

CHAPTER 3

PHILOSOPHICAL BASIS OF COMMUNITY HEALTH NURSING

Introduction

It has been suggested that community nursing is the same as hospital nursing; the skills are simply transferred to a different setting. It has also been suggested that generic education is sufficient. This belief is vehemently refuted by community practitioners and others (Cain, Hyde and Howkins, 1995, Lancaster & Stanhope, 1996, McMurray, 1993). These authors claim that there are differences in the hospital and community contexts which militate against transference of knowledge and skills. A key example of the difference is that community nurses practice in a client-controlled environment (McMurray, 1993).

Community nursing is portrayed through the media as primarily about visitation of the sick. This idea has much to do with the traditional nurse image, the origins of district nursing and the perpetuation of stereotypes via the media (Kalish and Kalish, 1985). Perhaps, it also has to do with the perceptions and expectations of other caring professions and of society (Cain et al, 1995). It is interesting to note that there is no shortage of current television programmes such as ER or The Casualty Ward, which seek to portray up-to-date role models of general practitioners, consultants, hospital nurses of all grades and hospital managers. However, if a community nurse is portrayed, it is usually a district nurse, whose role appears not to have been updated since the 1940's. This belief may also be perpetuated by some community nurses who have resisted political and professional pressure to adopt a health-oriented approach and assume responsibility for empowering others through the development of self care ability. In addition, there is often a failure to acknowledge the changes taking place in nursing and nurse education which affect methods of care delivery such as the specialist versus generalist debate. In this chapter the author aims to discuss the issue of specialism versus generalism in the context of community nursing. This will be followed by a critical analysis of the roles of some specialist nurses working in the community. Finally, the author will examine education for practice within the community and explore some management issues in community nursing.

3.1 Specialist v Generalist

The concepts of comprehensive, specialized care and generalism continue to be fraught with considerable ambiguity in the community nursing literature. In some countries such as Finland and Ireland the concept of community nursing appears to refer primarily to the work of public health nurses, adopting both curative care and primary prevention with different age and client groups. In other countries such as the UK, USA and Canada, educators and nursing organizations are determined to clarify the differences between public health nursing and community nursing. The Quad Council in the USA are currently drafting a 'white paper' on public health nursing, the purpose of which is to create a discussion document describing the current thinking on community health and public health nursing. The Quad Council of the USA is composed of the: American Nurses Association (ANA) Council of Community, Primary and long term care; American Public Health Association, section of Public Health Nursing; Association of Community Health Nursing Educators; and Association of State and Territorial Directors of Nursing.

The Quad Council of Public Health Nursing Organizations has recommended the term public health nursing be used to describe population-focused, community-orientated practice and the term community-based practice be used to describe personal health services provided to an individual or family in the community. Whether a nurse is practicing public health or community-based nursing will be determined by the nature of practice rather than by the type of employing agency (ANA, 1997). The ANA (1997) recommend that due to the complexity of the knowledge and skills necessary for effective public health nursing practice, a master's degree from an academic program specializing in public health nursing practice should be the recommended qualification. Educational preparation of diploma or associate degree nurses should facilitate the student having the skills to provide nursing care to individuals in the community but not as a public health nurse. Thus, the opinion appears to be similar to that of Stanhope and Lancaster (1996) who perceived public health nurses as specialists within the broad arena of community nursing in general.

The term 'specialist' lacks clarity. For many, it conjures up images of unique, singular or exceptional attributes or skills. Inherent in the concept of specialist are connotations of expert skills. According to Benner (1984) experts or specialists may be considered as leviathans of professional achievement, able to work to strategies of their own making. Moore (1970) suggests that if a profession is to be considered a highly specialized occupation, then its specialization must be based on a substantive field of knowledge, and the application of this knowledge over which the specialists claims mastery. Yet Kelly (1996) argues that the specialist status of the community nurse still needs to be substantiated, as assertions of specialist knowledge and skills gained through education do not provide empirical proof of professional expertise. Schon (1983) claims that to be accepted as a professional, practice must demonstrate uniqueness, use of an academic discipline, which is the rigorous in its use of meta-theory to attain its ends.

In the UK, the PREP Report (United Kingdom Central Council, 1994) suggests that specialist nurses will practice within a wide spectrum of specialty areas and will be recognized as providing leadership, support and supervision for nurses and support staff within these specialties. According to Kelly (1996) this arrangement provides an opportunity for nurses to be definitive regarding the unambiguity of their pursuit towards professionalism. The instrumentality of professional practice should be strengthened by the opportunity to focus upon a specific part of the spectrum of intervention between care

and cure. The aim is to develop systematic professional collaboration and understanding between specialist practitioners who have complementary but distinct specialist contributions to make to community care. This distinct specialist contribution must, if it is to be credible, according to Schon (1983) be firmly bounded, scientific and standardized, thereby allowing the distinct possibility of technical rationality to be made explicit. In addition, professional competence, must be demonstrable in an artistic intuitive process of 'knowing in action' – a process of making indeterminable judgments which through reflection can be fine tuned to match specific situations (Carper, 1986). Specialist nurses' professional practice is thus an instrumental activity.

The PREP recommendations provide an opportunity for nurses to define the boundaries of their practice, because the instrumentality of specialist practice allows the various specialists to focus on a point specific to them alone, along the spectrum between care and cure. According to Kelly (1997), each specialism has the opportunity to develop an empirical theory regarding the instrumentality of their particular activity. Thus distinct specialist contributions will be clearly delineated, scientific, standardized, able to withstand the challenges from shifting policy, and particularly sensitive and responsive to client need. McMurray (1993) supports this approach and suggests

community health nurse specialists should define nursing practice according to their specific 'specialist' or 'expert' commitment to primary health care with its associated concepts and values. Specialty should be focused on primary, secondary or tertiary interventions (p. 123).

If professional status is to be enhanced the service provided by specialist practitioners must be visible and indispensable within its specialist role boundaries. Specialists nurses working in the community internationally tend to be clinical nurse specialists in a specific area of nursing such as incontinence, palliative care, asthma care etc. However, their educational backgrounds appear to differ from country to country. For example in the US and Canada, the minimum educational level required is a masters degree in the area of specialty, whereas, in Finland, all nurses who are trained now have some specialism, public health nursing is one of those specialisms. With the option of attaining a master's or doctoral degree in health care with public health nursing as a major subject.

In Ireland, public health nurses work as generalists but are educated to Higher Diploma level at university. Clinical nurse specialists who work in the community do not necessarily have a community nursing educational background. Thus their focus may be illness rather than community oriented. According to Kelly (1997) objectives for community health nurse specialist's education must be centered on epidemiology, demography, community structure and organisation, community development, management, programme evaluation and policy development. These are all community focused activities. Public health nurses in Ireland have included in their High Diploma curriculum, all of the above subject areas. Therefore, it is the author's view that Irish public health nurses are educated as specialists with a focus on community, similar to their US and Canadian colleagues.

3.2 The Practice Nurse: Roles and Perceptions

In discussing generalists v specialists in community nursing it would be remiss not to include some discussion on practice nurses. The majority of practice nursing research was found in the UK literature. In Ireland the concept of practice nursing originated with the adoption of the new General Medical Services (GMS), General Practitioner contract in

1989 which aimed to support the development of general practice (Department of Health, 1989b). The GMS contract grants the GP a subsidy towards the cost of employing a practice nurse. Since that time the number of practice nurses employed by GP's has increased, with an estimated 350 nurses employed (Irish Practice Nurses Association (IPNA) 1997). However, as there is no register maintained for practice nurses, the exact number is unknown.

The introduction of the 1966 GP Contract in the UK enabled GP's to obtain up to 70% reimbursement for practice staff and several GP's took advantage of this arrangement to employ 'treatment room' nurses. Nevertheless by the early 1980's, nurse employees in general practice remained comparatively rare, numbering fewer than 2,000 whole time employees (Atkin and Lunt, 1995). Changes in health care policy and in the delivery of primary health care services in the United Kingdom have led to a substantial growth in the numbers of practice nurses employed in general practice. These nurses work to a range of role models (Robinson, Beaton and White, 1993; Ross, Power and Sibbald, 1994). Some work within the traditional model of a treatment room nurse while others are developing additional aspects of their work, such as chronic disease management or home visitation. Some practice nurses see themselves as nurse practitioners (Atkin and Lunt, 1996). Since the 1990 contract for British General Practitioners there has been a rapid rise in the numbers of practice nurses in the UK. Ten years ago nurses employed in general practice were comparatively rare. In 1992, there were an estimated 15,123 practice nurses' posts in England and Wales, representing the equivalent of 9,500 whole-time posts (Atkin, Hirst, Lunt and Parker, 1994). While this growth in practice nurse numbers has been welcomed by general practitioners, it has presented problems for all nurses working in the community in relation to role definition, role boundaries, education and training.

According to Trnobranski (1994) practice nurses have expanded rapidly in numbers whilst traditional community nurses, health visitors, school nurses, district nurses and community psychiatric nurses are uncertain about their future. Fears have been expressed by community nurses that practice nurses are impinging on their roles, often without any training in community work. There are concerns that practice nurses work alone and with limited, if any, supervision, and in accordance with the demands of the GP rather than within the limits of professional training (Martin, 1987). That some practice nurses do home visits is a further contentious area. Potrykus (1991) stated that some health visitors whose major role has been to search out health needs and promote healthy lifestyles, are fearful that they will be squeezed out of the health care system in favour of a directly employed (GP) practice workforce. Thus it appears that the different roles of nurses working in the UK community are ill defined. As the future of community nursing as a whole is in the process of change, it is imperative that all nurses delivering patient care in this arena should examine the changing needs of society in the context of political reform and consider how their roles may be developed and defined. What is agreed upon is that the needs of patients and clients are paramount to the consideration of nursing roles (Salvage, 1991).

Training and education, although central to current developments in practice nursing, are fraught with controversy. Some writers point to the lack of funds earmarked for practice nurse training (Evans, 1992, Stilwell, 1991); others suggest that general practitioners are often unwilling to support courses, particularly when no substitute nurses are provided (Slaughter, 1991). Furthermore, Martin (1987) raised the issue of content and quality of practice nurses' courses and study days. Ross, Bower and Sibbald (1994) in their qualitative study of 620 practice nurses in South West Thames Regional Health

Authority found the majority of respondents indicated that their GP's gave them time off (94%) and funded courses (92%) the remainder of nurses funding courses themselves.

In 1992, in the UK, the Department of Health commissioned the Social Policy Research Unit (SPRU), University of York, to undertake a study of the roles, responsibilities and training needs of practice nurses. Atkin, Hirst, Lunt and Parker (1994) presented the findings from this national census. Questionnaires were sent to 16,538 practice nurses and 12,589 were returned, a response rate of 81%. Results showed the 37% of practice nurses were aged between 40 and 49 years old, 95% were women, 55% were less than two years in the position and 85% worked part-time. These results reflect those of Ross et al (1994) where 100% were women, 88% were over 30 years and 27% were over 50 years of age. Of the 615 respondents 41.3% had been in current position for one year or less and 83% worked part-time hours. In the national census (Atkin et al, 1994), the educational profile of the practice nurses were very varied: 92% were Registered General Nurses (RGN), one in ten were Registered Enrolled Nurses (REN), and one in four held midwifery registration. Registered Health Visitors formed a small proportion of practice nurses (3%) and 12% held a District Nurse qualification. Only 42% had attended a course in practice nursing, validated by one of the national nursing boards and a quarter had attended a formal induction course organized by a Regional Health Authority (RHA), a District Health Authority (DHA), or a Family Health Service Authority (FHSA). However, 48% of practice nurses had not attended either course. A family planning qualification was held by 25% of practice nurses.

A similar study, but on a smaller scale was conducted in North-East England around the same time as the National Census (Atkin et al, 1994). This second study was conducted by Mackereth (1995) and questionnaires were distributed to 62 practice nurses in the area. The final response rate was 90%, (56 out of 62), almost exactly the same as the Atkin et al (1994) study. All practice nurses were female, with the average working week being 22.5 hours, and 74% of the sample being first employed in the past two years. These figures are similar to Atkin et al, (1994). Of the 56 respondents 89% were RGN's and 41% had completed the practice nurse course, similar to the percentages found in Atkin and Lunt (1994) study. Sixteen respondents had also trained as midwives.

The questionnaire in both studies asked which tasks the practice nurses carried out relating to health promotion, chronic disease management, general aspects of nurses work and work in client's home. More than 80% of practice nurses in the Atkin et al (1994) study engaged in immunization, and vaccination, venepuncture, auroscopic examination and measuring respiratory function, which were found to be the core tasks of practice nursing. Certain tasks, such as taking cervical smears and performing breast examination, assisting with minor surgery and preparing clinical equipment were also associated with the role. In Mackereth's (1995) study, the vast majority of practice nurses performed practical tasks, similar to above and over 70% were involved with measuring peak flow rates and elderly health surveillance. For the other tasks however, Mackereth (1995) found a variety of responses, indicating the lack of role definition. In both studies, virtually all practice nurses gave advice on smoking, nutrition, alcohol consumption, and lifestyle counseling and advice. Such findings were similar in Ross et al (1994) where 92% of respondents were involved in practical tasks and 67% were running health promotion clinics. In the Atkin et al, (1994) study, 27% run family planning clinics, 23% run antenatal/postnatal clinics, 52% run asthma clinics, 55% reported involvement in diabetes management and 65% were involved in managing hypertension.

Practice nurses appear to undertake a variety of tasks that go beyond traditional nursing tasks. These include preventive work, advice and counseling. For example, in the Atkin et al (1994) study, 86% of practice nurses were involved in health assessments of new patients. Other tasks include early identification of anxiety and depression in patients (43%) and providing advice on welfare benefits (20%). A total of 59% of practice nurses visited patients in their home. Mackereth (1995) found 89% of practice nurses visited clients at home. The median lay between 4 and 5 home visits per month. This raises questions about whether this is appropriate, given that few practice nurses have training in community nursing. However, Atkin and Lunt (1996) found it was rare for a practice nurse to offer continuous care in the home. Much of their work in the home represented 'one-off' home visits, for purposes of venepuncture and health assessment of older people. Community nurse managers responsible for commissioning community nursing services felt home visits by both the practice nurse and the district nurse were duplication of services and an intrusion to the privacy of the client especially the elderly client (Atkin and Lunt, 1995). Atkin and Lunt (1995) expressed particular anxiety about the competence of practice nurses to undertake either home visits or health promotion work since few had a health visitors qualification.

In both studies (Atkin et al, 1994 and Mackereth, 1995), the respondents identified training priorities in areas such as ophthalmoscopic examination, stethoscopic examination of the heart and chest, breast examination and taking electrocardiographs (ECG's). Other areas included health promotion clinics, chronic disease management clinics, giving advice on incontinence and identifying depression. In both these studies it was found that practice nurses were much less likely to perceive the need for training in areas in which they were already working. Furthermore, the respondents in Mackereth's (1995) study perceived themselves to be 'the specialists of health promotion', but many health promotion clinics were actually found to be 'disease management clinics which have a different focus than for example a well person clinic' which may focus on screening and lifestyle counseling. In Ross et al, (1994) study 92% of the respondents reported a need for further training opportunities in areas such as communication skills, theory and practice of health promotion, information technology and organization of health promotion clinics.

These studies are limited due to the use of postal questionnaires. Nevertheless the data shows a dramatic increase in practice nurses' numbers and also illustrates a changing role. Greenfield, Stillwell and Drury's (1987) study indicated that 67% of practice nurses undertook auroscopic examination compared with 84% in the national census (Atkin et al, 1994). Furthermore, 16% ran asthma clinics in 1987 (Greenfield et al, 1987) compared with 52% reported in the national census (Atkin et al, 1994). At present 59% (Atkin et al, 1994) and 89% (Mackereth, 1995) of practice nurses visit patients in their homes, which indicates that the figures have doubled since 1987 (Greenfield et al, 1987). However, most practice nurses who visit the home do not have a community qualification. Mackereth (1995) showed that 72.2% of practice nurses performed health assessment for clients over 75 years of age. Yet only 42.3% of these nurses considered themselves to have training in this area of work. Nurses and GP's are urged by the UKCC (1990) to remember accountability for nursing practice and the seriousness of assuming responsibilities for practice without adequately training. This is of particular importance as of those involved in antenatal and postnatal clinics, 70% do not have a health visitor or midwifery qualification. Moreover, one third of those involved in family planning clinics were neither registered health visitors nor had family planning qualifications (Atkin et al, 1994). Mackereth (1995) acknowledged that from the information obtained in the study it was

not possible to gain any insight into what actually happens in the practice nurses' health promotion activities, thus the question of quality could not be addressed. It is interesting to note however that only four practice nurses (from 56 respondents) made reference to social factors and none made any reference to wider environmental issues, such as housing, pollution or poverty. This could be attributed to the focus of the questionnaire or it could be because, working from a doctor's surgery the predominant approach is medically oriented. Thus, this leads the author to believe that practice nurses practice health education as opposed to the wider and more complex practice of health promotion. Ross et al (1994) reached similar conclusions where they found practice nurses engaged in a wide range of activities for which many had little formal training. Again, the majority wished to develop their role and undertake further training.

For practice nurses there is no mandatory post-basic training, despite the uncertainties of their role. As has been discussed, many nurses working in general practice are usually trained at RGN level, their post-basic training, however, is largely ad hoc. In the UK, the RCN recommended that the four national boards set up a 10-day course for practice nurses, covering professional role development, treatment room procedures and techniques and management of the treatment room. This is now established training for practice nurses and the four National Boards have approved 36 such courses. The UKCC review (1992) however, is critical of these courses and argues that they are inaccessible for many practice nurses; with nurses often finding it difficult to attend because of financial considerations, getting time off work and the problem of traveling long distances to courses (UKCC, 1992). Thus, a working group commissioned by the UKCC examined the wider issue of community nursing and recommended a common course for all community nurses (Health visitors, district nurses etc.) with specific modules for training a 'community health care nurse' (CHCN) (UKCC, 1992). Existing health visitors and district nurses would not need to undergo further training, but practice nurses would need to as a prerequisite to becoming a CHCN.

3.3 The Nurse Practitioner

The debate on the nurse practitioner's role provides a valuable opportunity to explore several concepts pertinent both to the role and to the roles of community health nurse specialists and practice nurses. The definition of a nurse practitioner is confusing and sometimes ambiguous; however, Lawson and Emmerson (1985) defines the role as a nurse

educated to recognize the difference between normal and abnormal anatomy and physiology, to use this and other information as a base for problem solving with the patient; and to plan appropriate care which includes prescribing, investigation, referral and education (p. 244).

The role of the nurse practitioner was first conceived in the USA in the 1960's and since this time has been evolving and developing. By 1991 there were an estimated 25,000 nurse practitioners in America (Trnobranski, 1994). In the USA the nurse practitioner was borne out of a need to adapt to changing health trends. These included the rising costs of health care provision and a move away from a general practitioner (GP) medical model to a broader approach to primary health care which was concerned with health as well as illness (Bennett, 1984). Similarly, in response to deficits in the provision of health care there was concern regarding the lack of medical care to underserved populations in rural and inner city areas. It appeared that such communities lived in unpopular locations for

doctors who preferred to practice in cities and focus their attention on the technological aspects of medical care. Thus the nurse practitioner provided improved availability and access to health care for these communities. At its inception the nurse practitioner concept was viewed as a means of extending the ability of physicians to serve the needs of the under-served communities. This necessitated that nurse practitioners should be trained to take medical histories, make diagnoses, prescribe treatment and perform medical tasks. This extended role of the nurse was viewed by many nurses as a retrograde step and in complete opposition to the 'caring' ethos of nursing (Salvage, 1991). The question often posed is whether nurse practitioners practice nursing or medicine. Some authors support the concept and suggest nurse practitioners provide health care to populations previously neglected (Trnobranki, 1994). Butterworth and Bishop (1995) question whether the public should choose between a medical practitioner and a community nurse practitioner and feel that the public attitude to an independent nurse practitioner may be ambivalent. It is the opinion of both Kelly (1997) and Trnobranski (1994) that the only means of assessing whether the public desires an alternative professional at the point of access to health care is through further provision and evaluation of nurse practitioner schemes.

In the UK, Cumberledge in her Report of the Community Nursing Review (1986) clearly affirms a future role for nurse practitioners especially in the area of health promotion. The report emphasizes that nurse practitioners are not physician substitutes and are as effective as doctors and as acceptable to clients. According to Drumond and Maynard (1988) nurse practitioners are cost-effective practitioners in primary health care. However, to be an independent autonomous, accountable nurse practitioner, appropriate education is recognised as essential. In the USA many nurse practitioners are educated to Masters Degree level, whereas in the UK nurse practitioner courses are evolving. The UKCC in 1991 proposes a broad new discipline of 'community health care nursing' with a common core preparation and additional modules to prepare nurses for particular areas of practice, e.g. 'district nursing', 'practice nursing'. The UKCC (1991) envisage nurse practitioner posts as providing a route for community nurses wishing to pursue 'advanced practice'. In this case, nurse practitioner educational programmes might be aimed at providing higher studies for qualified 'community health care nurses', with suitable experience. To the author's knowledge there are no Irish nurse practitioners working in the community.

3.4 The Link Between Community and Institution – The Liaison Nurse

Liaison is seen as co-operation between hospital and community nurses, in an attempt to effect continuity of care (Jowett, Armitage, 1988). Careful discharge planning is necessary to bridge the 'gap' with a liaison system to co-ordinate services at the interface of hospital and community. The designation of a specific healthcare professional, usually a nurse, to liaise with hospital and community staff is common in many hospitals. In Australia, discharge planning nurses are employed under an assortment of position titles including discharge liaison nurse, community liaison nurse, nurse discharge planner, discharge planning coordinator and discharge planning nurse (Hrepka, 1993). Regardless of the title employed, perceptions of the role of discharge planners include co-ordination of the discharge planning process and liaison between the hospital and the community. In the USA and Canada discharge planning has evolved as a specialty in its own right with specialist nursing staff providing a comprehensive full time service (Brunton, 1998). In the

United Kingdom liaison nurses have been introduced in many hospitals with most employed by community services (Jowett, Armitage, 1988). The reported benefits and advantages of the liaison nurses role include improved communication between healthcare professionals, and the provision of expert advice on community resources and needs (O'Leary, 1990).

Armitage and Kavanagh (1996) conducted a qualitative study in New South Wales, Australia, to identify and compare how hospital and community nurses perceived the provision of continuing care for patients and their experiences with discharge planning. Semi-focused interviews were conducted with 12 hospital nurses and 12 community nurses to explore their perceptions of discharge planning related experiences. Findings indicated that both hospital and community nurses relied on the discharge liaison nurse to provide a link between hospital and community services. According to the community nurses, hospitals without a discharge liaison nurse had no routine way of proceeding discharge planning with subsequent lack of co-ordination in planning. Conversely, discharges organized by the discharge liaison nurse were described as forward planned with occupational therapy needs assessed, equipment obtained and adequate notice given to community and ancillary services such as personal care and meal services. The perception of hospital nurses that discharge planning started and ended with a referral to the discharge liaison nurse obscures the important role ward nurses should play in discharge preparation. Discharge planning should be an ongoing process and not simply referred to community services. Evers (1990) warns of a danger of proliferation of discharge planning 'experts' with subsequent dilution of the responsibilities of the ward nurse and the community nurse who provide direct care.

It must be noted however, that while the direct, informal system of nurse to nurse referrals exercised between the ward nurses and the discharge liaison nurse was seen as facultative, it begs the question of who is responsible and accountable for continuity of patient care. Discharge planning has been recognised as a nursing function, yet nurses have little or no control over the timing of discharge. Ultimately it is the medical staff who exercise control over patient discharge but medical readiness for discharge may not necessarily coincide with nursing readiness for discharge. According to Batey and Lewis (1982) cited in Armitage and Kavanagh (1996) accountability requires authority to act on a responsibility. Armitage and Kavanagh (1996) states "this is blatantly absent from the ward nurses' experiences and responsibilities" (p. 220) as described in their study. Thus while the discharge liaison nurse plays an important role in ensuring continuity of care for patients by facilitating hospital discharge planning and the delivery of services in the community however the nurse is constrained in performance by an absence of organisational autonomy. The lack of opportunity to be directly accountable for practice defines and limits the role. Armitage and Kavanagh (1996) recommend a commitment by nursing managers and administrators to the practice of discharge liaison nurses together with the development of supportive organizational structures to ensure a quality, equitable service for all clients. Due to the lack of published literature, it is difficult to clearly identify the numbers, roles and functions of liaison nurses in the Irish health care system. However, such positions do exist especially in care of the elderly and for maternity services.

3.5 Implications for Education

It is appropriate at this point to discuss the level of education of nurses working in the community. In several industrialized countries, particularly in home care, there are two types of nurses employed by community nursing agencies; community nurses and general nurses. This differentiation is based on a distinction in educational preparation (Verheij and Kerkstra, 1992). Although both types of nurse have different types of training, however, due to uncertainty about demarcation in many situations, both types of nurse carry out largely identical duties. For example, research in the Netherlands showed role similarity between community nurses and general nurses in 41% of the agencies investigated (Jansen et al, 1993). Forsey, Cleland and Miller (1993) state that there is perhaps as much as 80% overlap between nursing roles in general, especially those elements relating to general care and hygiene.

Technological changes make it possible to provide more complex nursing care at home, but this does require special expertise from nurses (Barrett and Hudson, 1997, Papworth, 1995). Basic education and training cannot always address changes in demand on community nursing (Jansen et al, 1996). Under circumstances of employing generic basic qualified nurses, agencies delivering community nursing care are required to redesign nursing roles. To ensure high quality of care and efficiency, two principles seem to be appropriate (Jansen et al, 1996); differentiated practice and specialization. Differentiated practice is a personnel deployment model in which the roles of nurses are (re)defined based on education, experience and competence. Specialization concerns the way in which specialized knowledge is available in the community in order to meet the changing and increasing complexity of home care.

In 1965, the American Nurses' Association proposed two levels of education, a baccalaureate degree for the professional nurse and an associate degree for the technical nurse. In the USA, all registered nurses hold the same license to practice nursing regardless of their educational and experiential background. However, to utilize available nursing personnel more effectively, differentiated practice is also applied. Based on the premise that individual practitioners with different types of education, competence and experience should not be used interchangeably, differentiated practice seeks to ensure that the work of nurses is carried out by the most appropriate nurse in the most appropriate way (Boston, 1990) cited in Jansen et al (1996). Clinical nurse specialists are experts in a particular aspect of nursing; they demonstrate special clinical expertise, as a result of significant experience and advanced knowledge of a branch or field of nursing (Butterworth and Bishop, 1995). Nursing's shift of emphasis to both the community and highly specialized care has led to different views on what services, nurses are and are not to deliver. The examples of the Netherlands and the UK illustrate some of the differences of opinion. In the UK, community nurses are increasingly employed by group practices of general medical practitioners, which are given funds to buy health and social care for patients. GP's and the NHS recognise the cost-effectiveness of employing nurses to perform certain tasks such as minor surgery, immunizations, family planning and some patient consultations. However, in the Netherlands, the nursing profession in general opposes this type of role because of the perceived crossing of the boundaries between medical and nursing and the overlap with an existing occupational group of so-called doctor's assistants. The profession believes that an expanded medical role could damage the caring function of nursing and harm relationships with patients. As a result, the role

of specialist nurse practitioner or equivalent was not included in the new law on professions in health care in the Netherlands (Salvage and Heinjen, 1997).

3.6 Management Issues in Community Nursing

There is considerable literature pertaining to nursing management in general. This has over the years incorporated many general principles. According to Singleton and Nail (1988), within nursing, decentralization has been characterized by flatter structures, sometimes with unit managers reporting directly to chief nurse executives. Wellington (1986) states that participative management approaches empower managers at the sub department level by increasing discretion and authority. Traditional or newly created nurse management positions may be extended to include accountability for financial planning and control, quality of staff work life, medical relations, professional development, quality assurance or clinical practice decisions (Dienemann, Shaffer, 1992). The literature on management of community nursing appears sparse and at the very least, poorly documented. Some of the literature which is published is reviewed in the following paragraphs.

A descriptive study conducted by Dienemann and Shaffer (1992) in the US compared the responsibilities of Nurse Unit Manager (NUMs) in private industry with county health department nurse supervisors. The specific issues examined were: functions and activities of NUM's and supervisors, accountable held within organisations, allocation of working time and, differences on allocation of time to managerial functions.

Semi-structured interviews were conducted with the chief nurse executives in six hospitals and two county health departments. These interviews provided information about agencies and job descriptions. Questionnaires were distributed to all NUMs, coded only by agency and returned to the researchers thus maintaining anonymity. From the eight agencies, 73 questionnaires were returned (response rate of 63%), of these, 48 were from hospitals and 25 were from county health departments. Qualification levels of respondents varied, 25% held master's degrees in some discipline (but not always in nursing), not significantly different in either agency ($p < .05$). However, of the hospital NUMs, 69% held a Bachelors in Nursing (BSN) whereas 96% of the community health NUM's held a BSN. This difference was statistically significant ($p < .01$).

Evidence of decentralization was greatest in human resource management with 81% of the NUMs making hiring decisions and 75% having the authority to initiate termination of employment contract. In addition, NUMs consistently reported being responsible for orientation, development, counseling, scheduling, disciplining and evaluating unit staff. Other reported activities emphasized staff performance : directing and motivating staff, setting standards, and devising work procedures. There was less evidence however of decentralization in financial services where only 61.4% reported preparing unit personal budget and only 19% set salary level for newly hired staff. The amount of time allocated to financial services was only 6% and only 38% of NUMs were directly responsible for purchasing decisions.

On a more positive note most NUMs stated a function as communication link between staff and administration which was perceived as a critical function in a decentralized environment. When time allocation between the two positions were compared, some differences emerged. Community health NUMs spent 34% of their time on human resource management whereas hospital NUMs spent only 23.6% of time in this category of work. Conversely, hospital NUMs reported spending 15% of their time on direct patient

care as opposed to 3% of time spent by community health NUMs. However, overall the responses between the two practice positions held were fairly consistent. In both practice settings the NUMs job expanded, especially in the area of human resource management. Both stated the necessity for automated information systems upon which to base, and monitor management decisions. Both services reported being inundated with data, but lacked aggregated information on clients, personnel and services thus not facilitating their ability to monitor market behaviour of clients or service excellence. A suggestion made by the researcher was that Chief Nursing Officers should consider requiring formal preparation in management for the NUM position as clearly not all NUMs had the necessary managerial skills or knowledge.

In the United Kingdom an exploratory study of community nursing management was undertaken by Jacoby (1990). Community nurse managers in 17 health districts in England were interviewed about their strategies for identifying and coping with unmet need for nursing care in the community, and their efforts to plan community nursing services and to meet changing levels of demand for care. The interviews were semi-structured, based on a questionnaire employing both open and precoded questions. Of the 19 people interviewed, four had not attended a management course, the range of courses varying from those organised, locally to Senior Management Development Programme organized by the Kings Fund. Two managers were studying a Masters Degree in Business Administration. One was an associate member of the Institute of Health Services Management (HMS) and three held a certificate of the HSM, thus it appeared that a number of the managers had a commitment to management. All but one of the managers held a budget although its extent varied according to the organization. In most, it provided for staff salaries and traveling expenses; staff training; equipment and medical loans, including dressing and disposables and clerical and administrative support (Jacoby, 1990).

The Managers were found to have access to a wide range of information for planning services, but this information did not always seem to be used to its potential. Efforts to identify unmet needs were found to be piecemeal and uncoordinated. This may have been, in part, because of the difficulties in meeting existing demands. In five districts, managers reported that the community nursing services were not always able to accept referrals for care with one manager stating that it had been necessary to close caseloads for a few weeks because of staff sickness. These difficulties were attributed to the lack of commitment at senior management level to community care and a failure to redirect resources from the acute services into the community. As a result, several managers were beginning to establish priorities for care. All but two of the districts had a mechanism in place for measuring the quantity of workload activity. In 12 of the districts, managers were attempting to evaluate the quality of nursing care, though there was considerable variation in the sophistication of the approaches being adopted, the most popular being that of quality assurance. The main constraints to developing optimal community nursing services were expressed as: finance, staff shortage, and staff reluctance to change. Furthermore, some managers expressed reservations about the benefits to nursing of general management appointments. One manager commented "nurse managers in the field have no one to fight for them at a senior level, and general managers are not aware of the complexity and enormity of community nursing tasks" (p. 1416). Despite their disillusionment the researcher (Jacoby, 1990) stated that the managers' professional skills and commitment to the service were evident.

Due to the rapid changes in the UK, NHS Community Care Service, Traynor (1994) reported on preliminary findings from research being carried out on how community nurses and their managers were responding to changes. A measure of job satisfaction was

devised for the study and administered to the entire nursing workforce in the participating Trusts. Semi-structured interviews were carried out with managers at all levels in each of the Trusts. The preliminary findings arise largely from the first round of 24 tape-recorded interviews with trust managers, the comments added to the first round of questionnaires by 368 community nurses and discussion and observation at 35 meetings of community nurses and local managers. Traynor (1994) concentrated on the data arising from the study dealing with how nurses understood the values of managers and how managers viewed the nurse's value systems and perspectives.

Nurses described themselves as strongly orientated towards delivering personal care and drew their sense of meaning from this powerful special experience of caring. When they were unable to meet the client's needs of care due to the intrusion of paperwork, meetings or the pressure of workload, this caused them stress and dissatisfaction. They felt managers were 'out of touch' with patient care and well-being and too concerned with statistics and finance. Nurses also expressed a sense of profound powerlessness in the face of financial forces and the dominant values of management and government and those who held the 'purse strings'. Nurses felt managers did not share their philosophy of care and as the managers have the power to grant or withdraw resources, many nurses felt insecure if they believed that their work was not understood or valued.

On the other hand, managers' views of nurses identified five items; nursing outcomes, nurses' limited perspective, nursing as fearful, nurses as 'headless chickens' and nurses in traditional roles. Managers in general felt nurses were threatened by the language of management, finance, change and accountability. One nurse executive stated her interest in staff satisfaction was linked directly on positive effects to the organizational goal. A second nurse executive felt nurses went around like 'headless chickens' being all things to all people and not using the benefits of time management or reflective practice. She also expressed the necessity for nurses to quantify and qualify their work. Thus, it would appear that nurses tended to express their beliefs about managers as a series of us-them oppositions while the comments of managers were within a rational/irrational dualism. The researcher Traynor (1994) acknowledges that questionnaires can have a limited value in determining how nurses spend their time. One can only speculate as to the meaning of the negative comments from both nurses and managers.. It is possible according to Traynor (1994) that the nurses voiced their dissatisfaction and sense of alienation in terms of a care versus money dichotomy. This may be because it is both an easily visible target and a socially laudable contrast. It could also hint at something deeper such as a sense of alienation from management and government. Conversely, managers portrayed nurses as irrational, suspicious and almost unprofessional in their attitude to change. However, in today's economic climate of cost cutting, the nurses may have legitimate cause to be concerned.

The quest for evidence based practice at all levels of healthcare has become an important professional issue for nurses. In the UK in particular, service managers are required to ensure that care delivery is efficient, effective and relevant to improving the health of the population (Department of Health and Children, 1997). Managers also have an explicit responsibility to ensure that the service becomes more responsive to the needs of the users. It is the opinion of Kenrick and Luker (1996) that community health service manager's responsibilities, whilst remaining loosely defined, are perhaps becoming more complicated. The service manager has a pivotal role in ensuring the delivery of a high quality and low cost service. In meeting this objective, perhaps the main problem facing the service manager is balancing the competing demands of government policy,

professional interests and the needs of service users. Managers are often faced with a dilemma as to how to maximize their resources for the greatest benefit. Kenrick and Luker (1996) conducted a study which investigated five different providers of community health services from the perspective of the management practices operating in them, and the effect this may have had on research utilization in district nurses' clinical practice.

Interviews using a semi-structured schedule were utilized with twenty-two service managers. The schedule identified four areas for discussion: a) the manager's personal background; b) the organization's structure; c) organizational processes; d) extrinsic factors. During the pilot study the NHS was undergoing major reforms and the managers were reluctant to discuss sensitive issues relating to the organization and its structures during this period of uncertainty. However, once the researchers turned off the tape recorders the discussions changed in both nature and content. Thus the key to eliciting useful data about the organization was dependent on the rapport between the researcher and the manager and the feeling or threat on potential dangers in expressing opinions. The strategy for analysis was line-by-line content analysis and codes were developed to describe the recurrent themes within the data. The findings focused on the individual management styles identified in the five study sites. Two of the managers were men, the remaining twenty were women and 16 of the respondents were aged over 40 years. These findings are consistent with what would be expected in these positions (Salvage, 1995). Of the 22 managers, 20 had a nursing background and 18 had progressed through the professional ranks. One manager had been promoted by the employing authority due to her perceived managerial potential and underwent an intensive management training course. Another manager was a Bachelor of Nursing Graduate who had taken responsibility for her own professional development. The remaining two managers were graduates of the National Health Service's General Management Training Scheme (GMTS). In addition, eight of the managerial respondents believed that they maintained strong clinical insights and an understanding of the issues which were important to district nurses. However, Dean (1990) suggests that nurses in management positions place emphasis on managerial functions at the expense of clinical responsibility, which may not be in the best interests of evidence-based patient care.

Twenty of the twenty two informants had received some training specific to their role. The remaining two were senior clinical nurses acting in a long term temporary basis. However, the amount and types of training varied considerably between individuals. Four of the managerial informants from one established Trust had attended a management development programme to equip them with the knowledge and skills necessary for a new role. Their comments reflected their socialization into their new roles by use of terms such as 'performance' and 'service output' when discussing the management of district nursing services. The researchers (Kenrick, Luker, 1996) commented that this appeared to occur at the expense of their professional identity. The training of managers in the other districts was of an ad hoc nature and Kenrick and Luker (1996) described it in terms of 'old' and 'new' styles of management development. The 'old' style being predominantly experientially based and the 'new style' as being founded on structured programmes around the individual's identified training needs. To illustrate, one of the 'old' style managers stated "I'm very experienced, I've been doing the job for years. I don't really need it (training), but I go to planning meetings and seminars" (p. 702).

In contrast to this, the 'new' style of management training focus on structured programmes e.g. GMTS for those individuals who have a particular interest in management. While this may be more appropriate for management practice it still leaves

the question concerning the need for evidence-based management practice unanswered. To summarise, it appears that a training which provides a balance of management issues combined with clinical practice issues would be the most appropriate in accomplishing evidence-based practice both from a managerial and a clinical practice perspective. In four of the districts the reporting arrangements and the managers' extent of control of clinical staff was remarkably similar. The manager had a very clearly defined place in a strict hierarchical structure, with direct lines of reporting. Only one study site had an organizational structure that was very flat. The service managers in this district were all graded as clinical nurses, carried a nominal clinical caseload and reported directly to the director of services. The management arrangements in this health district were differentiated both by their structure and in their use of clinical symbols. The researchers (Kenrick and Luker, 1996) stated that by giving the service managers a clinical identity, the organization was stressing the central importance of clinical work and that, as a consequence, its ethos was perhaps more receptive to research utilization in clinical practice. Part of the process of care delivery is the effective use of resources, which is the services manager's responsibility. In this context, the managers need to ensure that their own practices are evidence-based and also that the district nurses in their charge are able to deliver the best possible care.

Closs and Cheater (1994) suggest, that in order for effective evidence-based practice to be carried out by nurses, a positive organizational culture is necessary. In this context, if service managers can ensure that clinical practitioners make the best use of their knowledge and skills, they would probably find that generally, efficiency of the service was improved. Furthermore, clinical nurses would benefit from knowing that their practices were making a contribution which not only met the needs of the client and the organisation but also satisfied their own professional values. The implications of the above for the management of Irish public health nursing are not clear. Presently there are two tiers of management, senior public health nurses and superintendent public health nurses. Based on the above, it would appear that managers require a training which provides a balance of management issues combined with clinical practice issues as the most appropriate in accomplishing evidence-based practice both from a managerial and a clinical practice perspective.

Summary

The debate on specialist versus generalist in the community continues to be fraught with ambiguity in the literature. Within this debate are the concepts of expertness and professionalism. Schon (1983) argues that a distinct specialist contribution to community care must be firmly bounded based on clinical competence, scientific and standardized. Thus a minimum educational level is required by specialist nurses. A university education which includes in the curriculum; epidemiology, demography, community structure and organisation, community development, management programme evaluation and policy development is recommended by Kelly (1997). These are all community focused activities which are presently included in the Higher Diploma for public health nursing in Ireland.

In some countries, such as the UK and more recently in Ireland, practice nurses are being considered 'community nurses'. However, from reviewing the literature, it appears that their roles and responsibilities are 'illness' focused and not 'community as client' focused as are community health nurses. Furthermore, they appeared to assume responsibilities for many activities for which they may not be adequately trained. Thus

their educational requirements and effectiveness needs reviewing in light of their contribution to primary health care practice. The role of the nurse practitioner in the community remains controversial. Researchers contend that the only means of assessing whether the public both desire and require an alternative professional at the point of access to health care is through further provision and evaluation of nurse practitioner schemes. Another specialist in community nursing is the liaison nurse where services, according to the literature, ensures continuity of care for patients by facilitating hospital discharge planning and the delivery of services in the community. The role is severely constrained as liaison nurses do not generally make discharge decisions.

Research on community nursing management shows great variety in the management educational preparation of nurse managers. It appears that training which provides a balance of management and clinical practice issues is most appropriate in accomplishing evidence-based practice both from a managerial and a clinical practice perspective.

CONCLUSION

With the development of primary health care and the new public health movement, commencing with the Declaration of Alma-Ata in 1978 (WHO, 1978), has come an international move towards more balanced health systems, focused on health promotion, disease prevention and on illness management. Community health nursing, which embraces primary health care, requires a focus on social justice, equity, community participation and responsiveness to the needs of the population.

Community nurses internationally appear to be striving towards providing equal access, high quality care services to their clients. In Ireland, public health nurses provide both curative and preventive care services. They work as generalists in a defined geographical area and their education at university provides a community focus. To enable them to develop the public health element of their role would require more resources to be deployed. Furthermore, no evaluation studies of the public health nursing service have been conducted in relation to quality, accessibility and efficiency of the service. In the UK, there are several types of community nurses with increasing numbers working from GP practices unlike in Ireland where all public health nurses are geographically based. The concept of the primary health care teams, providing comprehensive and high quality care remains a contentious issue for community nurses. There is a dearth of literature pertaining to the effectiveness of community nursing services in the UK.

In Finland, public health nurses are concerned with both curative and preventive care in a defined geographical area similar to the Irish model of community nursing. However, unlike their Irish colleagues, Finnish public health nurses make considerably less home visits. Their population responsible principle project has been evaluated both from the public health nurses' and the clients' experiences. While these studies were beneficial to the organisation, a study examining its effectiveness would enable the services to be improved accordingly.

In the USA, there is a clear distinction between public health nurses and community nurses where public health nurses' focus is the community. The services described in this paper were the visiting nurse service of New York and the Visiting Nurse Association of Greater Philadelphia, who are funded by Medicare and Medicaid. They provide a number of programs for various types of patients and employ both public health nurses, community health nurses and specialty nurses. However, as the total population are not entitled to either Medicare or Medicaid, the services of community nurses are not equitable or accessible to all, which contradicts the WHO (1978) health for all by the year 2000.

In Canada, each province is responsible for establishing its own health policies, thus there are twelve ways of organising community nursing in Canada. In this paper, the discussion focused on the services provided by the Victorian Order of Nurses and the St. John's District Health Unit. The VON provide home care nursing and preventive care similar to public health nurses in Ireland and Finland. However, the VON's public health nurses' role is specifically that of health promotion and assessment of groups at risk. Registered general nurses are mainly concerned with home nursing care. St. John's Health Unit Organisation provides preventive services and employs public health nurses only. Public health nurses in Ontario work as generalists since September 1997 and are employed by the public health services. They work in a defined geographical area, and refer to their colleagues for advice and support in their areas of specialty. They work on a community level with the population, deciding what the issues are for them. Research has been conducted examining the effectiveness of services which has proven beneficial when applying for funding for their service.

In the Netherlands, public health nurses are employed by the public health services, responsible for environmental health and children from four to nineteen years of age. As previously explained, information regarding this service will be included in this paper at a later date. The Cross Association are the largest home care organisation in the Netherlands and employ four grades of nurses in the community. They work in basic units in a defined geographical area with community nurses specializing in child health care and general and auxiliary nurses providing general care. Research indicated that patients receiving community care were predominantly elderly and female, similar to a study conducted in the UK. Research pertaining to community nurse effectiveness was not found, however research was conducted which examined the accessibility and quality of care provided by trained maternity workers from the patient's perspective. This found the service to be personalized, inexpensive and contributed to client satisfaction.

In New South Wales in Australia, community nurses work as generalists from community centres and are responsible for a defined geographical area. They provide both curative and preventive care.

The debate on specialist versus generalist nurse in the community continues. Within this debate are the concepts of expertness and professionalism. These issues are discussed in the literature in relation to level of educational preparation. Practice nurses, both in the UK and in Ireland are described as 'community nurses'. However, research indicates that roles and responsibilities of practice nurses are 'illness' focused and their educational requirements need to be reviewed in light of their actual and potential contribution to primary health care practice. The number of community nurse practitioners is increasing in the USA. Researchers contend however that provision and evaluation of their work and impact must be conducted if they are to become fully accepted as practitioners by the public. Discharge liaison nurses are considered valuable members of the community nursing services. They ensure continuity of care between hospitals and the community. However, absence of decision-making authority related to discharge severely constrains the role.

The research on management issues in the community showed great variety in educational preparation of managers and attitudes to education in management. It appears that an education which provides a balance of management issues, combined with clinical practice, may be most appropriate. To ensure an efficient service, that includes quality, effectiveness and accountability necessitates tailoring the organisation to identify population needs. The delivery of a community nursing service is dependent on the correct

utilization of resources and personnel. Evaluation of this service is essential to measure outcomes, indicating health gain and social gain. The correct use of appropriate tools is crucial in measuring health outcomes whilst acknowledging the difficulty in achieving this. This factor singularly indicates the requirement for further research. A model of community nursing service which encompasses the concepts of primary health care and encompasses the concepts of primary health care and health promotion would appear from the literature to be the optimum solution. However, before any changes are considered, a model which epitomizes the aforementioned desirable characteristics, such as Finland, need to be examined more closely, and possibly piloted.

In conclusion, the author acknowledges that public health nursing in Ireland has much to learn from the international perspective, but believes that this service has the potential to achieve the delivery of an effective, efficient community nursing service.

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APPENDICES

APPENDIX 1

SUMMARY OF CIRCULAR 27/66

1. Assisting District Medical Officers at clinics and dispensaries.
2. Domiciliary nursing in co-operation with the appropriate Medical Practitioner, including nursing of the aged and the chronic sick.
3. Compilation of a register of elderly persons with regular visitation, advice and assistance.
4. Domiciliary midwifery services where required.
5. Follow-up of at risk children in conjunction with the family doctor.
6. Aftercare of discharged psychiatric patients and duties relating to persons with mentally handicap.
7. Duties relating to Child Welfare Clinics and school health examinations.

Source: Department of Health (1966). District Nursing Services, Circular 27/66. Dublin: Stationery Office.

APPENDIX 2

% of Total Nursing Time (Burke Report)	
Category of Activity	% of Time Spent
Home Nursing	44.0
Child Welfare Visits	15.0
Ineffective Calls	0.6
Clinics	12.0
School Inspection	5.3
Team Consultation	3.0
Supportive Care	5.0
Clerical	15.0

Note: "Clinics" includes dispensary work. Most of the figures have been rounded to the nearest percentage point.

Activities in Home Nursing: % of Time Spent	
Activity Description	% of Time Spent
Care of Elderly Sick and Geriatric Surveillance	50.1
Leg Ulcers	14.0
Other Dressings	9.0
Physical Handicap	5.0
Acute Nursing	6.8
Terminally Ill	5.7

Source: Burke, T. (1986), *Survey of Workload of Public Health Nurses*, Dublin: Institute of Community Health Nursing.

