (Burggraf & Barry; Gill et al.; Grando et al., 2002; Haight et al.; Rosswurm, 2001).

According to Burggraf & Barry (1998), nurse practitioners that locate within rural or underserved areas are better able to meet the needs of the community-based elder. Poor, rural elders suffer far more negative outcomes than any other population whenever there is inaccessibility to optimum health care (Burggraf & Barry; Rosswurm, 2001).

The Balanced Budget Act of 1997 granted Medicare reimbursement for nurse practitioners (Burggraf & Barry, 1998; Evans & Yurkow, 1999). With this momentous legislation, nurse practitioners were able to actively seek elder clients within their practices (Burggraf & Barry). By setting up practices in rural areas, the needs of the community-based elder could be proactively assessed and supported (Burggraf & Barry). However, this reimbursement has been steadily cut since 1997, causing undue suffering

of the poor, rural elder by limiting options for healthcare services (Evans & Yurkow; Rosswurm, 2001).

A lack of timely healthcare intervention or prevention leads to postponement of critical health issues and often exacerbates chronic illnesses, thus limiting the ability to thrive (Evans & Yurkow, 1999; Haight et al., 2002; Gill et al., 2002; Griffith, 2002; Newbern & Krowchuk, 1994). The limited opportunities for early interventions by healthcare providers lead to a dependence upon premature institutionalization within rural nursing homes causing subsequent needless outlays of healthcare dollars as well as negative outcomes for the elder (Aminzadeh et al. 2002; Gill et al.; Grando et al., 2002; Newbern & Krowchuk; Rosswurm, 2001).

The FNP's emphasis on health promotion and disease prevention/management could postpone progressive exacerbations and increasing disabilities (Aminzadeh et al., 2002; Burggraf & Barry, 1998; Gill et al., 2002; Griffith, 2002). The FNPs' understanding and utilization of the thriving theory could guide the assessment to include not only the physical elements, but also the psychosocial, cognitive, and psychological components of the elder's life (Haight et al., 2002). The complexities of the elder's life and needs could be assessed, and documented within an enhanced history and physical tool, allowing the FNP to implement timely adjustments to the established plan of care (Aminzadeh et al.; Gill et al.). Research has demonstrated that with early intervention, elders can be maintained in their community settings and avoid unnecessary institutionalization (Aminzadeh et al.; Gill et al.; Grando et al., 2002; Griffith).

Maintaining functional status of a community-based elder is paramount to the state of thriving (Haight et al., 2002). Nursing research has clearly documented a need

for a holistic assessment and implementation of interventions to maintain such a functional state (Aminzadeh et al., 2002; Gill et al., 2002; Grando et al., 2002; Griffith, 2002).

Significance to Nursing

The significance to nursing in relation to elders' state of thriving could be addressed in three interrelated areas, clinical practice, nursing education, and nursing research. Implications for advanced practice are apparent in that a thorough, holistic assessment based on a theoretical framework could lead to improved outcomes (Polit & Hungler, 1999). When the practitioner understands the theoretical framework, the interventions are guided by that specific theory (Haight et al., 2002). This allows the practitioner to assess a problem in a more holistic manner and plan for dynamic changes over a continuum (Polit & Hungler; Haight et al.).

By directing care that is guided by the theoretical framework of thriving, the nurse practitioner could potentiate positive outcomes for the community-based elder (Haight et al., 2002). FNPs that accurately assess community-based elders for thriving could implement early interventions thus preventing further declines in functional/cognitive abilities, allowing the elder to flourish and thrive within his/her own environment (Aminzadeh et al., 2002; Gill et al., 2002; Griffith, 2002; Haight et al.).

The implications for education of nurses in the area of assessment of thriving among elders are immeasurable (Haight et al., 2002; Tesh, McNutt, Courts, & Barba, 2002). Current gerontological nursing focuses on care of the aging client and his/her morbidities (Newbern & Krowchuk, 1994). With the Thriving Model the focus is shifted

to promotion of thriving, health maintenance, and prevention (Haight et al., 2002). Nursing could focus on the alternatives of decline, and the alternatives of failure to thrive, directing its energies to promoting thriving (Tesh et al.; Haight et al.). Nursing curricula need to incorporate the positive aspects of thriving and the critical interventions that are needed to sustain thriving (Tesh et al.; Haight et al.).

Nursing research will greatly benefit from the theory of thriving (Haight et al., 2002). Not only does the theory need to be tested within the scenarios of primary care and long term care, but research is also needed in exploring the impact of thriving within the assisted living venue (Tesh et al., 2002). With continued research, the theory will gain new dimensions as evidenced-based practice supports the conceptualization (Haight et al.; Gill et al., 2002; Grando et al., 2002; Tesh et al.). Haight et al. recommended repeated use of the model as a framework for other gerontological research and stated that the theory could continue to evolve as other phenomena or attributes were realized through ongoing research.

The FNP, utilizing the theory of thriving could purposively assess for physical, psychosocial, and cognitive strengths/weaknesses (Aminzadeh et al., 2002; Gill et al., 2002; Griffith, 2002). It is within the theoretical framework of thriving that the elder's physical, cognitive, and functional needs are directly related to the ability of the elder to thrive within his/her environment (Haight et al. 2002).

The assessment of thriving is very detailed in that it encompasses not only the physical elements, but also the psychosocial, cognitive, and psychological components of the elder's life (Haight et al., 2002). The timely assessment and implementation of critical interventions could prolong the elder's ability to thrive. Published research has

clearly shown that with early intervention, elders can be maintained in their community setting and avoid unnecessary institutionalization (Aminzadeh et al., 2002; Gill et. al, 2002; Grando et al, 2002; Griffith, 2002). However, no research was identified in the literature related to FNPs' assessment of thriving among community-based elders. Therefore, the current study will contribute to the knowledge base of research concerning community-based elders.

Theoretical Framework

The theoretical framework for this study was "Thriving: A Life Span Theory", proposed as a new gerontological theory by Haight, Barba, Tesh, & Courts (2002). These nursing researchers published the theory in March 2002 after extensive conceptual analysis and review of literature based on failure to thrive (Newbern & Krowchuk, 1994). The authors developed a theory that defined a holistic aging process, portraying an optimum state of existence for elders.

Relying on prior nursing research by Newbern & Krowchuk (1994) on the concept of failure to thrive, Haight et al, (2002) were able to formulate key features of the thriving theory by proposing the antithesis of failure to thrive. Thriving was defined as a "fluid state by which one constantly adapts to continuous change in an ongoing, dynamic human and nonhuman environment" (p. 16). "The three interacting factors in a thriving continuum are the person, the human environment, and the nonhuman environment" (p.16). These factors intermingle to make an optimum state or they conflict with one another and produce the syndrome of failure to thrive (Haight et al.).

The concept of "person" as recognized by Haight et al., (2002), was defined as a "psychosocial biological entity" (p. 17) whereby gender, heredity, and innate intelligence are predetermined. The human environment was noted as either enhancing or distorting the predetermined psychosocial-biological traits, impacting the evolving person. The non-human environment was described as involving all the influences of an economic nature (Haight et al.).

Economic status has clearly been recognized as impacting a person's ability to succeed or thrive (Haight et al., 2002; Rosswurm, 2001). The combining factors of limited income and the physical/cognitive decline can accentuate the deterioration to the syndrome of failure to thrive (Haight et al.; Newbern & Krowchuk, 1994). The timely interventions by the FNP within the primary care setting could strengthen the elder's ability to adapt to the ever-changing dynamics of health and physical functioning (Aminzadeh et al., 2002; Gill et al., 2002; Griffith, 2002).

Haight et al. (2002) developed two critical attributes of the state of thriving: "social relatedness and physical/cognitive function" (p. 17). Within the thriving state, the "social relatedness" ensured that the elder maintained the necessary social-support networks and by staying connected, the "physical/cognitive function" either improved or was maintained (Haight et al.).

In the Thriving Model, Haight et al. (2002) proposed key phenomena that led to a state by which an accurate prediction could be made as to how the phenomena would interact. In developing their theory of thriving, the researchers were able to describe a holistic, gerontological theory by which clinical applications could be derived. Haight et al. recommended repeated use of the model as a framework for other gerontological

research and stated that the theory could continue to evolve as other phenomena or attributes are determined by ongoing research.

The FNP, in integrating the theoretical framework into practice habits could more accurately assess the elder client (Haight et al., 2002). The exploration of the person's psychosocial, biological, strengths and weaknesses could expand the routine history form into a more holistic approach and format (Aminzadeh et al., 2002). An enhanced history and physical tool could assess the person's social connectedness and evaluate the social support network that surrounds the elder (Aminzadeh et al.; Fassino, Leombruni, Daga, et al., 2001; Grando et al., 2002).

The "non-human environment" such as economic status could be identified early within the relationship between the FNP and the elder. By identifying the economic situation, appropriate social referrals and community contacts could be initiated before a crisis occurred (Aminzadeh et al., 2002; Fassino et al., 2001; Rosswurm, 2001). The whole person could be thoroughly assessed so that appropriate interventions could be initiated that helped the elder manage his/her own health and well-being (Haight et al., 2002).

The theoretical framework of thriving directed this research in which assessment practices by primary care FNPs were explored in relation to community-based elders. Clinical practice and research that is based on theory always produces optimal outcomes (Polit & Hungler, 1999).

Purpose of the Study

The purpose of this study was to ascertain the level of assessment by primary care FNPs for the state of thriving among community-based elders. Published studies have documented that with thorough assessment and early intervention, elders can be maintained in their community settings and avoid unnecessary institutionalization (Aminzadeh et al., 2002; Gill et al., 2002; Grando et al., 2002; Griffith, 2002). Assessment practices differ among all practitioners (Sheehy & McCarthy, 1998). This study attempted to determine how well FNPs assessed for the state of thriving among community-based elders.

Statement of the Problem

There are limited opportunities for elders to obtain timely and appropriate health care interventions in order to maintain a state of thriving (Burggraf & Barry, 1998; Evans & Yurkow, 1999; Haight et al., 2002). Many healthcare providers fail to holistically assess the elder for the thriving state (Haight et al.; Rosswurm, 2001). Many elders fail to thrive within their communities due to the lack of accurate and timely assessment of their social support, necessitating a move into a more supervised living arrangement (Aminzadeh et al., 2002; Fassino et al., 2001; Grando et al, 2002; Griffith, 2002).

Maintaining the functional status of community-based elders is paramount to the state of thriving (Haight et al., 2002). Nursing research has clearly documented a need for a holistic approach to assessment and implementation of interventions to maintain such a functional state (Aminzadeh at al., 2002; Gill et al., 2002; Grando et al., 2002; Griffith, 2002).

Research Question

The research question that guided this research was as follows: To what level do primary care FNPs assess for the state of thriving among community-based elders?

Definitions of Terms

To clarify the concepts of the problem statement for this study, the following definitions were set forth:

1. Primary care family nurse practitioners:

   Theoretical: Primary care FNPs are master's –educated, advanced practice nurses that work in ambulatory settings with the experience to care for the life span (Sheehy & McCarthy, 1998, p. 128).

   Operational: Primary care FNPs are master's-educated, advanced practice nurses who work in ambulatory settings with experience to care for the life span and who completed the LaBonte questionnaire.

2. State of Thriving:

   Theoretical: Haight, et al. (2002) described, "thriving as a positive concept that exists as a continuum, the ongoing process of growing through continuous human, environmental interactions, resulting in social, physical, and psychological resilience and growth" (pp. 16-17).

   Operational: Thriving was defined operationally as the ability of an individual to continue to live within his/her own environment and meet fundamental and essential activities of daily living.

3. Community-based elders:

Theoretical: Community was defined as "a body of people living in the same place under the same laws" (Merriman-Webster Dictionary, 1982, p. 226). Elder was defined a "rather old; especially past middle age" (Merriam-Webster Dictionary, p. 362).

Operational: The operational definition of community-based elder was an individual over 65 years of age, living within one's personal home, including assisted living, but excluding long term care.

Assumptions

The assumptions underpinning this study were as follows:

1. Thriving continues to be impacted by a person's ability to maintain some level of physical independence and decision-making (Haight et al., 2002).
2. Thriving has two critical attributes, "social relatedness and physical/cognitive function" (Haight et al., p. 17).
3. Thriving can be quantitatively determined.

Summary

In summary, the ability of an elder to remain in a thriving state is dependent upon his/her physical, cognitive, and functional abilities (Haight et al., 2002). Primary care FNPs that accurately assess community-based elders for the state of thriving could implement early interventions, preventing further declines in functional abilities and allowing the elder to flourish and thrive within his/her own environment (Aminzadeh et al., 2002; Fassino et al, 2001; Gill et al., 2002; Grando et al, 2002; Griffith, 2002;).

Chapter II

Review of Literature

A review of literature was conducted to identify any studies relevant to the current research. Research was found on the theory of thriving within a nursing home. In reviewing the current literature, the theory of thriving as it related to community-based elders was not specifically identified. However, there were relationships to the theoretical framework in that the tenets of promoting physical functioning, cognitive abilities, and psychosocial factors of elders were studied (Aminzadeh et al., 2002; Fassino et al., 2001; Gill et al., 2002; Griffith et al., 2002; Tesh et al., 2002).

The theoretical framework of the thriving theory was tested in a study conducted by Tesh, McNutt, Courts, & Barba (2002). Environments of long term care facilities in a southern state were compared in regard to key changes, including home-like transformations of such facilities. Citing prior research that substantiated improved quality of life and thriving with specific changes in the environments of long term care residents (Thomas, 1996), Tesh et al. sought to link the theoretical framework of thriving with the interactions between infirmed, elderly residents and their "non-human environments" of nursing homes (Haight et al, 2002).

Utilizing a survey method of data collection, questionnaires were mailed to administrators of certified nursing facilities within a southern state, seeking to identify

those facilities that had specific plans to remodel or those that had already remodeled their environments into a more home-like setting, specifically using the Eden Alternative™ (Tesh et al., 2002; Thomas, 1996). The Eden Alternative™ (Thomas) promoted changes within the environment of a nursing home that included pets, plants, and children, attempting to improve the lives of the residents and promote thriving (Haight et al., 2002; Tesh et al.).

The Eden Alternative™ as proposed by Thomas (1996) positively impacts an elder's quality of life by making an institution such as a nursing home more home like, including the addition of a live-in pets such as dogs, cats, and birds and fish in aquariums. Additional improvements recommended by Thomas encompassed less hierarchical management, including allowing the nursing assistants autonomous decision making in regards to work schedules. Thomas challenged that with the improved living and working conditions, the staff were happier, more relaxed, and more able to provide therapeutic care to the elders, promoting their ability to thrive (Haight et al., 2002).

In the study by Tesh et al. (2002), one hundred sixty-seven (n=167) surveys were returned from a targeted sample of 378. Twenty-eight percent (28%) of the returned surveys indicated that they had no plans for environmental changes, while 22% indicated that The Eden Alternative™ was being currently adopted. The remaining respondents indicated that changes were in process but did not necessarily involve The Eden Alternative™ (Tesh et al.). The purpose of the study by Tesh et al. was to determine the percentages of nursing homes in the southern state that had adopted the Eden Alternative™ and the reasons for their choices.

The research by Tesh et al. (2002) did not relate to the current study in its purpose or conclusions. However, the research was the only published study utilizing the Thriving Model as its theoretical framework. Additionally, The Eden Alternative™ as proposed by Thomas (1996) supported the foundation of the thriving theory especially in regard to environmental factors, the "non-human" environment (Haight et al., 2002). Tesh et al. recommended further research into The Eden Alternative™ as well as further research utilizing the Thriving Model within long-term care settings and assisted-living facilities.

The research completed by Tesh et al. (2002) implied that home-like settings benefit elders. In the current study regarding community-based elders, the proposed ability to remain within one's home or familiar environment impacts thriving and warrants further investigation (Grando et al., 2002; Haight et al., 2002).

The assessment of physical functioning was the focus of a study conducted by a multi-disciplined team that included nurses, social workers, and physical/occupational therapists. The purpose of the study was to evaluate a program on preventing functional declines in elders who remain in their own homes. The researchers, Gill, Baker, Gottschalk, et al. (2002), reviewed initial statistics on the prevalence of chronic disabilities impacting the elder population of this country. In their review of literature, the authors cited prior research that focused only on the restoration of function following an event such as hip fracture or stroke. The focus of this research was "prehabilitation" not rehabilitation, a groundbreaking approach.

By conducting a randomized clinical trial of a home-based program designed to prevent functional decline in a high-risk group, the researchers were able to test their

hypothesis of whether such "functional decline could be prevented" (Gill et al., 2002, p. 1068). Criteria for admission included the age requirement of being 75 years or older and living at home with "physical frailty". Physical frailty was defined as requiring more than "10 seconds to perform a rapid-gait test or if they could not stand up from a seated position in a hardback chair with their arms folded" (Gill et al., 2002, p. 1069).

Individuals meeting one criterion were considered moderately frail; those meeting both criteria were considered severely frail. After determining eligibility, the individuals (n=188) were assigned to either the experimental group where they received an intensive home-based intervention program or they were placed in a control group where they received health education (Gill et al., 2002).

The majority (85%) of the experimental group was female and white (90%). For the control group, 74% were female and 91% were white. Both groups were similar for the number of chronic illness (2), mini-mental state score (26), and level of physical frailty (Gill et al., 2002).

Targeting eight activities of daily living (ADLs), the researchers assessed and planned treatment modalities that could theoretically improve the functional status of the participants. Follow up assessments occurred at 3, 7, and 12-month intervals for progress related to the interventions, either the program or the educational sessions (Gill et al., 2002).

Measuring the outcomes of the eight daily activities with an instrument that summarized disability, the researchers identified subtle shifts from dependence to

independence. The experimental group received interventions that involved regular visits from research nurses, completing a thorough pre-intervention assessment (Gill et al., 2002).

A physical therapist made 16 home visits over a 6-month period, implementing client-specific treatment modalities with the goal of improving functional status based on the eight targeted ADLs. Additionally, the subjects were instructed on a home exercise program to reinforce the physical therapy (Gill et al., 2002).

The control group underwent the assessment process, but did not receive the intervention of home-based physical therapy. This group received detailed verbal health instructions from the research nurses. The targeted ADLs were the basis of the educational sessions (Gill et al., 2002).

The major difference between the intervention and control group was that the control group did not receive the individual client-specific treatment by the physical therapists. Their disability scoring was collected according to the intervals at 3, 7, and 12 months (Gill et al., 2002).

Gill et al. (2002) based their statistical analysis on the "intent to treat principle" (p. 1070). Using a two-tailed statistical analysis with a P value of < 0.05, the researchers determined statistical significance that supported their hypothesis. The experimental group had less functional decline at 7 months when compared to base line data ($P=0.008$) and at 12 months ($P=0.02$) (Gill et al., 2002).

The Gill et al. (2002) research clearly supported their hypothesis and provided credible data for evidence-based practice for elders living in the community setting. Gill

et al. determined that the elders with severe, physical frailty did not benefit from any intervention and consequently required admission to long-term care facilities.

Highly complex disabilities of elders, compounded with natural occurring events such as strokes and myocardial infarctions, impaired the ability of the severely, frail elders to improve. The researchers recommended further research to determine the actual cost of such "prehabilitation" programs as well as clarifying the program's ability to exert beneficial effects (Gill et al., 2002).

The study by Gill et al. (2002) provided credibility to the Thriving Model in that when functional abilities are supported, the elder can continue to thrive within his/her environment. This study was relevant to the current research in which assessment practices for the state of thriving among community-based elders were examined. A thorough assessment of a community-based elder's state of thriving could ultimately prolong his/her ability to remain in the community by implementing early interventions that enhanced the functional, cognitive, and psychosocial abilities (Gill et al., 2002; Haight et al., 2002). In this era, there are many more choices and opportunities for the elder to remain in his/her own home with social support for the complex, instrumental activities of daily living (IADLs), while obtaining physical support for the ADLs (Aminzadeh et al., 2002; Gill et al., 2002; Griffith, 2002).

Grando, Mehr, Popejoy, et al. (2002) explored the situation whereby elders requiring "light care" needs entered nursing homes instead of choosing less restrictive environments. The researchers obtained a sample of convenience consisting of 20 (n=20) elders living in nursing homes in the Midwest. Relying upon a triangulated style of design, qualitative interviews were blended with quantitative chart reviews producing

interesting themes and hard data regarding the reasons elders chose nursing homes over other options (Grando et al., 2002).

The multi-disciplined team discovered three themes within the interviews: 1) a perception of the inability to care for self, 2) the experience of a health event, a hospitalization, or a fall, and 3) having no support systems (Grando et al., 2002). The qualitative findings provided insight into the precipitating factors that influenced the decisions of elders in choosing long-term care (Grando et al.).

Qualitative data collection was obtained through a formal interview guide developed by the researchers. Quantitative data collection by chart review was completed by the researchers reviewing the Minimum Data Set (MDS), version 2.0 and the Resource Utilization Groups (RUG-III) and determining the degree of disability and the need for assistance with ADLs (Grando et al., 2002).

The sample of 20 participants ($\underline{n}$=20) was evaluated using qualitative software and a standard computer algorithm that is specific to the MDS data. Of the total 20, there were 18 (90%) over the age of 70 years, 16 of whom were women and 4 men. Forty-five percent (45%) had lived alone prior to moving to the nursing home (Grando et al., 2002).

Of the three themes that emerged from the interviews, 95% of the participants believed that they had no other option but to enter the nursing home. All would have preferred to remain in their own homes (Grando et al., 2002).

Of the twenty, 14 (70%) participants were in the two lowest care subcategories indicating that the majority of them required only minimal assistance with ADLs. Of the 14 more independent subjects, no cognitive impairment was present that could have interfered with their living in a less restrictive environment (Grando et al., 2002).

This exploratory study provided basic preliminary data on a subject not often researched, with vast implications for nursing practice. Advanced practice nurses who accurately assessed and planned for the holistic needs of elders could reduce the need for institutional care (Grando et al., 2002). The qualitative component of the study provided key reasons elders chose long term care facilities when their level of need was not consistent with admission criteria (Grando et al.).

The study by Grando et al. (2002) substantiated the current research exploring the assessment practices of family nurse practitioners (FNPs) for the state of thriving among community-based elders. A holistic assessment could identify the specific needs of elders, prolonging their ability to remain in their own homes.

Primary care FNPs that holistically assess an elder's needs for assistance with IADLs and ADLs could provide timely interventions and social support, thus maintaining the thriving state of the community-based elder. The purpose of this current study was to determine the level of assessment by primary care FNPs for the state of thriving among community-based elders (Aminzadeh et al., 2002; Gill et al., 2002; Griffith, 2002).

According to Haight et al. (2002), the cognitive/affective function of an individual determined whether or not the individual continued to flourish or spiraled downward to a state of failure to thrive. In order to maintain a thriving state, an individual must have a stable, normal mood, and a clear, cognitive ability in which to comprehend and adapt to the changing dynamics of life (Haight et al.). Elders who suffered from cognitive declines could not sustain a thriving state within their own home (Haight et al.).

The review of the literature provided another publication that substantiated the research conducted by Haight et al. (2002). Griffith (2002) outlined a thorough

assessment process by which an early screening, diagnosing, and treating of mild to moderate Alzheimer's disease and other cognitive-impairing diseases led to positive outcomes for the elder. With aggressive screening, Griffith maintained that with early diagnosis and treatment, maximum benefits were obtainable with the latest pharmacological therapies.

Using several different neuropsychological assessment tools and the Nurses' Observation Scale for Geriatric Patients, Griffith (2002) not only assessed memory and cognition, but also functional ability. The author recommended conducting this thorough evaluation over the span of three different clinic visits so that behavioral/cognitive patterns could be established. Once the diagnosis was confirmed, Griffith recommended a family meeting so that a thorough discussion of treatment options could occur. The author cautioned the clinician to expect initial denial by the family and/or the elder and that the family might choose to seek a second opinion.

Griffith (2002) stressed early treatment, citing various clinical trials using donepezil (Aricept). The author reiterated that current cognitive abilities could be preserved or that the disease progression could be slowed with prompt diagnosis and treatment. This same publication recommended close monitoring of caregiver stress, citing a fifty percent rate of clinical depression among caregivers of elders with dementia diagnosis. Prompt treatment of the entire family could only improve the outcomes of the elder being treated for dementia. Griffith also stressed early recognition of co-morbid states of depression among elders with dementia and that prompt treatment by anti-depressants could improve the quality of life of the elder.

The detailed assessment recommended by Griffith (2002) of an elder's cognitive functioning promoted thriving of the individual by identifying early, soft signs of neurological declines. Haight et al. (2002) maintained that in order to sustain a thriving state, an elder must have a stable, normal mood, and a clear, cognitive ability to comprehend and adapt to the dynamic changes in one's life.

Griffith's (2002) recommendation for a thorough assessment process supported the current exploration of assessment practices by primary care FNPs for the state of thriving among community-based elders. Research has shown that with early identification of physical, environmental, and psychosocial weaknesses, the elder can be supported within his own home (Gill et al., 2002; Grando et al, 2002).

The perceptions of elders regarding in-depth geriatric assessments were explored by Aminzadeh, Amos, Byzewski, & Dalziel (2002). A qualitative study was conducted, researching the elder's and caregiver's perceptions and feelings involving the assessment process. Using a convenience sampling of elders attending a geriatric day hospital in Ontario, Canada, the researchers were able to follow 116 (n=116) elder clients as they underwent an intensive, inter-disciplinary assessment of their functional, cognitive, and psychosocial well being (Aminzadeh et al.).

The assessments took place over four to six weekly visits, lasting approximately 3 hours each. The elders saw numerous health care professionals that included geriatricians, nurses, and occupational, speech, and physical therapists. A pharmacist, a social worker, and a dietician also assessed the client with the nurses functioning as case managers of the assessment process (Aminzadeh et al., 2002). A family conference concluded the assessment process whereby the interdisciplinary team members met with

each client and his/her family/caregivers. This session was designed to disseminate data gathered by the assessments and provided written recommendations for treatment (Aminzadeh et al., 2002).

Aminzadeh et al. (2002) then conducted follow-up home visits 3 months after discharge. If home visits were not appropriate, then telephone interviews were conducted. At these visits, qualitative data were collected that reflected the perceptions and feelings of the elders and the families after undergoing the geriatric assessment.

The perceptions by the elder clients ranged from gratitude for having such a thorough assessment to resentment for having to withstand such intensive, exhausting interviews and assessments. Elders with already established cognitive impairments expressed confusion and frustration with the in-depth cognitive testing (Aminzadeh et al., 2002).

There were many criticisms regarding the length of the assessments and several elders resented having their children informed of their weaknesses. The caregivers' perceptions were mostly positive; impressed by the process and the skill of the health care professionals, with few negative comments (Aminzadeh et al., 2002).

Most caregivers left the family session having more information regarding social and community supports and options available for their elder. Most felt that the recommendations were timely and appropriate (Aminzadeh et al., 2002).

At the 3-month post-discharge evaluation, 24.2% of the participants had been moved to a more supervised environment; either living with family/caregivers or admissions in assisted living or long-term care facilities. The caregivers expressed

gratitude for the recommended social/community referral agencies (Aminzadeh et al., 2002).

Aminzadeh et al. (2002) recommended that future studies focus on clients'/caregivers' perspectives at various key points of the assessment process, identifying critical adjustments to the assessment process. The authors also recommended that one person, an advanced practice nurse, could coordinate the entire process. This streamlining of the process could have better outcomes and improved perceptions by the clients/caregivers. A therapeutic relationship could be fostered between the advanced practice nurse and the elders/caregivers, allowing more opportunities for accurate assessments and interventions (Aminzadeh et al., 2002).

The findings from the study by Aminzadeh et al. (2002) supported the need for holistic assessment of elders by advanced practice nurses, thereby substantiating the need for the current study under investigation. The research by Aminzadeh et al. (2002) investigated the assessment of cognitively impaired elders requiring institutionalization, while the current study focused on a holistic assessment of thriving among community-based elders.

The supposition by gerontological clinicians that all elders wish to remain in their own homes was explored in a study by a team of gerontologists from Turin, Italy. Fassino, Leombruni, Daga, et al. (2001) conducted the exploration of this conviction through qualitative and quantitative research. Exploring the quality of life experienced by elders who remained at home or in the homes of their children/caregiver was the purpose of the study.

Using a specifically designed cross-sectional health interview along with an ADL index and the Zung rating scale for anxiety and depression, Fassino et al. (2001) were able to collect data that ran contrary to reputed beliefs concerning community-based elders. Using a convenient cluster method, the sample was composed of white, dependent elders living at home alone or with their children in the city of Turin. All participants were over 65 years of age and had the criteria of being unable to live or act independently, but did not have a diagnosis of dementia (Fassino et al.).

Analysis of the cross-sectional health interview coupled with ADL index and the Zung scale determined a definitive relationship between low ADL scores and anxiety and depression. Those participants with higher ADL scores usually did not live alone. Elderly males scored higher on the ADL index, while elderly females scored higher on the anxiety/depression scale (Fassino et al., 2001).

The qualitative data from the structured interviews were grouped into three themes, 1) dependence, 2) everyday living, and 3) inner resources or creativity. Within the category of dependence, the more dependent elder viewed life as less meaningful. Many of the subjects expressed shame and embarrassment with their dependency, feeling that their families were more burdened by their living (Fassino et al., 2001).

Within the category of everyday living, the subjects who were the most dependent generally did not participate in normal everyday activities such as using the telephone, performing domestic tasks, leaving the house, or even looking through a window at the outside. Nor did the most dependent individuals read newspapers, or books, or watch television (Fassino et al., 2001).

With the last category, inner resources and creativity, the most dependent elders felt that their solitude had a negative impact on their quality of life. Additionally, the most dependent suffered from the deepest depression, perceiving limited value to their families. All of these existential qualities cross-tabulated with the degree of dependency and the degree of depression/anxiety (Fassino et al., 2001).

The researchers substantiated their hypothesis that quality of life was directly related to the psychological, functional, and existential aspects of aging. Critical relationships between phenomena were formulated from this data; dependence can be culturally and relationally induced, and that the socio-cultural environment tends to prejudicioulsy describe elderly people as dependent, frail, and disabled. The impact of culture was directly related to the domain of inner resources and creativity (Fassino et al., 2001).

Fassino et al. (2001) cited their study's limitation in that the sample was not random, and that quite possibly the culture of northern Italy did not reflect other cultures. However, much data was obtained that led to interesting conclusions. Conclusions cited by the researchers included that dependence is impacted by culture and anxiety and depression negatively impacts the elder's perception of quality of life.

The study by Fassino et al. (2001) provided antithetic data and conclusions. The preconceived ideas regarding the appropriateness of remaining at home or living with relatives was questioned and found flawed through the research by Fassino et al.

The relevance of Fassino et al. (2001) study to the current research was immeasurable. The prudent FNP would be amiss if the culture of the elder was not considered (Fassino et al.). This study validated and supported the purpose of the current

study in exploring the elder's social arrangement within the confines of family and community. A holistic assessment of thriving among community-based elders should include the cultural and environmental influences (Fassino et al., 2001).

Summary

The review of the literature provided clear and substantial evidence for the need for a holistic assessment of elders for the state of thriving (Aminzadeh et al., 2002; Fassino et al., 2001; Gill et al., 2002; Grando et al., 2002; Griffith, 2002). The review was global in geography and in content, covering related topics of elder assessment and care, as well as exploring different cultures in other countries (Aminzadeh et al., Fassino et al.). The perceptions of the elders undergoing the aging process and the geriatric assessment process were presented and redefined (Aminzadeh et al.; Fassino et al., Grando et al.).

The literature presented here substantiated the Haight et al. (2002) theory of thriving in that with each study there was a direct or indirect linkage or reference with the Thriving Model. Grando et al. (2002), Aminzadeh et al. (2002) and Fassino et al. (2001) produced existential findings that substantiated the three interacting factors in the thriving continuum, "the person, the human environment, and the non-human environment" (Haight et al.). Fassino et al. and Aminzadeh et al. supported the concept of social relatedness.

A holistic assessment of the elder and his/her support system was validated through the studies conducted by Aminzadeh et al., (2002) and Gill et al., (2002). Griffith (2002) and Gill et al. supported the assessment process by focusing on the

physical/cognitive component of the Thriving Model (Haight et al, 2002.).

Throughout all the studies, implications for nursing practice and further research were presented clearly (Aminzadeh et al., 2002; Fassino et al., 2001; Gill et al., 2002; Grando et al., 2002; Griffith, 2002;). The review of the literature supported and validated the purpose of the current research by which assessment practices of primary care FNPs for the state of thriving among community-based elders was studied.

Chapter III

The Method

Design of Study

An exploratory, descriptive, and quantitative research design was utilized in the current research. The purpose of the study was to determine the level of assessment by primary care family nurse practitioners (FNPs) for the state of thriving among community-based elders. This research design was appropriate in determining current practice habits among primary care FNPs regarding elder care. Nursing research has historically used a descriptive, exploratory design to determine relationships and linkages between variables (Polit & Hungler, 1999).

Setting, Population and Sample

The setting for this study was primary care clinics located in a southeastern state. The primary care clinics were situated within both rural and urban settings.

The target population was family nurse practitioners (FNPs) that were licensed within the southeastern state and practiced within a primary care setting. FNPs who saw elders who were institutionalized within the confines of a long term care facility were excluded. The focus was on ambulatory primary care.

A convenience sample of 150 nurse practitioners was used for this study. A list was obtained from the State Board of Nursing of the southeastern state that provided the

subjects names and specificities of practice. An impartial statistician entered the first five hundred names on the State Board of Nursing's list of FNPs into a database. The database then randomly selected every third name on the list. The researcher did not see the list prior to the mailing nor was able to selectively include or exclude any individual.

FNPs were chosen based on the following qualifications: 1) licensed and practicing within the targeted southeastern state, and 2) working in primary care clinics either in a rural or urban setting. Those individuals who replied to the survey but did not meet the above qualifications were excluded from the study. Geriatric and pediatric nurse practitioners were excluded from the study.

Methods of Data Collection

Permission to conduct the study was obtained through the Mississippi University for Women Committee of use of Human Subjects in Experimentation (IRB), (see appendix A). FNPs that worked in primary care were chosen as the targeted population. The selected individuals were mailed a questionnaire along with a short demographic survey.

An introduction/consent letter accompanied the questionnaire that explained the purpose of the study and informed the subjects of their rights to anonymity and confidentiality (see appendix B). Informed consent of the study's participants was assumed upon return of the questionnaire and demographic sheet to the researcher.

A standard sized postcard was mailed to all subjects approximately two weeks after the questionnaire, as a reminder to fill out the questionnaire/survey and return viathe self-addressed, stamped envelope (see appendix C). In addition to reminding the subjects

to return the completed questionnaire, the postcard expressed gratitude for the subject's participation.

Instrumentation

A researcher-designed instrument was developed that explored the FNPs practices in assessment for the state of thriving among community-based elders. The questionnaire represented the "enhanced history and physical tool" proposed by the Thriving Model (Haight et al., 2002). The tool was developed through this researcher's experience and review of literature, using the research by Aminzadeh et al. (2002); Fassino et al. (2001); Gill et al. (2002); Grando et al. (2002); Griffith (2002) as well as including certain criteria set forth by Healthy People 2010.

The LaBonte Questionnaire had twenty-three questions in a Likert-like format whereby the researcher could accurately quantify the answers. The questions assessed the practices of FNPs in the care for community-based elders. Additionally, there were two questions numbered 22 and 23, that allowed the FNPs to identify their own particular form of assessment and their thoughts on the research.

The tool did not have any documented construct validity, as this was the first application of the instrument. However, the tool had face validity as it was reviewed and approved by a panel of board certified nurse practitioners with extensive experience in elder care (see appendix D).

The demographic survey was also researcher-designed. The tool gathered vital information regarding the years of practice by the surveyed FNPs and percentages of elders in the practice. The demographic survey did not have any documented construct

validity, as this was the first application of the tool, however it had face validity as it was reviewed and approved by the same panel of board certified nurse practitioners/educators (see appendix E).

Method of Data Analysis

Descriptive statistics were used to synthesize the data obtained from the questionnaire and demographic surveys. Data was compiled that reflected the practice habits of the FNPs that completed the questionnaire.

Frequencies, percentages, and measurements of central tendencies were the statistical measurements of the data. Qualitative analysis was conducted for the data originating from questions twenty-two and twenty-three. Each Likert-like question/statement of the questionnaire was measured quantitatively using frequencies, percentages, and measurements of central tendencies.

The demographic tool was also statistically analyzed using frequencies, percentages, and measurements of central tendencies as it related to the number of practicing FNPs who see elders. The numbers of elders seen in said practices were also analyzed using frequencies, percentages, and measurements of central tendencies.

Limitations

This study was limited due to its focus of FNPs that practiced in primary care settings. The research did not consider how well geriatric nurse practitioners fared in their assessment practices for the state of thriving among community-based elders. Nor did this study consider the state of thriving among elders living in long-term care

institutions. The ability to make broad generalizations from this research was limited in that the focus was narrow.

Summary

The design of this study was appropriate in describing a previously unfamiliar subject. The data obtained from this study was able to identify specific practice habits of FNPs who see the community-based elder. Additionally, the study tested a newly developed nursing theory regarding the thriving state of elders.

The exploratory, descriptive, quantitative approach gathers much data about unknown phenomena. Descriptive, exploratory studies are usually beginning points for other more definitive research to follow (Polit & Hungler, 1999). This study provided basic data by which future studies can evolve.

Chapter IV

The Findings

The purpose of this study was to explore the level of assessment by primary care family nurse practitioners (FNPs) for the state of thriving among community-based elders. A descriptive, exploratory design was used for this study. The settings for this study were primary care clinics located in a southeastern state. The target populations were FNPs that were licensed within a southeastern state and practiced in a primary care setting. The research sample was comprised of 39 (n=39) FNPs that worked in primary care. A description of the sample, the results of data analysis, and additional findings are presented in this chapter.

Description of the Sample

One hundred fifty questionnaires were mailed to FNPs licensed in a southeastern state. A demographic sheet accompanied the questionnaires that targeted such data as type of practice, years of practice, and percentages of elders seen within such practice.

Of the targeted (150) FNPs surveyed, there were 51 (34.0%) respondents. The final research sample was 39 (n=39) primary care FNPs. The twelve (23.5%) respondents who did not work in primary care practiced in various settings such as occupational health, college, student health, or other specialty practices. Only the primary care FNPs that saw elders were coded for data analysis.

Of the 39 (n=39) primary care FNPs that provided elder care, 36 (92.3%) responded to the demographic survey question regarding years of practice and the percentage of elders seen within the practice (see Table 1).

Table 1

Demographic Characteristics of the Sample by Frequency and Percentages

Demographics	Range	Median	Mean	%
Years of practice by FNPs[a]	2-24 yrs	6 yrs	8.3 yrs	
Percentage of elder care within practice[b]:				
0-20%				22.4%
21-49%				44.4%
50-75%				27.7%
76-100%				5.5%

[a]n=39

The demographic survey asked for explanations for the inclusions or exclusions of elders from their specific primary care practice. Several comments were noteworthy. Two (4.6%) out of the 39 respondents stated that they did not see elders within their primary care setting, that only their preceptors (MDs) saw the elders. The reason for this practice was cited as a low Medicare reimbursement rate for NPs. Only one out of the 39 respondents reported operating their own NP-run elder care clinic.

Data Analysis

The researcher-designed instrument, the LaBonte Questionnaire, provided significant data as to the level of assessment by primary care FNPs for the state of

thriving among community-based elders. Twenty-one Likert-like questions, plus two short answer queries were designed to measure specific criteria that reflected the cognitive, the functional, and psychosocial needs of the community-based elder (Haight et al., 2002). Additionally, the instrument attempted to capture specific components of the state of thriving as documented in the published review of literature (Aminzadeh et al., 2002; Fassino et al., 2001; Gill et al., 2002; Grando et al., 2002; Griffith, 2002; Haight et al., Healthy People 2010).

The initial coding of the individual question responses were as follows: almost never = 1, seldom = 2, occasionally = 3, usually = 4 and almost always = 5. The coding was then entered into a database and tabulated for all 39 respondents. This data provided the basis for all successive data analysis and was utilized to create the tables included herein.

Following the initial coding, the LaBonte instrument was grouped into comparable categories of questions based on the "three interconnecting factors of thriving: the human, the human environment, and the non-human environment" (Haight et al., 2002). This grouping of questions facilitated analysis of functional capabilities, cognitive, and psychosocial components of elder assessment as well as allowing statistical analysis that revealed trends of assessment practices by the surveyed FNPs.

There were four major categories of assessments developed from the LaBonte questionnaire. The categories were as follows: 1) routine primary care assessments (RPC), 2) activities of daily living (ADL), 3) at-risk assessments (ARA), and 4) psychosocial assessments (PSA). The routine primary care assessment category included the questions that pertained to routine laboratory data and immunizations. The activities

of daily living assessment category included the questions that pertained to a food diary, the ability to rise from a chair unassisted, the ability to ambulate 150 feet, the ability to dress upper and lower body, the ability to self bathe/shower, the degree of urinary/bowel continence/incontinence, and the ability to perform personal hygiene. The at-risk assessment category included those questions that referred to a yearly skin audit, the use of the Braden scale to determine risk of decubitus, and depression screening using the Beck depression scale or some other form of assessment. The psychosocial assessment category included the questions that were related to the initiation of advance directives, the ability to shop for food, assessment of the personal social support network, the knowledge of available community services, and the utilization of the case management approach by the surveyed FNPs.

The initial database data was then coded numerically to reflect the Likert-like responses of the questionnaire. The "almost never" response, coded as one (1), was multiplied to the actual number of responses to equal the weighted response. The "seldom" response, coded as two (2), was multiplied to the actual number of responses to equal the weighted response. The same mathematical principle was utilized for the remaining responses. These calculations are reflected in the Tables 2-5.

The average response for the category of routine primary care assessments indicated the ranking between "usually" and "almost always." The measurements of central tendency for each question grouped under routine primary care assessments are detailed in Table 2 (see Table 2).

Table 2

Routine Primary Care Assessment Characteristics by Measurements of Central Tendency

Routine Primary Care Assessments

Question	f	%	$\bar{X}$	σ
Weight is recorded[a]			4.95	0.22
Almost never	0	0.0		
Seldom	0	0.0		
Occasionally	0	0.0		
Usually	2	5.1		
Almost Always	37	94.9		
Laboratory data comprehensive metabolic Profile (CMP)[b]			4.54	0.643
Almost never	0	0.0		
Seldom	0	0.0		
Occasionally	3	7.7		
Usually	12	30.8		
Almost Always	24	61.5		
Laboratory data complete blood count (CBC)[c]			4.31	0.80
Almost never	0	0.0		
Seldom	1	2.6		
Occasionally	5	12.8		
Usually	14	35.9		
Almost Always	19	48.7		
Laboratory data routine urinalysis (U/A)[d]			4.10	0.94
Almost never	0	0.0		
Seldom	2	5.1		
Occasionally	9	23.1		
Usually	11	28.2		
Almost Always	17	43.6		

Table continued on next page

Routine Primary Care Assessments				
Question	f	%	$\bar{X}$	σ
Immunizations up to date[e]			4.64	0.58
Almost never	0	0.0		
Seldom	0	0.0		
Occasionally	2	5.2		
Usually	10	25.6		
Almost Always	27	69.2		

[a]n=39

The average response for the category of activities of daily living indicated the ranking just above "occasionally." The measurements of central tendency are detailed for each question under the category of activities of daily living in Table 3 (see table 3).

Table 3

Activity of Daily Living Assessment Characteristics by Measurements of Central Tendency

Activities of Daily Living (ADL)

Question	f	%	$\bar{X}$	σ
Nutritional status assessed[a]			2.56	1.07
Almost never	7	17.9		
Seldom	12	30.8		
Occasionally	12	30.8		
Usually	7	17.9		
Almost Always	1	2.6		
Ability to raise from chair assessed[b]			2.26	1.14
Almost never	13	33.3		
Seldom	11	28.3		
Occasionally	7	17.9		
Usually	8	20.5		
Almost Always	0	0.0		

Table continued on next page

Activities of Daily Living (ADL)

Question	f	%	$\bar{X}$	σ
Ambulate 150' unassisted[c]			3.13	1.32
Almost never	5	12.9		
Seldom	10	25.6		
Occasionally	5	12.8		
Usually	13	33.3		
Almost Always	6	15.4		
Ability to dress oneself[d]			2.90	1.39
Almost never	9	23.1		
Seldom	6	15.4		
Occasionally	10	25.6		
Usually	8	20.5		
Almost Always	6	15.4		
Ability to bathe/shower oneself[e]			3.05	1.38
Almost never	9	23.1		
Seldom	3	7.7		
Occasionally	9	23.1		
Usually	13	33.3		
Almost Always	5	12.8		
Level of continence/incontinence of bladder[f]			3.95	0.92
Almost never	0	0.0		
Seldom	4	10.3		
Occasionally	5	12.8		
Usually	19	48.7		
Almost Always	11	28.2		
Level of continence/incontinence of bowel[g]			3.90	1.05
Almost never	2	5.1		
Seldom	2	5.1		
Occasionally	5	12.8		
Usually	19	48.8		
Almost Always	11	28.2		

Table continued on next page

Activities of Daily Living (ADL)

Question	f	%	$\bar{X}$	σ
Ability to perform personal hygiene[h]			3.18	1.23
Almost never	4	10.3		
Seldom	9	23.1		
Occasionally	7	17.9		
Usually	14	35.9		
Almost Always	5	12.8		

[a]n=39

The average response for the category of at-risk assessments indicated the ranking between "seldom" and "occasionally." The measurements of central tendency are detailed for each question under the category of at-risk assessments in Table 4 (see table 4).

Table 4

At-Risk Assessment Characteristics by Measurements of Central Tendency

At-Risk Assessments

Question	f	%	$\bar{X}$	σ
Skin audit conducted semi annually[a]			3.18	1.14
Almost never	4	10.3		
Seldom	6	15.3		
Occasionally	12	30.8		
Usually	13	33.3		
Almost Always	4	10.3		
Braden scale conducted semi annually[b]			2.28	1.30
Almost never	14	35.9		
Seldom	11	28.2		
Occasionally	6	15.4		
Usually	5	12.8		
Almost Always	3	7.7		
Depression screening with Beck/Geriatric scale[c]			2.92	1.27
Almost never	7	17.9		
Seldom	7	17.9		
Occasionally	11	28.3		
Usually	10	25.6		
Almost Always	4	10.3		

[a]n=39

The average response for the category of psychosocial assessments indicated the ranking just above "occasionally." The measurements of central tendency are detailed for each question under the category of at-risk assessments in Table 5 (see Table 5).

Table 5

Psycho-Social Assessment Characteristics by Measurement of Central Tendency

Psycho-Social Assessments

Question	f	%	$\bar{X}$	σ
Education regarding advance directives[a]			3.21	1.34
Almost never	6	15.4		
Seldom	5	12.8		
Occasionally	11	28.2		
Usually	9	23.1		
Almost Always	8	20.5		
Assess ability to shop and prepare meals[b]			3.18	1.35
Almost never	6	15.4		
Seldom	7	17.9		
Occasionally	7	17.9		
Usually	12	30.9		
Almost Always	7	17.9		
Assess social support network[c]			3.74	1.23
Almost never	3	7.7		
Seldom	3	7.7		
Occasionally	8	20.5		
Usually	12	30.8		
Almost Always	13	33.3		
Education of available community services[d]			3.72	0.97
Almost never	1	2.6		
Seldom	3	7.7		
Occasionally	10	25.6		
Usually	17	43.6		
Almost Always	8	20.5		
Utilization of case management approach[e]			2.95	1.26
Almost never	6	15.4		
Seldom	10	25.6		
Occasionally	6	15.4		
Usually	14	35.9		
Almost Always	3	7.7		

[a]n=39

These findings answered the research question; To what level do primary care FNPs assess for the state of thriving among community-based elders? The FNPs were consistent in the practice of assessing the elders for criteria of weight, analysis of laboratory testing, and status of immunizations (RPC category). However, they were inconsistent in assessing for those categories that reflected the physical/functional abilities of the elder (ADLs), and for conditions that would place the elder at risk for failure to thrive. They were also inconsistent in assessing for the psychosocial, supportive network. Research has shown that with proactive assessments, timely interventions, and a supportive psychosocial network, an elder could continue to thrive within his/her own familiar environment (Aminzadeh et al., 2002; Fassino et al., 2001; Gill et al., 2002; Grando et al., 2002; Griffith, 2002; Haight et al., 2002).

Additional Findings

The two short-answer queries, questions numbered 22 and 23, allowed the surveyed FNPs to comment on the term "thriving" and to list additional assessment tools utilized in their practices of elder care. Twenty-two (56.4%) respondents commented on the term 'thriving' and offered additional assessment practices not included in the LaBonte questionnaire.

The general consensus of the subjects in describing the state of thriving concurred with the theoretical definition proposed by Haight et al. (2002). An optimal state of being was described whereby the elder was able to live independently or semi-independently and enjoy a safe, fulfilling existence within a familiar environment. One subject wrote that she did not "care for the term thriving," and another stated "thriving

means different things to different individuals". Another respondent stated, "it's good to think out of the box" and "the questionnaire opened my eyes to new ideas regarding elder care". One interesting comment regarding thriving stated, "I haven't thought about elders thriving…and I'm ashamed of some of my responses to the criteria of assessment for thriving".

Question number 23 asked for any additional assessment tools utilized in their current practice habits. Many respondents reported utilizing the Mini-Mental Exam in the assessment for cognitive deficits. Other diagnostic screenings not included in the LaBonte questionnaire were vision and hearing. Yearly mammograms, chest x-rays, and colonoscopy were also listed. Several respondents listed specific laboratory testing such as prostate specific antigen (PSA) and Pap smears. A few respondents listed the digital rectal exam (DRE) to determine prostate status and for occult blood.

Summary

Basic information on a key subject relevant to elder care was gathered from this study. The level of assessment by the surveyed primary care FNPs for the state of thriving among community-based elders was only adequate for one category of elder assessment, i.e., routine primary care assessments. The surveyed FNPs failed to consistently assess for physical/functional abilities, conditions that could put the elder at risk for failure to thrive, and for the psychosocial, supportive network of the community-based elder.

The short answers to the term "thriving" revealed similar definitions, however several respondents reported never considering the fact that elders could "thrive." Only

one out of the 39 respondents reported autonomous primary care practice of community-based elders. Two respondents validated the exclusionary practice by physicians in limiting the scope of practice for NPs due to lower Medicare reimbursement for the NP.

The assessment of community-based elders for the state of thriving by primary care FNPs was found to be inadequate. The specific assessment components that reflected the theoretical definition of thriving as proposed by Haight et al. (2002) and supported by the review of literature were inconsistently documented by the surveyed FNPs (Aminzadeh et al., 2002; Gill et al., 2002; Grando et al., 2002; Griffith, 2002). The categories of activities of daily living (ADL), at risk assessments (ARA), and psychosocial assessments (PSA) were at best only "occasionally" completed.

Chapter V

The Outcomes

The ability of an elder to remain in a thriving state is dependent upon his/her physical, cognitive, and functional abilities (Haight et al., 2002). Primary care family nurse practitioners (FNPs) that accurately assess community-based elders for the state of thriving could implement early interventions, preventing further declines in functional abilities and allowing the elder to flourish and thrive within his/her own environment (Aminzadeh et al., 2002; Fassino et al, 2001; Gill et al., 2002; Griffith, 2002; Grando et al, 2002).

Summary and Discussion of the Findings

The level of assessment by primary care FNPs for the state of thriving among community-based elders was examined in this study. The design of the study was exploratory and descriptive. The settings for this study were primary care clinics located in a southeastern state. The population was FNPs that were licensed within a southeastern state. A convenience sample of 150-targeted family nurse practitioners was used for this study. The final research sample consisted of 39 (n=39) primary care FNPs. The research question that guided this study was as follows: To what level do primary care family nurse practitioners assess for the state of thriving among community-based elders?

The results of data collection obtained from the demographic inquiry and the LaBonte instrument were presented in Chapter IV. The interpretations of data are examined in this chapter. The outcomes of the research are correlated with studies found in the review of literature. The findings are presented in relation to theoretical framework of Thriving: A Life Span Theory (Haight et al., 2002). The conclusions determined by the study are discussed as well as implications for nursing as it relates to education, administration, theory, research, and practice. Lastly, the researcher's opinions and recommendations for further studies are presented.

The demographic survey provided quantitative data regarding the respondents' length of practice and percentages of elders seen within such practice. Of the 150 FNPs that were surveyed, 51 (34%) returned the survey in the allotted data collection time frame of one month after the initial mailing.

Of the 51 respondents, 39 (76.5%) worked in a primary care setting. The average (mean) length of practice by the 39 primary care respondents was 8.3 years. The demographic survey also determined the predominate percentage of elder care by the 39 primary care respondents. Approximately 44% of the respondents reported the percentage of their practice devoted to elder care as between 21-49%.

The LaBonte questionnaire provided quantitative data regarding assessment practices of the primary care FNPs for the state of thriving among community-based elders. The twenty-one Likert-like questions, plus the two short answer responses measured specific criteria that reflected the holistic assessment for the state of thriving as proposed by Haight et al. (2002) and supported by the review of the literature

(Aminzadeh et al., 2002; Fassino et al., 2001; Gill et al., 2002; Grando et al., 2002; Griffith, 2002).

The grouping of the assessment questions into relevant categories of similar criteria facilitated the statistical analysis of the LaBonte questionnaire. The categorization of the questions in the LaBonte tool reflected the theoretical framework as proposed by Haight et al. (2002). The "three interacting factors of the thriving continuum…the person, the human environment, and the non-human environment" (Haight et al., 2002. p. 16) were reflected in the grouping of related questions. The "person" was represented by those questions that addressed ADLs and the at-risk assessments. The "human environment" was reflected in the questions that focused on the psychosocial assessments and the "non-human environment" was reflected by the routine primary care assessments. These categories allowed for similar content of questions to be grouped, allowing for statistical analysis of trends of practice by the surveyed FNPs.

The four categories of assessment criteria were routine primary care assessments, activities of daily living assessments, at-risk assessments, and psychosocial assessments. The specific responses to each question were quantified numerically, allowing the data to be coded and loaded into a database whereby percentages and measurements of central tendency were calculated.

With each category, the percentages, the mean, and the standard deviations were calculated and represented in table format. The data analysis identified the level of assessment by primary care FNPs for the state of thriving among community-based elders. The analysis of the data supported the relevancy of the current study by which

assessment practices of primary care FNPs for the state of thriving among community-based elders were examined.

The category of routine primary care assessments (RPC) included measurements of weight, laboratory tests such as complete blood count (CBC), complete metabolic profile (CMP), and urinalysis (U/A), and the monitoring of immunizations for elders. The overall average (mean=4.5) response by the FNPs was "almost always" with a total standard deviation (SD= +/- 0.64) from the average mean. This final data analysis revealed consistent responses of "almost always" to the category of routine primary care assessments (RPC).

The reasons for the high compliance with implementing the routine primary care assessments could be related to the fact that these assessments take very little time to complete, as well as the fact that ancillary staff can perform these assessments for the FNP. Most medical protocols require the monitoring of laboratory data and do not require the clinician to sit down and interview the elder client or his/her caregiver.

The category of activities of daily living (ADL) included the basic ability to self feed/maintain nutrition, to rise unassisted from a chair w/arms folded, the ability to ambulate 150ft., the ability to dress, to bathe, the degree of urinary/bowel incontinence, and lastly the ability to maintain personal hygiene. The overall average (mean = 3.12) response by the FNPs for the category was "occasionally" with the total standard deviation (SD = +/- 1.20) from the average mean. This final data analysis indicated inconsistent responses to specific items within the category of activities of daily living (ADL).

The reasons behind the low scoring of the ADL assessments could be that the FNPs are not as familiar with the activities of daily living, as are gerontological nurse practitioners (GNPs). Only nurses who have worked extensively with the geriatric population fully understand the implications and importance of maintaining functional status of community-based elders. The inability to perform these ADLs without assistance is one of the primary criteria that qualify an individual for assisted living facilities or long-term care.

The category of at-risk assessments included annual skin audits, use of Braden scale to determine risk of skin breakdown, and depression screening. The overall average (mean= 2.79) response by the FNPs for the category was slightly below " occasionally" with a total standard deviation (SD= +/- 1.23) from the average mean. This final data analysis indicated inconsistent responses to specific items with the category of at risk assessments (ARA).

The inconsistent practice of assessment by the surveyed FNPs for at-risk conditions was truly surprising. In one comment by a participant, the suspicion of elder abuse was sometimes considered within the primary care setting. Yet, very few ever performed a body audit. Even if one did not suspect elder abuse, the elder's skin condition should be routinely assessed for cancerous lesions and other serious skin disorders.

The lack of assessment for depression was very disturbing. Griffith (2002) maintained that greater than 50% of elders screened for cognitive impairment also had concomitant depression. The prevalence of depression in the elder client is well documented within the studies conducted by Aminzadeh et al. (2002) and Fassino et al.

(2001). It is inconceivable that primary care FNPs would not take the time to complete a simple depression screening tool, when the didactic component of nursing education clearly addresses this condition both in undergraduate and graduate nursing curricula.

Failure to assess for risk of skin breakdown is also a poor practice by primary care FNPs. Many elders are kept at home too long and are admitted to long-term care facilities with stage II or higher decubitus. In fact, a pressure ulcer is often why home health is ordered for the community-based elder. The primary care FNP who took the time to do a skin audit would find the ulcer, providing an opportunity to explore with the family the possible need for either at-home assistance or institutional care.

The category of psychosocial assessments (PSA) included discussion of advance directives, the ability to food shop, assessment of the social support of the elder with referrals to community services, and the use of the case management approach by the FNP in implementing interventions. The overall average (mean=3.36) response by the FNPs was slightly above "occasionally" for the category with a total standard deviation (SD= +/- 1.23) from the average mean. This final data analysis indicated inconsistent responses to specific items within the category of psychosocial assessments (PSA).

It is a tragedy when advance practice nurses fail to discuss advance directives with their clients. It is a misconception that Do-Not-Resuscitate orders are the responsibility of the physician. FNPs who take the time to truly educate the elder client and their families have provided the elder client the opportunity to make autonomous decisions about his/her life. Failure to discuss such critical issues and failing to allow the elder to make his/her decision is a form of ageism. Ageism is apparent when a culture predetermines an elder's inability to make wise, informed decisions, following a

thorough discussion of the available options. In an age that proposes to shun racism and sexism, ageism is allowed to flourish within a culture that "worships" youth and vitality.

Many people find it very difficult to discuss physical or cognitive decline with elders; care-giving children find it very difficult to switch roles with their parents, yet this cyclical process is a natural occurring phenomenon. The primary care FNP who holistically assesses, educates, and implements key interventions such as taking the time to discuss advance directives with the client and his/her family has promoted thriving of that individual, not to mention has offered the highest respect for that elder.

The FNP who utilizes the case management approach in elder care will have better outcomes for that elder. The case management approach can be easily divided among ancillary personnel with the FNP acting as the coordinator. The FNP working within a busy primary care clinic does not have time to act as a social worker, however, she can see that the necessary interventions are implemented by the clinic nurse/medical assistant, even the receptionist can make referrals under the direction of the FNP.

The review of the literature supported the validity of comprehensive, holistic assessments by advanced practice nurses (Aminzadeh et al., 2002; Gill et al., 2002; Grando et al., 2002; Griffith, 2002). The results of the data analysis suggested that there were at the very least inconsistent patterns of assessment for the state of thriving among community-based elders by the surveyed sample.

Tesh et al. (2002) researched the number of nursing home facilities in a southeastern state that were adopting an environmental transformation based on the Eden Alternative™. While the research did not relate to the current study's focus, Tesh et al. proposed that the intervention of altering the environment of nursing homes would

improve the thriving of residents living within the facilities (Haight et al., 2002; Thomas, 1996). A home-like environment that included pets, plants, and children provided the nursing home residents with an enhanced quality of life.

The research by Tesh et al. (2002) was the first and only published research utilizing the Thriving Model as its theoretical framework. Tesh et al. study provided substantiation to the influence of a "non-human environment" upon a thriving elder (Haight et al., 2002). The FNP who implements timely interventions that enable an elder to remain in his/her own home has supported the ability of that elder to "thrive" within a familiar environment.

The data analysis of the ADLs were directly related to the assessment of physical functioning as proposed by Gill et al. (2002) whereby physical functioning and frailty impacted the elder's quality of life and ability to remain in his/her own home. In the Gill et al. study, the ability of the elder to rise from a seated position with arms folded, determined the elder's degree of physical frailty. The identification of the deficits and the interventions by the multi-disciplined team prevented premature institutionalization of the elders within the study (Gill et al.).

In the current study, the surveyed FNPs responded with an "occasional" assessment (mean= 3.12), (SD= 1.20) of the activities of daily living. Research has shown that with timely assessment and interventions an elder can receive the necessary assistance to maintain the ability to perform the essential and basic activities of daily living (Gill et al., 2002). FNPs who consistently and proactively assess for the criteria of "thriving" could greatly impact an elder's ability to thrive within the community.

Grando et al. (2002) explored the reasons why individuals with "light-care" needs entered nursing homes rather than seeking less restrictive environments. The reasons determined were as follows: 1) having a perception of frailty, 2) experiencing a health event such as a hospitalization or a fall, and 3) having no social support network. This study validated the need for advanced practice nurses, utilizing a case management approach to assess the elders' current level of need and to educate the elders regarding the options of supportive assistance that many communities provide. The investigation by Grando et al. into a little-researched subject paralleled the current study whereby primary care FNPs assessment for the state of thriving among community-based elders was examined.

However, there were differences between the study by Grando et al. (2002) and the current study. The intervention proposed by Grando et al. occurred after a crisis or event, whereby the current study proposed that FNPs proactively assess for deficits so that timely interventions could be implemented to support the elder's ability to thrive within the community.

The data analysis of the psychosocial assessments by the surveyed FNPs revealed a practice that occurred "occasionally" (mean= 3.36), (SD= 1.23). The surveyed FNPs were inconsistent in their assessments of psychosocial needs, potentially contributing to the elder's failure to thrive within the community.

In the assessment process proposed by Griffith (2002), advanced practice nurses were strongly encouraged to screen all elders for cognitive deficits and any underlying depression that might mimic or potentiate dementia symptoms. Griffith maintained that with early identification and diagnosis of cognitive deficits, the indicated

pharmacological interventions had improved efficacy. The author believed that the ability of the elder to remain functioning within his/her familiar environment was dependent upon the cognitive capacities and that undiagnosed dementia or depression quickly impaired the elder's ability to thrive. This study by Griffith supported the current research into the utilization of the at risk assessment for depression.

The data analysis of the category of at-risk assessments revealed the lowest score. The overall mean response (mean = =2.79), (SD= 1.23) of the FNPs fell between "seldom" and "occasionally", indicating inconsistent assessments of all criteria within the category.

In the qualitative study by Aminzadeh et al. (2002), the purpose of the study was to determine how well the elders responded to intensive gerontological evaluations and how those evaluations affected the outcomes for the elder. The study revealed mixed reactions and perceptions by the elders and their caregivers/families. However, the research determined that the assessment process, although lengthy was beneficial in determining the elder's ability to function within a community. Despite the reluctance of many elders to undergo such extensive, exhausting evaluations, the appropriate interventions were made in a timely manner resulting in more positive outcomes for the elder and the caregivers/families.

The study by Aminzadeh et al. (2002) supported the current research whereby community-based elders are assessed for the state of thriving. The published research revealed perceptions and misconceptions held by many elders and their families that need to be assertively addressed by the FNP in the primary care setting. The results of the data

analysis regarding the categories of psychosocial and activities of daily living revealed inconsistent practices among the surveyed FNPs.

The study conducted by Fassino et al. (2001) explored community-based elders' insight into their quality of life. Although, the findings were antithetic to the premise of thriving within one's own environment, the elders' reflections regarding aging, dependency, and isolation provided credibility to the thriving concept of "social-relatedness" (Haight et al., 2002). The study by Fassino et al. substantiated the current study's emphasis on assessing the social network and determining the presence and degree of depression experienced by the community-based elder (Griffith, 2002).

The analysis of the data obtained through the LaBonte instrument indicated an inconsistent pattern of assessment by the primary care family nurse practitioners for at-risk conditions such as depression. Additionally, the surveyed FNPs did not consistently assess the community-based elder for social supportive networks that are vital for thriving.

Conclusions

The review of the literature supported the current study's purpose and the data analysis revealed inconsistent practices of assessment by the surveyed primary care FNPs. The theoretical framework was validated through the review of the literature and represented by the LaBonte questionnaire. The conclusions of the short answer queries revealed misconceptions by the FNPs regarding the thriving of elders. The research question was answered: To what level do primary care family nurse practitioners assess for the state of thriving among community-based elders?

The surveyed FNPs only excelled in one category of assessment to the level of "almost always", that of routine primary care assessments such as weight, laboratory diagnostics, and immunizations. The assessments of psychosocial needs, at-risk conditions, and activities of daily living were assessed only "occasionally" by the surveyed FNPs.

Implications for Nursing Education

The implications for nursing education are apparent in that the theoretical framework of the Thriving Model needs to be included in elder care curricula. It is vitally important that all nurses, but especially new nursing graduates understand the capacity of elders to thrive. The basis of care is transformed from a "maintenance" emphasis to a "thriving state" supported by nursing interventions. Proactive interventions need to be stressed with the enhancement of assessment skills in detecting subtle, soft signs of physical, cognitive, and spiritual decline.

The next generation of nursing graduates will have more elders to care for than at any other time in history. The life span continues to lengthen in the developed countries. It is imperative that these elders are nurtured to thrive in the same manner as infants.

Implications for Nursing Administration

The implications for nursing administration are especially vital for those nurses who care for elders in their homes, in assisted living facilities, and skilled nursing units. Strong leadership by experienced, knowledgeable, gerontological nurses only supports the staff's ability to execute those interventions that promote thriving. The education of the unlicensed nursing assistants within assisted and long-term care facilities usually falls

on the shoulders of the nursing administrator. The understanding and embracing of the transformations of the "human environment" and the "non-human environment" will enhance therapeutic interactions between residents and staff and promote thriving (Haight et al., 2002; Thomas, 1996).

Implications for Theory and Research

The implications for theory development and research are immense. The future testing of the theoretical framework will emphasize the salient concepts and strengthen the linkages between the phenomena of thriving and evidence-based practice. Further research into the areas of elder thriving will only validate the conceptualization of thriving and reveal new pathways for further development of the Thriving Model.

Implications for Practice

The implications for practice have been thoroughly explored and proposed by the current study. The health concept of the nursing metaparadigm stresses health promotion and prevention. The major focus of primary care is also one of health promotion and prevention. The primary care FNP that focuses on the concept of health and thriving could implement early interventions that support thriving among community-based elders.

Advanced care planning is essential to preventative health practice. The FNP who proactively assesses elders for strengths and weaknesses related to thriving will have improved outcomes with the implemented interventions. The specific assessment of the abilities to perform key ADLs could help the FNP in determining the level of thriving of the community-based elder. The physical and cognitive ability to perform the basic ADL

is directly related to the "person" in the theoretical framework (Haight et al., 2002). By determining physical, functional status, the primary care FNP could implement early interventions in collaboration with other disciplines and social agencies that could strengthen the elder's physical ability to "thrive" and function in his/her own environment.

The assessment of key psychosocial concerns such as understanding and implementing advance directives, assessing the ability to shop for food, and determining the level of social support of an elder will support his/her ability to remain functioning in a familiar environment (Grando et al., 2002). FNPs who proactively assess for at-risk situations such as depression, cognitive decline, and impaired skin integrity could improve an elder's ability to thrive within the community setting by implementing appropriate pharmacological therapies and other health preventative measures.

Limitations of the Study

The current study's focus was narrow, hindering the ability to make broad generalizations from the outcomes of the data analysis. Additionally, generalizations cannot be made based on such a small research sample within one southeastern state. Regional and cultural influences need to be considered. Replications of the study within other "environments" might reveal totally different results. Research involving the assessment practices by gerontological nurse practitioners versus FNPs might reveal new and challenging data that could ultimately impact the education and practice of each

discipline. Additionally, the comparison of assessment practices by nurse practitioners and physicians could provide interesting results, possibly strengthening the role of the FNP.

Recommendations

Further research utilizing the Thriving Model as the theoretical framework is recommended to further expound and substantiate the key concepts of the "human person, the human environment, and non-human environment" (Haight et al., 2002). Studies that focus on the concept of "social-relatedness" will assist nurses in assessing the critical social, support network that is necessary for thriving community-based elders.

Research that involved a broader geographic area and a larger sample size would enhance the ability to make broad generalizations from the results of the research. Having a larger population sample would help to substantiate the statistical significance of the research.

This current research should be published so that other gerontological nurses and educators can critically examine the research and thereby conduct future research in elder assessment. The specific components of the LaBonte Questionnaire could be individually studied for trends in practice and outcomes of the elders assessed. Additionally, the continued use of the LaBonte Questionnaire within research could further define and refine the questions to represent thriving. Studies researching the facilitators and barriers that FNPs experience in the assessment of community-based elders could answer questions that this research created.

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APPENDIX A

APPROVAL OF MISSISSIPPI UNIVERSITY FOR WOMEN'S COMMITTEE ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION

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March 3, 2003

Ms. Judy M. LaBonte
c/o Ms. Terri Hamill
P. O. Box W-910
Campus

Dear Ms. LaBonte:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research under the condition that the consent be expanded to contain a confidentiality statement, to state that the return of the survey reflects agreement to participate, and to state that the subject may withdraw at any time.

I wish you much success in your research.

Sincerely,

Vagn K. Hansen, Ph.D.
Provost and Vice President
for Academic Affairs

VH:wr

cc: Mr. Jim Davidson
Ms. Terri Hamill
Dr. Mary Pat Curtis

Where Excellence is a Tradition

APPENDIX B

INTRODUCTORY LETTER

Dear ,

I am a graduate student and registered nurse conducting research on the practices of primary care nurse practitioners in the assessment of the state of thriving among community-based elders.

You are invited to participate in this research by filling out the attached survey and demographic sheet. The survey will take approximately 20 minutes of your time. Before filling out the questionnaire, flip over and complete the demographic sheet first.

Your name will not appear on the returned questionnaire or on the demographic sheet. Study participants will not be identified in any way in the report of this study. In choosing to answer and return this questionnaire in the stamped, self-addressed envelope, you are consenting to this research. If you would like the results of this research, please indicate your request on the bottom of the demographic sheet.

You will find this research interesting in that it is testing a recently formulated theory that was proposed by several nurse researchers associated with the University of North Carolina at Greensboro. Additionally, findings from this research will have key applications for your practice related to elder care.

Thank you for taking your time in answering this questionnaire. I know how busy your days are and I appreciate your input in helping me to determine the degree of elder care within the primary care setting.

Sincerely,

Judy LaBonte B.S.N., R.N.
Graduate Learner

TITLE

Family Nurse Practitioners' practices of Assessment of the State of Thriving in Community-Based Elders.

Principal Investigator: Judy LaBonte B.S.N., R.N.

PURPOSE

You are invited to participate in a study of family nurse practitioners' practices of assessment of thriving in community-based elders. The main objective of the study is to determine percentages of FNPs who see elderly in an ambulatory primary care setting and to determine their practice protocols related to thriving of the elder client. You were selected as a possible participant because you meet the criteria of being a family nurse practitioner licensed in a southeastern state. There will be approximately 150 participants who will participate in the study.

PROCEDURES

If you decide to participate, you will fill out a short demographic tool and a questionnaire exploring your practice protocols related to elders within your practice. These tools should not take more than 20 minutes of your time. The questionnaire consists of 23 questions that will define your current practice protocols as it relates to community–based elders.

BENEFITS AND RISKS

You may benefit from participation in this study by becoming more aware of your current practice protocols as it relates to the thriving state of community-based elders. You may find applicable screening tools/assessments that actually assists the elders within your practice to remain in a thriving state within their own personal homes or at assisted living facilities. There is no physical risk involved in your participation and any psychological risk is minimal. The major inconvenience will be the time it will take to complete the questionnaire.

COSTS

There is no cost for participating in this study and no compensation will be made to study participants.

CONFIDENTIALITY

Your name will not appear on any questionnaire. The only identifications related to you will be the county in which you practice, the type of practice and the length of practice. Actual names will not be identified in any way in this study. Your decision whether or not to participate in this study will not prejudice you or your practice in any way. If you decide to participate, you are free to withdraw from the study at any time without penalty.

Please feel free to ask any questions you may have about study or your rights as a research participant. You may contact the principal investigator: Judy LaBonte B.S.N., R.N. at (901) 755-6683 or e-mail: judylabonte@aol.com . You may keep this informed consent letter for your records, if you so desire. Receipt of the completed questionnaires within the self-addressed, stamped envelope is a confirmation of your decision to participate in this study. Thank you for your time in completing the questionnaires.

APPENDIX C

REMINDER POSTCARD

Just a friendly reminder to complete the demographic sheet and questionnaire that was mailed to you on April 15, 2003. Your return is critical to this research. Your comments are valued. I would appreciate your return of the surveys.
Thank you,

Judy LaBonte, Graduate Student

APPENDIX D

LABONTE QUESTIONNAIRE

LaBonte Questionnaire©

The following questions/statements are related to established practices regarding elder care within a community setting. For the purposes of this research, **community settings include assisted living facilities, private residences either solitary living or living with family member/caregiver but exclude long term care.**

Directions: Select one of the five categories for each question based on the percentage of times the item is done.

Five categories of answers will be as follow:

□ Almost never (0-20%) □ Seldom (21-40%) □ Occasionally (41-60%)
□ Usually (61-80%) □ Almost always (81-100%)

1. When screening an elder within the clinic setting, the weight is recorded.

   □ Almost never □ Seldom □ Occasionally □ Usually □ Almost always

2. Annual laboratory data analysis is obtained through a comprehensive metabolic profile.

   □ Almost never □ Seldom □ Occasionally □ Usually □ Almost always

3. Annual laboratory data analysis is obtained through a CBC w/auto diff.

   □ Almost never □ Seldom □ Occasionally □ Usually □ Almost always

4. Annual laboratory data analysis is obtained through a routine urinalysis.

   □ Almost never □ Seldom □ Occasionally □ Usually □ Almost always

5. The nutritional status is assessed using a food diary.

   □ Almost never □ Seldom □ Occasionally □ Usually □ Almost always

LaBonte Questionnaire©

6. A head to toe skin audit is conducted semi-annually on elders.

   ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

7. The Braden Scale or a pressure sore risk assessment is conducted semi-annually.

   ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

8. Elders are screened for depression using Beck or another Geriatric depression scale.

   ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

9. Elders/significant others are educated regarding advanced directives.

   ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

10. The ability of the elder to rise from a chair with arms folded is assessed.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

11. The ability to ambulate 150 feet assisted/unassisted is assessed.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

12. The ability of the elder to dress himself/herself either upper body or lower body is assessed.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

13. The ability of the elder to bathe/shower himself/herself is assessed.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

14. The level of continence/incontinence of bladder is assessed.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

LaBonte Questionnaire©

15. The level of bowel continence/incontinence is assessed.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

16. If incontinent of bladder/bowel, the ability of the elder to perform personal hygiene, i.e., wash hands following hygiene and the ability to change incontinent products without supervision is assessed

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

17. The ability of the elder to shop for food and prepare meals without supervision is assessed.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

18. The social supportive network on which the elder is dependent upon is assessed.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

19. The elders/family members/caregivers are educated about their options regarding services in assisting the elder to maintain continued independence or semi-independence.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

20. A case management approach is utilized in caring for community-based elders.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

21. Appropriate immunizations (influenza, Pneumoccal) are reviewed as indicated.

    ☐ Almost never ☐ Seldom ☐ Occasionally ☐ Usually ☐ Almost always

22. Would you like to comment on the term "thriving" as it applies to elder care?

23. Other assessment you routinely use/do with elders include:

APPENDIX E

DEMOGRAPHIC SURVEY

Demographic Survey©

Please take the time to check the items below:

1. Current practice setting: ___Primary Care, __Long term care

   ___Other/Please specify __________

2. Years in of practice: ____________________________________

3. County in which clinic/practice is located: ________________

4. Is your medical preceptor/collaborator on site? ____________

5. If off-site, how many hours/days per week are spent in collaboration?

   ____

6. Do you see Medicare clients or elders 62 years of age or older?

   ____Yes ____No

7. If yes, then what percentage of clients are Medicare or elders 62 years of age or older?

   □ 0-20% □ 21-49% □ 50-75% □ 75-100%

8. If not, for what reasons?

   Medicare has a low reimbursement rate for NPs? ______________________

   Only your medical preceptor/collaborator sees the elderly? _______________

   Your clinical setting does not accept Medicare assignment? _______________

   Other ________________________________