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Because nurse practitioners (NPs) have expanded their nursing knowledge and skills into medicine they need a model that reflects this expanded role. This article presents the Shuler Nurse Practitioner Practice Model, which is wellness-oriented and suggests how patient interaction, assessment, intervention, and evaluation should occur.

Research indicates that nurse practitioners (NPs) have a fairly strong nursing orientation, but are limited in their ability to apply conceptual nursing models to their practice (Thibodeau & Hawkins, 1989). This dilemma is understandable because NPs combine both nursing and medical skills when interacting with patients. It is difficult for NPs to use the current collection of nursing models and conceptual frameworks in their clinical practice because approaching the patient from a purely nursing perspective is inappropriate. Similarly, sole reliance on the medical model is problematic.

Because NPs have expanded their nursing knowledge and skills into medicine (Bates, 1990) they need a model that reflects this combined role. An interactive systems approach to problem solving, the Anderson Model (Anderson, 1978), was developed for NPs in the late 1970s. In this model the NP role was conceptualized using Kuhn’s Intersystem Theory. Emphasis was placed on joint decision-making and recognition of the biological, psychological, social, as well as cultural aspects of people. This model has been used successfully by some NP clinicians, educators, and researchers. However, it is the belief of the authors that a second model is needed, one that is wellness-oriented and more definitive in terms of how the patient interaction, assessment, intervention, and evaluation should occur.
THE RELATIONSHIP AMONG THEORY, MODELS, AND NURSING PRACTICE

Walker and Avant (1983) proposed that an intrinsic characteristic of a profession is commitment to a practice that is supported by theory and based on sound, reliable knowledge. Nursing supports this premise and has described several relationships between theory and nursing practice in the literature. For the purposes of this article, a theory-practice interaction is supported, where the "two are viewed as related components in a unified nursing discipline. Theory arises out of practice, and once validated, returns to direct or explain that practice" (Stevens, 1984, p. 92). The alliance between the process of theory development and the practice of nursing is open, dynamic, and reciprocal (Chinn & Jacobs, 1987).

Models and theories are related; the model provides a view of the entire stratagem, whereas the theory or theories specify relations among variables in the model (Kerlinger, 1986; Riehl & Roy, 1980). In other words, the theory provides the working insides of the model (Riehl & Roy, 1980). The relationship between theory and a model is independent as well as cooperative. The theory highlights, explains, and predicts a certain empirical reality, whereas the model displays the parts of nursing and how they are related, so that the nurse can have a cohesive and systematic approach to the patient in the practice setting (Riehl & Roy, 1980).

Since the realm of nursing includes a unique group of nurses who have expanded their role into medicine (NPs), it is suggested that with slight modification, these same theoretical and practice linkages can be applied to NP practice. By formally augmenting or reformulating nursing theories and models with selected components from the medical model, a resourceful conceptual framework, such as the one presented in this article, can be produced that depicts the combined role of the NP. As a result, the valued relationship between theory and nursing practice is retained.

PROBLEMS WITH CLINICAL APPLICATION OF NURSING MODELS

Prior to the presentation of a proposed NP model, an examination of model application in nursing practice is warranted because areas of divergence have been identified between nursing theory and practice. Miller (1985) proposed that one of the greatest barriers to using nursing models in practice relates to vocabulary and communication within the models. Theorists tend to use obscure and complicated language such as contextual stimuli (Roy, 1970), reality convergence (Orem, 1985), reconstitution (Neuman & Young, 1972) and helicy (Rogers, 1970), words that are unfamiliar to many practicing nurses. Even after studying these nursing theories and models, the terminology often precludes nurse clinicians from applying the underlying theoretical principles to their practice areas (Miller, 1985).

A second barrier to the application of nursing theories and models to practice arises from the incongruence of points of view between theorists and nurse clinicians. Often theorists have been away from nursing practice and tend to focus on how nursing "ought to be," rather than how nursing "really is" (Miller, 1985; Stevens, 1984). This situation is ironic because most nursing theorists support the tenet that nursing theory must arise from nursing practice.

A third factor that may be related to the problem of underuse of existing nursing models is the theorists' broad viewpoint. Many of these existing models may be defined as grand theories and, therefore, not amenable to direct application in the practice arena. Because these models are not based on specific practice theories, they can only serve as philosophies for practice.

THE NP ROLE

NP's scope of practice encompasses wellness and the traditional nursing role of diagnosing and treating human responses to actual or potential health problems (ANA, 1980a), as well as medicine's role of diagnosing and treating the condition itself. Typically, as with many physicians, NPs work in ambulatory, primary care settings and carry a caseload that consists of patients who are in need of preventive, as well as curative, health care services. However, as a health care provider, the NP's approach to patient care is unique, because it has been maintained that the clinical responsibilities of NPs focus on evaluating total (holistic) patient needs with patient input while providing episodic, as well as comprehensive, care (Fowkes & Hunn, 1973).

Therefore, it follows that an effective model should guide the NP in the following: (a) conducting holistic patient assessments; (b) identifying potential and actual health and health-related problems; (c) evaluating patient responses associated with the problem area(s); (d) diagnosing acute and chronic illnesses; (e) developing and implementing treatment plans that include pharmacological and nonpharmacological components; (f) including the patient and family as active participants in the treatment plan development phase; (g) focusing the NP/patient interaction on wellness (health promotion and disease prevention) and self-care; (h) evaluating patient outcomes; and (i) conduct-
ing NP self-evaluation. The intent of this article is to
discuss the theoretical development of a model for NPs
that employs common nursing and medical terminol-
ogy.

DEVELOPMENT OF THE SHULER NURSE
PRACTITIONER PRACTICE MODEL

The presented NP paradigm, The Shuler Nurse Practi-
tioner Practice Model (Shuler, 1991), evolved over the
past 14 years as the primary author consistently used the
framework in clinical practice; theoretical refinement
occurred as a result of doctoral studies (Figure 1). Well-
ness Nursing Theory (Clark, 1986) and the Nursing
Process (ANA, 1980a) form the primary theoretical basis
for the model. In addition, it is supported by a unique
combination of theories from a variety of disciplines that
have been reformulated to embody a philosophical
approach to the NP practice domain.

The Shuler Nurse Practitioner Practice Model is based
on views, beliefs, and theoretical underpinnings that are
broadly reflected in the model assumptions presented in
the Table. The theoretical model constructs and corre-
sponding underlying theory that have been identified
within the model are depicted in Figure 2.

The model has both inductive and deductive features
and strives to describe and logically analyze the pre-
ccepts, procedures, and processes used by NPs while they
are interacting with patients. This includes gaining
information from and knowledge about patients
through assessing needs, making clinical decisions,
identifying problems, making diagnoses, and develop-
ing intervention and evaluation measures.

The presented practice model is defined as a theoreti-
cal model because it is based on nursing research and
scientifically supported generalizations that are relative
to NPs’ practice areas (McFarlane, 1976). As a result,
the model is predictive and lends itself to testing
through the development of hypotheses.

MODEL CONCEPTS

Using nursing theory as a basis for practice requires
an integration of values and beliefs regarding the
concepts of person, health, nursing, and environment
(Yura & Torres, 1975). The manner in which these
aspects of a nursing theory are conceptualized is the
basis upon which the nursing process is mobilized and
patient care goals are set. These four concepts, along
with the concept NP role, are intrinsic to the Shuler
Nurse Practitioner Practice Model and are defined
below. It is important to note that NPs can substitute

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<td>MODEL ASSUMPTIONS</td>
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<tr>
<td>1. People are physiological-psycho logical-social-cultural-environmental-spiritual beings.</td>
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<td>2. People have the right to accept or reject health care.</td>
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<td>3. The nurse practitioner and patient are partners in health care.</td>
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<td>4. Health is a dynamic state and wellness is an ongoing process; both are related to physiological, psychological, social, cultural, environmental, and spiritual aspects of the patient.</td>
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<td>5. Nurse practitioners assist patients with wellness, health promotion, prevention, maintenance, and restoration through self-care activities.</td>
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<td>6. The nurse practitioner acts as a role-model during patient interaction and can influence the patient's health-related attitudes and behaviors.</td>
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<td>7. People can learn to move to a higher level of wellness when facilitated by nurse practitioners who are well-grounded in wellness theory and practice.</td>
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<td>8. The family can be the greatest single influence on the health behaviors of patients since health beliefs, practices, values, and attitudes are often determined and monitored by this unit.</td>
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<td>9. Patient health education can improve health and wellness status.</td>
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<td>10. Patient health educator is one of the most important roles performed by the nurse practitioner.</td>
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<td>11. The patient is an active participant in the teaching/learning process.</td>
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<td>12. Learning abilities and learning needs change throughout the lifespan.</td>
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their personal definitions of the following concepts
while using the model.

PERSON

The model is based on a philosophy that recognizes
people as wholistic, feeling, thinking, rational beings with
intrinsic value and worth. Each person is viewed from a
general systems perspective as a whole being comprised
of physiological, psychological, social, cultural, and
spiritual aspects (Bertalanffy, 1968; Roy, 1970). NPs
recognize that people are in constant interaction with a
dynamic environment and are constantly seeking to
maintain stability (Roy, 1970). People are influenced and
changed by their future, heredity, and life experiences in
general. They have the ability and freedom to choose how
they will adapt (Roy, 1970). Individuals have the right to
accept or reject health care. They are ultimately
responsible for their own health and should be provided
with encouragement and information that enables them
to be active participants in their health care and level of
wellness (ANA, 1980b). People are believed to have
innate self-healing and self-repair abilities (Clark, 1986).

HEALTH

The NP is encouraged, in the model, to view health
as a dynamic and ongoing state that is related to
physiological, psychological, social, cultural, and spiritual aspects of individuals. The requirements to cope and adapt effectively with the environment and changing life situations are also reflected in this vibrant state (Roy, 1970). Health encompasses the processes of wellness, illness, disease prevention, health promotion, self-care, rehabilitation, and education. An individual’s health status is both a personal and social responsibility. Health care services should be developed and rendered in the most cost-effective manner possible.

NURSING

Nursing is viewed as a process and profession. Nurses function by employing a scientifically based, goal-directed, interpersonal process. This process involves assessing, diagnosing, and treating human responses to actual or potential health problems and promoting wellness (ANA, 1980a). Patient care, which occurs in a variety of settings, is directed toward individuals, families, and communities. Nurses are professionals who are members of a multidisciplinary health care team.

NP ROLE

The role of the NP requires mastery of nursing as well as medical skills, such as diagnosing and treating acute and chronic illnesses. As a member of the health care team, the NP serves as a facilitator who assists patients toward restoration and wellness through nursing and medical interventions, self-care, health promotion, disease prevention, and wellness activities (Clark, 1986). Therefore, important supportive elements of the NP role include serving as an effective role model for wellness, a patient advocate, a proponent of patient/family participation and self-care, a facilitator of disease prevention and health promotion activities, a stimulus for positive NP/patient communication, and a partisan for wholistic health care.

Upon completion of a wholistic patient assessment, the NP determines whether interactions with the patient are to focus on (a) health restoration (illness or disease present), (b) health maintenance, or (c) wellness. The NP’s personal commitment to wellness impacts her/his ability to influence positive patient outcomes. Therefore, NPs are encouraged to investigate the potential effects that wellness theory has on them as human beings and subsequently on their quality of practice.

ENVIRONMENT

NPs should appreciate the relationships that exist between people and their environments. Environment encompasses all of the conditions, circumstances, and influences that surround and affect the development and existence of an individual or group of individuals (Guralnik, 1972). It includes animate and inanimate objects, climate, geographical location of residence, housing, and other human beings. The environment is a changing field that is external to persons but is related in a continuous and contiguous manner (Clark, 1986). The environment modifies people and is modified by their presence or actions; it has a direct affect on the health of populations, groups, families, and individuals (ANA, 1980b). An individual’s environment and health status are closely linked; a deficiency in one area can lead to a deficiency in the other.
MODEL COMPONENTS

The presented theoretical model (Figure 1) is an open system that consists of an organized set of dynamically and rhythmically interrelated parts and processes. Individuals are holistically conceptualized as physiological-psychological-social-cultural-spiritual energy systems that are in constant interaction with the environment. Therefore, General System Theory (Bertalanffy, 1968) was used to integrate the model concepts and to organize use of the components.

The model is capable of taking in energy and information from the environment, as represented at the top of Figure 1 as the inputs from the patient and NP. The type of tisit (episodic, comprehensive with an existing health problem, or comprehensive without an existing health problem) guides the interaction between the NP and patient. Energy and information is then exchanged through the data gathering and NP role modeling model processes.

In the patient/NP throughput phase, the NP synthesizes the gathered information by diagnosing and identifying problems while affirming unique combinations of needs, factors, and [associated] problems. The NP continually adjusts conditions of the interaction so that the patient remains an active participant (patient input regarding diagnoses). Furthermore, the patient is included in the health care planning process through contracting. The goal of the NP/patient interaction is to improve the patient’s health status and well-being through participation in self-care, wellness care, disease prevention, health promotion, and restorative activities (consultation/referral, treatment plan development, and self-care planning and implementation aspects of the model).

During the outputs phase, energy and information are released back into the environment via the NP and patient (Clark, 1986; Hazzard, 1971). Feedback is an important component of the model in that it not only does input effect output, but output also alters input. The model receives feedback internally (from within the system), as well as externally (feedback that occurs between the system and the environment). The evaluation portion of the model addresses the effectiveness of the NP/patient interaction and determines, through feedback mechanisms, whether or not modifications in the treatment plan are needed.

SIGNIFICANCE

The Shuler Nurse Practitioner Practice Model (Shuler, 1991) has the potential to impact the NP domain at four levels: theoretical, clinical, educational, and research. Theoretically, the model presents a framework from which NPs can define their unique health care provider role. Clinically, the model is designed to guide NP practice, a blend of nursing and medicine; educationally, the model can be used to direct NP curricula. Finally, with respect to research, the underlying theoretical concepts can be tested relative to their efficacy in guiding and interpreting clinical research relevant to NP practice.

In this article the authors maintain that NPs are adding new dimensions to primary care as they are struggling to clarify their role. It is proposed that the Shuler Nurse Practitioner Practice Model (Shuler, 1991) can enable NPs to carve this definitive, visible niche in the health care delivery arena. The model can serve as a much needed theoretical guide for NPs who work in clinical, academic, and research settings.

ACKNOWLEDGMENT

The primary author would like to sincerely thank Linda Oakley Bowlin, RN, MNSc, JD, and Jacquelyn H. Flaskerud, RN, PhD, FAAN, for their guidance and consultation during earlier stages of the model’s development. Deepest appreciation is also extended to former and current NP students at UCLA and University of Kentucky who have integrated the model into their practices.

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The Shuler Nurse Practitioner Practice Model: Clinical Application, Part 2

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Nurse practitioners' unique contributions to primary care can be demonstrated more clearly if clinicians would adhere to a theoretical framework that reflects their combined nursing and medical role. This article explicitly delineates the process of utilizing the Shuler Nurse Practitioner Practice Model in clinical practice.

As nurse practitioners (NPs) combine nursing and medical skills in clinical practice, many may be struggling to maintain a nursing identity. It is critical that the nursing, as well as medical component, is reflected in practice, as NPs are being asked to demonstrate unique contributions as health care providers. Acquisition of expertise in two health care disciplines makes NPs distinctive: the customary domains of nursing practice, as well as selected aspects of medicine are inherent to the NP role (Capell & Case, 1976).

NPs are therefore challenged to address the patient's response to potential and actual problems (nursing role), while assessing/treating the condition itself (medical role) when appropriate. This article proposes that the Shuler Nurse Practitioner Practice Model (Shuler, 1991), as previously discussed in an article by Shuler and Davis (1999), is the missing link that can ensure an NP's retention of a nursing orientation in a clinical practice that contains a medical component.

CLINICAL SIGNIFICANCE

The literature asserts that NPs function in an interdependent relationship with physicians, but maintain a unique role in the provision of primary care services (Fowkes & Hunn, 1973). However, research indicates...
TABLE 1. NURSE PRACTITIONER OUTCOMES

Nurse practitioners who adopt the Shuler Nurse Practitioner Practice Model can:
1. Reflect the combined role of nursing and medicine more consistently.
2. Assess their patients more holistically and comprehensively.
3. Be more systematic in their approach with patients.
4. Be more likely to include patients in the assessment, planning, intervention, and evaluation processes.
5. Encourage self-care activities more frequently among their patients.
6. Be more likely to include disease prevention and health promotion activities in the treatment plan.
7. Become less frustrated when working with patients who have a variety of complex health and health-related needs.
8. Experience an increase in job satisfaction.
9. View themselves more readily as members of a holistic multidisciplinary health care team.
10. Consult and/or collaborate with diverse members of the multidisciplinary team more readily.
11. Be more likely to utilize referral agencies other than health care facilities.
12. Be more professionally aware of wellness theory and practices.
13. Be more likely to personally participate in wellness activities.
14. Be more cost-effective in their practice.

that in actual clinical practice, NPs often serve as substitutes for physicians (Chen, Barkauskas, & Chen, 1984) which could indicate heavy reliance on the medical model. Chen and colleagues (1982) assert that NPs will retain primary care management in their repertoire of roles and functions only if they begin to document unique nursing contributions.

It has been proposed that NPs have the potential to bring to primary care practice an added dimension of wholistic and humanistic care that incorporates principles of health maintenance, health promotion, disease prevention, patient education, counseling, advocacy, collaboration, and comprehensive patient-centered care (Stanford, 1987). The authors contend that NPs do bring these added dimensions to primary care. However, retention of a wholistic and wellness focus in practice is threatened unless NPs utilize a theoretical framework that is based in wellness nursing theory, as well as the medical model.

It is proposed that utilization of the Shuler Nurse Practitioner Practice Model (Shuler, 1991) in clinical practice would ensure demonstration of the NP's combined role. As NPs subscribe to the model for guidance in patient interactions, wholistic assessments that reflect nursing and medicine will begin to emerge more clearly. As a result, clinical application of the model can have immediate and long-term significance for NP practice. Patient outcomes will reflect preventive, curative, and restorative NP/patient efforts. Furthermore, NPs will become more consistent in their interactions with patients while utilizing a wholistic perspective and more cognizant of the use of both nursing and medical skills. Over time NPs' distinctive contributions to primary care will subsequently become more evident.

TABLE 2. PATIENT OUTCOMES

Use of the Shuler Nurse Practitioner Practice Model with patients can:
1. Ensure inclusion of psychological, social, cultural, environmental, and spiritual aspects of the patient's condition as well as the physical aspects.
2. Increase confidence in the patient with respect to his/her health care needs, self-care treatments, and wellness activities.
3. Improve the patient's lifestyle by increasing participation in disease prevention and health promotion (wellness) activities.
4. Decrease the number of patient follow-up visits.
5. Decrease complications and exacerbations of acute and/or chronic health conditions.
6. Improve compliance to the mutually agreed upon treatment and/or wellness plan.
7. Encourage patients to seek health care early when a problem is beginning to surface.
8. Encourage patients to "take charge" of their health care.
9. Improve the patient's quality of life by recognizing him/her as a wholistic being, encouraging participation in wellness activities and addressing underlying psychological, social, cultural, environmental, and spiritual needs.

POTENTIAL BENEFITS OF USING THE SHULER MODEL IN CLINICAL PRACTICE

Use of the Shuler Nurse Practitioner Practice Model (Shuler, 1991) in clinical practice can be advantageous for the NP as well as the patient. The authors propose benefits for each. Benefits for NPs who adopt the model in their practice are presented in Table 1, while patient benefits related to NPs' use of the model are in Table 2.

Furthermore, the Shuler Model (Shuler, 1991) is an ideal framework from which to investigate NP effectiveness in clinical practice as partially outlined by Crosby and colleagues (1987). These important NP clinical research areas focus on investigating: (a) the nursing domain of the NP role; (b) the effect NPs have upon patients' functional abilities, quality of life, and morbidity/mortality rates; (c) the cost-effectiveness of primary care delivered by NPs; (d) the ability of NP practice to improve clinical outcomes in designated populations; (e) the nature of the NP role in collaboration with a multidisciplinary health care team; (f) the future of the NP role in primary care; (g) additional practice setting characteristics conducive for NP practice: (h) the ef-
ffects of NP educational preparation on effectiveness in delivering primary health care services; and (i) the identification of current conditions that either enhance or impede NP clinical practice.

EXAMPLES OF CLINICAL USE OF THE MODEL

According to the Shuler Nurse Practitioner Practice Model (Shuler, 1991), three types of patient visits can occur: (a) episodic, (b) comprehensive with an existing health problem (either acute or chronic), and (c) comprehensive without an existing health problem (see Figure 1 of Shuler & Davis, 1995). The type of patient visit directs the clinical interaction that transpires between the NP and patient. An example of how the model can be applied to clinical practice with a patient who has an existing health problem (acute or chronic) and is being seen for a comprehensive examination is presented in the Figure that follows this article.

SUMMARY

It is proposed that the Shuler Nurse Practitioner Practice Model (Shuler, 1991) equips the NP with a theoretically based guide for patient assessment and interaction that is consistent with the goal to provide unique primary health care services that reflect nursing and medicine. Furthermore, the model is based in wellness theory and explicitly guides the NP in educating and counseling patients in the areas of health promotion and disease prevention. This is important since research suggests that NPs demonstrate the use of more wellness care management with patients than do physicians (Barkauskas, Chen, & Chen, 1985; Chen, Barkauskas, Ohlson, & Chen, 1992).

Adoption of a unique theoretical NP practice model has the potential of unifying the discipline and clarifying the practitioner’s combined clinical practice role. It is recognized that NPs use theories pertaining to illness/disease, wellness, self-care, family/community, teaching/learning, communication/interaction, and stress reduction (Stanford, 1987) with their patients, but a formalized conceptual frame of reference that provides theoretical linkages is often lacking in practice. If practicing NPs would cooperatively ascribe to an NP model such as the one presented here, they would begin to clinically operate from a common theoretical and conceptual base. As a result, the dimensions of NPs’ unique clinical practice would become more clearly delineated.

References
PURPOSE OF THE VISIT

Yearly Physical and Evaluation of ___________________________ (Existing Health Problem)

SUBJECTIVE DATA GATHERING: COMPONENTS OF THE HISTORY

Subjective Data would be gathered through a "wholistic", comprehensive history. The NP should ensure that the following areas are investigated during the interview: 1) physiological status/needs; 2) psychological status/needs; 3) social support/networks; 4) cultural/health beliefs; 5) environmental/occupational conditions; and 6) spiritual needs. A standard history format could be used and may cover all patient areas that need to be explored. The history content below is based on Bates (1991) and Halasanos et al (1990) and supplemented by The Shuler Nurse Practitioner Practice Model (Shuler, 1991).

Biographical Information

Usual Components

Full name, address, birthdate, sex, race, religious preference (affiliation with organized religion), marital status, educational level, social security number, occupation (usual and present), usual source of health care, source of referral (if applicable), insurance, source and reliability of information.

Additional Model Components

No additional components.

Chief Complaint

Usual Components

"I came for my yearly check-up and also want you to check ___________________________ (Existing Health Problem)."


Additional Model Components

No additional components.
History of Present Illness

Usual Components

Introduction - Patient's summary of condition and usual health; Description of the condition in chronological order - onset, date, setting, manner (gradual or sudden), duration, precipitating factors, course since onset [incidence or frequency, manner, duration (longest, shortest, and average times), patterns of remissions and exacerbations], location, quality, quantity, setting, associated phenomena, alleviating or aggravating factors, treatments; Pertinent negative information; Relevant family information; Disability assessment.

Additional Model Components

PHYSIOLOGICAL STATUS/NEEDS - Effects the condition has had on fitness and/or sexual activities.

PSYCHOLOGICAL STATUS/NEEDS - Psychological response to the condition, i.e. is the patient depressed, anxious, angry or accepting of the condition and/or related limitations?; Coping strategies and perceived effectiveness; Effects the condition has had on relaxation and recreational activities.

SOCIAL SUPPORT/NETWORKS - Family/friend responses to patient's condition; Amount and types of tangible/emotional support that patient receives from family/friends regarding the condition; Deficit areas regarding support, i.e. does the patient have transportation or childcare problems related to clinic visits, pharmacy trips or self-care activities?

CULTURAL/HEALTH BELIEFS - Cultural/health beliefs regarding the condition, treatment and prognosis; Current use of non-traditional treatments or remedies, i.e. folk healers, hypnosis, accupressure/puncture, massage, herbs, poultices.

ENVIRONMENTAL/OCCUPATIONAL CONDITIONS - Effects the condition has had on ability to work and maintain household responsibilities; Presence of environmental factors that could impede treatment or recovery from the condition, such as housing problems (lack of heat, food, shelter, clothing, sanitary drinking water, refrigeration etc.); or Residence in an area where environmental hazards are present i.e., air pollution.

SPIRITUAL TENETS - Participation in religious customs/rituals such as fasting, church going, praying, reading the Bible or other religious book, avoidance or partaking of particular foods or avoidance of particular behaviors such as touching one's own genitalia as in breast or testicular self-examination, that are disrupted by the condition or treatment plan; Participation in any customs/rituals that affects treatment of or recovery from the existing health condition.
Past Medical History

Usual Components

Childhood illnesses and major adult physical and psychiatric illnesses, serious injuries, hospitalizations, operations, allergies (food, medication and/or environment), immunizations, transfusions, medications (practitioner and self-prescribed) and dates of last screening tests i.e., pap smears, mammograms, serum cholesterol.

Additional Model Components

PHYSIOLOGICAL STATUS/NEEDS - No additional components.

PSYCHOLOGICAL STATUS/NEEDS - History of child abuse and/or incest; Past use of alcohol and/or drugs, i.e. recovering alcoholic or cocaine addiction.

SOCIAL SUPPORT/NETWORKS - No additional components.

CULTURAL/HEALTH BELIEFS - Past use of non-traditional, culture specific treatments or remedies, i.e. folk healers, hypnosis, accupressure/puncture, massage, herbs, poultices.

ENVIRONMENTAL/OCCUPATIONAL CONDITIONS - Past environmentally induced health conditions, i.e. cholera from contaminated drinking water and/or past history of health problems that were exacerbated by environmental conditions, i.e. asthma intensified by air pollution; Past occupationally-related health problems.

SPIRITUAL TENETS - Past use of spiritual/religious healing practices, i.e. praying, participation in spiritual healing teams, exorcism.

Family History

Usual Components

Presence or absence of family members with condition(s) similar to patient's "present illness"; Health status or cause of death of grandparents, parents and siblings with ages at death; Family history of specific illnesses including: heart disease, high blood pressure, cancer, tuberculosis, stroke, diabetes, gout, kidney disease, thyroid disease, allergies, blood disorders, hereditary diseases; Age and health of spouse and children.
Additional Model Components

PHYSIOLOGICAL STATUS/NEEDS - No additional components.

PSYCHOLOGICAL STATUS/NEEDS - Presence or absence of family members with mental health problems; Family history of suicide, violent crimes, alcoholism and/or drug use; Presence or absence of family inner-marriage, spousal/child abuse and/or incest.

SOCIAL SUPPORT NETWORKS - Presence or absence of "family support" (emotional and tangible), i.e. are family members willing and available to listen to each other and assist with problem-solving, childcare, transportation, seeking health care etc.

CULTURAL/HEALTH BELIEFS - Family beliefs/practices related to illness, wellness, self-care, use of the health care delivery system.

ENVIRONMENTAL/OCCUPATIONAL CONDITIONS - Family residential exposure to environmental hazards such as asbestos, radon, toxic waste, nuclear radiation, polluted water/air; Presence or absence of family employment, i.e. business ownership, farming, factory work, mining, craftsmanship etc.

SPIRITUAL TENETS - Family religious/spiritual practices that differ from or are similar to patient's, i.e. church attendance (what type), praying, reading Bible or other religious book; Participation in spiritual/religious "healing" practices.

Personal and Psych-Social History

Usual Components

PERSONAL STATUS - Birthplace, where raised, home environment as youth (parental death, divorce or separation, socioeconomic status), position in family, hobbies, recreational activities and interests.

HABITS - Usual diet, regularity of eating, sleep and exercise patterns (quantity and type) and tobacco, caffeine, alcohol and/or drug use (type, frequency, amount and length of time used).

HOME CONDITIONS - Type of housing, heating and cooling, inside/outside pets and their health status.

OCCUPATION - Description of usual work and present job if different, work conditions and hours, physical and/or mental strain, any protective devices required, duration of employment, present and past exposure to heat and cold, industrial toxins (especially lead, arsenic, chromium, asbestos, beryllium, poisonous gases, benzene, and polyvinyl chloride or other carcinogens).
ENVIRONMENT - Travel and other exposure to contagious diseases, residence in tropics, water and milk supply, other sources of infection if applicable.

PERSONAL SAFETY MEASURES - Use of seat belts; Presence or absence of home safety activities i.e. use of smoke alarms.

MILITARY RECORD - Dates and geographic area of assignments.

Additional Model Components

PHYSIOLOGICAL STATUS/NEEDS - 24-hour dietary recall; Familiarity with basic first-aid and cardiopulmonary resuscitation (CPR).

PSYCHOLOGICAL STATUS/NEEDS - Patient's "life view", i.e. does the patient have a positive or negative view about his/her current life situation and the future?; Presence or absence of relaxation techniques and perceived effectiveness; Perception of degree of harmony in home and personal life.

SOCIAL SUPPORT NETWORKS - Presence or absence of someone who listens, cares and spends time with the patient; Presence or absence of someone who can assist the patient with tangible support needs such as lifting, transportation, cleaning, childcare etc.; Role of pets, if any, in providing social support.

CULTURAL/HEALTH BELIEFS - Participation in general cultural customs/rituals and feelings about such activities.

ENVIRONMENTAL/OCCUPATIONAL CONDITIONS - Participation in activities such as recycling, organic gardening, professional/work-related organizations and feelings about such activities; Perception of degree of harmony in work life; Presence or absence of work-related safety activities, i.e. using safety equipment when needed, participating in fire/disaster drills; Description of the two jobs preceding current position (job duties and length of employment).

SPIRITUAL TENETS - Participation in general spiritual/religious practices on a regular basis and feelings about such activities.

Review of Systems

Usual Components

GENERAL - Fever, chills, fatigue, malaise, fatigability, night sweats; weight (average, preferred, present, recent change).
SKIN - Rash or eruption, itching, pigmentation or texture change, dryness, excessive sweating, abnormal nail or hair growth.

HEAD - Frequent or unusual headaches, dizziness, syncope, severe head injuries.

EYES - Visual acuity, blurring, diplopia, photophobia, pain, recent change in appearance or vision, glaucoma, cataracts, use of glasses or contact lens.

EARS - Hearing loss, pain, discharge, tinnitus, vertigo, use of hearing aid.

NOSE AND SINUSES - Sense of smell, frequency of colds, obstruction, epistaxis, postnasal discharge, sinus pain.

THROAT AND MOUTH - Hoarseness or change in voice, frequent sore throats, bleeding or swelling of gums, tooth pain, abscesses or recent extractions, use of dentures, soreness of tongue or buccal mucosa, ulcers, disturbance of taste.

NECK - Pain, stiffness or lumps.

BREASTS - Pain, tenderness, nipple discharge, bruising, lumps, self-examination and date of first and last mammogram if applicable.

RESPIRATORY - Pain relating to respiration, dyspnea, cyanosis, wheezing, cough, sputum, (character and quantity), hemoptysis, night sweats, exposure to TB; date and result of last chest X-ray.

CARDIAC - Chest pain or distress, precipitating causes, timing and duration, relieving factors, palpitations, dyspnea, orthopnea (number of pillows needed), edema, hypertension, estimate of exercise tolerance, past ECG or other cardiac tests.

GASTROINTESTINAL - Appetite, digestion, intolerance for any kinds of foods, abdominal pain, dysphagia, heartburn, nausea, vomiting, hematemesis, regularity of bowels, constipation, diarrhea, change in stool color or contents (clay-colored, tarry, fresh blood, mucus, undigested food), flatulence, hemorrhoids, hepatitis, jaundice, dark urine, previous X-rays (where, when, findings).

URINARY - Dysuria, flank or suprapubic pain, urgency, frequency, nocturia, hematuria, polyuria, hesitancy, dribbling, loss in force of stream, passage of stone, edema of face, stress incontinence.

GENITALIA - Sexual Activity: Ever been sexually active?, age sexual activity initiated, sexual preference, frequency of intercourse, date of last sexual encounter, number of sexual partners in last month, in last year, in life-time, libido, problems with orgasm, other sexual difficulties, satisfaction with sex life, sexually transmitted disease exposure.

Male: Discharge from or sores on penis, hernias, testicular pain or masses, problems with erection or ejaculation, infertility.

Female: Onset and regularity or menses, duration of flow, exposure to DES, dysmenorrhea, last period, intermenstrual bleeding, vaginal discharge or itching, dyspareunia, date and result of last Pap smear, reproductive history (parity, gravida, miscarriages, abortions, duration of each pregnancy and any complications, problems in postpartum period), birth control use, age at menopause if applicable, menopausal symptoms, postmenopausal bleeding.

PERIPHERAL VASCULAR - Intermittent claudication, varicose veins, leg cramps, status ulcers, thromboses, thrombophlebitis.

MUSCULOSKELETAL - Muscle or joint pain, stiffness, restriction of motion, weakness, swelling, redness, heat, bony deformity, backache, arthritis, gout.
NEUROLOGIC — Syncope, seizures, weakness or paralysis, abnormalities of sensation or coordination, tremors, involuntary movements.

HEMATOLOGIC — Anemia, tendency to bruise or bleed easily, any known abnormality of blood cells.

ENDOCRINE — Thyroid enlargement or tenderness, heat or cold intolerance, unexplained weight change, diabetes, polydipsia, polyuria, changes in facial or body hair.

LYMPH NODES — Enlargement, tenderness, suppuration.

PSYCHIATRIC — Depression, mood changes, difficulty concentrating, loss of memory, nervousness, tension, suicidal thoughts, irritability, sleep disturbances.

**Additional Model Components**

No additional components

**OBJECTIVE DATA GATHERING**

Objective data would consist of the information gathered through a typical, complete physical examination (Bates, 1991, p. 122-127) and routine laboratory/diagnostic tests. Further examination and additional testing may be required, depending upon the patient's health condition.

**Comprehensive Physical Examination**

**Usual Components**

**GENERAL SURVEY** — General health status, stature, sexual development, posture, motor activity, gait, dress, grooming, personal hygiene, body/breath odors, patient's affect, response to environment, speech and state of awareness or level of consciousness.

**VITAL SIGNS/MEASUREMENTS** — Pulse, respiration, blood pressure and body temperature.

**SKIN** — Inspect: Temperature, hydration, pigmentation, lesions (location, distribution, arrangement, type and color), rashes, abnormalities in nails and body hair.

**HEAD AND FACE** — Inspect: Hair, scalp and skull.

**EYES** — Testing: Visual acuity, visual fields; Inspect: Position/alignment of eyes, eyelids, sclera, conjunctiva, cornea, iris, lens, pupils (equality, shape, reaction to light and accomodation), ocular fundus.


**NOSE AND SINUSES** — Inspect: External nose, nasal mucosa, septum and turbinates; Palpate: Frontal and maxillary sinuses.

**MOUTH AND PHARYNX** — Inspect: Lips, buccal mucosa, gums, teeth, hard/soft palate, tongue and pharynx.

**NECK** — Inspect and Palpate: Cervical lymph nodes, thyroid gland, trachea (note any deviation) and unusual pulsations or masses.

**BACK** — Inspect and Palpate: Spine alignment and muscles; Inspect spine range of motion; Percuss for costovertebral angle (CVA) tenderness.
POSTERIOR THORAX AND LUNGS - Inspect, palpate and percuss chest; Estimate diaphragmatic excursion; Auscultate lung fields (evaluate bronchophony if indicated).

UPPER EXTREMITIES - Inspect and palpate joints and check range of motion for hands, arms, shoulders, neck and jaw; Examine muscle tone and strength of hands, arms, shoulders and neck; Palpate radial pulses.

BREASTS AND AXILLAE - Inspect breasts with arms relaxed at sides, hands relaxed behind neck and hands pressed against waist; Inspect and Palpate axillae; Palpate breasts and continue to inspect.

ANTERIOR THORAX AND LUNGS - Inspect, palpate and percuss chest; Auscultate lung fields (evaluate bronchophony if indicated).

CARDIOVASCULAR SYSTEM - Inspect and palpate carotid pulsations; Auscultate for carotid bruits; Inspect for jugular venous pulsations and measure the jugular venous pressure in relation to the sternal angle; Inspect and palpate precordium (note location, diameter, amplitude and duration of apical impulse); Auscultate with diaphragm and bell over 2nd right intercostal space, 2nd left intercostal space, along lower left sternal border (2nd-5th spaces) and apex.

ABDOMEN - Inspect, auscultate and percuss 4 quadrants; Palpate lightly and then deeply (try to feel liver, spleen, kidneys and aorta).

LOWER EXTREMITIES AND FEET - Inspect and palpate joints and check range of motion for hips, knees, ankles and feet; Examine muscle tone and strength of legs and feet.

MUSCULOSKELETAL SYSTEM - Done with Back, Upper and Lower Extremity exams.

PERIPHERAL VASCULAR SYSTEM - Inspect legs for: varicose veins, edema, discoloration, ulcers; Palpate for pitting edema; Palpate dorsalis pedis, posterior tibial and femoral pulses (popliteal if indicated); Palpate inguinal lymph nodes.

NEUROLOGIC - Motor activity not already examined with Back, Upper and Lower Extremity exams: Rapid alternating movements of hands; Cranial nerves not already examined: Sense of smell, temporal and masseter muscle strength, corneal reflexes, facial movements, gait reflex, trapezius and sternomastoid muscle strength; Sensory function: Pain and vibration in hands/feet, light touch on limbs and stereognosis in hands; Deep tendon reflexes and plantar responses; Gait, heel-toe walking, hop in place, walk on heels, walk on toes, Romberg, Check for pronator drift and arm winging.

MENTAL STATUS - May be done during interview; Assess: mood, thought processes, thought content, abnormal perceptions, insight and judgement, memory, attention, information, vocabulary, calculating abilities, abstract thinking and constructional ability.

FEMALE GENITALIA AND RECTUM - Inspect and Palpate the external genitalia (labia minor and majora, clitoris, urethral orifice, introitus, anus), vagina and cervix; Obtain Pap smears and cultures as indicated; Palpate uterus and adnexa; Perform rectovaginal; Assess strength of pelvic muscles; Perform rectal examination (stool guaiac if indicated); Search for hernias of the groin if indicated.

MALE GENITALIA AND RECTUM - Inspect and Palpate: Penis (skin, prepuce, glans), scrotum (skin, scrotal contours - note swelling, lumps, veins); Palpate: Testicles, epididymus, spermatic cord with vas deferens; Transilluminate if scrotal swelling noted; Inspect and Palpate for inguinal and femoral areas for hernias; Perform rectal examination - Inspect macroscopic and perianal areas; Palpate anal canal, rectum and prostate (stool guaiac if indicated).

Additional Model Components

No additional components
Laboratory/Diagnostic Tests

**Usual Components**

Urine dipstick; Hematocrit/Hemoglobin (Other tests as individually indicated, i.e. Complete Blood Count, Cholesterol/Triglycerides, Blood Sugar, Electrocardiogram, Chest X-Ray etc.).

**Additional Model Components**

No additional components

**ROLE MODELING**

As the NP is gathering subjective and objective data, she/he should be aware that the patient is observing the following NP characteristics and/or behaviors: 1) fitness state; 2) ability to handle stress; 3) nutritional status; 4) commitment to wellness activities, i.e. time allotted for rest and recreation, use of tobacco products, alcohol or illicit drugs; 5) self-care attitude; 6) cultural sensitivity; 7) positive relationship skills; 8) environmental sensitivity; and 9) spiritual awareness.

If the NP is asking the patient to change behaviors or participate in activities that the NP does not "role model", communication may be blocked and/or patient compliance may be reduced. The NP is not expected to be a "perfect" specimen of health; however, it is important that the NP communicates to the patient that she/he is cognizant of the difficulties associated with lifestyle changes.

**CLINICAL DECISION MAKING**

The process of clinical decision making is on-going and dynamic. Initially the differential diagnoses guide the NP in determining: 1) what subjective information is gathered; 2) what the physical exam should entail; and 3) what diagnostic and/or laboratory tests are needed to identify and/or confirm the patient's current health status and/or problem(s). Throughout the data gathering process, the NP's investigation of the problem may take specific turns depending upon the patient's situation. For example, if the chief complaint is "sore throat X 3 days" the NP will think rule-out streptococcal pharyngitis, gonococcal pharyngitis, mononucleosis, etc. Depending upon the patient's responses in the historical interview, i.e. positive for oral sexual contact within the past 2-4 weeks, the NP may suspect a gonococcal infection and would, therefore, include examination of the patient's genitalia. Whereas that aspect of the physical exam would probably be deferred if the NP strongly suspects other etiologies such as a streptococcal pharyngitis. The NP determines the working diagnosis as the combined data from the history, physical or mononucleosis. The NP determines the working diagnosis as the combined data from the history, physical or planning processes.
IDENTIFYING PROBLEMS

This is the point in the examination when the NP and patient jointly determine deficit areas, i.e. stress overload, environmental distress and/or illness/disease. The problem areas are viewed collectively and individually so that if appropriate, diagnosis(es) can be made from isolated or related problems. Some problem areas may be clearly linked, i.e. stress overload, obesity, inactivity and high blood pressure, whereas other conditions, such as leukemia, may be related to an unidentified environmental problem. Some problems will remain as problems, i.e. "Lack of Contraception", while others will be linked with diagnoses.

DIAGNOSING

During this process, diagnoses are either definitively determined or classified as "rule-outs". The model elements of Unique Combinations of Needs, Factors and Problems, Diagnosis(es) and Patient Input Regarding Diagnosis(es) constitute the process of Diagnosing.

Unique Combinations of Needs, Factors & Problems

Some patient problems such as child abuse, battered wife syndrome and anorexia are often not reported by the patient; however, the NP should rule-out such conditions if the patient presents with a combination of several "individual" problems. For example, if a woman presents at a Family Planning Clinic requesting treatment for a bruise on her breast that she said was sustained from a fall, and requests to have her IUD removed upon her husband's request, the NP should suspect domestic violence and attempt to investigate the situation with the patient.

Diagnosis(es)

The diagnosis(es) is (are) made after the NP has considered all of the subjective and objective data that were gathered. Some diagnoses will be definitive while others may remain as rule-outs until further testing, consultation (physician, psychologist, nutritionist, physical therapist, etc.) or information from referral sources is obtained.

Patient Input Regarding Diagnosis(es)

The NP shares her/his assessment and diagnostic findings with the patient in order to obtain feedback regarding the patient's reactions, beliefs and treatment preferences. In addition, the patient is given an opportunity to clarify previously reported historical information and/or to provide additional information that may assist the NP in confirming the diagnosis(es).
CONTRACTING

Contracting between the NP and patient should occur throughout the model processes of Identifying Problems, Diagnosing, Planning and Implementation. The NP involves the patient in the decision making process as much as possible which can empower the patient and in turn enhance wellness and self-care behavior.

PLANNING

Planning is a process that involves developing the wholistic nursing/medical treatment regimen and determining what can be done to assist the patient through self-care activities and/or referrals. The model elements of Consultation/Referral, Treatment Plan Development, Self-Care Planning and Implementation comprise the Planning process.

Consultation/Referral

Depending upon the type(s) of patient problem(s) identified and the diagnosis(es) that is (are) made, the NP may need to consult and/or collaborate with other members of the multidisciplinary health care team (another NP, a physician, a psychologist, a minister/priest, a nutritionist, a physical therapist, a social worker, etc.) prior to the establishment of the treatment plan at an initial visit or the NP may seek consultation/collaboration at a follow-up visit if the desired patient outcome(s) was (were) not achieved subsequent to the initial treatment plan.

With respect to referrals, the NP may provide a portion of the treatment and also refer the patient for assistance from other professionals who provide various health and health-related services. On the other hand, the NP may determine that the patient problems are beyond her/his scope of practice and refer the patient for further evaluation and treatment (i.e. conditions requiring surgery or complex diagnostic evaluation such as rule-out brain tumor).

Treatment Plan Development

During this part of the assessment, a mutually agreed upon wholistic nursing/medical treatment plan is devised by the NP which often includes prescribing medications and ordering medical procedures. The treatment plan focuses on setting goals, identifying patient strengths and weaknesses, establishing priorities, developing a pragmatic treatment regimen that includes pharmacological and/or non-pharmacological components, inclusion of consultation/collaboration activities as indicated, identifying referral sources/community resources as needed and designing methods to prevent future health problems, as well as improve the patient's current level of wellness. The patient's physical health, psychological status, social support system, cultural/health beliefs, environmental/occupational conditions and spiritu-tones should be considered as the treatment plan is developed, implemented and evaluated in the future.
Self-Care Planning and Implementation

When the patient exhibits that she/he is ready and willing to participate in her/his care (this may occur at the first visit or it may be delayed until a follow-up visit), the NP utilizes the self-care aspect of the model. Self-care planning and treatment plan development are explored in four main areas with the patient: Problem Judgment, Self-Care Activities, Disease Prevention and Health Promotion Activities. In using this portion of the model, the type of visit, i.e. Episodic, Comprehensive Without an Existing Acute or Chronic Health Problem or Comprehensive With an Existing Acute or Chronic Health Problem, determines to what degree the patient moves longitudinally from left to right through the four model areas of Self-Care Planning and Implementation. The example in this article focuses on a comprehensive exam with an existing health problem.

Problem Judgment. Under the Problem Judgment element, the NP involves the patient in his/her care by teaching pertinent Diagnosis Judgments. For example, the patient with an acute or chronic problem is taught how the diagnosis(es) was made, signs and symptoms of the condition and parameters indicating complications or problems that should be reported to a health care provider in the future.

Self-Care Activities. Within this model element, the focus is on Self-Care Treatment. The wholistic nursing/medical treatment regimen will include pharmacological (i.e., prescription and over-the-counter medications) and/or non-pharmacological (i.e., sitz baths, physical therapy, keeping a menstrual calendar, obtaining nutritional or spiritual counseling, participating in family therapy) components. The NP and patient negotiate which aspects of the treatment regime will be managed by the patient at home. The patient is taught how to carry out the mutually agreed upon treatment plan including possible complications or reactions to medications and/or treatments, and recommended preconsult home treatment for future use.

Disease Prevention Activities. Primary, secondary and tertiary prevention activities are included in the wholistic nursing/medical treatment plan as appropriate for each individual patient. The mutually agreed upon regime for the patient being seen for a comprehensive exam with an existing problem would include both general and problem specific prevention activities.

General Primary Prevention Activities include teaching the patient how to directly prevent unhealthy conditions such as the acquisition of communicable diseases through immunizations. Specific Primary Prevention Activities focus on the patient's individual problem(s). For example, if the diagnosed condition is contagious, the patient would be taught how to prevent its dissemination.

Under General Secondary Prevention Activities, the patient is taught means of detecting potential health problems early such as breast cancer, testicular cancer, cervical cancer and tuberculosis through the practices of Breast Self-Examination, Testicular Self-Examination, PAP Smears and TB Skin Testing respectively. Specific Secondary Prevention Activities would focus on teaching the patient how to detect recurrence of a particular health problem such as angina, hypoglycemia, otitis media or streptococcal pharyngitis so that early treatment could prevent serious complications, i.e. encephalitis from otitis media or glomerulonephritis from streptococcal pharyngitis.

Tertiary Prevention Activities are reserved for patients that are recovering from acute or chronic health problems. The NP would teach the patient rehabilitative activities that could range from the consistent and appropriate administration of medications to methods of optimizing the therapeutic effects of physical therapy.
Health Promotion Activities. Health promotion activities are directed toward improving or sustaining the patient's level of wellness. This model element encompasses the areas of Fitness, Diet, Rest/Sleep and Stress Management. As with the disease prevention activities, the comprehensive exam with an existing problem requires the NP to negotiate with the patient, which general and problem specific health promotion activities would best improve the patient's health status and level of wellness.

The NP initially detects Disease Prevention and Health Promotion problem areas during the Identifying Problems process in the NP/Patient Throughput Phase of the model.

IMPLEMENTING

The process of implementation involves action. This is the time when the NP and patient initiate and complete the activities deemed necessary in the Planning process to improve the patient's health and wellness status. The implemented wholistic nursing/medical treatment regimen usually includes pharmacological and/or non-pharmacological components, as well as, disease prevention and health promotion activities. As with previous model phases, the Type of Visit (Episodic, Comprehensive With An Existing Problem and Comprehensive Without An Existing Problem) directs the implementation process. As outlined below, implementing the treatment plan with a patient that is being seen for a comprehensive exam with an existing problem differs slightly depending upon whether the condition is acute or chronic.

Comprehensive Exam with an Existing Acute Health Problem

During a comprehensive exam with an existing acute problem, the patient is involved in all the Self-Care Planning and Implementation areas which include Problem Judgment, Self-Care Activities, Disease Prevention Activities and Health Promotion Activities. The Disease Prevention and Health Promotion Activities would be general, as well as those that specifically pertain to the patient's problem or disease.

Comprehensive Exam with an Existing Chronic Health Problem

The NP/patient interaction that occurs when a patient needs comprehensive care, but has an existing chronic problem, focuses on those Self-Care Activities that are related to the patient's problem and on Disease Prevention and Promotion Activities that are both general and specific to the chronic condition.

EVALUATING

Evaluation is an ongoing process that is conducted by the NP, patient and sometimes family. Follow-up contact through mail, telephone, home or clinic/office visits is warranted for select conditions. At the end of the patient visit, the NP should review the mutually agreed upon wholistic nursing/medical treatment plan with the patient and give the patient an opportunity to ask questions. In addition, the selected patient goals with time-frames should be reviewed.

The NP should also evaluate her/his outcomes from the patient interaction in terms of personal movement toward wellness and adoption of a professional wholistic, wellness patient orientation. In addition, the NP should focus on identification of professional learning needs such as the need to update knowledge regarding patient education materials/methods, new diagnostic testing options for specified conditions, new treatment modalities (pharmacologic and non-pharmacologic), alternative health care options (i.e., acupuncture, massage) and availability of professional consultants/collaborators, as well as community resources.