Community nursing diagnosis

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THE TERM *diagnosis* has been used in a nursing context for a relatively short period of time. Nursing diagnosis began to appear regularly in nursing literature in the 1950s and was initially applied to the individual client or family. A review of the nursing literature indicates that interest in nursing diagnosis increased during the 1960s with attempts to define and operationalize the concept.

Abdellah's definition of nursing diagnosis is an early attempt to define the term: "Nursing diagnosis is a determination of the nature and extent of nursing problems presented by individual patients or families receiving nursing care."[1(p 25)] In 1973, Gebbie and Lavin initiated the first national conference on classification of nursing diagnosis.[2] They viewed nursing diagnosis as a concept critical to nursing, and they asserted that the classification of nursing diagnoses represents "nothing less than the

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systematic description of the entire domain of nursing."[2(p250)]

In approximately 30 years a new concept has become a part of society's definition of nursing, mandated to form the basis for professional practice by many state nursing practice acts.[3] In addition, the American Nurses' Association's Social Policy Statement published in 1980 states: "Nursing is the diagnosis and treatment of human responses to actual or potential health problems."[4(p9)] Professional nurses now define their practice as being based on nursing diagnosis, and society legally requires it.

In light of these mandates for practice, it appears essential to develop a clear conceptualization of nursing diagnosis as it is applied in each area of practice. Significant work is being accomplished in regard to nursing diagnosis. Biennially, the National Conference on the Classification of Nursing Diagnosis meets to give direction to inquiry into the nature of the concept. Gordon[5] and Campbell[6] have published references for use in the education of beginning nurses and in the work of those nurses already practicing. Monographs, journal articles, and entire issues of journals have been devoted to the study of nursing diagnosis.

Much of the work concerning nursing diagnosis seems to be more applicable to the care of individuals than to the nursing of entire communities. Many authors make the assumption when writing about nursing diagnosis that conclusions drawn concerning ways to develop, classify, and act on nursing diagnosis will be the same whether nursing relates to individuals, families, groups, or entire communities. This assumption requires testing, and the analysis of the concept in a community context is a critical first step in developing research into nursing diagnoses made by community nurses. Such an analysis should include an investigation of relevant nursing theories, the actual practice of community nursing, and the idea of community as client.

Many authors assume that conclusions about nursing will be the same whether nursing relates to individuals, families, groups, or communities, but this assumption requires testing.

Riehl and Roy,[7] who have worked extensively in analyzing and comparing nursing theories, report that systems theories and models for nursing practice are the ones most widely used in academic settings. Neuman,[8] Roy,[9] Johnson,[10] Orem,[11] and Rogers[12] are theorists whose work is considered to be based on systems theory. Because of the widespread use of these works and their potential for influence on future nursing practice, these models were reviewed for their relevance to the concept of community nursing diagnosis.

Open systems models, by their nature, consider persons to be constantly exchanging energy, matter, and information with their environment. Although persons and their environment may be conceptualized uniquely by each theorist, it is assumed that environment in some way includes the geographic community. When theorists refer to society, culture, or groups it is assumed that these concepts influence or are influenced by geographic community and are, therefore, related.

Johnson's model of nursing[10] depicts persons as behavioral systems and subsystems. Nursing acts as an external regulatory force to assure balance and stability in both external and internal affairs. The strongest inference that can be drawn from Johnson's model for community health nursing is that the environment, including community, can affect balance and stability in behavioral systems and subsystems. Therefore, it might be concluded that nurses should consider the influence of communities on individuals.

Roy's adaptation model[7] is useful in community health nursing. She claims that "the person and his interaction with the environment are ... units of analysis of nursing assessment while manipulating parts of the system or the environment is the mode of nursing intervention."[7(p170)] Roy identifies three types of stimuli that affect persons as focal, contextual, and residual, each of which can arise from conditions influenced by environment or community. She sees recognizing adaptation to environment as crucial in understanding the human condition and in directing nursing practice.

In applying Roy's model in a community setting, Schmitz[13] gives the example of a mother caring for an infant experiencing diarrhea. The residual stimuli influencing the adaptation of the mother and child might be "the cultural perception of the meaning of elimination problems."[13(p198)]

Neuman's model[8] depicts individuals as open systems, striving to maintain harmony and balance between their internal and external environments. Using the Neuman model, the nurse would assess human variables of four types: physiologic, psychologic, sociocultural, and developmental. The nurse would then plan intervention in one of three modes: primary, secondary, or tertiary prevention.

Venable considers the Neuman model as congruent with society's expectations of community nurses: "Primary prevention is more frequently seen as a nursing role in public health and community nursing."[14(p140)] Beitler et al[15] applied Neuman's model to community health nursing education and concluded that the stressors inherent in the poverty culture, the intrapersonal, interpersonal, and extrapersonal factors that contribute to the problems of the low-income client, and the primary, secondary, and tertiary forms of prevention, could be the basis for organizing content in a community health nursing course.

Flaskerud and Holloran[16] point out that the Orem self-care model[11] of nursing practice, although an open systems model, does not focus as much attention on interaction with the environment as do the models of Roy, Neuman, and Johnson.[8-10] Nevertheless, Orem clearly states that ways of meeting self-care needs are cultural elements and vary with individuals and larger social groups. The influence of society or community on nursing practice is quite explicit in Orem's writings. She believes that societies "specify the conditions that make it legitimate for its members to seek the various kinds of human services that are provided. These conditions become the criteria that members of the society use in determining whether or not a particular human service can or should be used."[11(p3)]

Orem sees four categories of nursing as a service:

1. home nursing,

2. ambulatory nursing for adults,
3. infant and child nursing in clinics and offices, and
4. nursing of all age groups in long- and short-term care institutions.

Three of the four categories have traditionally been settings of community health nursing practice. Orem also addresses nursing education by describing five disciplines that need to be offered in undergraduate nursing curricula. One of these disciplines, nursing's social field, is especially applicable in community health nursing. She describes nursing's social field as "dimensions of nursing as institutionalized service in social groups under fixed and changing social, cultural, economic, and political conditions."[11(p31)] Orem's work is useful when the community influence in nursing is considered, but her concept of the client seems to be the individual, not the larger community.

On the other hand, Rogers sees the individual and the community as "continuously shaping one another."[12(p124)] Rogers' model of individuals and their environment precludes separating them for consideration. She believes that to deal with a wide range of diverse human problems "requires the seeing of a pattern, a concept of the wholeness of man and his environment, and a recognition of escalating, dynamic evolution."[12(p124)] Rogers addresses community health services directly in explaining the theoretical basis of nursing. She sees a critical need to "incorporate within community based centers services designed to maintain and promote health (not to be confused with disease prevention) and to transmute the present limited ventures into truly community health resources."[12(p130)]

Rogers sees a strong desire of consumers to shape the nature and quality of public services because they are no longer content to be passive recipients of care. A recognition of unity and wholeness of persons and their surroundings pervades Rogers' model and has strong implications for recognizing the importance of the community in any nursing activity.

Based on these systems theories of nursing, the following empirical and analytical generalizations can be made.

- Communities influence the health of individuals.
- Individuals, in turn, influence communities.
- The community is an appropriate setting for nursing practice.
- Communities influence the practice of nursing.

Each of the systems theories has components of use to community health nurses. However, although communities were viewed by these theorists as dynamic forces, the theories contain little to guide the nurse in considering the community as the primary recipient of care. As Stevens points out, "some theories leave room for both individuals and groups as subject matter. More often than not, however, theories that claim this dual approach address only the singular man when they unfold the theory components."[17(p235)]

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COMMUNITY NURSING PRACTICE

Theories of singular persons can be used in community health settings such as school, occupational, and home health nursing, in which practitioners deliver nursing care to individuals in much the same way as nursing care is delivered in emergency departments or nursing homes. What, then, are the differences, if any, between community health nursing and other types of nursing? The work of Archer[18] and Archer and Fleshman[19] in developing a typology of community health nursing practice may help in determining the nature of community health nursing. They conducted a 3-year longitudinal study of community health practitioners: those nurses who identified themselves as community health practitioners at a national American Public Health Association meeting. After an initial classification of five functional categories of community health practice, a revised typology was constructed to include six subsystems of practice classified by the nature of client services (Table 1).

Subjects in the Archer and Fleshman study[19] responded to open-ended queries to identify their functions as community health practitioners. The responses were then categorized. In the group studied, the researchers found that 40% of the respondents listed at least one of their functions in the indirect category. Indirect services in the revised typology included administering a nursing division or school of nursing; working for a professional organization; serving as a lobbyist; and participating in health planning, research, and evaluating services.

Table 1. Typology of community health nurse practice*

Direct client services	Semidirect client services community nursing	Indirect client services
1. Primary care	5. Middle management teaching	6. Administration systems management
2. Disease specialty		
3. Population groups		
4. Place or spatial unit		

*Adapted from Archer SE, *Nurs Outlook* 1976; *24*:500. Reprinted with permission.

This typology represents the various foci of community health nursing practice of those individuals studied. The researchers realized the limitation of studying only those who considered themselves to be community health practitioners. There was uncertainty about what was meant by this title. Some of those who responded in the study had associate degrees in nursing, some had bachelor's and master's degrees, and at least two had completed work at the doctoral level.

Nevertheless, it is important to note that almost half of those who participated in the study functioned at a systems level of nursing practice and the implication for the classification of indirect client service appears to be that activities directed at a community system are an indirect means of serving individuals. Before these findings can be generalized to all community health nurses, replication with a different

population is necessary. Replication of such a study should also include the analysis of nursing diagnoses made by community health nurses.

Some would argue that nursing is an activity directed to persons, not communities, and that health care cannot be given to a community.[20] Archer and Fleshman[19] counter the argument that community health practitioners involved at a systems level are no longer nurses by stating: "Our feeling is that to the extent that community health practitioners working with systems are involved in advancing the delivery of improved health services to clients, these community health practitioners are very much involved in nursing."[19(p10)] Doster concurs: "Giving health care to a community is essential for the achievement of the highest state of wellness for each individual in the community."[21(p83)]

Perhaps another reason there is uncertainty in the validity of nurses ministering to entire communities is that other disciplines consider community intervention to be their domain. As Fromer points out: "Within the past decade health planning for existing and proposed communities has become such an important factor in society that it has developed into a large academic field with studies leading to a doctoral degree."[22(p159)] Because of the complexity of working with entire communities, some experts in nursing advocate the preparation of nurses at the master's and doctoral levels for this type of specialized practice.[23]

Williams[23] recommends that more attention be given to the distinctions among diagnosis, treatment, and evaluation at the individual level and at the aggregate level. Considering either level alone diminishes the effectiveness of nursing. Although nursing of individuals need not be the only focus of nursing, individual well-being is the ultimate goal.

But a perspective that overemphasizes individual services can be counterproductive. Williams warns that as the components of primary care services are strengthened, individual and family services can monopolize attention and resources. The danger is that this perspective recognizes those individuals who place themselves in the acute care system for existing services and does not consider who needs services but cannot obtain them, which services might be more useful, and whether the services are resulting in a *real* improvement in the health of the community.

Is there adequate justification to assume that general nursing theory is sufficient to serve as a basis for the nursing of communities? Archer and Fleshman submit that community nursing is uniquely different from clinical nursing of individuals: "The core of our uniqueness, we believe, includes our breadth of knowledge of community processes and our expertise in adapting health promotion and health maintenance activities, as well as clients' life styles and environments."[19(p2)] Adapting interventions to environments and life style is addressed in general nursing theory, but degree of knowledge of community processes represents a gap in the existing theoretical bases for nursing.

COMMUNITY AS CLIENT

Current theory gives little direction to the understanding of the type of client of communities. Countless questions are unanswered. What exactly is meant by the

term *community*? What are the characteristic similarities or differences among individuals, families, groups, and communities as recipients of nursing? If persons are bio-psycho-social beings, What are the dimensions of communities? Do persons and communities have the same needs and goals?

Current definitions of community health nursing practice seem to assume that these questions have already been answered. Clemen et al say: "In community health nursing the family is the unit of service and the client is the community."[24(p318)] The Nursing Development Conference Group identifies the goal of public health nursing as "the health of a neighborhood, a local, state, national or international community with focus on prevention of disease and disability, promotion and maintenance of health, and comprehensive care of the sick and disabled; and this can be accomplished through assisting communities toward self-care which contributes to the above."[25(p123)] The self-care concept also appears in Fromer's assertion that "the community must recognize and meet its own health needs, but it is the nurse who can lead the way."[22(p152)]

These definitions imply that there is some "whole" of a community that might be different from and greater than the sum of all its parts, an entity capable of decision making and action. There is a need for clarification of whether the community is merely the setting or context of the individual's existence and of nursing intervention or whether it is the primary client. Until nursing theory addresses this distinction, there will be confusion concerning community diagnosis. To illustrate the confusion that exists in community mental health literature over the focus of nursing services, some related terms will be discussed. Each related term has appeared in the literature as the distinguishing focus of community health nursing.

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RELATED TERMS

Words that have been used to describe community health nursing clients include individuals, families, aggregates, groups, populations, systems, and communities. Although community nurses use the terms *individual* and *family* in virtually the same way as do other nurses, the terms *aggregate, group, populations, systems,* and *communities* may be used in ways that are unique to community health nursing. Kurtzman et al[26] refer to aggregates as "population groups." In considering the nursing process at the aggregate level, they used elementary school classes and dormitory residents as examples of aggregates.

Another frequently used term to identify the community health nursing client is "group." According to Spradley, "a group is two or more persons engaged in repeated, face-to-face communication, who identify with one another and are interdependent."[27(p288)] Spradley gives classes as examples; people gathered together for support, as in Alcoholics Anonymous; and people who come together to share a task, as in committees. A significant amount of

working with a group takes place in community health nursing practice.

Populations can often be distinguished from groups in that face-to-face interaction and interdependence may be lacking. Spradley defines population or population group as "a large, unorganized aggregate of people, based on one or more common characteristics."[27(p289)] She gives adolescent girls, the elderly, and electricians who work in the communications industry as examples. In view of Kurtzman's definition of aggregate,[26] it appears that aggregate and population group are interchangeable terms. On the other hand, group has a connotation of unique personal interaction. When certain populations are identified as having a common characteristic, activity, or attribute that places them in danger of illness, injury, or health problem, they are referred to as a population at risk.[24]

Systems are referred to by some as the clientele of community health nurses.[18,19] The use of the term *system* in community health nursing has often been synonymous with community.

Hanchett says that in community assessment, system refers to "the community itself, no more, no less."[28(p12)] Rapoport defines a system as "a whole which functions by virtue of the interdependence of its parts."[29(pxvii)] Spradley[27] describes a community as having three dimensions: its physical location, its population demographics, and its social system dimensions. She lists as subsystems of a community its social system, communication, health, family, economics, education, religious, welfare, political, recreation, and legal systems. Thus, it appears that to some, system refers to the entire community and to others, it is a unit or component of the community, such as the economic system.

Society is another term that is often associated with nursing in general, especially community health nursing. Some would conceptualize society as being one level above community in a hierarchy of social organization. Weaver says that "society has often been called the suprasystem with regard to community, and as such, is considered to function as an open system as well."[30(p166)]

Nurses and sociologists have investigated the concept of community, and there is much confusion regarding its definition. Experts feel the word community is used so often to refer to diverse phenomenon that it now has multiple, ambiguous connotations.[31]

A review of nursing literature reveals a diverse use of the term *community*. The literature mentions a community of need, problem ecology, concern, special interest, viability, resources, action capability, concern, an urban community, a rural community, an academic community, and a professional community, to name a few. It appears that community has been used to refer to both groups of people and to places.

Poplin,[32] a sociologist who has studied communities extensively, prefers to use the term *social group* instead of community when referring to groups of people. One reason that nurses might want to heed his advice is that it is misleading to imply that only community health nurses are concerned with groups (often termed *communities*). Prenatal classes for pregnant women, cardiac rehabilitation programs, and therapeutic groups in mental health facilities are all focused on a group of per-

sons or a community of concerns or needs, yet the nursing intervention involved in caring for these groups is not generally referred to as community nursing.

When taken as a whole, community health nursing literature appears inconsistent and confusing in attempts to describe the focus of its practice. A variety of terms—aggregate, population, systems, groups, and many others—have been used to point out the unique forms of community health nursing. However, rather than clarify, often these terms have created more confusion. What is needed is a conceptualization that incorporates the dimensions of human environment in such a way that the various theories and models of nursing might eventually aid in explicating community nursing practice. One such conceptual model of community has been developed.

A CONCEPTUAL MODEL OF COMMUNITY

Sanders[33] identified four dimensions of communities.

First, Sanders describes "communities as a spatial unit."[33(p26)] This concept includes demographic characteristics, physical location and organization, environment, and technology. Second, the "community as a place to live"[33(p24)] is its qualitative nature in the view of its residents. Some objective measurements might be levels of income and crime rates, but more subjective information would come from interviews. Third, the "community as a way of life,"[33(p27)] an anthropologic view, is a way of defining the unique style of functioning from an ethnographic approach. Finally, Sanders sees the community as "an arena of social interaction."[33(p33)] To study the community from this perspective would require investigation of social systems, the distribution of power and resources, and the struggle to equalize their distribution. Spheres of influence and patterns of change (social field) would be also analyzed.

Using Sanders' model for community assessment, community health nurses might apply the public health sciences of epidemiology, biostatistics, sanitation, and human ecology to determine the levels of health and illness within the community and the identification of populations at risk for health problems. This would be a disease-oriented approach.

Sanders describes the community as a spatial unit, a place to live, a way of life, and an arena of social interaction.

Investigation of the ways of life of the community can give insight into methods of making services acceptable and into the cultural meaning of health or illness; it can help to determine ways in which life-style affects health.

The social interaction dimension gives us a great deal of insight into the community of solution, the means of effecting change. An assessment of the dimension may require going beyond the city limits and looking at ways this community interacts with other communities. Clemen et al stated that "a community is a part of a larger society and has patterns of communication, leadership, and decision making which either facilitate or inhibit interac-

tions within the community and between the community and the larger society."[24(p55)]

CRITICAL DISTINCTION

The typology of practice developed by Archer and Fleshman[18,19] helps to explain the unique functions of community health nurses in regard to communities and groups. Although the direct and semidirect care provided to individuals and groups takes place outside hospital walls, it has much in common with the commonly understood general practice of nursing.

Community health nurses functioning in direct and semidirect contact with individual clients and groups could use existing theories and conceptual frameworks for nursing; they could assess, diagnose, intervene, and evaluate outcomes in much the same way as nurses who practice in inpatient institutional settings because it is only the place they are practicing that separates them from other practitioners of nursing. This type of practice might be referred to as nursing *in* the community or as the nursing of individuals *influenced by* the community. Archer and Fleshman did, however, identify the critical element distinguishing community health nursing practice from other types of nursing: the indirect or systems approach to all those factors that impinge on the health of individuals and groups in a community. The critical element is the nursing *of* communities.

COMMUNITY NURSING AT A SYSTEMS LEVEL

Rather than merely taking environmental stressors into account or helping groups to overcome common threats to health, the community health nurse focusing on the overall system works toward implementation of strategies to eliminate or minimize stressors or threats to health on a systems level.

In an effort to identify a term or concept that would communicate this understanding of the importance of community at a systems level for action, the National Commission on Community Health Services[34] coined the term *community of solution.* Health hazards arise from conditions that can be affected by local, regional, state, national, or even international influences. For example, citizens of Canada are concerned with acid rain related to air pollution from American industrial cities. Community health nurses interested in this problem could not effectively limit their assessment to a single geographic community but would have to broaden their scope to the community of solution, which in this case would necessitate action on an international level.

There are those who echo earlier challenges that this type of concern and the types of intervention implied, including political and social action and economic analysis, may fall outside the realm of nursing. On the other hand, this unique form of nursing practice may be the only functional area that sets community health nursing apart from other types of nursing practice. Archer and Fleshman warn: "Unless community nurses can differentiate their area of practice and expertise from the area of those adopting an expanded community orientation within their fields, it is possible that Community Health Nursing could be integrated out of existence."[19(p2)]

Considering the increasing interest in the

politics of health care delivery and the widening opportunities for nurses in all practice areas to participate in health planning, it may become an artificial distinction to call some nurses community nurses simply because they focus on the organizations or systems in communities that influence the health of individuals. For the sake of nurses and their clients, it may become imperative that all nurses adopt this broader view of caring.

Nursing theory as applied to individuals guides assessment, implementation, and evaluation. For example, in a model based on adaptation, a nurse can draw inferences about phenomena that exemplify adaptation or maladaptation. But nursing theory has not developed sufficiently to guide community health nurses in assessment, diagnosis, intervention, and evaluation of ways community systems influence health. Community health nurses have used public health science for this guidance, and in some cases, community health nursing is defined as the merging of nursing with public health science.[35]

Williams[23] points out that public health science directs the attention of nursing to the effects by environmental factors on the health of populations. The study of sanitation, communicable diseases, and biostatistics historically developed as public health sciences and these were adopted for use by community health nurses. But considering the views of nurse theorists, primarily Rogers,[12] concerning the unity of persons and their environment and the wholeness of all dimensions of human experience, it is clear that the public health sciences based largely on a biomedical model are inadequate to explain the influence of individuals on communities and of communities on the health of individuals.

Nursing diagnosis is "the judgment or conclusion that occurs as a result of a nursing assessment."

Conceptualization of communities as physical/sociocultural/experiential entities provides a framework for assessing the community in terms of functional and structural characteristics. This is a task that Braden et al[36] see as a necessary part of applying the nursing process at a community systems level.

NURSING DIAGNOSIS

The definition of nursing diagnosis accepted at the First National Conference on Classification of Nursing Diagnoses in 1973 stated that nursing diagnosis is "the judgment or conclusion which occurs as a result of a nursing assessment."[2(p250)] In the intervening years, the concept of nursing diagnosis has been expanded and refined. In 1982, Andrews defined nursing diagnosis as "a clear, concise, and definitive statement of the client's health status and concerns that can be affected by nursing intervention." She says: "A nursing diagnosis is derived from inferences of assessed validated data and from perceptions. It follows a careful investigation of the data and results in a decision or opinion."[37(p111)]

Nursing diagnoses have to meet explicit guidelines of form and process. Andrews has outlined four steps to follow in developing a nursing diagnosis.[37(pp116-118)]

1. Determine health status and concerns.
2. Write a nursing diagnosis.
3. Validate the nursing diagnosis and recheck it.

4. Arrange the nursing diagnoses in order of priority.

The structure of the actual nursing diagnosis has been considered by numerous nurse theorists.[3,5,37] Gordon and Sweeney address the structural components of nursing diagnosis by stating that it should be a "concise term representing a cluster of signs and symptoms and describing an actual or potential health problem or state of the patient which nurses by virtue of their education and experience are licensed and able to treat."[3(p2)] They assert that the statement of nursing diagnosis must contain the problem, etiologic factors, and signs and symptoms.

In addition to process and structure, there are conceptual considerations. How to go through the steps of the process and what a nursing diagnosis must include are much simpler to determine than what type of framework is needed to conceptualize a nursing diagnosis. Gordon and Sweeney summarize the work of Soares,[38] Yura and Walsh,[39] and Little and Carnevali[40] to determine a conceptual focus for nursing diagnosis. These major theorists in the field have proposed conflict in needs, deprivation or alterations in meeting human needs, and response to stressors or potential stressors as models to guide nursing diagnosis. As previously demonstrated by the diversity in nursing systems models, the frameworks for assessment and diagnoses might also include adaptation, self-care deficits, and maladaptation patterns of unitary humans.

Again, the community health nurse is faced with using theories and models based primarily on singular persons to organize data gathering and decision making on a community level. Gordon addresses the multiplicity of nursing models for nursing practice by proposing health patterns that she believes transcend most nursing theories and can be applied regardless of the area of practice:[2(p81)]

- health perception-health management,
- nutritional-metabolic,
- elimination,
- activity-exercise,
- sleep-rest,
- cognitive-perceptual,
- self-perception/self-concept,
- role relationship,
- sexuality-reproductive,
- coping-stress-tolerance, and
- value-belief.

If a model such as the Sanders[33] model were applied to community health nursing practice, could the Gordon typology be used as well? At first glance, the model seems to be aimed primarily at assessment and diagnosis of individuals. Yet, some enlightening examples provided by Gordon show that there may be some pertinence to a community focus. Considering the Sanders model, which includes the community as a place to live (the qualitative nature), it is clear that Gordon's functional patterns of role relationships, coping-stress-tolerance, and self-perception/self-concept are pertinent. But it is not as obvious how this typology would aid the community health nurse concerned with inefficient allocation of health care resources or the rising cost of health care.

Perhaps this is the reason why the diagnoses accepted at the Fourth National Conference on Classification of Nursing Diagnosis are ostensibly appropriate for individuals, not communities. It is more apparent how the nurse might develop a nursing diagnosis of an individual *in* a

community setting or *influenced by* a community, rather than a nursing diagnosis *of* a community. If these theorists do not provide an example of a nursing diagnosis of a community, then other sources must be scrutinized.

A unique book by Griffith and Christensen[41] which applies theories, frameworks, and models to the nursing process, includes a helpful section on nursing diagnoses for community health concerns. The following are model cases representing nursing diagnoses *of* communities:[37(p125)]

- increased number of respiratory diseases related to air pollution,
- increased number of dog bites related to inadequate code enforcement,
- increased infant mortality rate related to increased teenage pregnancies,
- increased number of lead poisoning cases in toddlers related to substandard housing or lack of prevention or knowledge,
- decreased communication related to sectionalism,
- lack of neighborhood participation related to apathy.

DIAGNOSTIC AND PROVISIONAL CRITERIA

The criteria that set Andrews' diagnoses[37] apart from nursing diagnoses of individuals *in* the community or individuals *influenced by* the community are as follows:

- They are generated from assessments, not only of the state of individuals, but also of the state of the community as a physical/sociocultural/experiential entity.
- Relational statements imply intervention not by providing direct client services, although these may be the ultimate result, but by instituting some change in the present community.
- The implied direct client is the community; the indirect client is the individual.

In other words the one provisional criteria is the community being the direct client. It is primarily this feature that distinguishes community nursing diagnoses from nursing diagnoses of individuals *in* the community or individuals *influenced* by the community.

EMPIRICAL AND CLINICAL REFERENTS

Sanders' [33] community model can guide in identifying the empirical/clinical referents for nursing diagnoses of communities. To study the community as a spatial unit suggests demographic data collection. Such information as maps, census bureau reports, and morbidity and mortality statistics by area would all be useful.

To consider the community as a way of life, the cultural dimension, lists of civic groups, observations of neighborhoods, and census reports on ethnicity would be examined.

To examine the community as a place to live, opinion polls, oral and written community histories, crime rates, employment figures, and housing and work conditions would be studied.

Finally, to become aware of the social forces at work in a community, personal reports of conflicts and cooperation among groups would be obtained, and community agency directories; city, county, state, and federal budgets; voting records; and newspaper articles would be examined.

ANTECEDENTS AND CONSEQUENCES

Those factors that must be present to facilitate development of nursing diagnoses of communities are similar to the antecedents of other types of nursing diagnoses. Nurses need sound decision-making skills, as well as experiential and educational preparation adequate to enable them to understand all the dimensions of individual-community interaction. There must also be some assessment tool or scheme that can aid in gathering pertinent information. Andrews,[37] in agreement with other nurses, sees diagnosis as a part of the nursing process as shown in Fig 1. She says: "The diagnostic process is never complete as long as there is a nurse-client contact."[37(p116)]

Classification of nursing diagnoses will likely occur in the future, providing insight into the true practice of community nursing. Gordon and Sweeney[3] believe nursing diagnoses can serve to

- guide the education of nurses,
- aid in writing outcomes in quality assurance programs,
- assist in measuring the cost-effectiveness of care, and
- determine staff assignments.

They could also be used to provide a framework for resource allocation.

Some consequences of clearly stating nursing diagnoses of communities can be somewhat threatening. Mundinger and Jauron point out that "it demands risk taking for the nurse, because she is putting her inferences in print to be scrutinized by other chart readers."[42(p98)] Tucker speaks specifically to community health nurses making explicit diagnoses:

> The implication for community health workers is inescapable. The most meaningful preventive actions, those most effective in producing a safe and healthy existence for the community are universalist, that is, political. . . . Participating in these activities will involve some risk.[31(p186)]

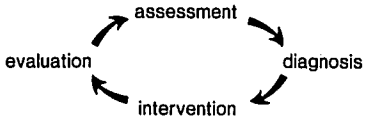

Fig 1. Diagnosis as part of the nursing process.

RECOMMENDATION FOR RESEARCH

The analysis of the concept of community nursing diagnosis reveals a variety of areas of potential research. First, there is great need for investigation into the nature of communities. Related to this is the question of the type of clients in communities. What are communities like and in what ways do nurses enter into association with communities to work for change in health status?

Studying the scope of effectiveness of nurses with communities as clients would also be worthwhile. This might be accomplished in part by replication and expansion of the typology of community nursing practice begun by Archer and Fleshman.[19]

As the concept of nursing diagnosis is applied by community nurses, perhaps it will become clear if nursing of individuals *in* the community, nursing of individuals *influenced by* the community, and nursing *of* the community are real or artificial distinctions. The assumptions that the nursing of individuals will improve communities and that nursing of communities will improve the lives of individuals are also in need of validation.

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