Plugging the gaps and getting assessment right: a new holistic assessment framework for Community Practitioner Nurse Prescribers

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Abstract

Currently there is no recognised assessment framework for Community Practitioner Nurse Prescribers (CPNPs) to apply in practice. Existing Models of Nursing and Assessment Checklists previously thought adaptable for use in prescribing have limited value and may not address the assessment requirements laid down by the NMC (2006). In order to provide CPNPs with assessment guidance using a holistic approach that embraces shared decision making, various sources of empirical and theoretical literature were sourced and an alternative framework developed. This framework is included at the end of this paper.

This first paper explores the background and rationale for the Holistic Assessment Tool for Community Practitioner Nurse Prescribers and draws on contemporary literature to underpin it. This is then linked to decision making and a partnership approach for CPNPs. The subsequent paper will address management issues in prescribing and provide a template for a management plan.

Key Words

Community practitioner nurse prescribers, holistic assessment, decision making, NMC practice standards, assessment framework.

Introduction

According to Lashley (2005) health assessment skills are vital to professional nursing practice. The Nursing and Midwifery Council (NMC) (2006) supports this in its Standards of proficiency for nurse and midwife prescribers (NMC, 2006) as practice standard 3 clearly highlights the accountability for prescribers in relation to assessment practice. Community

Practitioner Nurse Prescribers (CPNPs) should be able to evidence all of their practice and individual assessment is clearly a crucial area. This is because if assessment is not undertaken robustly then all the subsequent care is likely to be flawed.

Community Practitioner Nurse Prescribers (CPNPs)

CPNPs are currently those registered nurses with a specialist community practitioner qualification who have successfully undertaken the V100 prescribing programme (NMC, 2006). These practitioners can prescribe from the Nurse Prescribers' Formulary for Community Practitioners listed in the British National Formulary (BNF).

Currently there appears to be no agreed assessment tool for CPNPs to use when assessing their patients. It is simply seen as an additional aspect that nurses need to record in their existing documentation. Potentially this is an issue because according to Benner (1984) if qualified nurses enter a new area of practice then they may be limited to the 'novice level' within that situation. So it would seem appropriate that novice CPNPs are supported with guidelines to allow them to embed their knowledge in practice and work towards becoming an expert.

If educators wish to ensure that their students can meet the NMC proficiencies laid down by the NMC (2006) then a closer look at prescribing practice and in particular assessment practice is warranted. In the first of two articles in relation to CPNPs, this paper aims to take a fresh look at assessment practice and consider an alternative approach drawing on both empirical and theoretical perspectives. Using this eclectic approach, a framework for assessment in prescribing is suggested.

Nursing Process and Assessment

In 1976 the Nursing Process was published (Yura and Walsh, 1967). This highlighted the four stages of the nursing process that nurses have become very familiar with, namely

assessment, planning, intervention and subsequent evaluation. The emphasis was clearly on assessment along with subsequent care plans, which provided a framework for nurses to identify actual and potential problems (Aggleton and Chalmers, 2000). It is worth noting however, that care plans have not always found favour with nurses and critique of them in practice is evident (Irving et al., 2006). Nevertheless the nursing process does provide a structure for nurses, although guidance for undertaking the assessment, depends on the philosophy and record keeping documentation provided by the service provider. This in itself can be problematic as each NHS or private sector provider will produce their own specific documentation and related guidance.

According to Worth (2001) assessment can be explained as the way in which practitioners determine the needs of their patients or clients and plan the care or services in relation to what is currently available. Vernon et al (2000: 283) are more specific and suggest that individualised assessment is a "diagnostic process leading to suitable medical and nursing interventions". The Royal College of Nursing RCN (2006) agree with the importance of the individualised nature of assessment as this informs the subsequent management plan. However, they also identify the importance of the patient involvement in the process. So it would appear that identifying patient need by accruing relevant information including the views of the patient is an obvious way forward. The difficulty here is that specific guidance required for the novice CPNP is less evident and although post registration students use their experiential learning to inform their practice of assessment, articulating what theoretical perspectives guide their prescribing assessment can be more problematic.

It is perhaps no surprise then that in the early years of nurse prescribing Humphries and Green (2002) recommended that nurses adopt a systematic way of organising and collecting data. This implies a very simplistic approach to assessment however in relation to

organisation of data it is realistic, as it may serve to ensure that vital information is not missed by a novice prescriber. Furthermore Humphries and Green (2002) suggested that existing models or frameworks could be evaluated for their use in nurse prescribing. Although a re-evaluation of nursing models is not new (Tierney, 1998) perhaps the time has come to develop contemporary alternatives to reflect current education and practice.

A Model for Nursing: Roper, Logan and Tierney

Nursing models were produced from a theoretical stance and the problem of re-visiting previously developed assessment frameworks means that associated limitations can simply be reinforced. This was identified by Irving et al (2006) who analysed documentation in relation to nursing assessments. The study found that the documentation of assessment emphasised the physical aspects of an individual, even although the Activities of Living (Roper et al., 1980) was the framework that was most frequently used within the location (Irving et al., 2006). This suggests that the Activities of Living was simply being used as a check list and the model for nursing in its entirety was not being fully embraced. This approach is concerning for CPNPs as they take their skills of prescribing into the workplace because NMC practice standard 3 in relation to accountability of assessment practice might not be achievable or indeed not recordable if the existing documentation fails to include prescribing assessment. Arguably by taking a fresh look at assessment and bypassing existing models and frameworks, old habits and influences may be placed to one side.

Frameworks for prescribing assessment

Prior to the development of any new framework it is worth reviewing what is currently available to prescribing practitioners. A starting point is the Nurse Prescribing Bulletin (The

National Prescribing Centre (NPC, 1999) where the prescribing pyramid is introduced and explored. This certainly provides the novice prescriber with a framework to work to and it is worth further investigation. Step one of the pyramid recommends an examination of the holistic needs of the patient. The term holism is not defined and unfortunately this assumes that nurses all have a common understanding of the term when in fact conceptual diversity is likely. Indeed the prescribing pyramid (NPC, 1999) relates the holistic approach to taking a medical and social history only and as a result ignores significant additional influences on health such as psychological and environmental factors. It would appear that holism is an oft articulated term in relation to nursing assessment (Beckwith and Franklin 2007; RCN, 2006; Fox, 2003; Aggleton and Chalmers, 2000; Roper, Logan and Tierney, 1996) but a more detailed analysis is often absent. Freeman (2005) explores the term 'holism' and links the definition to a bio-psychosocial model where health problems are considered in relation to the individual's physical, psychological, social, cultural and spiritual aspects. This consideration of a whole person and not merely a person with a set of symptoms encompasses a view of holism that underpins the assessment framework that has been developed here.

Dimensions of Health

Holistic assessment could arguably begin with reviewing the concept of health along with the variables that impact on it. The Dimensions of Health (Box 1) adapted from Aggleton and Homans (1987) and Ewles and Simnett (1992) align with the existing influencing factors on health described by Roper et al (1980) in their model for nursing and so will likely be familiar to nurses. By drawing on alternative dimensions of health nurses have an opportunity to re-visit familiar terms and concepts but not to have them aligned to an existing model of nursing. The dimensions of health provide an opportunity for nurses to analyse

each dimension in relation to each prescribing consultation and explore the impact on the individual. Furthermore the Dimensions of Health link to Freeman's (2006) bio-psychosocial model and provide a basis for the CPNP to consider when undertaking an assessment.

Dimensions of Health Box 1

- Physical health
- Emotional health
- Spiritual health
- Social health
- Sexual health
- Psychological health

Adapted from
Aggleton, P., Homans, H. (1987) Educating about AIDs and Ewles, L., Simnett, I. (1999) Promoting Health : a practical guide to health education cited in Naidoo,J., Wills, J (2000) Health promotion Foundations for Practice (2nd ed) London Harcourt Publishers

The dimensions of health however do not provide a sufficient framework alone as they provide a broad view of health and gaps could be identified in relation to lifestyle choices and the impact of the workplace or school. This is where an additional concept is required to investigate the dimensions further and provide a more specific approach to the individual.

Determinants of Health

The determinants of health (Dalgern and Whitehead, 1991) provide an opportunity to augment the dimensions of health in building an approach to a holistic assessment that impacts on individuals in relation to inherited, social, community and lifestyle factors. These are detailed in box 2 below. These *layers of influence on health* represent the specifics of an individual assessment and provide both a wider and deeper analysis of the individual's circumstances.

Main determinants of Health Box 2

1. Age, sex, and hereditary factors
2. Individual lifestyle factors
3. Social & community networks
4. Living and working conditions
5. General socio-economic, cultural and environmental conditions

Dahlgren & Whitehead (1991) Policies and Strategies to promote social equity in health Stockholm Institute for Further Studies cited in Naidoo, J., Wills. J. 2000) J.Health promotion Foundations for Practice (2nd Ed) London Harcourt Publishers

It can be seen that by combining both of these frameworks an opportunity to construct an assessment tool suitable for CPNPs exists, however even with this amalgamation of existing frameworks, gaps need to be acknowledged. This is especially true in relation to patients' existing medication and any risk assessment required (NMC, 2006). The NMC (2006) are clear that prescribing involves gathering specific information such as details about the patient's prescription-only medication (POM), their pharmacy obtained medication (P), and of course general sales list medication (GSL). Given the NMC (2006) clearly identify these as important aspects of an assessment in nurse prescribing and Beckwith and Franklin (2007) reinforce this, it is no surprise then that assessment tool would need to reflect this.

To assist CPNPs when concentrating on the presenting complaint described by patients/clients during an assessment, the NPC (1999) highlight a useful mnemonic 'WWHAM' used by pharmacists when advising clients about treatments that can be purchased (see box 3). This provides additional direction for CPNPs and emphasizes the significance of taking an accurate drug history. Clearly this mnemonic on its own would be insufficient for a holistic approach, but it by adding it to the developing assessment tool it would "ensure a risk assessment has been undertaken in respect of the patient/client's current medication and any potential for confusion with other medicines" (NMC, 2006: 30).

Box 3

W	**W**ho is it for?
W	**W**hat are the symptoms?
H	**H**ow long have the symptoms been present?
A	**A**ny action taken so far?

The prescribing pyramid, the dimensions of health, the determinants of health and the mnemonic WWHAM all offer a perspective on designing an assessment tool for CPNPs, however it could be argued that a clinical examination may need to be undertaken and this has not yet been considered. Depending on the patient's complaint CPNPs may wish to perform a general clinical examination in relation to, for example, oral thrush, eczema and head lice and this too would need to be incorporated into an assessment tool for CPNPs.

Clinical examination

A medical model approach detailed by Bickley (2006) adds to the body of nursing literature on assessment and provides additional direction when assessing patients with particular complaints. A review of systems (usually going from head to toe) is recommended (Bickley, 2006) although for CPNPs this is likely to be too in depth and require skills and competencies not taught in the V100 curriculum. That said, the approach taken by Bickley (2006) can be transferred to CPNPs and may include examination of the mouth, skin or head. Clearly for the CPNP if a detailed physical examination of systems, for example, respiratory, ear, nose and throat or neurological is required then referral to the GP is indicated.

With the addition of clinical examination it would seem that the basis for an assessment tool for CPNPs, underpinned by distillation and analysis of existing concepts related to assessment, is becoming apparent. The assessment tool synthesised from the literature can be found at the end of this article and any feedback regarding its content and layout will be gratefully received. Just such a tool could provide structure to assessment for the novice prescriber and would help the prescriber meet the NMC competencies. That said, undertaking a health assessment does not simply rely on an assessment tool as Beckwith and Franklin (2007) identify; The approach taken to the assessment in relation to developing a trusting and supportive relationship is also very important. This means that once this

assessment tool is drawn up consideration needs to be given to its implementation and the approach taken by the CPNP. This is supported by Nolen (1999) and Hobden (2006) who both highlight that communication, skills of listening, along with exploring the patient's perspective, are as equally essential as the actual tool.

Research into Nursing Assessment

The way in which the assessment is undertaken will now be explored as accurate assessment requires knowledge, experience, recognition and prioritisation (Bryans and McIntosh 2000) and not simply reading out a list of questions. Furthermore assessment is recognised as a dynamic ongoing process that requires review in conjunction with a decision making approach (Kennedy, 2004; Bryans and McIntosh, 2000; Bryans and McIntosh, 1996: 1245). According to Bryans and (2000) "Nursing assessment practice was construed as an inherently social, dynamic and interactive process, in which the role of the patient as well as the nurse plays an integral part". This suggests that during a nursing assessment the interpersonal skills utilised by the nurse both initially and in response to the patient's signals, impact on the relationship. This supports a concordant approach to prescribing and underpins the NPC (2007) shared decision making process detailed in their competency framework.

The qualitative research study carried out by Bryans and McIntosh (2000) focused on the knowledge involved in community nursing assessment practice. The study provided an insight into the ways in which experienced District Nurses (DNs) carried out an initial assessment on a patient. Some DN participants demonstrated an interactive approach with the patient by responding to the patient cues and depending on metacognition to guide the assessment process whereas others established a more rigid, nurse led approach (Bryans and McIntosh, 2000). This insight into differing approaches to assessment provides an opportunity for CPNPs to review their current assessment style and where required seek ways

to build on and improve this vital skill. Moreover, Bryans and McIntosh (2000) had revealed additional areas of nursing such as prior knowledge and experience as well professional artistry which would inform an assessment. This suggests that nurses undertaking assessment and, in this particular case, in nurse prescribing, need to know how to harness these skills and tacit knowledge in order to address successfully the needs of their patients or clients, "while at the same time securing the patients trust and confidence " Bryans and McIntosh (1996: 30). Kennedy (2004) whose research also focused on district nursing assessment practice concurs with this approach.

Bryans and McIntosh (2000) determined that the DNs collaborative approach to assessment and the positive response to patient cues linked more to the holistic model of health rather than a medical model. It is this interaction and "getting to know the patient" and their environment that Kennedy (2004: 6) unravels in her research of district nurses' first assessment visits. Although these research studies relate to DN assessment practice, it seems appropriate to apply the findings to CPNPs undertaking individualised assessment in nurse prescribing.

Decision Making

The skill of assessment cannot exist in a vacuum without decision making processes with which to move the episode of care along. In 1996 Bryans and McIntosh analysed decision making in relation to community nursing assessment practice. Using the seven stages of decision making sourced from decision making theory by Carroll and Johnston (1990), Bryans and McIntosh (1996) linked the stages to community nursing assessment practice. Although the decision making framework was originally published in 1990 and included in Bryans and McIntosh's research work six years later its perspective for community nurses is still very relevant today. Not only can the seven stages analysed in relation to community

nurses be applied to the process of prescribing, the framework also provides CPNPs with a clear process that supports their rationale for treatment. Nonetheless it is not the sole decision making framework for prescribers as the competency framework for shared decision making developed by NPC (2007) clearly demonstrates. The NPC (2007) framework for decision making is very detailed and describes behaviours that will guide a prescriber when building a relationship with the client/patient. Furthermore the competency framework meticulously lists the steps to take when deciding on the best management strategy to follow. It is clearly an excellent resource and although at first it appears to be complex, closer examination reveals that it is not until the final part of the framework 'sharing a decision' that the real fundamental aspect of decision making in prescribing is revealed.

One of the reasons that the Carroll and Johnston (1990) decision making framework has been selected for CPNPs in this article is because it commences with a valuable first stage prior to meeting the client (pre-decisional) and ends with revisiting the client (feedback). Furthermore it has been contextualised for community nurses (Bryans and McIntosh, 1996) and helps CPNPs to provide a step by step rationale for their decisions. The first two stages of Carroll and Johnston's (1990) decision making framework are, problem recognition and formulation which are explained as "pre-decisional activity" (Bryans and McIntosh, 1996: 25) when the nurse forms ideas about the situation, a new referral for example, and the expected responsibilities. Past experiences and prior knowledge will be explored internally and although these thoughts may not be articulated these will impact on the nurse's perceptions of the 'defined health need', possible interventions and any subsequent decision making. This means the CPNP may start to organise her thoughts about the subsequent visit and begin advance preparation for the assessment. One limitation of this 'pre-decisional stage' may be that nurses make assumptions and judgements about their patient or clients, for example, from their address if the referral is for a child with head lice who lives in a deprived

area, or age if elderly or indeed if the family name is well known to health and social services. Before the nurse and patient meet, these assumptions need to be addressed to ensure nurses have an awareness of their accountability in relation to equity and diversity in relation to their assessment (NMC, 2008; NPC, 2007).

The Carroll and Johnston (1990) decision making framework is further unravelled to include stages 3 (alternative generation), 4 (information search) and 5 (judgement or choice) which Bryans and McIntosh (1996) explain is where the nurse undertaking the assessment begins to problem solve and weighs up 'the pro's and con's' of the choices available. At this point the CPNP would consider the treatment options, for example with a patient with constipation it would be expected that the CPNP would firstly consider her knowledge base for all four groups of laxatives in relation to the findings from the holistic assessment. Although this touches on management which is the focus of a subsequent paper, brief discussion here allows the systematic approach of the decision making framework in relation to the assessment process to be explained. Finally, by writing a prescription, the CPNP actions the decision which is recognised as stage 6 in the decision making framework.

When the nurse returns to the patient to evaluate the outcome then the whole process is once again commenced using (stage 7) feedback. This is a strong benefit of this particular decision making framework as it includes the feedback stage essential for community nursing. The assessment process can therefore be seen as a dynamic process and Bryans and McIntosh (1996) clarify that these stages may not be rigorously followed in a linear progression as in reality there could possibly be movement in any direction. The way in which the assessment and management in prescribing is actually carried out relies on an analysis of the CPNPs behaviour in relation to engaging the patient and responding to cues and this will be explored more fully in the next article.

Assessment Framework

From the literature and concepts explored above an assessment tool for CPNPs based on the prescribing pyramid, dimensions and determinants of health, the mnemonic WWHAM along with guidance for clinical examination has been developed. Provision of such a tool has the potential to support CPNPs at the novice stage and provide guidance when it would be most needed. The tool is generic in style but allows for additional assessment tools (if required) in relation to pain, wound, or nutrition for example to be included. It is hoped that such an assessment tool along with an understanding of the need for an interactive approach with patients and clients will encourage a concordant approach to the assessment process. This along with a grasp of decision making in relation to assessment and management of patients and their health needs will provide a framework for practice that will facilitate practitioners to meet the practice standard for assessment (NMC, 2006) and provide a quality service to their clients /patients.

Limitations

Limitations in the holistic assessment framework for community practitioner nurse prescribers include the fact that as yet, this framework still has to be validated. By testing it in practice and seeking views from colleagues throughout the UK it is hoped that comments and suggestions will result in an approved assessment tool. Although the holistic framework at first appears to be geared to adults it is important to highlight that for the assessment of children, key areas that include family behaviors, for example, if a child with asthma is living in a home where the adults smoke, are also considered and documented.

Conclusion

It would appear that no one perspective or theory underpins assessment in nurse prescribing and in fact assessment draws on various sources taking an eclectic approach. Providing a holistic assessment depends on the CPNP being able to assess all of the factors that influence an individual's health whilst responding to the patient cues. A novice CPNP can utilize the assessment tool in tandem with a decision making framework to support her practice in the early stages and at the same time reflect on their ability to undertake a partnership approach that responds to patients' needs and concerns.

Appendix

HOLISTIC ASSESSMENT TOOL FOR COMMUNITY PRACTITIONER NURSE PRESCRIBERS

Name and Address	
DOB	
Occupation (hazards, working conditions, risks)	
Reason for assessment/presenting complaint	
PHYSICAL HEALTH	
Onset, duration and severity of condition	
Previous history of complaint, treatment and results	
PMH	
Family history	
Current health status and appearance	
Medication POM, P, GSL and other Herbal/homeopathic	
Known allergies (Drugs and substances)	
Alcohol history (can include family if client a child)	
Smoking history (can include family if client a child)	
Diet and fluids	
Mobility (aids and adaptations)	
Dexterity (aids and adaptations)	
Visual acuity (aids and adaptations)	
Additional physical findings	

specific to complaint (for example bowel habit, oral hygiene, broken skin……)	
Clinical findings (if examination required)	
Additional specific assessment tool required (pain, wound, depression, nutritional assessment tool)	
EMOTIONAL AND PSYCHOLOGICAL HEALTH	
Emotional effects of condition	
Cognitive (ability, Disability, memory)	
Mental Health (anxiety, worry , confusion, depression, dementia)	
SOCIAL /ENVIRONMENTAL HEALTH	
Home occupants	
Dependents	
Carers (statutory and voluntary)	
Living conditions (housing, access, safety)	
Financial (needs, allowances, exemptions)	
Local amenities (shops, transport, sanitation)	
SEXUAL HEALTH	
Impact of condition on sexuality and sexual health	
SPIRITUAL HEALTH	
Impact of condition on religion, beliefs, faith and culture	
Additional information	

Bibliography

Aggleton, P., Homans, H. (1987) and Ewles, L., Simnett, I. 1999. *Educating about AIDs Promoting Health: a practical guide to health education* cited in Naidoo,J., Wills, J (2000) *Health promotion Foundations for Practice* (second edition). London: Harcourt.

Aggleton, P., Chalmers, H. 2000 *Nursing Models and Nursing Practice* (second edition). London: MacMillan.

Beckwith, S., Franklin, P. 2007. *Oxford Handbook of Nurse Prescribing.* Oxford: Oxford University Press.

Benner, P. 1984. *From Novice to Expert excellence and power in clinical nursing practice.* California: Addison-Wesley.

Bickley, L.S. 2006. *Bates' Pocket Guide to Physical Examination and History Taking* (Fifth edition) Philadelphia: Lippincot Williams and Wilkins.

British Medical Association (BMA) and the Royal Pharmaceutical Society of Great Britain (RPS). 2008. *British National Formulary.* London: BMJ and RPS Publishing.

Bryans, A. 2000. 'Providing new insight into community nursing know-how through qualitative analysis of multiple data sets of simulation data'. *Primary Health Care Research and Development*, 1: pp.79-89.

Bryans, A., McIntosh, J. 1996 'Decision making in community nursing: an analysis of the stages of decision making as they relate to community nursing assessment practice'. *Journal of Advanced Nursing*, 24: pp.24-30.

Bryans, A., McIntosh, J. 2000 'The use of simulation and post simulation interview to examine the knowledge involved in community nursing assessment practice'. *Journal of Advanced Nursing*, 31(5): pp. 1244-1251.

Carroll, J. S., Johnson, E.J. 1990 *Decision research: a field guide.* Newbury Park California: Sage.

Dahlgren, G., Whitehead, M. 1991. *Policies and Strategies to promote social equity in health.* Stockholm Institute for Further Studies cited in Naidoo, J., Wills. J. 2000. *Health promotion Foundations for Practice* (second edition) London: Harcourt.

Freeman, J. (2005) 'Towards a definition of holism' *British Journal of General Practice,* 55(511): pp. 154-155.

Fox, C. 2003. 'The holistic assessment of a patient with leg ulceration' *British Journal of Community Nursing*. 8(3 supplement): pp. 26-30.

Hobden, A. 2006. 'Strategies to promote concordance within consultations'. *British Journal of Community Nursing*. 11(7): pp. 286-289.

Humphries, J.L., Green, J. (eds.) 2002. *Nurse Prescribing* (second edition), Basingstoke: Palgrave.

Irving, K, Treacy, M., Scott, A., Hyde, A., Butler, M., MacNeelea, P. 2006. 'Discursive practices in the documentation of patient assessments'. *Journal of Advanced Nursing,* 53(2): pp.151-159.

Kennedy, C. (2004) 'A typology of knowledge for district nursing assessment practice'. *Journal of Advanced Nursing*, 45(4): pp.401-409.

Lashley, M. 2005. 'Teaching Health Assessment in the virtual Classroom' *Journal of Nursing Education*, 44(8): pp.348-350.

National Prescribing Centre NPC. 1999. 'Signposts for prescribing- general principles of good prescribing'. *The Nurse prescribing Bulletin,* 1(1): pp. 1-4.

National Prescribing Centre NPC. 2007. *A competency framework for shared decision making with patients.*

http://www.npc.co.uk/pdf/Concordant_Competency_Framework_2007.pdf. (17 Noverember 2008)

Nursing and Midwifery Council. 2006. *Standards for proficiency for nurse and midwife prescribers.* London: Nursing and Midwifery Council.

Nursing and Midwifery Council. 2008. *Standards of conduct, performance and ethics for nurses and midwives.* London: Nursing and Midwifery Council.

Naidoo,J., Wills, J. 2000. *Health promotion Foundations for Practice* (second edition). London: Harcourt.

Nolan, M. 1996. 'Assessment: identifying the barriers to good practice' *Health and Social Care in the Community*, l 4(2): pp.77-85.

Roper, N., Logan, W., Tierney, A. 1980. *The Elements of Nursing.* Edinburgh: Churchill Livingstone.

Roper, N., Logan, W., Tierney, A. 1996. *The Elements of Nursing* (fourth edition). Edinburgh: Churchill Livingstone.

Royal College of Nursing. 2004. *Nursing assessment and older people a Royal College of Nursing toolkit.* London: Royal College of Nursing.

Royal College of Nursing. 2006. *Caring in partnership: older people and nursing staff working towards the future*. London: Royal College of Nursing.

Tierney, A. 1998. 'Nursing Models: extant or extinct'. *Journal of Advanced Nursing,* 28(1): pp.77-85.

Vernon, S., Ross, F., Gould, M. 2000. 'Assessment of older people: politics and practice in primary care'. *Journal of Advanced Nursing*, 31(2): pp.282-287.

While, A. 2002. 'Practical skills: prescribing consultation in practice' *British Journal of Community Nursing*, 7(9): pp.469-473.

Worth, A. 2001. ‘Assessment of the needs of older people by district nurses and social workers: a changing culture’. *Journal of Interprofessional Care*, 15(3): pp. 257-266.

Yura, H., Walsh, M. 1967. *The Nursing Process*. Norwalk: Appleton-Century-Crofts.