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Welcome to the fourth edition of *Contexts of Nursing*. As with the previous editions, this volume introduces students to the theory, language and scholarship of nursing and healthcare. Since we prepared the first edition, our major objective has been (and remains) to provide a comprehensive coverage of key ideas underpinning the practice of contemporary nursing. This book is a collection of views and voices; consequently, the chapters are not all identical in nature. This reflects our position that it is important that students/readers engage with various (and sometimes conflicting) views to challenge and extend them. This will hold them in good stead for the future, as the discipline and profession of nursing continues to evolve, mature and develop within Australia and New Zealand and globally.

We have specifically sought out a range of contributors who not only reflect the dynamic nature of nursing scholarship in Australia and New Zealand, but who are helping to shape contemporary nursing in this part of the world. These scholars have been chosen not only because of their expert knowledge, but also because of their professional standing, leadership and the sometimes controversial stances they take on various contemporary issues. We have not sought to silence the controversies or quieten the debates; rather, we present them to you, the reader, as a stimulus for reflection, discussion and debate and as a catalyst to further develop your own positions on various issues.

We have explained previously why the notion of ‘contexts’ has appeal for us in conceptualising nursing knowledge as a fabric composed of theoretical threads. This ‘knowledge-as-fabric’ metaphor provides access to a number of other related ideas, such as weaving and tapestry. Some new threads have been woven into the fabric of nursing knowledge presented in this work. Selection of these topics was based on extensive consultation with nurses who found previous editions useful in undergraduate and graduate courses and in their educational development and practice. Of course student evaluations of the previous issues were also considered. In addition, a number of experienced nurse authors and editors provided useful critique and feedback, which has helped us in shaping this new volume. We hope that the new contexts and topics we have included in this edition will make the book truly comprehensive and contemporary.

Though we have updated and added new content to this edition of *Contexts of Nursing* it is based on the same aims and objectives that underpinned the design and development of the first edition of the work. Nursing knowledge and its foundational elements are explored and considered in relation to professional nursing practice and the context of healthcare. Our emphasis on pedagogic strength and accessibility, and the use of reflective questions and exercises to stimulate critical thinking and learning, has been maintained.

The editors acknowledge Elizabeth Coady, Libby Houston, Martina Vascotto, Jo Crichton, and the entire team at Elsevier, for their ongoing enthusiasm, encouragement, support and assistance in the preparation and production of this new edition.
Most of all, we thank our contributors, who have risen again to the challenge of developing engaging, scholarly and learning- and teaching-oriented work to stimulate reflection, discussion and debate.

John Daly
Sandra Speedy
Debra Jackson

Sydney, July 2013
LEARNING OBJECTIVES

When you have completed this chapter, you will be able to:

• explain the conceptual foundations of community health
• discuss the importance of primary healthcare to maintaining health in a community
• develop a working knowledge of community assessment
• be prepared to undertake public health surveillance for a range of issues compromising the health of people living in the community
• identify risks and opportunities in promoting the health of a community
• explore a range of contexts and roles for community nurses
• establish a set of realistic goals for maintaining the health of a given community.

KEY WORDS
Community health, public health, community nursing, primary healthcare, social determinants of health, health promotion
INTRODUCTION
As others have argued in this text, nursing is a contextualised activity. What nurses do, how they think about what they do, the research evidence that informs what they do and the responses of those they care for are all dependent on the context or situation. The community is one of the most interesting contexts of nursing practice; one that requires comprehensive and sophisticated assessment skills as a basis for planning interventions for various population groups and the community itself. In the community nurses require self-confidence, an attitude of inquiry, adaptability to different situations and the leadership skills to develop processes and programs. These characteristics are invaluable to community nurses as their role involves anticipating needs beyond the immediate health issue and setting. In many cases they are also the only health professional on site, which may be a person's home, workplace, school or recreational facility, day care centre or clinic. Community nursing is therefore multidimensional. The caring role is distinctive in being carefully and systematically tailored to the needs of each different community and the diversity of its people.

Caring for a community may involve joining advocacy movements to promote such things as healthy environments, services, accessible food and safe water, conducting research studies to identify risks and opportunities to shape people's access to health and health services, or helping community residents access the knowledge and skills to change or sustain the community themselves. Caring for the citizens of a community can involve home visiting, monitoring the health of population groups, such as farmers or inner city dwellers, or providing services for various groups across the age continuum from children to older persons. Each type of community nursing provides inordinate rewards, particularly when the outcomes to health and wellbeing are recognisable as having resulted from nursing work. This chapter explores the various community contexts within which nurses foster personal health and wellbeing, and community health and vibrancy.

CONCEPTUALISING COMMUNITY
Most people consider their community in terms of geography. We all live somewhere, even those whose lives are transient, including the homeless. A geographical community can be defined by a city, town or rural area, the region, country or continent. These geographies shape people's lives in sometimes predictable ways, and often determine the extent to which they have access to health services, adequate resources for living and care when it is needed. But closer examination of any particular geographical context reveals numerous variations. Planning care for residents of any community must accommodate the different needs and resources of men and women, young and older persons, people who are healthy, ill or living with a disability and those whose lives are affected by education, employment, financial resources, family and cultural factors and access to neighbourhood supports (CSDH 2008). These constitute the social determinants of health (SDH), and they are crucial to conceptualising ‘community’. Although each person has individual biological and psychological characteristics, we are all social beings, and our social interactions occur in the communities that define our lives. If a given community is unable to provide jobs, education or culturally appropriate care and support, the challenges inherent in living healthy lives or providing care for community residents are much greater than when these factors are accommodated. The social determinants (listed in Box 18.1) are therefore central to
HEALTHY COMMUNITIES: THE EVOLVING ROLES OF NURSING

the context of community health, as they are the key to building community capacity for health and wellbeing (CSDH 2008).

Another construct related to the social determinants of community health is the social ecology of community health. Healthy communities are the product of interactions between people and their environments, a synthesis of actions and interactions in the spaces people inhabit and the resources they use (McMurray & Clendon 2011). Baisch (2009:2467) describes this as evolutionary: ‘a dynamic and evolving process’ that creates community health. The ecological perspective also means that relationships between people and their environments are reciprocal. The interactions and exchanges that occur in any given community therefore benefit both the residents and the community itself. The dynamic nature of community health is essential to community vitality. In the community context, people are better able to achieve positive health outcomes when their health is understood as part of the overall ecology of their lives; when they live, work, play, study, worship or shop with a sense of belonging, in a safe, supportive and sustainable place. The ecological perspective demonstrates the close relationship between health and place. Health is created and maintained in places with relatively high assets for capacity building and relatively low community risks to health (McMurray & Clendon 2011).

As outlined above, communities can be conceptualised as geographical entities, a set of influential social determinants of health, the ecological relationships that arise from interactions between health and place and a set of assets or risks to capacity building. In addition, communities are influenced by change. Changing circumstances can create threats and/or opportunities for people whose lives are affected by such physical characteristics as global warming, natural disasters, fires or extreme weather events. Cultural changes also affect families, and therefore their communities (McMurray & Clendon 2011). For example, certain expectations or group norms can change over time, so that the current generation may behave in ways that differ from their forebears. These changes are evident in contemporary society in relation to such things as the acceptance of out-of-home care for young children and non-traditional roles for women. Other changes may arise from government policy decisions to develop or withdraw certain essential services people need to live healthy lives, or to create redevelopments or industries that either promote or inhibit living opportunities

Box 18.1
The social determinants of community health

- Personal factors: biology, gender, genetics, health and developmental status, coping skills, health practices, health literacy
- Family factors: culture, social status, financial resources, generational changes
- Social networks: social supports, neighbourhood assets, social changes
- Employment opportunities, working conditions
- Educational opportunities and supports
- Physical resources, climate, geographical features, developments and hazards.
or employment. Most of these policy changes have a profound effect on family life. For example, providing a baby bonus or other subsidy scheme for child support can encourage some people to increase the size of their family. Changing the age at which older people are eligible to receive a government pension influences the workplace by encouraging some people to retire at a certain age (McMurray & Clendon 2011). Providing disability insurance coverage to all families may have an effect on the workforce by freeing up home carers to return to paid work.

Most changes occur because of the interaction between a number of factors; for example economic factors, natural events such as climate change and policy responses to these changes (McMurray & Clendon 2011). One example of this type of change is evident in rural communities, where many farming families have found their livelihood threatened by the changing fortunes of producing certain agricultural products. Some have diversified their farms to produce goods that attract government subsidies determined by trade agreements with other governments, while others have simply downsized their properties and their productivity (McMurray & Clendon 2011). Many rural families have experienced dramatic health issues related to their changing fortunes, which have been exacerbated by the reduction of health and other services in rural areas. Another community change that has had a major impact on family life is the new wave of Fly-in-Fly-Out (FIFO) workers. The FIFO workforce has arisen from the resources boom in many Australian communities, which has seen many workers (mostly fathers) FIFO to mining sites, in some cases contributing to an erosion of family social life. Fathers spend inordinate time in isolation from services and social supports and the spouse or partner left behind (typically mothers) has had to adjust to living a large proportion of their lives as single parents, with little hands-on support for child rearing. These changing community conditions require people to adapt, to find supports outside the family and to become resilient in ways they may not have anticipated in previous stages of their relationships (McMurray & Clendon 2011).

Global changes such as the Global Financial Crisis and other economic problems have also changed urban communities. With the increasing trend towards inner city living in many capital cities, a large number of older city dwellers have found their lives disrupted by redevelopments that have left them unable to remain in their previously safe, predictable, affordable neighbourhoods. With the resultant need to relocate, many have had to access healthcare and other services that may not be quite as appropriate to their needs as they had experienced in the past. Since the information revolution and the rapid escalation of communications technologies, younger people tend to access health information from the internet and social media. However, the new technologies are often difficult for older people, who may have relied on health professionals for health information throughout their lives. In contemporary society there is a need for everyone to become health literate to make sound health decisions in everyday life (McMurray & Clendon 2011). A health literate community is one ‘where people are not only aware of the things that keep them healthy, but they feel confident and comfortable making choices that influence their health, and they are comfortable working with health professionals to improve their health and the health of their community’ (McMurray & Clendon 2011:16). The implications for nurses and other caregivers are important, as it is more time consuming to provide guidance and health education where people have little understanding of their condition, and there may be a need for repeated home visits and referrals to ensure that they receive adequate and appropriate care. A further factor that affects the pervasiveness of health
literacy in a community is the extent to which communities promote an ethos of participation. When community members are encouraged to participate in assessing their needs and planning strategies to address these needs there is a greater likelihood of successful outcomes. Without input from community residents, there is always the risk that service planning and therefore effectiveness of care may not achieve its intentions. This issue is important for all care providers and a critical element of primary healthcare.

**PRIMARY HEALTHCARE**

Primary healthcare (PHC) is a pathway to achieving health for all people. The principles of PHC revolve around social justice and the shared expectations of health professionals and the public (De Vos et al 2009). Clearly, this is an inclusive approach, where all members of the population are considered equal in terms of their right to health. In all contexts of care, but particularly in the community, nurses use a PHC philosophy to guide their work by recognising people’s right to equitable social circumstances, equal access to healthcare, self-determination and participation in all aspects of life (McMurray & Clendon 2011, World Health Organization (WHO) 2008). Because of this focus on inclusiveness there is an expectation that community members, rather than health professionals, have control over the decisions about priorities and resources that affect their health. In this respect, a PHC approach is empowering for the community (McMurray & Clendon 2011). What PHC means for nurses is that their role is to act as a resource for community decision making, encouraging health literacy among the population, and providing direction for people to achieve their self-defined goals. In many cases, the role translates into coordinating care. However, in other situations, the focus may be on health education targeted to a specific health problem such as care during a chronic illness; or a family’s need for guidance in preventing illness such as immunising a child or preventing falls in older persons. Even while providing education, there remains a focus on self-determination.

New Zealand was one of the first countries in the world to formalise a national commitment to PHC through government policy (Ministry of Health New Zealand [MOHNZ] 2001). Nurses and midwives throughout New Zealand have readily adopted the principles and practices of PHC to demonstrate their professional commitment to better health through PHC. The objective of nursing within a PHC framework is to accommodate people’s preferences and choices while ensuring that they have sufficient and appropriate information to make informed choices and the resources to support these choices (McMurray & Clendon 2011). Assessing their health, their information needs and the type of assistance they require can help foster self-determination when it is undertaken collaboratively, from a position of partnership. Partnerships between different sectors also lead to better planning. For example, when health, education and transportation personnel are all involved in planning services there is a greater likelihood that the right people will use the right services for the right reasons with the right outcomes. Partnerships between health and other professionals and those who need their services will help develop realistic solutions that not only are accessible and appropriate in the local community, but also suit the timing, conditions, social and cultural expectations of the individual or family requiring assistance (McMurray & Clendon 2011). From a healthcare system perspective, tailoring solutions to family and community conditions enhances efficiency and effectiveness, including use of appropriate, locally available technologies. These factors underline the importance
of context in community care. Within a PHC framework, plans are developed for the longer term, beginning with a focus on preventing illness or injury in the community, restoring people to good health once they have become ill, disabled or injured and arranging the structural conditions in their homes and communities to support their return to normal living. This comprehensive approach embodies health promotion, wherein the goal is to promote the structures, supports and decisions for good health (McMurray & Clendon 2011).

PUBLIC HEALTH IN THE COMMUNITY
Like PHC, the public health approach is also aimed at preventing disease and promoting the health of a given population. Public health initiatives are typically based on population-level data such as the rates and distribution of disease in a given population. An important public health focus is therefore on measuring and analysing certain diseases or conditions that may place a population at risk of illness or injury. The information is then used to plan interventions that will either treat the disease or condition, or prevent it from spreading further. This is an epidemiological approach: studying the risks of various diseases; accessing surveillance information on apparent or imminent epidemics; and identifying signs of vulnerability in a population. The object of public health interventions is to ensure the highest level of health for the greatest number of the population (McMurray & Clendon 2011). Like PHC the overarching goal is to work with communities to achieve equitable, accessible care that promotes health through culturally and socially appropriate community participation. Both PHC and Public Health are therefore aimed at encouraging people to become healthy, maintain health and wellbeing and control their health destinies.

ASSESSING THE COMMUNITY
There are numerous models, tools and guidelines for assessing community capabilities and existing levels of community health, some of which are compared in Table 1. One approach is to follow carefully prescribed rules for analysing assessments as a basis for planning care and promoting health. For example, the Epidemiological Model is based on a Web of Causation, whereby assessment includes defining the Agent (an infectious

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organism, for example); the Host (individual or group health status or behaviours such as the rate of immunisation); and the Environment, which includes the interactions between the agent and host (Valanis 1988). Another model is the Health Belief Model, which guides identification of a person’s perceptions about their susceptibility to disease or the seriousness or severity of a disease, modifying factors such as age, social class, knowledge or prior contact with the disease and the likelihood of action—their perceptions of benefits or barriers to taking steps to prevent disease or maintain health (Becker 1974). The model has been adapted for nursing in Pender’s Health Promotion Model, which further explained individual perceptions as cognitive perceptual factors. Cognitive perceptual factors include the definition, importance of and control over health (rather than a focus on disease) and acknowledgement of situational and interpersonal influences on whether or not people modify their health behaviours (Pender & Pender 1987).

Both Becker and Pender models guide identification of lifestyle factors and behaviours that may either be positive in triggering preventative actions, or have a negative effect in that they increase the risk of ill health or injury.

Another model for assessment that can be used to guide community change is Lewin’s (1951) three-step Unfreezing, Changing (Moving) and Refreezing model. Lewin developed the model on the assumption that we all live in a life space composed of experiences that are valued as positive, negative or neutral. Assessing and weighing up the driving and restraining forces that influence either complacency or a willingness to change and communicating goals and expectations clearly can help ‘unfreeze’ habits, and help people move their position to create sustainable change.

Green and Kreuter (1991) developed the PRECEDE-PROCEED model. This model begins with gathering diagnostic information: first, a social diagnosis, including such issues as education, community crime, population density, unemployment and other variables similar to the SDH. This phase is followed by an epidemiological diagnosis, intended to reveal rates of morbidity, mortality, disability and fertility. Next, a behavioural and environmental diagnosis is undertaken. Included are indicators such as dietary patterns, preventative actions such as safe sexual behaviours, self-care indicators and coping skills. The environmental diagnosis includes economic and geographic indicators of community health and services. Analysis of these factors is complemented by an educational and organisational diagnosis to reveal Predisposing, Reinforcing and Enabling factors that could lead to behavioural and environmental change. Predisposing factors include knowledge, attitudes, values and perceptions that may hinder or facilitate motivation for change. Reinforcing factors include the attitudes and behaviours of others. Enabling factors are those skills, resources or barriers that could help or hinder the desired changes. Following this phase, an administrative and policy diagnosis is conducted to examine the community’s capabilities and resources to respond to needs. With this level of assessment, implementation of changes can begin, based on careful evaluation of each of the previous aspects of the model (Green & Kreuter 1991).

The most effective assessments are those that consider the multidimensional and dynamic nature of community life as well as individual and family strengths and constraints. Accurate assessments should therefore include the known SDH in the population and be aimed at tailoring interventions to the community’s specific needs. The SDH may be embedded in the Health Belief and Health Promotion Models as Modifying Factors, and in the PRECEDE-PROCEED Model as part of the various stages of diagnosing community problems. In many cases, community nurses are guided
by their knowledge and familiarity with the community employing them to identify health issues and develop strategic plans for health promotion and intervention.

Some nurses like to adhere to the type of guidelines for assessment mentioned in the previous paragraphs. However, a slightly less structured approach such as the ‘Big Picture Assessment’ can also reveal information that may not correspond to the strict categories identified in the traditional models. This model is particularly useful when the focus is on visible indicators of community life and information on people-place relationships as well as health issues provided by community residents.

The ‘Big Picture’ assessment or ‘Lay of the Land’ approach often begins with the nurse conducting a ‘windscreen survey’, driving around the community to gain the ‘lay of the land’—a big picture of life in that context. Such a survey can yield information about spaces for recreation, transportation and access, child care services, the location of schools, clinics, hospitals and other health services, places of employment, the state of available housing such as whether there are affordable homes or whether certain sections of the community seem to be in decline. This type of information can also be confirmed by speaking to various community groups or by analysing records of community activities such as immunisation rates, public health indicators and data from other policy documents that indicate activities of the local council or other authorities (fitness programs, elder day care facilities). Community assets, strengths and risks can also be identified by being attentive to people’s visible health behaviours such as observing people out walking, older persons engaging in T’ai chi and/or parent get-togethers.

In addition to the ‘big picture’, talking to people often yields a wide range of information that shows the demographic ‘mix’ in the community—how many people in which population groups may require certain specific services (e.g. older persons, young children); the mix of cultures in the community; what people think about their lives; opinions about environmental strengths that may support healthy lifestyles or barriers to health. Once this information is gleaned, step two involves mapping resources—trying to understand the capacity for supporting health, the assets and support systems that may be mobilised for certain interventions. Phase three is aimed at identifying the key players who may help in establishing and supporting resources for health, while phase four involves identifying people and place relationships. In the final phase, assessment can take the form of a SWOT analysis to identify strengths, weaknesses, opportunities and threats to community health. A systematic approach to this type of assessment is outlined in Box 18.2 on the next page.

**COMMUNITY NURSING ROLES**

**Home visiting**

As mentioned above, there is a wide range of nursing roles in the community context. Perhaps the most well known of these is home visiting, which distinguishes nursing in the community from most hospital-based roles (St John et al 2007). Home visits are integral to ‘domiciliary nursing’, where a nurse may be employed by a government health department or private agency to provide care in either a person’s home or a group residence, such as aged care facility. The objective of this type of nursing is to maintain continuity of care for those who have been discharged from hospital following illness or injury, or to prevent hospitalisation or re-hospitalisation for those at risk of exacerbation of illness. In many cases continuity of care relies on caring for the caregivers, whose burden is often substantial, particularly where a family member is
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Box 18.2
An example of big picture assessment

PEOPLE
• demographic and psychosocial characteristics
• family caregivers
• communication networks
• professional and volunteer support systems
• community leaders
• community cultures, ethnic mix
• people–place relationships, connections

PLACE
• community geography (urban, rural, regional, remote)
• natural resources, access to land, water, food
• unique structural features
• community development capacity, formal and informal supports
• access to welfare, housing, home ownership, transportation, schools

HEALTH PATTERNS
• local burden of disease and disability
• social determinants of health
• access, availability, affordability of health and disability services
• local patterns of service utilisation

GATEKEEPERS
• intersectoral coalitions vs barriers to collaboration
• local, state, national health policies and priorities
• distribution of health professionals
• global factors (social, economic, developmental)

in the latter stages of life (Ward-Griffin et al 2012). Home visits are therefore focused on identifying and addressing the needs of all family members. Because of the need for family-centred care it is important for the home visiting nurse to understand health across the lifespan. In-depth understanding of developmental needs at each stage of life will help ensure appropriate assessments to assist people across all age groups, including new parents, their infants and/or other children, adolescents, adults and older persons (Mitchell & Ellis 2011, O’Connor & Alde 2011).

The home visiting nurse role is also a feature of some general practice (GP) clinics where nurses are employed by either the practice or a specialist surgeon to assist them with pre-surgical or post-treatment assessments and follow-up. These roles do not have specific designations, instead they tend to be negotiated by the nurse and the employing medical practitioner or surgeon. For example, a cardiac surgeon may employ a part-time nurse to conduct a pre-operative home visit to prepare the client
for surgery, assess their home environment to ensure adequate support for them on returning home post-operatively and provide any health education and guidance required by the client and family. Similarly, some general practitioners employ nurses to conduct home assessments and specific health teaching for chronic conditions such as diabetes, cardiac conditions or any other issue that may require ongoing monitoring, as outlined under practice nursing (below).

Historically, home visiting has been mainly concerned with assessments and minor treatments under medical instructions for such things as maternal and child care, child development concerns, chronic conditions such as wounds, diabetic or cardiac indicators or activities of daily living (Mitchell & Ellis 2011, O'Connor & Alde 2011). The home visit has always focused on holistic assessments, encompassing identification of physical, psychological, social and environmental needs and resources. However, in the contemporary healthcare context, the role of home visiting nurses has been extended to include a greater emphasis on the diagnostic role and provision of acute care in the home. Many home visiting agencies provide programs such as Hospital in the Home (HITH), and offer a range of services from diagnostic tests to treatments that can include intravenous infusions, pump infusions and a range of complex treatments (Duke & Street 2003). The breadth and protracted nature of these programs have shifted the focus from a public health orientation of surveillance and monitoring in the home to treatment and extended PHC planning which, in turn, requires advanced practice skills as well as technological skills, including expertise in information technologies.

Community nurses providing advanced care typically find this level of practice rewarding, particularly with the level of autonomy that comes with being a sole practitioner responsible for rapid and critical decision making. However, being a sole practitioner can also be daunting, and requires ongoing skill and knowledge development to inform clinical decision making and appropriate guidance for members of the community. In the home visiting context there are also unique concerns about nurse-client relationships. In the first instance, entering a person's home or residential domain of any kind is a privilege rather than a right, and must be carefully planned. Balancing client needs with the demands of the organisation is another consideration. Home visiting nurses typically have a daily caseload based on the mix of clients assigned to their care. Employers usually set a standard for time management of visits to ensure they are able to cover the type and number of client needs and allow sufficient time for the nurse to travel between visits and establish or maintain the nurse-client relationships. Time management techniques include maintaining adequate planning knowledge of the issues to be encountered in the home, with careful documentation of the goals of the visit and any preliminary plans for care (St John et al 2007).

Home visiting requires sensitivity to a multitude of circumstances. The invitation to enter a home needs to be respected, and often there are situations that have to be accommodated before assessments or treatments can begin. Sometimes the visit involves innocuous but important relationship negotiations such as sharing a cup of tea or sitting with a person until they are ready to disclose health issues. In other cases there may be a threat to the nurse's safety. In the latter case the nurse must be aware of the need to follow all agency safety guidelines (St John et al 2007). These typically include learning to 'read' the home situation for any threats to personal safety, wearing visible agency identification but refraining from wearing any jewellery or items that may attract unwanted attention, ensuring the vehicle and mobile phone are maintained and that there are no barriers to leaving the home quickly if any threat
arises. The latter situation involves staying in communication with the agency, and maintaining mobile phone access, especially to emergency numbers, at all times.

Once the visit has been completed, accurate documentation is essential. Documentation is usually completed using the agency proforma to identify the individual(s) assessed and/or treated, and the outcomes, extent and effectiveness of the intervention. Also documented are comments about client satisfaction with care or requests for changes, any diagnostic information including health status, new needs and/or services including those from other care providers, identification of resources and referrals and plans for continuing care. In addition to these formal categories of information, home visiting nurses often mention any preferences or features of the home or situation that may help the next nurse in conducting subsequent home visits.

Community child health nursing

Although there are some differences in titles across states (child health, maternal child health, child and family health), the role of the child health nurse in the community is relatively similar throughout Australia. In New Zealand child health nurses practise as ‘Tamariki Ora’ nurses or, for those employed by the New Zealand Plunket Society, ‘Plunket’ nurses (McMurray & Clendon 2011). In both countries, child health nurses are specialists who provide holistic care to children and their families in either clinics or home visits. Some child health nurses provide a range of services in primary schools, especially where there is no designated school nurse, including student screening, health education for teachers and parents and community engagement activities. Another type of specialised child health practice involves acting as the expert resource person in special schools for children with disabilities (McMurray & Clendon 2011).

In the clinics, child health nurses conduct developmental assessments on infants and children, but their practice also encompasses considerable health promotion activities. The role includes assessing and responding to individual needs, case management, home assessments, early identification and primary intervention of clients with psychosocial and mental health issues, group facilitation and multidisciplinary team functions to support parenting (Borrow et al 2011). Some nurses work in outreach programs that are aimed at developing parenting capacity, while others are attached to early learning centres. Most also conduct parenting groups, acting as family advocates and promoting family networks to share common issues and knowledge of local resources (Munns et al 2004). Throughout all of these activities the child health nurse maintains a focus on the community to promote community development and capacity building in partnership with parents and other members of the community (Borrow et al 2011). In the context of these activities a major goal is health literacy, enabling parents to develop the knowledge and skills they need to nurture their children through the developmental continuum and to maintain current and practical knowledge of supportive processes and structures in the community (McMurray & Clendon 2011). This embodies the advocacy role enacted by most community nurses.

School health nursing

School nursing is a multidimensional role combining child health, mental health, case manager, occupational health and team coordinator (Brooks et al 2007, Smith & Firmin 2009). School nurses (SN) in both Australia and New Zealand assess students' developmental needs, promote their health and wellbeing and intervene when they have health problems, all while advocating for a healthy environment in the school.
community that will also support school staff members. SNs' roles are slightly different for primary and secondary school. In Australian primary schools the role is focused on ensuring students are safe, healthy and ready to learn, and this includes developmental screening for conditions affecting learning, such as vision and hearing (McMurray & Clendon 2011). They also respond to children's needs for support in relation to diet, behaviours at school, issues related to the home environment and coping with stress. Like child health nurses, SNs working in schools where young people have disabilities often act as the mediator between the health and education systems. This aspect of the role includes liaising with teachers, parents, peers and others affected by the child's journey along the health and development continuum (McMurray & Clendon 2011).

An important aspect of the SN role is screening and surveillance for infectious diseases and developmental problems, which can also include administering immunisations. Careful documentation is a large part of this type of surveillance and monitoring, and is essential to organising referrals to specialist services when necessary and maintaining clear and sensitive communication between parents, other health professionals and education staff (Wallis & Smith 2008).

High school nurses tend to deal with student needs that revolve around adolescent psychosocial issues such as problems with parental relationships and other issues that affect students' mental health. These can include issues related to sexuality, risky behaviours or other areas where peer pressure causes conflict between the young person's struggle for identity formation and family or group norms (McMurray & Clendon 2011). Included is the need to help students deal with bullying, stress-related illnesses, obesity and prevention of chronic conditions. Nurses are also called on to work collaboratively with staff for vulnerable students, some of whom may have social issues such as family crises, immigration or refugee-related problems, poverty and violence or substance abuse, family relationship challenges or major personal issues such as pregnancy and/or sexually transmitted infections or a risk of suicide (Barnes et al 2004, Brooks et al 2007).

Some SNs also teach health education classes, either alone or in partnership with the relevant school staff member. Most SNs gain enormous satisfaction from the role, a substantial part of which is based on a trusting, socially inclusive relationship with students. Relationship building is seen as the key to supporting young people, being there at the right time to help them make positive choices when they are confronted with social issues (McMurray & Clendon 2011). A cornerstone to building this type of relationship is the need to maintain current knowledge of adolescent behaviours, and sensitivity to the changing nature of their social world, whether this lies inside or outside the school; for example, in the context of their social media interactions (McMurray & Clendon 2011). SN practice is therefore philosophically aligned with primary healthcare. It requires a balance between close engagement with particular students and promoting health and capacity development in the entire school community, which can be achieved by maintaining extensive networks with a wide range of personnel, family members and community resources (Smith & Firmin 2009, Wainwright et al 2000).

**Occupational health nursing**

Occupational health nursing carries the primary healthcare philosophy into the workplace, focusing on education, health promotion, clinical services, case management and other industry-specific innovations to keep the workplace and its workers safe and healthy (Guzik et al 2009, Marinescu 2007). Occupational health nurses (OHNs)
practise in partnership with workers and their employers to maintain healthy and safe working practices and a healthy and safe environment. The role requires diplomacy, especially in situations where the nurse participates with others in lobbying for safe working conditions, which may be costly to the employer. OHNs therefore need high-level communication skills, in-depth understanding of interpersonal and industrial relations and familiarity with professional and government standards and legislation. Other factors influencing OHN practice include knowledge of environmental issues, the context and expectations of the employing organisation, in-depth understanding of employer and union philosophy and policies, budgetary restraints and familiarity with the boundaries of OHN practice (McMurray & Clendon 2011).

In some cases, OHNs are responsible for safety in the workplace, while in others they may be safety specialists to provide first aid and develop injury surveillance and prevention programs. Irrespective of the extent of the safety team, nurses need to have sufficient environmental knowledge and assessment skills to conduct surveillance and monitoring of workplace hazards (McMurray & Clendon 2011). Ergonomic assessments are also important to understand the fit between the worker and their interface with the work environment. Ergonomic risks can include boredom, glare, repetitive motion, poor workstation–worker fit, lifting heavy loads or tasks that require the worker to assume an abnormal position. Physical hazards can include such things as extremes of temperature, noise, radiation or poor lighting. Biological hazards include exposures to chemical or various biological agents. Psychosocial hazards are those that produce inordinate stress, such as shiftwork, or negative interpersonal relationships on the job, such as bullying and incivility. Other employee assessments can include pre-employment health examination and updates during periodic health assessments. As with other nursing roles mentioned previously, careful documentation is a pivotal part of the OHN role, particularly when disputes arise over differences in expectations by employers and employees (McMurray & Clendon 2011).

Like school nursing, a large part of the role is in dealing with stress. OHNs can help monitor worker stress, providing education, counselling, worksite stress reduction programs or referrals to specialist services (Wallace 2009). Another workplace issue revolves around disaster planning, which requires close collaboration with emergency services, other health professionals and workplace health and safety personnel (Lobaton Cabrera & Beaton 2009). The OHN also needs to maintain current and high-level skills in first-aid procedures, crisis intervention and trauma management, including threats from workplace violence. For employees with chronic conditions or disabilities, the OHN provides liaison between the employee, their GP, PN, specialists, social worker, physiotherapist or other health professional, particularly as workers recover from injury or illness (Aziz 2009). Some OHNs maintain a range of health intervention programs to engage workers while they are recovering from an illness episode or injury. These include employee assistance for those with substance abuse problems, corporate smoking cessation, and workplace health and fitness programs. In many cases, successful implementation of rehabilitation or health promotion programs also relies on having an extensive referral network, which brings in the necessity to maintain intersectoral collaboration, a feature of PHC.

**Practice nursing**

Practice nurses (PN) are those employed by a general practice, but also includes New Zealand nurses attached to Primary Health Organisations. As mentioned above
some PNs are employed specifically to conduct home visits, but most work collaboratively alongside the GP in the practice. Some undertake practice management roles and quality improvements as well as clinical roles (Walker 2010). Because general practice is mainly concerned with providing primary care rather than primary healthcare (which has a broader focus on health promotion) many PN roles revolve around such primary care activities as chronic illness management (Halcomb & Hickman 2010). In Australia assessment, health promotion and monitoring of those with chronic conditions has evolved as an important part of PN practice, particularly since 2010, when Commonwealth policies began to fund PN activities through Medicare and Practice Incentive Payments (PIP). As a result, GPs now receive remuneration for practice nurses to undertake immunisations, provide wound care, cervical screening, assessments of older persons and management of conditions such as asthma, diabetes and mental health through the Chronic Disease Management Initiative (Halcomb et al 2005, Keleher et al 2007, Porritt 2007). Historically, the PN role was up to the employing general practitioner, but in response to government subsidisation of GP practices and a growing awareness of the knowledge and skills of PNs approximately 60% of general practices now employ a PN (Australian General Practice Network 2010). The scope of their practice varies according to the nurse’s expertise and experience, practice arrangements, the GP’s understanding of the role and the needs of the local population (Halcomb et al 2005, Keleher et al 2007). In rural areas, where there are acute shortages of GPs, the number of PNs is expanding and this is expected to demonstrate improvements to the health of the rural population. As PNs become more prevalent, one would expect greater clarity of their role for clients, GPs and other health professionals. Together with specialisation and accredited systems of education, this could help promote greater interdisciplinary collaboration and ultimately better access to quality healthcare for a broader segment of the population (Walker 2010).

**Nurse practitioners**

Nurse practitioners (NP) have been practising in Australia and New Zealand only since 2001, but this role is gaining legitimacy, as more NPs complete advanced education and clinical specialisation (Duffield et al 2009). In New Zealand some NPs work within the PHOs, while others are attached to agencies that require specialist services such as child health, family planning, sexual health or wound care. The focus of the NP role is on health promotion, education and extended practice, including limited prescribing, initiation and interpretation of diagnostics, referral to medical specialists and, in some states, admitting and discharging patients as well as approving absence from work certificates (Lee & Fitzgerald 2008). A growing number of NPs specialise in emergency nursing to help alleviate the pressure on emergency departments, and they have been found to improve efficiencies and quality of care in that setting (Searle 2007). Others work as gerontological NPs in residential or community settings, meeting the needs of underserved older persons (Caffrey 2005), and some NPs work in general practice settings. NPs are invaluable in rural areas, sometimes being the only health professional for vast distances.

**Rural and remote area nursing**

In Australia rural nurses are usually employed by state health departments or specific agencies, such as occurs in remote Indigenous areas, where the employer may be Aboriginal Medical Services (AMS). New Zealand rural nurses have developed special
rural nurse services for Māori such as ‘By Māori for Māori’ as well as a number of nurse-led clinics that serve rural populations (McMurray & Clendon 2011). The nurses in these New Zealand clinics are called ‘iwi providers’, and their services to vulnerable people in the rural settings are an integral part of New Zealand’s initiatives within the national PHC strategy. In all countries remote area nursing is challenging, particularly in terms of the isolation, which means the nurse, like others in the community, must deal with being at a great distance from friends, services and resources. Although there are financial incentives to practise in remote areas, this type of nursing requires broad knowledge of healthcare, including emergency care, as well as in-depth understanding of people, their physical, cultural and psychosocial needs and their strong connection to community (the people-place relationship) (McMurray & Clendon 2011). Remote area nursing typically means being the sole practitioner and treating a wide range of conditions from critical injuries to chronic conditions and the disabilities of ageing. Because remote areas often have limited choices for healthcare and restricted access to goods, services and opportunities for social interaction, the nurse is often placed in a multidimensional role as emergency nurse, mental health counsellor and community development manager (Allan et al 2007, Greenhill et al 2009, Wong & Regan 2009). These roles require advanced clinical skills, comprehensive knowledge of family and people-place relationships and a level of familiarity with cultures that will enable the nurse to act as a ‘culture broker’ or intermediary between people who hold various cultural beliefs about health and health care. Home visiting is usually an integral part of the role. In many cases, remote area and rural nurses also need technological skills for communication, particularly if they are expected to use telehealth systems (McMurray & Clendon 2011).

In both remote and rural nursing, working closely with the community where a nurse is on call 24 hours a day can be stressful, given that in small communities there is little separation between a person’s personal and professional life. Where there may be more than one health professional, maintaining relationships with colleagues outside of work can have an effect on the work dynamic as well as social relationships (Mills et al 2010). Some nurses relish this close engagement with community members and the opportunity to practise in a primary healthcare context, but the added responsibilities of managing a health clinic and supervising health workers who often leave after short periods of time can also be tiring (Hegney et al 1999). For this reason most employers make sure that nurses from other geographic areas who work ‘out bush’ have periods of respite to get back to their friends and families at least once a year.

**CONCLUSION**

In planning for the health of any community and its population there are a number of goals common to each of the roles outlined above. These goals are aimed at any activities that can create and maintain high levels of population health as well as fostering an ‘enabling community’, guided by the principles of PHC. They include the following:

- Encouraging empowerment of the population by adopting an inclusive, partnership approach to planning, ensuring authentic communication that will help people make their views, goals, preferences and priorities understood.
• Adopting a culturally safe and appropriate approach to planning, which requires knowledge of your own and others’ cultural preferences, norms and conventions.
• Basing plans on comprehensive assessments as a basis for promoting equity of access to healthcare and to community capacity building.
• Being mindful of health promotion principles: assisting people to become health literate while helping them rearrange the structures, supports and policy decisions for good health.
• Using appropriate technologies so that interventions are affordable, achievable and fit for the population.
• Including other sectors such as education, transportation and environmental plans in planning for community health.
• Acting as an advocate for the community in all nursing activities.

In addition to these common goals, effectiveness in community health nursing requires political advocacy; knowledge of the government and non-government structures that will help people achieve and maintain health. To help a community through such a multilayered, multidimensional role exemplifies the notion that high-quality, safe care for communities and the people who live there can only be achieved when the context of care is carefully considered in conjunction with the specific health issue being addressed. This geographic, cultural and socially embedded nature of community nursing makes it one of the most rewarding and inspiring roles in nursing.

REFLECTIVE QUESTIONS
1. Describe the role of nurses in establishing and sustaining healthy communities.
2. What are the key aspects of a community assessment?
3. What strategies would you use to promote a healthy community?
4. How would you use primary healthcare principles to guide community assessment?
5. How are community health nurses able to achieve public health goals?

RECOMMENDED READINGS

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