The role and scope of practice of Community Health Nurses in Victoria, and their capacity to promote health and wellbeing (Phase 2)

2010
Advocating for Health
Acknowledgements

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Introduction

In 2008, the Community Health Nurses Special Interest Group (CHN SIG), representing community health nurses in Victoria embarked on a two phased project to identify the role and scope of practice of community health nurses. The purpose of this project was to identify the direction the CHN SIG could take to represent their membership in strengthening the role of community health nursing (CHN) in primary health care in Victoria.

Phase 1 of the project explored the role of community health nurses (CHN) who work within community health services in Victoria and identified common characteristics of their health care delivery. Analysis of the data collected through a self-administered questionnaire about the role, nursing competencies and knowledge used in community health nursing, indicated that the majority of community health nurses regularly undertook advocacy (83.0%), needs assessment of individuals and family (75.5%), health education/health counselling (75.0%) and monitoring health status of individuals or families (72.5%). The nursing competencies the majority of community health nurses utilised regularly included referral to other services (88.5%), collecting data on clients’ functional status (83.0%), contributing to multi-disciplinary services (81.4%) and health education (79.6%). In undertaking their role, the majority of community health nurses drew on their knowledge of anatomy and physiology (87.6%), a social model of health (82.3%), primary health care and the social determinants of health (81.3%) and comprehensive assessment (79.5%).

In Phase 2, CHN described their role in more detail, expanding on the nursing competences and knowledge reported in Phase 1.

The objectives of Phase 2 are to:

1. Explore the manner in which community health nursing interventions identified in Phase 1 contribute to the communities in which they work and in doing so identify
2. Factors that influence CHN capacity to provide community health services

This report should be read in conjunction with ‘The role and scope of practice of Community Health Nurses in Victoria, and their capacity to promote health and wellbeing: Phase 1’.

Literature review

See ‘The role and scope of practice of Community Health Nurses in Victoria, and their capacity to promote health and wellbeing: Phase 1’ for a comprehensive literature review, which sets the context for this project.

Method

An experienced facilitator and interviewer facilitated four focus groups and two individual interviews involving 32 community health nurses from metropolitan, inner regional and outer regional community health centres. Participants commenced by describing what advocacy meant to them as community health nurses and then discussed its influence on their work. Transcripts of recorded focus groups and interviews provided the data for thematic analysis.
Analysis

The data provided examples of how advocacy in community health nursing contributes to the communities in which CHN work. Throughout the data, CHN consistently referred to their belief in the social determinants of health and the necessity for individuals, groups and communities, whatever their life experiences or backgrounds, to determine their personal and community health outcomes. The examples of CHN practice in the data reflected where CHN direct their resources; to high risk or marginalised groups such as adolescent mothers, the aged and those who care for them, people from culturally and linguistically different (CALD) groups, people with disabilities, people living with HIV and refugees, for example.

Advocacy Themes

CHN acknowledge the complexity of the health system, largely driven by a bio-physiological, individualist, authoritarian, and ‘top-down’ model of health. The CHN experience of working within a complex health system combined with their commitment to the social model of health places them in a unique position to advocate with individuals, groups and communities.

CHN view advocacy as part of community development as it involves collaborative, participatory relationships with the community.

‘For me [advocacy]... would be ensuring that I am embedded in the community and have a relationship with my community and then taking the community needs, health in particular, and then being able to go and access programs and funding to provide health promotion and education and promote good health in my community’ (CHN - Generalist: Focus Group 2)

‘... sit down with young people and say well, OK it sounds like we need to develop some material around delivering childbirth education, lets have a chat about how we are going to do that’. (CHN - Childbirth Educator: Interview 1)

Three advocacy themes emerged from the data: ‘giving voice’, ‘encouraging agency’ and ‘standing beside’.

Giving Voice

An essential component of advocacy for CHNs is to let their client, group or community speak; to listen to what they are saying they want.

‘We listen to our clients I guess, don’t we? We follow what they want rather than what we perceive they need’ (CHN - Generalist: Focus Group 1)

‘... it’s about meeting people where they are and listening ... taking on board ... with the listening, that’s then advocating... working with the community, hearing what the issues are for them’ (CHN - Generalist : Focus Group 3)

‘I think it’s about listening to where they’re at, getting their understanding of what their needs are. (CHN - Diabetes Educator: Interview 2)
The willingness to listen comes from a belief that what the speaker has to say is worth hearing; that what they have to say is equally as important as the opinion of the listener. CHN work from the premise that by listening, they are:

1. **Building trust:**
   
   ‘If they could see that I was listening to what they said they needed help with, and I was responding and coming up with the goods, then they were keeping connected with me and we built trust and then I could go on from there and do the more educative stuff …’ (CHN - Childbirth Educator: Interview 1)
   
   ‘It’s about trust too. I think that’s a special thing that nurses have; that people trust us and we have a bit more time than other health professionals’... how often do people come into your office and disclose something personal about their health or their family’s health and it’s only because you are a nurse that they’re doing... It doesn’t happen to the physio next door or the podiatrist... (CHN - Generalist: Focus Group 1)

2. **Assessing:**
   
   ‘... about the client’s perception of their own health. I mean it is all very well for us to go through everything to find this but it is terribly important to find what their perception is’. (CHN - Generalist: Focus Group 2)
   
   ‘... we were listening and hearing client’s stories, ...so there was clearly a whole lot of assessment work going on …’ (CHN - Generalist: Focus Group 3)
   
   ‘... she gave that statement to me, so I explored why that ... and just got her to talk. We also ask the questions... open questions, not closed questions. It’s being not afraid to ask “why is that?”...Other people can ask the same questions and they don’t get the same responses but they... I think it is something perhaps about the way that we are trained or something.’ (CHN - Generalist: Focus Group 1)
   
   ‘... there is a skill in actually hearing something; you’re writing... it’s just like... no there’s something more there. There is another question that needs to follow from... this. So if the client is telling you something ... it is what you do with that.... I [ask] something and suddenly it just opens up. It’s just one extra question and gives more information and it’s OK, then what do you do and it’s writing down what would the client like to do with that’. (CHN - Generalist: Focus Group 1)

3. **Learning:**
   
   ‘... we just sat and chatted to this lady and then came out and [the CHN] said all these things that she’d achieved and learnt’ (CHN - Childbirth Educator: Interview 1)
   
   ‘[The clients] were so empowered about their own health; ...that was a total eye opener to me [CHN]’ (CHN - Nurse Consultant: Focus Group 3)
   
   ‘... the assessment gives you the knowledge to be able to take with you in your advocacy at whatever levels. If you are going to advocate, [at a community level] you’ve got to have some knowledge, some
understanding, some assessment data to take with you’. (CHN - Generalist: Focus Group 3)

Encouraging Agency

There is an underlying assumption in CHN work that clients have the ability or capacity to develop skills to improve their health outcomes. CHN work with people at an individual, group or community level to facilitate their health literacy skills so that they have the confidence to:

1. express their own or their community’s health needs

‘To me advocacy is about walking hand in hand so the client obviously has some skills and needs and you have some skills ... and I think it’s about working with people and walking along side each other in order to implement change’. (CHN - Childbirth Educator: Interview 1)

‘... it’s also encouraging people to learn to approach other professions so you identify where there might be a problem, do the education about that, ... you might give them the referral themselves to take in and discuss ... The reasons why you do that, you explain to the person so that they’ve got more strength’ ... ‘I’m working with a young woman at the moment, ... I’ve linked her with a service, ... she actually talks for herself. We talk about what do you [want] to get out of this meeting, and then ... the actual person who we’re meeting with talks to her’. (CHN - Generalist: Focus Group 1)

2. navigate a complex health system

‘I think it’s my job to know who to send them to and to give them the confidence to go and seek that support’. (CHN - Generalist: Focus Group 2)

‘Often it’s about supporting the client to be able to navigate what is often a complex pathway ... It’s a very complicated system that we have’. (CHN - Nurse Consultant: Focus Group 3)

3. or develop knowledge and skills to assist them determine their own health outcomes.

‘...it’s informing the client of management options... getting them to understand their condition..., giving them resources and options to look at other alternatives for management and it’s about empowerment too... and, trying to assist them to find better ways, options, look at options of care or options of management’. (CHN - Diabetes Educator: Interview 2)

‘... help them break through some of the barriers that prevent them from making the most of their lives. ... it’s also about building a skill base ... with my young mums ... the potential for them to go back into some form of education or training to skill them up to improve their outcomes further down the track for them and their children. ... but also to use them as a resource to go and talk to young people who are, I think, ... much more receptive being spoken to by their peers rather than old people like me’. (CHN - Childbirth Educator: Interview 1)
Standing beside

Often nurses describe their role as ‘supporting’ people or community. In the data for this project, the nebulous term ‘support’ consistently refers to CHN metaphorically ‘standing beside’ the person, group or community while they make and implement decisions. CHN provide people with opportunities to access and interpret current and relevant information to give them the confidence to make informed decisions that are right for them and then ‘stand beside’ them while they implement those decisions even when, with the best intentions, family, friends or the complex health system try to convince them their choice is wrong.

‘I think some of it is about empowering the person, the client; sort of giving them the knowledge and the courage to actually advocate for themselves. And then being their backstop; supporting them …’ (CHN - Generalist: Focus Group 1)

‘Often it’s about supporting the client to be able to navigate what is often a complex pathway … It’s a very complicated system that we have’. (CHN - Generalist: Focus Group 3)

‘… That’s OK and supporting her in doing that if that’s what she chooses to do… it’s helping [her] realise that she doesn’t have to be sticking with this particular person in this system if it’s not meeting her needs’. (CHN - Childbirth Educator: Interview 1)

‘… what the GP may want … very conflicting with what the client wants. Often we do a full plan, about the issues; what they want and actually work with them about taking it back to talk to the GP. Education, say with an asthma assessment, talking about the role of spirometry, written action plans, those sorts of things… encouraging them to see their doctor, about making a return appointment… supporting them with a letter to the doctor about findings and recommendations. And when they come back, there’s review, see what’s happened and have those things happened and if they haven’t happened, then we take the next step’. (CHN - Asthma Educator: Focus Group 1)

Factors influencing CHN practice

Nursing knowledge underpins the advocacy principles that CHN apply to their practice. Nursing knowledge includes knowledge of the social determinants of health, knowledge of the health system and its component services, knowledge of the local community and its support services, knowledge of human structure and function, knowledge of the disease process, an understanding of pharmacotherapy and assessment skills. CHN emphasis and priorities differ from nurses working in other areas of the health system. CHN express their knowledge and skills within a social model of health. These differences were reflected in their discussions.

When asked directly, CHN weren’t always able to articulate the theoretical or philosophical basis that informed their practice. Some identified the preparation for practice in their nursing training.
'It’s also your training I think. I think a lot of it is about training and knowing and using the system and a huge part is assessment' (CHN - Generalist: Focus Group 1)

‘Best practice guidelines’ (CHN - Asthma educator: Focus Group 1)

Those who identified a theoretical model emphasised the social determinants of health and agency:

‘... theoretical social model of health, ... advocacy, ... enabling, ... mediating, all the theory around that as well as plunging myself into it was really helpful so I suppose you bring along all that knowledge’ (CHN - Generalist: Focus Group 3)

‘I think in my case it was more the actual sector; ... so empowered about their own health’ (CHN - Nurse Consultant: Focus Group 3)

Social model of health

Despite the lack of a shared understanding of the theoretical underpinning of their practice, CHN understanding of the social determinants of health does appear to drive their work in promoting advocacy in health.

‘I have a strong commitment as a nurse ... around the importance of ... the social determinants of health. The fact that ... if you address a lot of those issues with people, you’re going to get on top of their health concern. ... I just literally can’t see any other way of working. To me it’s so blatantly obvious, that you just work better working from a social model of health. ... I think ... when you work in the community sector, you are ... confronted with the issues. When you think about the social determinants of health, you’re confronted with that on a daily basis... So I suppose for me, being a nurse working in the community sector, it’s been a lot easier to commit to and also to believe in how the social determinants of health affect people’s health and well being’. (CHN - Childbirth Educator: Interview 1)

‘[CHN] don’t work from a medical model; they look at the individual and what’s going on in those circles so the mum whose child ... don’t tell her about a medication. She’s got no home; partner’s just left her ... it’s about those broader determinants [of health]. Until those issues are addressed ... people can’t concentrate on medication’. (CHN - Nurse Consultant: Focus Group 3)

The multi-disciplinary team

Working within a social model of health CHN promote learning and health literacy within their multidisciplinary teams.

‘... one of the unique things of working as a community health nurse, is that you get to work in a multidisciplinary team and you get to learn from other clinicians or other disciplines and you get to work together about what is the best outcome for that client. It’s not just about the nursing, what the nursing role might be. ... you really get to know what the other disciplines do and how to ... start thinking about prioritising someone’s problem because you are actually learning all the time. ... and nurses are probably very open to learning everything rather than just sticking to one
little thing. ... we sort of feel compelled to ... because you feel as though you should be on top of the broad spectrum of what is going to present to you. (CHN - Generalist: Focus Group 1)

The CHN contribution to multi-disciplinary teams includes their nursing skills embedded within a social model of health:

1. Comprehensive and timely assessment
   ‘...the team leader has often talked about the fact that the [CHN] on the team are much more effective at identifying initial needs ... in making links and in drawing [out] information’. (CHN - Generalist: Focus Group 1)
   ... there’s something that’s inherent in you that somebody comes to talk to you and you take that whole person in and you, ... I understand about ensuring that we’re practising from a really evidence base, but there’s a knowledge base there that’s rich with understanding. ... ‘I always think that you’ve got about fifteen seconds when you get inside the door to empathise with a person and to make yourself comfortable with them. I think that’s a nursing skill ... that we know how to involve a person fairly quickly. Looking at their particular health needs, you can see if there are other health issues ... I think our skills of observation and assessment ... are essential nursing skills’. (CHN - Aged Care: Focus Group 3)

2. Knowledge of human structure and function
   ‘I think that everyone would bring ... the different disciplines to that social model of health. I think what the nursing bit does is that you have this broad understanding of the human body...about what makes us tick’. (CHN - Generalist: Focus Group 3)

3. Knowledge of the disease process and pharmacotherapy
   ‘Look they’ve got this ... can you explain to me a little more about this condition? ... They’re on this medication, how will this impact on them? (CHN - Generalist: Focus Group 1)
   ‘... what’s that mean, what’s that abbreviation for; what’s that medication ... what does this mean; ... it’s that generalist stuff again’. (CHN - Generalist: Focus Group 3)

4. Knowledge of services
   ‘I think you do a lot of secondary consultation with [the multi-disciplinary team], a lot more than you realise. Our brains get picked a lot. ...what would you do with this or, where would you refer this?’... I think we’re the first port of call for a lot of [service providers] ... if you don’t quite know where to go, they’ll ask [the CHN],’ (CHN - Generalist: Focus Group 1)
   ‘... Mostly [allied health] are doing clinical work and they find that their knowledge of other services is limited and so they, ... seeing their clients in a difficult place ... [ask] can [the CHN] shed some light or direct them ... or help them advocate ... or ... refer them... I actually don’t take on a lot of those clients; I just help the person work through what the options are. (CHN - Nurse Consultant: Focus Group 3)
5. Making connections

[CHN] have a really good understanding of holistic care ... they’ve got a good understanding of... chronic conditions, ... health, the effect of medical conditions, ... how this affects the client ... that it’s not just about the client; it’s about the people around the client;... the family, carers, community, all of that. (CHN: Diabetes Educator; Interview 2)

[CHN] are ... very committed to having a team approach... knowing that the best way of going about it for the success ... [is] to consult widely, to involve other team members ... the importance of communication. [CHN] are very good at consulting and taking into consideration other perspectives, around the importance of things like the social determinants of health. [You] know that if you address a lot of those issues with people, you’re going to get on top of their health concerns. So bringing that sort of perspective I suppose and knowing that it [is] really important [to] do a lot of planning [to] consult widely. (CHN: Childbirth Educator; Interview 1)

‘My biggest question when I started in the role was well how do you know? How do you know that this is what the community need[s] ... when you are not even looking at, there is an absolute black hole when it comes to local statistics, local information on health in rural areas’. (CHN - Generalist: Focus Group 2)

6. Care coordination

‘I think the nurses bring the cohesiveness to [the multi-disciplinary team]. I think the nurses ... do a lot of the coordination and care planning ... we give an understanding to how everything is linked in together and ... where it sits with the client. ... OK, we’ve got this multidisciplinary team, but in our notes ... there is no cohesiveness to each kind of documentation from the different disciplines. We still very much do our own discipline specific note taking and I think that’s where community health nurses bring it all together. They will look back ... over the other team member’s role in a client’s interventions so to speak and try [to] bring it all together and say well where are you going with this? Say for instance with podiatry, well what do you see the long-term goal for this person or the activity ... I suppose that’s what nurses kind of do ... they look at the big picture, and that you’ve got all these other players involved like podiatry and physio’. (CHN - Diabetes Educator: Interview 2)

Tensions in community health nursing

Community health nursing provides an interpretative bridge between the acute sector and the community. CHN knowledge of the language and customs, that is the culture of the acute sector is useful when advocating with individuals, groups and communities to make the health services work for them or assisting the acute sector to understand the ‘patient’s’ perspective. This interpretative role causes tensions for CHN. At times from nurses working in the acute sector, CHN are told they are taking the ‘easy option’ by choosing to work in community health. From some of their non CHN colleagues in the community health sector, CHN are being told their work in health promotion and community development is inappropriate because they should be working ‘within a medical model’ or that they are ‘too
expensive’ to be undertaking such roles. CHN find these attitudes incomprehensible, as they view health promotion, which involves advocacy and community development, as an important and integral component of community health nursing.

‘... my mates in the acute sector ... they can’t quite get their head around my role in ... community development. ... I’d say ... well if you think about someone who might be living with diabetes ... keep on unpacking it till we get to that broader social level ... it’s like it’s not real nursing; yet for me it’s me, I am a nurse...’ (CHN - Generalist: Focus Group 3)

‘... [build] more contact between the maternal and child nurses and young mums and they can get a broader picture of what’s the sort of issues for young mums and how are they as people. ... it’s just about resourcing, in this case, maternal and child health nurses to better understand what happens for young mums and what’s happening in their lives. And we’ve tried to do a little bit around, well post-natal wards ... ante-natal clinics ... around just being maybe a bit more supportive of young mums and sometimes a little bit less judgemental. I’ve tried sometimes to just maybe give them a slightly broader perspective.’ (CHN: Childbirth Educator; Interview 1)

‘I find it very difficult to distinguish between health promotion and nursing because a lot of my work is around community development. ... when I am working on a program that will promote health, will empower the community to achieve good health ... that to me is health promotion ... building the capacity of clients to seek help to change ... lifestyle behaviour change. (CHN: Diabetes Educator; Interview 2)

**CHN and community development**

CHN include advocacy and health education as part of community development and their legitimate contribution to health promotion.

‘... health education is a really important building block for health promotion ... I provide the health education in my role but then from there I say OK we have this information now how can you apply that? What services are out there ... part of health promotion ... is linking them in to other programs and other services so when they leave, they feel empowered that they can step forward with this information and this knowledge and you find once they start taking those steps forward ... doors open and that helps with their healthy living and their wellbeing.’ (Focus Group 2)

‘I think advocacy ... is central to the community development role ... it’s about meeting people where they are and listening. Rather than taking ... high risk issues for people and saying that person’s at high risk of ... I need to work with them or otherwise they’ll develop all these things; it’s about working with the community and taking that overall population risk away. It’s working with the community as a whole ... hearing what the issues are for them and then tackling it at that level. So for instance, one of ... the communities I was working with, we knew that there was high rates of chronic illness and when I went ... the things we worked out were things
around their safety; their perceived and actual ... ideas about their safety in their community... access to their local park. So there [were] a whole lot of wider, broader things happening for them.’

(CHN - Generalist: Focus Group 3)

**Trends in Community Health Nursing**

There is a perception that the CHN role is changing with a move away from the generalist role to more specialised and narrower roles. Funding streams focus on chronic illness with key workers with generic backgrounds, and CHN working in specialist roles in chronic illness. There is increasingly less emphasis on advocacy at a community level. CHN examples of community development were often finished with the rider of ‘like we used to do’ or ‘but not a lot now’. Nurses who were advocating within the health system needed to take on other roles within the community health sector to continue this work.

‘Well, I have ... a leadership role in terms of health promotion, ... and so getting, particularly allied health professionals on board to reduce ... the number of clients that they see and allocate a bit of time to working in a health promoting way has taken time. I’ve got some health promotion qualifications so I have a role ... in running ... introductory health promotion workshops with staff ... working with different teams around what it means to adopt a health promotion perspective in your work and how you can go about doing that and maybe reduce waiting lists’. I’ve been ... at Board of Management level... helping support the implementation of health promotion in the agency.

(CHN: Childbirth Educator; Interview 1)

In their specialist roles, CHN endeavour to maintain a focus on the social determinants of health and maintain their commitment to advocacy. However, they, like other clinicians, have far fewer opportunities to develop an understanding of the full potential of the communities in which they work as their generalist colleagues and draw on the knowledge of the generalist CHN as other allied health professionals do.

‘The diabetes educators do diabetes education. If it gets more complex.... they call us in for a consultation with them just to know the links; perhaps we’ve got more information about the links in the services around because that’s part of our role’. (CHN - Aged Care: Focus Group 3)

**Influencing the future of Community Health Nursing**

CHN believe the social model of health is being undermined by creating nursing specialists and allocating the role of generalist CHN to more generically qualified people to cut costs.

‘We are too expensive, we’ve been told... that’s what they’re looking at, that probably underpins everything, is the money; and we are not expensive, not when you look at what they get.’

(CHN: Diabetes Educator; Interview 2)

‘I suppose there will only be a particular focus on what that person presents with. That’s ... one thing that I can see ... that’s all some people will look at. They haven’t got the broadness of skills to pull it all together’.

(CHN: Diabetes Educator; Interview 2)
‘I can see our community health centre being very focussed on treatment based; treatment based for specific disorders...the medical model... and trying to get Medicare money’. (CHN - Aged Care: Focus Group 3)

While the changing role is recognised, CHN are not yet ready to withdraw their contribution to community development.

‘I think we are really... well placed to do that population health work because it’s about working with individuals in a community and getting rapport and relationship and trust and then working with ... groups of people ... then neighbourhoods ... extending that out to partners, stakeholders ... advocating with government about neighbourhood ... it’s just taking advocacy to a different level. ... We’ve worked out ... how we need to work to do that with ... other providers ... we are able to do it on a much broader spectrum and able to empower groups of people to do it for themselves.’ (CHN - Generalist: Focus Group 1)

‘Community health nurses can do [community development] ... we’ve done it. [W]e have some structure. ... we don’t network for the sake of it ... we do it with a purpose ... for an outcome ... the way we fit in and interact with our clients and our communities ... people let nurses into their homes and into their social groups and they are happy to discuss things with nurses. A women’s group .... involved key stakeholders within the community to say we won’t have it down in the middle of town because nobody will come. We need to have it over at ... another centre ... the meetings were held in the community. So it’s about looking from their perspective, not our perspective. That’s how we work’.

(CHN - Generalist: Focus Group 1).

CHN acknowledge that they could be better at voicing what they do and evaluating the outcomes of their work. The outcomes of which CHN appeared to gain the most satisfaction related to community development but are not reflected in the statistical data produced.

‘In the community ... that I worked with for over five years ... one of the things that was profound for me was, [when] some of the community members ... said. This is such a different community... everyone waves to each other now. They don’t peer out from behind the curtain anymore and stay behind their doors. They actually wave to each other. ... It wasn’t just about me. It was about our partnership work. And it wasn’t really about me or our partnership; it was about the community. The community had made that difference, in the work they were doing ... about ... the difference they wanted to make to their community’

(CHN - Generalist: Focus Group 3)

‘...she’s actually got employment out of it and she wants to work in the youth sector, so it’s been a real, huge boost to her confidence and her skill level, to be employed by the program.

(CHN: Childbirth Educator; Interview 1)
‘... the youth were getting into a lot of trouble with the shopkeepers ... a little group of them. We gathered them all together and we ran a fashion parade and we got all the storekeepers and we sent all the youth out; they had to do all the work themselves. They choreographed it. We did it in the main centre. ... But it was the most wonderful experience and ... three of them got jobs out of it. The storekeeper’s attitudes changed completely. It was really the most positive thing that happened in that place. It wasn’t the actual event; it was the process.’ (CHN - Generalist: Focus Group 3)

‘But that qualitative data ... is really important isn’t it ... your evaluation processes, that the people you are working alongside, that they contribute to that through their observations of what’s happening too. That evidence is really, really important I think in terms of indicators for the department ... the opening up of something like the positive living centre to people of CALD background that have never stepped inside is... you can’t beat that.’ (CHN - Generalist: Focus Group 3)

Evaluation of CHN influence on community health and wellbeing may be enhanced through qualitative activities such as narratives and case studies.

‘... the two community members actually told their story as a narrative [at]... a story telling health promotion workshop. They were the only people at that conference on that day that weren’t ‘a professional’ in italics [because] they are experts in their own [way], with their own body of knowledge. ... there was so much feedback from the participants around the story that these two women told about their community. It was really again a very significant moment...’ (CHN - Generalist: Focus Group 3)

‘... the hospital would [request] observed therapy on people, like give them their medication every day because it has been shown to work in TB so therefore it’s going to work for HIV. [W]e’ve got some great case studies; it’s taken us ... six to twelve months to get someone ... [to] the stage where therapy is an option and the hospital staff [say] ... but they’re going to die if they don’t take this. We go OK, housing, child care ... mental health... Treatment [commenced] but it took us over six months because they didn’t have stable housing ... her relationship had broken down. She had no money. She couldn’t even feed her kid. She wasn’t going to take and we weren’t going to go and do directly observed therapy on her and yet that did work out ... but all those other things were her priority not the directly [observed therapy]. We wouldn’t even have got in the door with her’. (CHN - Nurse Consultant: Focus Group 3)

**Discussion**

The World Health Organization’s (WHO) framework for addressing the social determinants of health has increasing universal acceptance. Within this framework, the WHO (1986) identified five action areas for health promotion: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. The Victorian Government’s interpretation of this framework
for Victorian communities is outlined in its Community Health Policy (Department of Human Services, 2004). This vision clearly envisages a sector providing a comprehensive range of integrated primary health care services, including health promotion, disease prevention, treatment, rehabilitation, support and advocacy, chronic disease management and links to secondary and tertiary services within a defined geographic area requiring population oriented planning. These services will give priority to greatest existing or potential health risks, they will focus on improving the health and wellbeing of individuals, families and communities and addressing the social determinants of health. The services will work to enhance the power of individuals, families and communities to be self-reliant in managing, maintaining and enhancing their health and wellbeing. Nurses are referred to in this policy statement (in relation to disability), as are practice nurses and nurse practitioners (in relation to supporting general practitioners), community nurses (in relation to mental health services), clinical nurses and primary school nurses. Nowhere within the fifty page document, is there any mention of community health nursing or community health nurses. Nevertheless, the CHN who participated in Phase 2 revealed the full spectrum of community health nursing described by St John (2007). These nurses reflected their work with high-risk and vulnerable populations such as adolescent mothers, frail older people and those who care for them, people with chronic illness, people with HIV and refugees. They reflected their work in health promotion, disease prevention, chronic disease management, their links to the acute and community support sectors, and their work in community assessment. While the proportion of individual, group and community engagement may differ with each CHN, the focus on advocacy and the social determinants of health was common to all CHN, whether working as generalists or in more specialist clinical roles.

In Phase 1, over 80% of the respondents indicated that they regularly practiced advocacy. Phase 2 offered the opportunity to explore consistencies in the concept of advocacy as defined in community health nursing when compared with advocacy as employed by CHN. Nursing defines advocacy as ‘understanding the worldview, life circumstances, and priorities of those requesting or receiving care and exploring possible options with them in light of their preferences’ (Gadow, S in Anderson & McFarlane, 2006, p.86). In this definition, for the nurse advocate, the client’s rights are paramount and the advocate works with the client to promote client autonomy and self-determination to achieve client independence in decision-making (Stanhope and Lancaster (1992) p.682). The social determinants of health that the CHN in this study described embrace the notion of understanding the ‘life circumstances’ of those seeking independence in decision-making about their health. The concept of ‘giving voice’, parallels the notion of coming to understand the life circumstances of those who seek assistance or affirmation, while the concepts of ‘encouraging agency’ and ‘standing beside’ are consistent with achieving client self-determination of their health choices and health outcomes.

The CHN belief in the social determinants of health is not just a reflection of the Victorian government’s community health policy but from CHN experience of nursing in the acute sector where their intense contact with patients exposes them to the intimate details of patients’ lives and the conditions outside of their control that influence their health. The CHN referred frequently, to the inability of the acute sector to be able to attend to anything other than the physical and psychological determinants of health during a hospital stay. This inability of the acute sector to address the social determinants of health is what led many CHN into community health nursing. CHN who transfer from the acute sector bring nursing knowledge and skills, awareness of the acute health sector, plus intense and
intimate experience of people’s lives. The combination of these characteristics sets CHN apart from other disciplines in the community health and support sectors, and they are the characteristics that other disciplines draw on when they consult with and refer clients to CHN.

How then can CHN, who have such a strong philosophical commitment to the social model of health, respond to charges that ‘you work within a medical model’ or ‘you are too expensive’? The biomedical approach focuses on treating individuals (Germov, 2002) whilst social, economic, and environmental factors receive lower priority. How is it then that CHN recount narratives of population focused community development and health literacy, amongst the most satisfying health outcomes of their practice? Would CHN not be more satisfied with outcomes based on a change of medication if they worked within a medical model? As advocates, CHN ‘give voice’, ‘encourage agency’ and ‘stand beside’ people and communities while they exercise their right to self-determinism in decision making about their health management and health outcomes. The language and focus of community health nursing does not reflect a ‘medical approach’. There is also potential for CHN, with their knowledge and experience of both the acute and primary health care sectors, to place more emphasis on re-orienting health services to meet the needs of their communities.

Answering the charge that CHN are ‘too expensive’ is more difficult in the absence of any cost-benefit analysis. Certainly, the nature of community health nursing requires long-term engagement with communities while they build the health literacy skills for self-determinism, and outcomes are difficult to demonstrate. Separating the CHN role into specialist nurses and generic ‘key workers’ appears to acknowledge the contribution of community health nursing but fails to recognise that nursing knowledge and expertise are central to all aspects of the role when undertaken within a social model of health. It also runs the risk of losing the capacity to connect the relationship between population health and individual health outcomes. Questions that arise from the charge of being too expensive include:

- What effect will reduced nursing knowledge have on comprehensive and timely assessment?
- What effect will reduced nursing knowledge have on multi-disciplinary teams’ understanding of the community, its health resources and needs
- What effect will reduced nursing knowledge have on allied health and specialist nursing services waiting lists?
- What effect will reduced nursing knowledge have on each community’s ability to interpret and respond to population health data?

Although literature outside the nursing domain rarely mentions CHN, their ability to draw together the physical with social, economic, political, cultural and behavioural determinants of health places them within the ‘new public health’ model, which Germov (2002), and Baum (2002), use to describe a system that recognises the combined influence of these factors on health. CHN can be proud that their earlier involvement in community health assessment, community participation in interpreting population risk data and developing health literacy, suggests that although there is less opportunity for CHN to engage in these roles, they were one of the early drivers of the new public health model.
Conclusion and Recommendations

Politico-economic factors are placing pressure on the future of community health nursing in Victoria. These factors may be undermining the social model of health that underpins community health nursing practice and that will continue to be important to integrate the physical, social, economic, political, cultural and behavioral determinants of health through a new public health model.

Nursing roles in community health have changed dramatically in the past decade, the generalist role has been eroded and specialist roles have emerged. The drivers of this change have been external and largely due to funding and political agendas rather than from the CHN profession itself. The move away from the generalist CHN role creates new challenges and new opportunities for CHN in Victoria and the communities with whom they work and it is imperative that the CHN workforce lead these future developments.

Recommendations

- Develop a set of Practice Standards for Victorian Community Health Nurses that articulates their role and scope of practice and the underpinning theoretical and philosophical basis for community health nursing practice.
- Continue to apply the social model of health framework to CHN practice, promoting consistent interpretation and application of the model amongst CHN.
- Combine the generalist and specialist nursing role within the CHN role and scope of practice
- Seek opportunities to advocate community health nursing positions in health promotion and community development teams through leadership roles within community health structures
- Seek opportunities to undertake CHN practice related research and disseminating knowledge about the role outside the nursing domain, including CHN presenting at conferences and publishing in primary and community health literature
- Undertake process and impact evaluation that gives voice to clients and communities through qualitative and quantitative methods, to measure the impact and effectiveness of CHN action.
References


Department of Human Services, (2004) *Community Health Services - creating a healthier Victoria*, Primary and Community Health Branch, Victorian Government Department of Human Services, Melbourne Victoria

