Useful tool for general practitioners, home health care nurses and social workers in assessing determinants of the health status and treatment of patients visited in their homes

Narzędzie pomocne dla lekarza rodzinnego, pielęgniarki środowiskowej i pracownika socjalnego w oszacowaniu uwarunkowań stanu zdrowia i leczeniu pacjentów odwiedzanych w ich domach

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(a) *idea*
(b) *compilation of method of research*
(c) *collection of material for research*
(d) *working on text and references*

Abstract

The necessity is emphasized to distinguish between the traditional model of data acquisition reported by a patient in doctor's office and the more valuable and desired model to become acquainted with the core of the problem by going to a patient's domicile.

In the desired model it is possible to come across various determinants of health during home visits. Family members can be approached and there is a possibility to evaluate the relationships between the patient and his loved ones. One can visually assess one's living conditions and predictable environmental hazard. For several years, the desired model has been put into practice by general practitioners and home health care nurses. Recently this model is also promoted by "health care therapists" who are members of "teams of home health care".

The authors, being convinced of the merits of "home and environmental model" of practical medicine, have developed a method of recording and illustrating data collected during visits in patient's home.

The elaborated tool helps to communicate and exchange information among general practitioners, home health care nurses, social workers of primary health care centers and specialists. The method improves the formulation of the plan of further therapeutic steps and remedial interventions in psycho-social relations and living conditions of patients.

Key words: general practitioner, home health care nurse, social worker, primary health care

Nadesłano: 20.06.2012
Zatwierdzono do druku: 12.07.2012

Streszczenie

Autorzy pracy podkreślają na wstępie, iż należy rozróżnić tradycyjny model obsługi problemu zdrowotnego, zgłaszanego przez pacjenta w gabinecie lekarza, na ogół przy jego biurku od bardziej wartościowego sposobu zaznajomienia się z istotą problemu poprzez udanie się do miejsca zamieszkania chorego.

W trakcie takiej wizyty domowej jest możliwe zapoznanie się z rozmaitymi uwarunkowaniami stanu zdrowia pacjenta. Można poznać członków rodziny i ocenić relacje jakie zachodzą pomiędzy chorym a jego osobami najbliższym. Można naocznie ocenić jego warunki bytowe i ewentualne szkodliwości środowiskowe.

Od kilkunastu lat ten drugi model czasami realizują lekarze rodzinni i tzw. pielęgniarki środowiskowe (środowiskowo – rodzinne). Ostatnio propaguje się poszerzenie takiego sposobu zaznajamiania się z problemami zdrowotnymi przez zalecenie go tzw. terapeutom środowiskowym, którzy są członkami tzw. „zespołów leczenia środowiskowego".

Autorzy pracy, będąc przekonani o zaletach owego „środowiskowego modelu" medycyny praktycznej opracowali metodę odnotowywania i ilustrowania danych pozyskiwanych w trakcie wizyt w domu chorego.

Opracowanie przez nich narzędzie ułatwia przekazywanie i dyskutowanie danych pomiędzy pielęgniarka środowiskową, a lekarzami ośrodków podstawowej opieki zdrowotnej i specjalistami jak i pracownikami socjalnymi. Metoda doskonali ustalanie planu dalszych działań terapeutycznych i interwencji korygujących relacje psychospołeczne i warunki bytowe pacjentów.

Słowa kluczowe: lekarz rodzinny, pielęgniarka środowiskowa, pracownik socjalny, podstawowa opieka zdrowotna

Introduction

It seems there are two different models of solving the health problems of patients. Usually the need for assistance of a doctor appears during a patient's first visit to a GP or to other outpatient clinic or to emergency room of a hospital.

In a traditional model the first verbal contact between the doctor and the patient takes place in doctor's office. During the visit the patient informs about his complaints, symptoms, and gives more information typical for family history. Afterwards the doctor usually examines the patient.

Note that in this traditional model all data come from only one "source of information" – verbally. Only sometimes the patient is accompanied by family members and a doctor gets some information from them.

A desired model of data acquisition is to go where the patient resides. Home visits are sometimes made by general practitioners (home doctors).

On site the doctor collects information about the patient not only from him. Doctor's presence enables contact with family members. He looks around and notices the environmental determinants of health.

What's more the doctor may notice signs of specific symptoms of relationships which exist between the patient and his partner, or between the patient and his parents. He may then ask questions relevant to the assessment of the relationship. He can also assess the living conditions of the patient including environmental hazard.

The desired model described here is similar to the investigating steps, although in this case it is encouraged by friendly motives – the willingness to help the patients. This model illustrates perhaps quite accidentally – the screen play of a popular movie series "House M.D".

Recently medical journals emphasize the favorable characteristics of "in patient's home visit" model of data acquisition.

One of these journals informs about "a new occupation", called "Environmental therapist" and about a new form of action "Environmental Treatment Teams" [1].

The author of one of these articles says.: "I visit a patient in his home as a specialist and spend at least one hour there, I talk to him, I see his home – an environment in which he lives, I meet and talk to his family, loved ones… his home can be visited by several specialists… After returning to the office of "Environmental Treatment Team" – I discuss the collected data with my fellow doctors. We work as a team. We exchange ideas, decide whether, how often and by whom the patient is to be visited. What has to happen as a result of our visits..."

Although the role of the "environmental therapist" and "environmental treatment teams" is recently widely promoted it should be emphasized that the organization of health service in Poland provided the posts called "environmental nurses", acting on behalf of general practitioners at patients' homes.

The new initiatives extend a "new profession" of "environmental therapist" to the doctors – which is obviously a valuable initiative.

Having had a good chance to talk with many environmental nurses in seminars conducted during "bridging studies for nurses supplementing their knowledge", we noticed the need and opportunity

to develop an additional tool that would be helpful for the environmental therapist and the environmental nurse to assess health status and the situation of the visited patients.

We have formulated the procedure and have developed the tool facilitating the recording of collected data during the visit at patient's home and have illustrated the recorded health background of his being and health.

Material and methods

General theoretical assumptions of the method

The most important function of the presented procedure fulfilled by an environmental nurse or therapist, necessary to implement a single-application of this method, is to obtain patient's data and record them in eight "scales" (domeins). That way we will obtain the whole set of health aspects and also life experience, harmful social and environmental factors and also psychological challenge.

The methodology of formulating these "scales" is consistent with the rules of construction of sociological tools. Sociologically structured interview for a given area is created according to the specific needs arising from the consideration of the problem from literature and personal experience.

We propose that the predicted domains include some of the areas described in our earlier work concerning evaluation of health status [3,4] with addition of "scales" determining environmental conditions. The predicted pattern of collected data is presented in the appendix, which serves also as a protocol of the planned structuralized interview.

An important part of the tool is a method of graphical illustration of results of the evaluation of a patient's situation. As a tool of illustration we propose to implement the "multi-dimensional graphs (called profiles in the shape of rosettes) applied – as it seems for the first time in: "The World Justice Project – Rule of law index" [5].

Determination of the areas most relevant to characterize health and environmental conditions

Earlier we have proposed the following definition of health status 4.

The current health status is determined by:

[# 1] condition of organs, which takes into account unfavorable changes of the body structure
[# 2] important determinants of psychological well-being,
[# 3] not externalized, but potentially yet important genetics determinants of health
[# 4] the functional efficiency of the body and the size of the living space

Adopting this definition as basis for formulation of planned structured interview for implementation by environmental nurse – we consider the following areas (domains).:

1. Review of physical condition of the body, applied therapy, nutrition and genetic conditions
2. Adverse events in childhood
3. Loneliness – emotional engagement – partner
4. Relationship with other people, communication skills, general mental condition
5. Professional and social challenges
6. Living conditions
7. Environmental hazard
8. The functional capacity of the body.

Domains no 2, 3, 4, 5 of the structuralized interview provides a practical and simple way to estimate the patterns of behavior and mental well-being and health conditions. Interview within the domains 6 and 7 allows for estimation of environmental determinants of health. Domain no 8 on functional capacity of the body is added to estimate health status.

Content of enumerated domains is included in Annex, so that it can also serve as a protocol of the structuralized interview helpful to a nurse and/or an environmental therapist.

Method of graphic illustration of health status and environmental conditions of visited patients

Procedure of the proposed method enables data collection according to the content of the structuralized interview contained in 8 domains. It is expected that the result obtained for each of such "dimensions" will be pushed on one of eight axes of multidimensional profile – named here also as "rosette". This way of illustration, is borrowed from the "The World Justice Project – Rule of Law Index" [5]. This action leads to development of a map drawn on the chart presented in Figure 1.

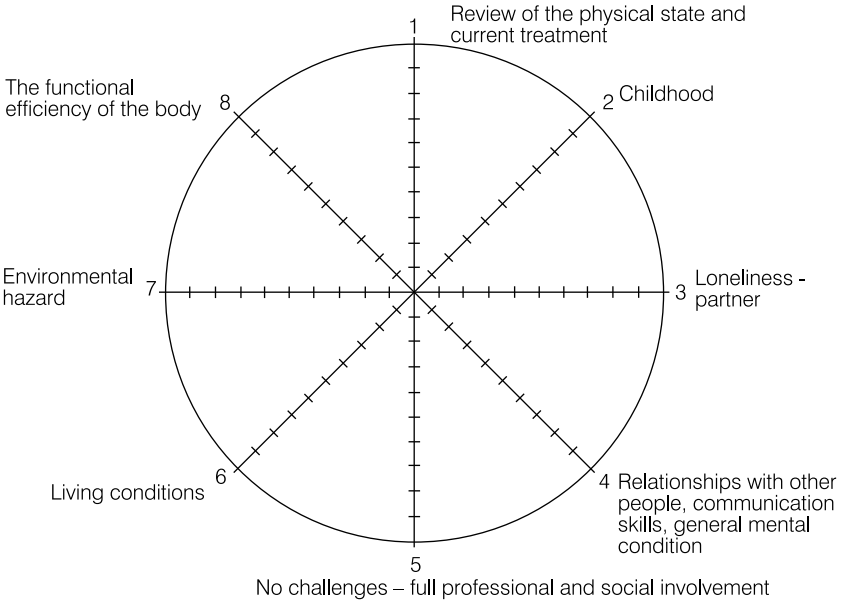

Figure 1. Multidimensional matrix of the profile tailored to the needs of a health care nurse and the therapists-members of the team of a primary health care

Rycina 2. Matryca wielowymiarowego profilu dostosowanego do potrzeb narzędzia wspomagającego pielęgniarkę środowiskową i członków zespołu terapeutycznego podstawowej opieki zdrowotnej

It is necessary to note following characteristics of such multi-dimensional profiles.

1. The different kind of scales can be included into the multi-dimensional profile. It can be called nominal scales (e.g. such as the Richter scale or Beaufort) or cumulative scales which define the number of points awarded for a set of questions not related to the increasing gradation. They can also be called "repertory grids", resulting from the personal construct theory of George Kelly [6, 7]
2. The scales should be set up in such a way that the values in each of them come from the interval ⟨1, 10⟩
3. The scales should be oriented in such a way that the favorable result is ranked to external directions of the profile and negative values are located near the center of the graph.
4. Under such circumstances, the results for people who show little adverse effects determine a large area encircled by bounding line. This will allow for fast acquainting oneself with conclusions.
5. After getting the ability in interpretation of such plots, it is possible to estimate the specific situation of the tested person immediately.

Results

Preliminary application of the method

This paper aims to present mainly theoretical basis of a new method, therefore we present only preliminary results of its application.

This procedure was used to obtain data from 16 patients who were visited in their homes by a nurse. Three patients were visited in their homes by a doctor. We present data obtained from only three patients and own data from the therapist. These data are presented in the form of a (1) short medical report and (2) the obtained answers, numbers according to the protocol set out in Appendix and (3) by presenting the graphs of the multidimensional profiles.

We depict also figures with drawing of two profiles on one graph, it means: therapist's superimposed profiles and patient's mother.

A. Patient F.R.

Case history in short.: Male, age 19, a student of high school. Complains of diffuse abdominal pain, only during the day which have occurred for several months intermittently, not depending on other tangible factors. The patient has lost weight – about 3 kg.

Data obtained during the structuralized interview. For nominal and cumulative scales [ ] the number of items are given if the answer is "yes". For the repertory grid {} after the number of item the obtained value is given, which is the number from the range ⟨–10, 0, +10⟩

[1.18, 1.21]
[2.2, 2.9,]
[3.8 (relations of friendships only)]
{ 4.1+, 4.2+, 4.3–0, 4.4+, 4.5–0, 4.6–0, 4.7+, 4.8+, 4.9+, 4.10+ } = + 7, ie 85 % of scale
{ 5.1+, 5.2+, 5.3+, 5.4+, 5.5+, 5.6+, 5.7+, 5.8+, 5.9+, 5.10+ } = +10, ie 100 % of scale
{ 6.1–0, 6.2+, 6.3+, 6.4+, 6.5–0, 6.6+, 6.7+, 6.8–0, 6.9+, 6.10–0 } = +6, ie 80 % of scale
{ 7.1+, 7.2+, 7.3+, 7.4+, 7.4+, 7.5+, 7.6+, 7.7+, 7.8+, 7.9+, 7.10+ } = + 10, ie 100% of scale
{ 8.1+, 8.2+, 8.3+, 8.4+, 8.5-0, 8.6 –0, 8.7+, 8.8+, 8.9+, 8.10+ } = +8, ie 90% of scale

The results obtained from patient F.R., are presented on the multi-dimensional profile showed in. fig. 2

B. Patient R.K.

Case history in short.: Male, age 45, does not work, the living has been provided by the family for several years. A significant alcohol abuse. Patient's family has asked for an appointment with general practitioner because of seizures.

Data obtained during the structuralized interview. For nominal and cumulative scales [ ] the numbers of items are given if the answer is "yes". For the repertory grid {} after the number of item the obtained value is given, which is the number from the range ⟨–10, 0, +10 ⟩

[1.1, 1.2 (take periodic drug treatment), 1.5, 1.6 (quite often seizures after a trial of alcohol elimination), 1.7 (for a few years of alcohol dependence), 1.13. (father died at the age of 50) 1.15 (grandfather died of a heart attack at the age of 52), 1.18,1.19 (do not eat well because of frequent binge drinking), 1.20 alcoholism for about 7 years.]
[2.1 (father's death) , 2.6 (his father was also an alcoholic), 2.10 (overprotective mother)
[3.3 (breakdown of sexual relations with a partner)]
{ 4.1–1, 4.2–1, 4.3 –0, 4.4–0, 4.5–0, 4.6–0, 4.7–1, 4.8–1, 4.9–1, 4.10+–1}= + 6, ie 20% of scale
{ 5.1–1, 5.2–0, 5.3–0, 5.4–1, 5.5–1, 5.6–1, 5.7–1, 5.8–1, 5.9–1, 5.10–1 } = +8, ie 10 % of scale
{ 6.1–0, 6.2–0, 6.3+, 6.4+, 6.5+, 6.6+, 6.7+, 6.8–0, 6.9+ ,6.10–0 } = +6, ie 30 % of scale
{ 7.1+, 7.2+, 7.–1, 7.4+, 7.4+, 7.5+, 7.6+, 7.7+, 7.8+, 7.9+, 7.10+ } = + 9, ie 95 % of scale
{ 8.1–1, 8.2–1, 8.3–1, 8.4–1, 8.5–1, 8.6 –0, 8.7+, 8.8–1, 8.9–1, 8.10–1 } = – 9, ie 5 % of scale

The results obtained from patient R.K., are presented on the multi-dimensional profile showed in. fig. 3

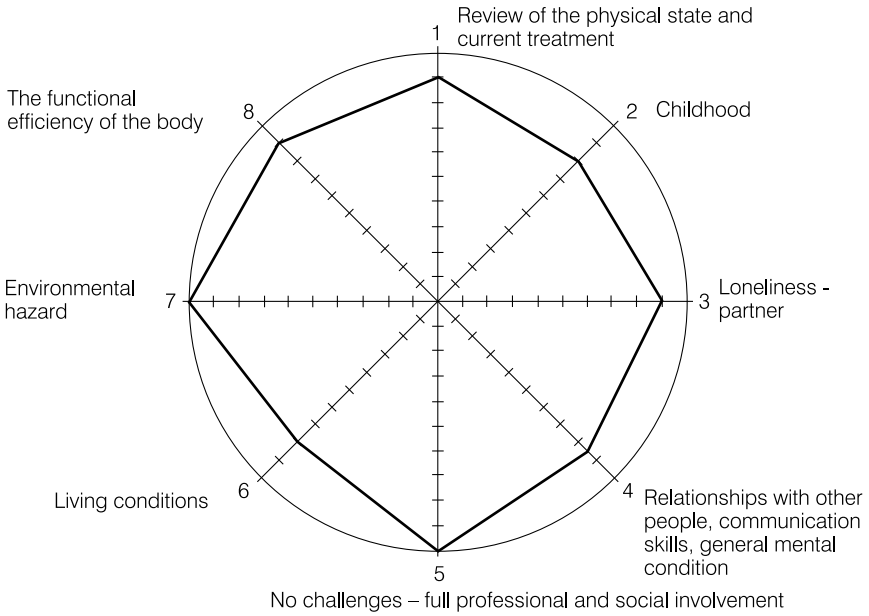

Figure 2. Illustration of the results obtained during a home visit of the patient F.R.
Rycina 2. Ilustracja wyników pozyskanych w trakcie wizyty domowej u pacjenta F.R.

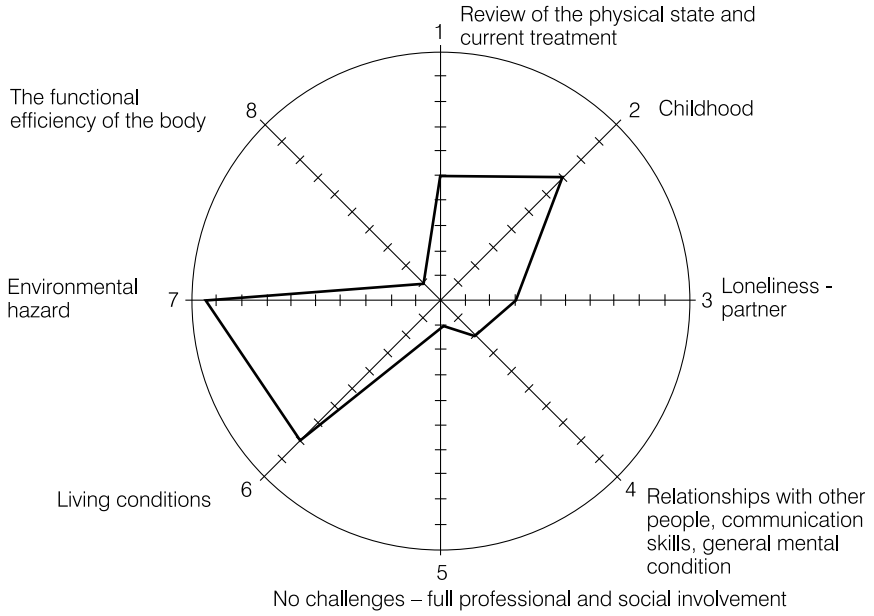

Figure 3. Illustration of the results obtained during the home visit of the patient R.K.
Rycina 3. Ilustracja wyników pozyskanych w trakcie wizyty domowej u pacjenta R.K.

Data for the family doctor. For nominal and cumulative scales [ ] the numbers of items are given if the answer is "yes". For the repertory grid {} after the number of item the obtained value is given, which is the number in the range ⟨–10, 0, +10⟩

[1.1, 1.8, 1.20]
[2.8]
[3.8]
{4.1–0, 4.2–0, 4.3 +, 4.4–0, 4.5–0, 4.6–0, 4.7+, 4.8+, 4.9+, 4.10+ } = + 5, ie 75 % of scale
{ 5.1+, 5.2-0, 5.3+, 5.4+, 5.5+, 5.6+, 5.7+, 5.8+, 5.9+, 5.10+ } = +9, ie 95 % of scale
{ 6.1+, 6.2+, 6.3+, 6.4+, 6.5+1, 6.6+, 6.7+ , 6.8+, 6.9+ ,6.10+ } = +10, ie 100 % of scale
{ 7.1+, 7.2+, 7.3+, 7.4+, 7.4+, 7.5+, 7.6+, 7.7+, 7.8+, 7.9+, 7.10+ } = + 10, ie 100% of scale
{ 8.1+, 8.2+, 8.3+, 8.4–0, 8.5+, 8.6+, 8.7–0, 8.8+, 8.9+, 8.10–0 } = +8, ie 85 % of scale 8

The results for patient F.R. and for the therapist presented on multi-dimensional profile superimposed on one graph are showed in fig. 4

Data for H.K. – patient's R.K. mother

Patient's R.K. mother is suffering from several syndromes (obesity, rheumatic symptoms). She worries about her son's condition. Her general psychological condition is not good.

[1.1, 1.2, 1.5, 1.12 1.13, 1.14, 1.15, 1.19]
[2.1]
[3.4.]
{4.1–0, 4.2+, 4.3–0, 4.4–1, 4.5–0, 4.6–1, 4.7–0, 4.8–0, 4.9–0, 4.10+ } = 0, ie 50 % of scale
{ 5.1–0, 5.2–0, 5.3–0, 5.4–0, 5.5–0, 5.6–0, 5.7–0, 5.8+, 5.9–0, 5.10–0 } = +1, ie 55 % of scale
{ 6.1+, 6.2–0, 6.3+, 6.4+, 6.5+, 6.6+, 6.7+ , 6.8+, 6.9+, 6.10+ } = +9, ie 95 % of scale
{ 7.1+, 7.2+, 7.3+, 7.4+, 7.5+, 7.6+, 7.7+, 7.8+, 7.9+, 7.10+ } = + 10, ie 100% of scale
{ 8.1–0, 8.2–0, 8.3+, 8.4–0, 8.5–1, 8.6+, 8.7+, 8.8–0, 8.9–0, 8.10–1 } = +1, ie 55 % of scale 8

The results for patient F.R. and for patient's H.K. mother presented on the multi-dimensional profile superimposed on one graph are showed in fig. 5

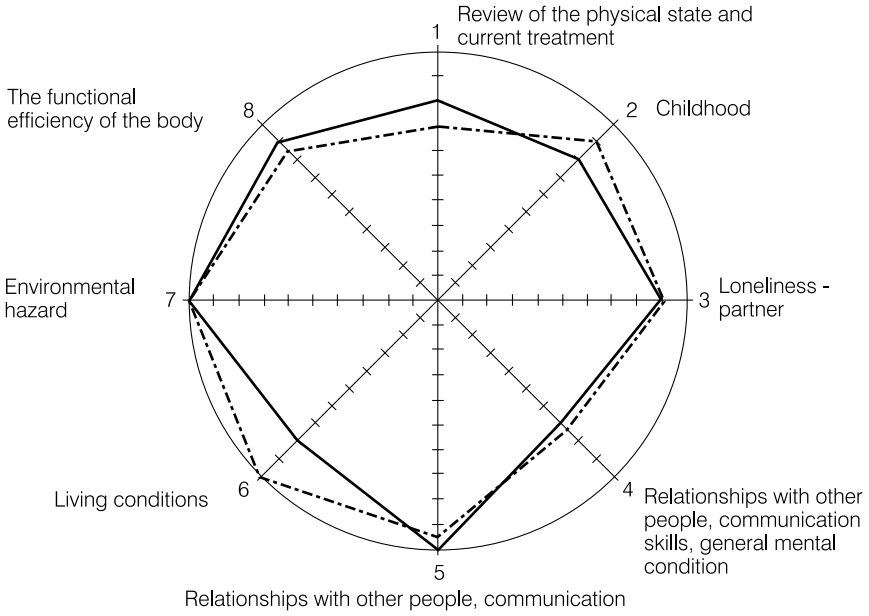

Figure 4. Illustration of the results for the patient F.R. (continuous line) and for the therapist (dotted line) presented by two multi-dimensional profiles superimposed on one graph

Rycina 4. Ilustracja wyników pacjenta F.R. (linia ciągła) i terapeuty (linia przerywana) przedstawione przez dwa wielowymiarowe profile nałożone na jeden wykres

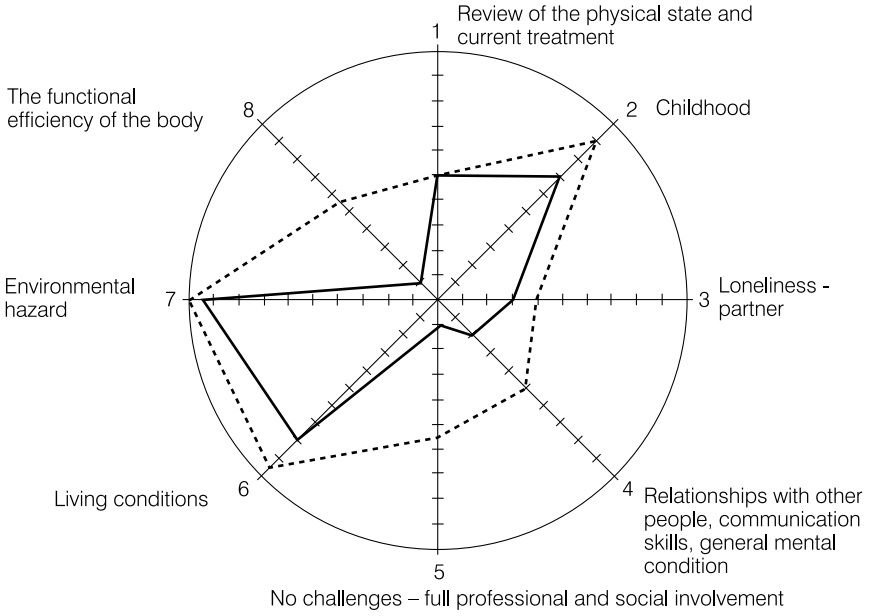

Figure 5. Illustration of the results for the patient R.K. (continuous line) and for the R.K.'s mother (dotted line) presented by two multi-dimensional profiles superimposed on one graph

Rycina 5. Ilustracja wyników pacjenta R.K. (linia ciągła) i matki R.K. (linia przerywana) przedstawione przez dwa wielowymiarowe profile nałożone na jeden wykres

Discussion

The proposed method is to facilitate the flow of information concerning a patient visited by health care representatives at his home [8–12].

Several authors recognize the need to consider communication between people undertaking the care and treatment of patients visited in their homes [13–15].

Currently in Poland environmental family nurse at work makes files of e.g.: "Environmental Chart – a family social inquiry", "Individual nursing record" [16].

In some western and South American countries there are several assessment models available that have been used in a variety of settings and are supported by scientific research. They include the Friedman Family Assessment Model, the Calgary Assessment Model (developed by Wright & Leahey), and the Family System Stressor Strength Inventory (developed by Berkey-Mischle and Hanson) [17–19].

Our tool tries to supplement the existing, known methods of assessment through focusing on the problem of graphical synthetic illustration of the collected data. Our method encompasses the structuralized interview and leads to produce a clear, graphical illustration of the living and social conditions of the patient. This graphical illustration allows for a quick and smooth transfer of patient's related data and his family to the visiting nurse, social worker, family doctor and specialist doctors.

It should be emphasized that the recorded multi-dimensional profile, although originally drawn up by a nurse, it also summarizes the physical health, the medical treatment, diet and genetic determinants drawn up by doctors. It is clear that the details of the patient's status must be specified after the physical examination and appropriate additional tests ordered commonly by a family doctor.

The data presented above, obtained from two patients show how significant are differences in the determinants of mental health. The method used for graphical illustrations helps to introduce these differences. These examples highlight the need for cooperation with a psychologist (family psychotherapist) for the effective treatment of the patients.

It should be noted that the method facilitates the comparison of data obtained from several family members. This comparison procedure is supported by drawing of several profiles on one graph. It is also possible to relate patient's profile to the profile of a doctor or a nurse. We propose to name it as self – reference procedure. This makes it easier to capture the essence of family relationships and provide tips of psychological and social nature.

Comparison of results obtained from several family members e.g. the patient and his mother or referring them to a profile of the nurse or family doctor helps to provide tips and guidance.

Preparation of a multi-dimensional profile and the imposition on the graph of the patient on graphs formulated for people who are potentially able to affect the patient (e.g. patient's mother, patient's partner, the nurse) facilitates the formulation of tips. Tips are to take into account the real psychological possibility of flat mates or family members resulting from their mental condition.

What's more, the method could be computerized and within the formulated supporting tool (the computerized file) the data can refere to the nurse (therapist) in various forms of indirect psychotherapy (books, movies).

The proposed method could also be applied in conducting multi-center international comparative research on determinants of public health [20–23]. The proposed method of illustration could improve the tools of "health related quality of life measurements" like EQ-5D [24].

It seems that the proposed method is a valuable supplement to documents used by public environmental – family nurse at present.

Conclusions

1. Implementation of the proposed method incline people involved in treatment of patients to take into account not only physical health but also determinants of mental health status, living and ongoing harmful environment.

2. Filled up protocol of structuralized interview and multi-dimensional profile facilitate the transfer of collected information among the team members involved in care and treatment of a patient visited in his home.

3. Filled up protocol of structuralized interview and multi-dimensional profile helps to discuss and to plan the activities that should form the next steps of treatment, and also useful actions taken.

4. Only after a long-term use of this method it will be possible to determine an optimal set of elements of the structuralized interview and provide guidance for its modifications.

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Appendix:

Guidelines for standardized interview and health assessment during the visit in patient's home.

1. Review of physical condition present, therapy, diet and genetic factors

If the answer is yes – tick ✓ in column No. 3		
1	Does the patient take any medications currently?	
2	Does the patient attend an outpatient clinic – a doctor regularly?	
Do you suffer or have suffered from any of the following diseases, disorders or symptoms.:		
3	Diseases of respiratory system?	
4	Diseases of circulatory system?	
5	Gastrointestinal diseases?	
6	Epilepsy or other neurological diseases?	
7	Psychiatric symptoms, mental illness, addiction?	
8	Diseases of genito – urinary?	
9	Symptoms of skin diseases, including allergic symptoms?	

10	Endocrine disorders?	
11	Symptoms of haematological diseases and/or immunological disorders, AIDS?	
12	Symptoms of rheumatic diseases?	
Genetic predispositions		
13	Were in the patient's family cases of sudden death due to health reasons – under the age of 50?	
14	Do patients family members often die before being old?	
15	Does anyone in the patient's close family suffered from coronary heart disease or have had a myocardial infarction?	
16	Does anyone in the family suffer from diabetes?	
17	Does anyone in the family suffer from bipolar disorder?	
18	Does anyone among close relatives suffer from schizophrenia?	
Diet and drugs		
20	Does food you consume meet the body's energy needs?	
21	Is patient's nutrition consistent with the principles of healthy diet?	
22	Do you use drugs (cigarettes, alcohol)?	
23	Is health status impaired by other past illnesses, events or group influences? If necessary describe this situation verbally ….....	

2. Adverse events in childhood.:
[a cumulative scale, ↓ max. 10, does not require standardization]

Nurse/therapist notes the adverse events based on answers provided by the patient.

1. Parent's death
2. Parents' divorce
3. Loss of other significant person (e.g. grandmother – who raised)
4. Violence (physical abuse) at home
5. Sexual abuse in the family
6. Alcoholism in the family
7. Criminal behavior of family members
8. History of serious illness (es) in childhood
9. Lack of family support (no signs of love, rejection)
10. Bad upbringing (bad patterns, lack of good example on parents side lack, of inculcation of elementary rules of conduct)

3. Loneliness – Emotional engagement – partner
[Nominal scale, ↑ max. 10, does not require standardization]

Nurse/therapist writes down the opinion about the nature of the situation on the basis of the answers given by the patient. The nurse can show the patient the list of options for inspection. The situation of the examined patient should be determined by one of the following statements:

1. I'm all alone, feeling lonely, I have no one to talk to.
2. I live with a partner, but due to his character I feel very limited (restricted, often terrorized).
3. I live with a partner, but due to differences in our characters I feel alone / lonely.
4. I am widowed / divorced – but I am looking for a person who could be my partner.
5. I am leading the life of a free single person. I have only temporary, loose relationships. This situation doesn't satisfy me and I am looking for someone who could be my partner.
6. I am widowed / divorced and I have only ad hoc, loose relations, but the situation pleases me.
7. Over the past few years I had some periods of time lasting relationships with people who I treated as partners. These relations didn't satisfy me, although this situation is better than a complete lack of a partner.
8. Over the past few years, I had periods of lasting relationships with people who I treated as partners. These relations satisfied me.
9. I am emotionally involved in a successful relationship with someone who is my permanent partner, although he/she is not a free person and is holding other liabilities
10. I am fully emotionally dedicated to a good relationship with my partner. This fully satisfies me sexually, emotionally and is good in everyday life.

4. Relationship with other people, communication skills, general mental condition

[Repertory Grid, the results is from the interval ⟨–10, +10⟩, standard is to divide the result by 2]

Nurse/therapist writes down the opinion on the basis of answers given by the patient. The nurse can show the patient the following table.

If you agree with the term on the left – put in the column "No. 3" – 1. If you agree with the term on the right – put in the column "No. 5" +1, if you are of no opinion or if you think that the truth is in the middle – insert in the column "No. 4" 0.

	2	3	4	5	6
1	I have not many friends or acquaintances. I live like a hermit.				I have many friends and I often spend time with them.
2	My contacts with the family are not too frequent or intense.				I also maintain contacts with more distant family.
3	My role as a parent (and/or grandfather) is not satisfactory.				I feel fulfilled as a parent (and/or grandfather).
4	My children (and grandchildren) are in considerable trouble.				I'm proud of my children (and/or grandchildren).
5	I am not a practicing religious person				I am a religious person taking an active part in church life.
6	I survived significant negative events e.g. problems at school, university, unwanted pregnancy, death of a loved one.				I have not experienced such events that led to considerable stress.
7	I have a lot of reservations about myself. Sometimes I feel like someone worse.				I highly apprise myself. I have high self – esteem.
8	I am often depressed, frightened, unsure of myself.				I am almost always in good mood.
9	I am often filled with anger and I feel that I need to get revenge.				Usually my approach to people is friendly. I'm flexible. I avoid conflicts.
10	I have often a feeling of helplessness, lack of hope.				I reasonably consider problems I am usually convinced that I will find a way out of a difficult situation.

5. No challenges – full involvement in professional and social matters

[Repertory Grid, the results is from the interval –10, +10⟩, the standard is to divide the result by 2]

Nurse/therapist writes down the opinion on the basis of answers given by the patient. The nurse can show the patient the following table.

If you agree to the term on the left – put in the column "No. 3" –1. If you agree with the term on the right – put in the column "No. 5" +1, if you are of no opinion or if you think that the truth is in the middle – insert in the column "No. 4" 0.

	2	3	4	5	6
1	I am not working, I am dependent from a partner/parents. I'm unemployed, pensioner, retired.				I am leading an active, interesting life (school, university) and I am fully satisfied
2	The atmosphere in my work place is not good.				Relationships with co-workers (colleagues) are good.
3	My superiors at work are demanding and often unjust				My superiors at work are friendly.
4	In my work I always do the same things and don't develop.				I have the opportunity to continue professional development.

	2	3	4	5	6
5	I am often bored. Apart from watching TV and listening to the radio I do not have any other specific and amusing interests.				I have many interests (hobbies) and I am dedicated to them.
6	I am not reading a lot. I acquire knowledge about the world from television and the radio.				I read a lot. Sometimes I make use of a library and Internet (and/or mobile phone).
7	I am not interested in politics or social problems.				In general I feel that I understand what is going on around me, and in the world.
8	Living doesn't make sense.				My life is meaningful and purposeful. I have set the image of the target situation of my own actions in life.
9	Cases discussed during talks in the media do not interest me.				I am curious about the world, and satisfying my curiosity gives me a great pleasure.
10	I do not undertake social activities.				I set myself the mission of life which includes my personal predispositions. I like to undertake some social activities and be engaged in professional world.

6. Living conditions

[Repertory Grid, the results are from the interval ⟨– 10, + 10⟩, standard is to divide the result by 2]

Nurse/therapist record the result on the basis of answers given by the patient. The nurse can show to the patient the following table.

If you agree with the term on the left – put in the column "No. 3" –1. If you agree with the term on the right – put in the column "No. 5" + 1, if you are of no opinion or if you think that the truth is in the middle – insert in the column "No. 4" 0.

	2	3	4	5	6
1	I do not make my living and my financial situation is not stable.				My income allows me to keep myself and my family on sufficient level.
2	I am greatly indebted.				I have no debts.
3	I am homeless.				I have a pretty good home.
4	My flat conditions are poor (small area, constrained by the inmates).				The floor area of my flat and the number of inmates is such, that we are not squeezed.
5	The flat where I live has not adequate heating , it is often too cold.				The flat where I live has proper heating, adequate ventilation in the summer.
6	The place I live is constantly bothered by noise.				The flat where I live has a good location with no disturbing noise.
7	View from the windows of my flat is gloomy.				View from the windows of my flat is nice.
8	From place where I live there is a considerable distance to shops, pharmacies, outpatient clinics.				There is a good access to public sites relevant to living (shops, outpatient clinic, pharmacy, bus transport).
9	The district where I live is not very safe, and/or the neighborhood is densely populated.				The district where I live is considered to be quiet and safe.
10	Unfortunately, despite the fact that my living conditions are pretty good I do not have a sense of security and good prospects for the future.				I think that my conditions will not deteriorate in the future.

7. The absence or presence of environmental hazard

[Repertory Grid, the results is from the interval ⟨–10, +10⟩, standard is to divide the result by 2]

Nurse/therapist record the result on the basis of answers given by the patient. The nurse can show to the patient the following table.

If you agree with the term on the left – put in the column "No. 3" –1. If you agree with the term on the right – put in the column "No. 5" +1, if you are of no opinion or if you think that the truth lies in the middle – insert in the column "No. 4" 0.

	2	3	4	5	6
1	I have often to stay in stuffy air.				I have a constant access to fresh air.
2	The potable water is often of poor quality.				The water I consume is, I think, safe to drink.
3	In the place where I live there are negative				In the place where I live there are no bad impacts of chemicals. effects of chemicals.
4	In the place where I live there are some physical hazard.				In the place where I live there is no physical hazard.
5	I think I'm exposed to bacterial infections and/or other adverse biological effects.				I am not exposed more than the average to bacterial infections.
6	I have limited access to sanitation facilities (clean toilets, bathing options).				Good access to sanitation facilities (clean toilets, bathrooms, hot water for washing and bathing).
7	My household is humid and with mold.				Where I live is dry, with no humidity.
8	In the place where I live there is not enough daylight and/or insufficient lighting most of the time.				I have constantly plenty of daylight and appropriate artificial lighting with pleasant colors.
9	Around the place where I live there is often garbage and/or the sewage system is not good.				Where I live garbage is disposed off regularly and there are no problems with the sewage system.
10	The area where I live is ugly, grim and dangerous.				I live in a nice neighborhood (town of attractive architecture).

8. Functional capacity of the body

[Repertory Grid, the results are from the interval ⟨–10, + 10⟩, standard is to divide the result by 2]

Nurse/therapist record the result on the basis of answers given by the patient. The nurse can show to the patient the following table.

If you agree with the term on the left – put in the column "No. 3" –1. If you agree with the term on the right – put in the column "No.5" +1, if you are of no opinion or if you think that the truth lies in the middle – insert in the column "No. 4" 0.

	2	3	4	5	6
1	I'm disabled, my movement functions are impaired.				I do not have any impairment or limitation of movement activities.
2	I get tired easily.				I am physically fit and efficient.
3	My sleep is not of a good quality.				I sleep very well.
4	I am not practicing sport, I lead a sedentary life, not much moving.				I am still very active physically. I practice sometimes/constantly sport. and devote myself to entertainment
5	My sexual activity is low and does not				I'm satisfied with my sex life. satisfy me.
6	I have some visual impairment.				I do not have, physiological visual impairment.
7	My hearing is impaired.				I have a good hearing

	2	3	4	5	6
8	I can not stand long journeys and perform complex new tasks.				Even travels abroad and completely new situations do not trouble me much.
9	I feel safe if I am active mentally and physically to move about in the world that I know and feel.				My general physical and mental capacity allows to carry out any complex project, even if it requires mastery of new skills.
10	I have chronic health problems.				I do not suffer from any chronic illnesses.