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Rural community nurses: Insights into health workforce and health service needs

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Abstract: Community nurses often work in isolation, particularly in rural areas where many other non-government adjunct health services are absent. At times, they feel overwhelmed, stressed and undervalued while undertaking diverse responsibilities. The study aimed to examine the benefits and challenges community nurses experience when working in rural and remote areas of Tasmania, Australia while determining the specialty skills and practices to meet rural health needs. An explorative research design using a phenomenological approach was adopted. Data were collected through semi-structured interviews with a convenient sample of 15 community nurses from the North and North-west areas of Tasmania. This yielded insight into the rural workforce challenges, gaps in services and the community nurses' lived experience of providing adequate health services to these communities. The results indicated significant variations in the structure and type of community nursing services. The key challenges identified included coping with altered expectations of the role, maintaining the knowledge and skills to deal with the diversity of the role, communicating and integrating with other services, particularly those in the acute care sector, coping with increasing administrative and documentation aspects associated with the role and coping with the emotional stress and pressure of working with palliative care clients. Despite these challenges community nurses interviewed indicated high levels of job satisfaction and long term employment. Given the diversity in both community nursing roles and factors impacting on the role further research is required to examine the exact roles and levels of integration between specialist and generalist community nursing roles while exploring and more clearly defining the role of the contemporary community nurse in Australia. Consideration should also be given to embracing community nursing diversity which is an important aspect of best practice for future community nursing.

Keywords: *Community Health, Rural Health, Nursing, skills, challenges, employment satisfaction*

Introduction

A community nurse's role has undergone many changes and the role remains less well defined. It is influenced by many extrinsic and intrinsic factors driven by policy, organisation and economic change (Bennett and Robinson 2005, Kennedy et al. 2011, Madsen 2009, Philibin et al. 2010). Many nurses who work in the primary care setting continue to feel overwhelmed, stressed and undervalued while undertaking a diverse number of responsibilities (Kemp, Harris, and Comino 2005). This has led to work overload and difficulty in maintaining certain responsibilities within the role, such as health promotion and anticipatory care (Kennedy et al. 2011, Philibin et al. 2010, Teo, Yeung, and Chang 2012). In addition to these pressures, the collective voice of community nurses often remains overshadowed by many debates with which they are faced.

The most significant change for community nursing has been the move towards less specialised nursing staff and the addition of lower paid unlicensed staff (Bennett and Robinson 2005, Conway and Kearin 2007, Huang et al. 2011, Lee et al. 2005). While policymakers view this as an answer to some of the economic challenges, it is detrimental to the nursing

profession and impacts on patient care. Health service funding can only be described as being “driven by financial concerns rather than through reference to an evidence base or consequences to the quality of the service” (Bennett and Robinson 2005, 27).

There are also external factors which have shifted community health nurses’ practice away from communities to individuals, such as increased day surgery and earlier hospital discharge (Bennett and Robinson 2005, Kwok et al. 2008). The number of community nurses employed needs to reflect the higher numbers of dependent or acute patients with complex needs. There also needs to be a greater focus and culture of proactive or anticipatory care rather than simply reacting to crisis intervention (Dinsdale 2002, Kennedy et al. 2011).

As the debate regarding the changing roles of the nursing profession as a whole continues, a lack of specific role clarification is apparent for community nurses. Without an appropriate articulation, definition and professional development of the community nursing discipline, this may lead to an opening for the role to be demoralised, changed and manipulated to suit policy, rather than policy being developed to encompass the role’s defining attributes (Madsen 2009, Terry 2012). The discipline has the potential of losing its own identity due to a lack of definition, policy decision making power with the potentiality of being reduced to one of menial tasks completed by non-nursing staff (Brookes et al. 2004, Madsen 2009).

Background

A number of factors have contributed to changing expectations and focus of the community nursing role. Australia, like other industrialised countries, has developed policy initiatives aimed at reducing costs, improving access, ensuring quality, and improving consumer satisfaction of health care (Brookes et al. 2004). This health care reform has resulted increasingly in care being shifted from acute in-hospital settings to community-based services (Terry 2012). Research by Kemp, Harris, and Comino (2005) indicated that Australian Community nursing services were being subjected to increasing service demand, higher levels of client acuity, new and more tasks, and more complex workloads, and delivering shorter, more intensive clinically focussed services rather than less intensive longer term care as previously.

Community nurses reported increasing levels of stress associated with the demands of the job and their working environment (Kemp et al 2005). These increasing workloads were resulting in the loss of a holistic primary health focus which was considered significant due to the strong links between primary health approach and illness prevention. Research regarding the changing nature of nursing work in rural and small community hospitals conducted by Montour et al. (2009) further suggests that workloads are increasing and that rural nurses are expected to change their knowledge and skills in response to new and evolving roles, new technology and policy changes.

This changing focus of care has previously been identified in the UK where a study by McDonald, Langford, and Boldero (1997) identified changing client types. In particular, care was being focussed more on older clients with increasing chronic illnesses and disabilities with a shifting focus from secondary to primary care, coordination and communication between service providers. These were highlighted as key concerns among Community nurses.

In addition to these issues, elements such as demographic factors are increasingly impacting community nursing services. Nurses working in community health are of a higher average age than nurses working in any other nursing discipline. For example, the average age of Tasmanian community health nurses is among the highest in Australia (ABS 2012). Consequently a high proportion of community nurses are likely to retire within the next decade

and there will be an associated loss of clinical expertise which has implications for the sustainability of community nursing services (Hunsberger et al. 2009).

Beyond the ageing workforce, the population of Tasmania has the highest median age in Australia and one which is ageing at a more rapid rate than other Australian states or territories (ABS 2012). This is further exacerbated in rural areas where younger people tend to migrate to urban areas to find employment (Bushy 2002). These demographic factors indicate there is likely to be an increasing demand on community nursing services in rural areas where health care services are often already limited and strained.

Geographical factors are another significant issue. In rural areas health outcomes tend to be poorer and rural people tend to access health services later rather than sooner (Australian Institute of Health and Welfare 2013). In addition, rural communities often have limited, inadequate or antiquated health infrastructure and lower levels of access to medical and allied health services than their urban counterparts (Bushy 2002). These factors suggest that community nurses in rural areas are caring for less healthy people in more acute care situations and may have to practise more crisis management with limited access to physical and human resources to support them.

Further geographic factors such as distance, travel time, terrain, and transport are additional issues that complicate community nursing service delivery in rural areas. Travelling long distances to visit clients and spending large amounts of each day on the road often with less than ideal terrain and in bad weather can create stressful working conditions (MacLeod, Browne, and Leipert 1998). The geographic environment of care is another consideration. Community nurses are working in environments which have not been designed specifically for the delivery of health services which can present challenges. Clinical tasks such as insertion of a supra-pubic catheter or provision of wound care can be vastly different between a structured health setting and a home environment where there may be animals, relatives, children, excess clutter, and limited equipment (McGarry 2003).

Geographical factors can also make it difficult for Community nurses to access opportunities for education and professional development which are essential to nurses' wellbeing and ultimately that of their patients. Hegney et al. (2002) suggests that rural nurses have limited access to educational and training programs that are specifically designed for their context of practice. Andrews, Stewart, and Pitblado (2005) found that barriers to accessing education resulted in decreased work satisfaction. Telehealth, telecommunications, and biotechnology are expanding at exponential rates and are increasingly being used to lessen the isolation experienced by health professionals and to promote access to training and development and the delivery of care in rural and community settings. However, this approach has implications for community nurses who may increasingly be expected to adopt this role which requires additional knowledge and skills and altered practice (Bushy 2002).

Nurses working in rural areas, much more than their urban counterparts, often have a high profile and as a result they may be 'accessed' by clients when they are 'off-duty', at the supermarket, at community activities and in public places. This means that community nurses can often feel they have no 'down time' and are never off-duty (MacLeod, Browne, and Leipert 1998). In addition there are often pervasive informal networks which operate which can present challenges in maintaining individual anonymity and confidentiality within a small community (Bushy 2002). Workplace safety issues have also been highlighted in a number of studies including one by Hanna (2001) which identifies personal safety as being a significant issue for rural and remote area nurses.

McDonald, Langford, and Boldero (1997) believe that the advent of specific specialist community nursing roles such as breast care nurses, continence nurses, and palliative care

nurses is a further issue impacting on the community nursing role. They suggest that these specialist roles which are providing aspects of health care traditionally undertaken by Community nurses have the potential to 'erode' the Community nursing role and downgrade it to performing more menial tasks which has impacted job satisfaction. Similarly, many General Practitioners (GPs) now employ practice nurses who undertake some of the same functions as community nurses. In addition, there are an increasing number of private providers and overarching program and policy changes such as the implementation of consumer directed care which has the potential to further impact on the community nursing role (McDonald, Langford, and Boldero 1997).

Despite the significant issues impacting on service delivery, previous research regarding levels of job satisfaction indicates that this is high among community nurses and that they enjoy the diversity of the role (Hegney et al. 2002). There were, however, limited comparative studies in this area and if community nursing job satisfaction levels have increased or decreased over recent time.

This previous research indicates that expectations of the community nursing role have altered significantly and, when combined with the diversity and isolation of working in rural settings, this adds additional load on the community nursing workforce and has the potential to create significant dissatisfaction with the role and potentially impact on the ability to recruit and retain community nurses in the future.

Methods

The research design adopted a phenomenological approach to examine and understand the skills, practices and experiences of community nurses when caring for clients in rural community settings. The principles of phenomenology were used to generate an understanding, which views world of lived experience as a fundamental source of research and are not attainable through other research methodologies (Campbell 2011, Van Manen 1990).

A convenient sample of fifteen community nurses from public and private rural services throughout the North and North-west of Tasmania were recruited for the study through third parties such as site managers or area managers. Semi-structured interviews were used to collect information regarding rural workforce challenges, gaps in services and community nurses' current ability to provide adequate health services to rural communities, and the organisational and personal factors impacting on the provision of community nursing services.

Consented participants were interviewed either by phone or in person between September and October 2013. Each interview was between 30 and 90 minutes and was audio recorded with the permission of the participants. The project was approved by the Human Research Ethics Committee (Tasmania) Network.

The transcribed raw data was cleaned, verified and imported into NVivo 10 software. Data were subject to double checking to ensure the integrity of the information. All of the interview participants were coded according to the order in which they were interviewed, such as CN 1, CN 2 etc. Data were then thematically analysed to systematically identify recurring themes, behaviour and experiences arising from the interviews. In the first stage, broad categories were identified within an overall schema, and in the second stage, a detailed series of hierarchical nodes and sub-nodes was developed. A number of quotations are included in the report to illustrate and support the accounts emerging from the textual responses.

Results

The participants comprised 15 community nurses, including 13 females and two males. Public employees consisted of 13 community nurses, while two were private community nursing service employees. Eleven nurses were from the Northern region and four were from the North-west Tasmanian region. The years of experience varied from community nurses with less than 12 months to more than 25 years' experience (average 8 years and 10 months).

There were many variations in the structure of Community nursing service delivery across the North and North-west of Tasmania. Some community nursing services were twenty-four-hour seven-day-a-week, some were Monday to Friday with additional after hours and weekend services, while other areas provided day services with no weekend or public holiday cover. Similarly some were predominantly centre-based and others were predominantly community based; some used a team approach with varying mixes of staff, while other services were sole practitioner.

There were some commonalities in the types of services and clinical care provided by community nurses with the majority having a significant focus on the provision of wound care, palliative care and continence advice and support but there were also significant differences in the types of services provided. Some community nurses were required to provide emergency care and support, others were involved in the provision of more acute care such as the administration of antibiotic therapy. There also was evidence that community nurses had 'picked up' care of clients when no other services or staff were available to do this. For example, the provision of foot care or providing GP 'practice nurse' services in more isolated areas.

A number of key themes were identified within the data, namely, motivation for being a community nurse; the benefits of community nursing; changes in community nursing service delivery; the current challenges associated with the community nursing role, and future needs and issues.

Motivation for being a Community nurse

Three key factors emerged regarding the participants motivation for becoming community nurses; the appeal of the approach and philosophy of community nursing care, practical factors, and client factors.

The approach and philosophy of the role was the most common motivating factor for nurses choosing to work in community nursing. Nurses spoke about wanting to "help clients to remain independent"; "empower people to make decisions about their own health care"; being able to "have more of a positive impact on peoples' lives"; "keeping people out of hospital"; "utilising a collaborative approach"; and being able "to work with clients and their families' long term and in a holistic way".

Practical aspects were the second reason for nurses choosing to working in a community nurse role. Nine of the fifteen nurses indicated working as a community nurse was an important lifestyle consideration. The community nursing role was seen to provide more family friendly hours, day work and an alternative for those wanting a change or needing an alternate nursing job. In addition, there was a belief that community nursing experience would make them more employable in the future. Lastly, working as a community nurse was also about proximity and being close to where they lived and allowed more flexibility in their lifestyle.

The third motivation for working in community nursing included factors associated with the client group. Nurses spoke of clients being more appreciative, being able to develop relationships with clients and their families, being able to work with client's long term, and supporting isolated clients. They enjoyed the positive response of clients regarding the care they received. Each of these aspects of the role was highly valued. In addition to the aspects of

client care, participants also commented on valuing the flexibility, autonomy and diversity of the role.

Benefits of Community nursing

The benefits of being a community nurse were primarily related to client factors. Participants commented on factors such as seeing progress and increasing independence of clients, clients being more appreciative and resilient, and clients actually wanting the services. Nurses also commented on knowing clients longer term and on a more individual level. Participants felt knowing clients on a more personal level enabled them to better tailor care to meet client needs and promoted more positive outcomes. This was summarised when one stated

Working in a small town you really are part of that community so it's really worth putting the effort in because everyone's an ongoing story in a sense, I just find it so much more satisfying. (CN 15)

In addition, other benefits were focussed on the approach utilised in community nursing delivery. Nurses particularly commented on the benefits of a team approach to care and the diversity and variety in the role. One nurse stated, "it's a team approach and they're included in that team, it's not just us it's them as well, family and carers" (CN 07).

Community nurses also commented on being able to educate clients regarding their health and wellbeing, utilising a holistic approach, and being able to incorporate consideration of the social determinants of health in their work role. Three of the nurses interviewed commented on community factors as benefits of the role including being involved with the community and the associated sense of belonging, care and support, one commented "it's unique in that you are privileged to be in a position of knowing the people as a member of the community and then having to deal with them in a professional capacity" (CN 03).

In addition, autonomy and independence of the role was an important benefit cited many nurses commenting that they liked to be able to structure their own workload, to have flexibility and no set times to have things completed. It is about being independent and responsible for the outcomes of the care they were providing.

Changes in community nursing service delivery

All community nurses were asked about changes and trends they observed in service delivery. Seven participants commented on an increase in the acuity of community nursing clients and the need to undertake more technical tasks as a result. Four nurses commented on altered expectations in relation to their role such as the expectation that six weekly checks on clients, visiting clients for "monitoring", and use of Dosette® boxes ceased and that preventing admission of clients to hospitals should be a focus. These nurses spoke about no longer undertaking tasks such as showering and bathing of clients, not visiting clients unless they had a specific health issue and providing more time limited nursing care to clients. One nurse felt that this was a more effective utilisation of nursing skills, while another felt this was moving away from a holistic to a more task oriented approach when they stated

I feel like our role is now limited to merely mechanical issues, there's a catheter so we go, there's a wound so we go, but if there's a psychological or social issue it's not our place, there isn't necessarily anyone else there for these people, so I find that frustrating that that should be limited (CN6)

When asked more about the source of the altered expectations in relation to their role nurses made comments that “we’ve sort of been told at the health forums” (CN 08), “well I think it came from [the manager]” (CN 02) or that it was an expectation expressed by their Director of Nursing. From the interviews, there was no clear indication that these were organisational wide expectations or related to strategic service delivery changes in certain areas of the state. Community nurses were also asked if their role had become busier. While two felt that it definitely had, five commented that it was more cyclical with busy periods and “runs of things” (CN 07) scattered with quieter periods.

Community nurse – a challenging role

Service delivery challenges

In addition to the changes in community nursing service delivery, a number of challenges pertained to service delivery. One of the service delivery challenges was concerning nurses having sole responsibility for decision making and care, with some nurses worrying about what is coming in the door, and being able to cope with the sheer diversity of the role. This was a particular issue for services where nurses worked in isolation and where there was an expectation to provide emergency services. Other concerns were about client challenges such as clients having unrealistic expectations of their care; coming at inappropriate times for services; not being compliant, ; and feeling obligated to the community because of the level of contact and involvement.

Beyond client challenges, having limited access to resources and support and needing to be able to think outside the square or utilise alternative approaches to care was another issue. Lastly, it was highlighted there were some challenge when trying to refocus community nursing services to utilise more of a primary health approach when managers were, perhaps, not supportive of this or when previous service providers had created a culture of dependence rather than independence.

Communication was highlighted to be an additional service delivery challenge among community nurses. The varying challenges associated with communication included issues associated with working with other service providers, obtaining feedback regarding referrals, and appropriate and timely discharge planning for clients. This was particularly evident in cases where visiting service providers did not have the same level of knowledge and awareness of the community as local services, which impacted their expectations in relation to service delivery.

Boundary issues were also a poignant service delivery challenge highlighted by the nurses, particularly among those who were living in the communities they were providing service to. The following comments illustrated this fact

The challenge is living in a small community. Confidentiality is a huge issue... I know everyone and everyone knows me. It's difficult to separate the role of health care provider and just a person on a Saturday or a Sunday. (CN 13)

The more experienced nurses commented that it had been more of an issue previously, however they had learned to more clearly set limits regarding their role and function.

I got over that long ago, I've got very clear boundaries about where my work load begins and ends and I'm quite clear about letting people... I don't think you'd survive without that. (CN 1)

Management and structural challenges

In addition to the service delivery challenges, a number of management and structural challenges were identified. These included staffing, and workplace safety issues. Most nurses cited factors such as “lack of relief staff and working in isolation.” This did not provide any avenues for debriefing, discussion or self-development through visiting clients with colleagues. A lack of a stable staff structure was also identified, in addition to a loss of senior experienced staff resulting in a loss of knowledge and capacity of the service. Beyond these issues there was a lack of flexibility in service delivery such as no after hours or weekend services and working with agency staff that have less knowledge of the local area as challenges.

In addition to staffing issues, a number of workplace safety issues were raised. Nurses cited the challenging home environments, pets, a lack of mobile phone coverage and reliable communication systems and abusive clients. Three nurses gave examples of occasions when they were on their own with clients and felt threatened, while another nurse recounted an incident of a client bullying her on Facebook. Further issues included geographical factors such as isolation of services and accessing resources, difficulty in recruiting staff or obtaining relief staff for services. Lastly the weather and being open to the elements, the quality of some roads and driveways and the distances needing to be travelled were also highlighted by a number of the participants.

Future community nursing needs

Many nurses were reasonably satisfied with their work situations and struggled to provide insight into the future needs of community nursing services. As previously outlined, community nurses had identified needs and been creative and innovative in establishing strategies to address these needs. Some common needs were however identified, and often related to previously identified challenges of the role.

Additional resources were highlighted throughout the data and across a number of areas. This included the need for additional staffing, specifically relief staff; increased Community care packages; improved IT resources and systems, particularly telehealth facilities and improved systems to address occupational health and safety (OH&S) issues, such as duress alarms and more reliable communication systems. Regarding the need for additional staff one nurse commented:

I'd like to see a reasonable ratio of community nurse to patient ratio... when it first started there was probably about a quarter of the people that need community nursing that do now, the area has grown significantly... I've been to other sites and spoken to other people and know that we are in a particularly bad way in terms of staffing.
(CN15)

In terms of physical resources, many nurses commented that they felt well-supported by their managers and well-resourced in undertaking their role, while individual nurses did identify equipment that would support their practice and this was in-line with specific needs and services provided at individual sites. For example, one community nurse felt that “a Doppler would be beneficial to assist to undertake vascular assessments” (CN 2), while another nurse stated that “large mobile telehealth facilities would be beneficial to enable them to remain with their patient while they linked with any necessary other service providers and support” (CN 14). In addition to increased resources, more than half of the nurses felt they required increased training and support with an enhanced ability to attend professional training and development

activities. Additional needs included easier access to best practice information, more specific training regarding the community nursing role, and improved levels of professional support. A number of nurses indicated that the funding was available for training and development, but there were challenges utilising this due to lack of relief staff. Four nurses felt the community nurse forums are a valuable training and development tool and need to be retained. Others stated that they felt “technology could be used more effectively to help staff access additional training by linking with the urban centres who conduct weekly training programs” (CN 8).

Discussion

This study identified key challenges and issues faced by Tasmanian community nurses. These included the role being altered and having increasing expectations; challenges maintaining the skills required to meet the diversity of the role; feeling the need to maintain services at times because no one else was available to do so; and difficulties with communication and integration with other health services, particularly between the acute and community sector.

In addition it was indicated that there was a poor perception and lack of understanding regarding the community nurse’s role and its perceived value; issues maintaining professional boundaries; challenges meeting workload pressures which a number of nurses felt were increasing; difficulty accessing ongoing training and professional development; and workplace safety concerns (Montour et al. 2009, Madsen 2009, Hegney et al. 2002). Despite the challenges, community nurses indicated high levels of job satisfaction and many had been in the role long term. Generally the nurses felt well supported by their managers and well-resourced from a practical perspective.

A need was identified for improved access to relief staff; improved communication systems to address workplace safety issues; and improved IT resources and systems particularly telehealth facilities to promote access to training and support. The variation between services suggests the establishment of appropriate standard community nurse to patient ratios is required, including consideration of factors such as travelling and terrain. Beyond this, additional community support services or processes are required to facilitate out-of-hours and palliative care support, an issue which may become increasingly vital as the role expectation to take on more acute and technical care occurs.

Improving access to training and support to facilitate greater involvement by community nursing staff in professional development activities was also an identified need. Greater ease of access to best practice information, more specific training regarding the community nursing role, and improved levels of professional support, particularly among those working in isolation are important aspects. Consideration should also be given to additional training and support in instances where community nursing staff are required to ‘pick up’ additional functions such as the provision of foot care, and GP nursing services which are not normally part of the community nursing role (McDonald, Langford, and Boldero 1997).

The lack of professional identity raised by some of the community nurses in the study highlights that the profile of the community nursing role is required to be increased and further valued. This is required to be an across the board process, where the value of the role be recognised and reinforced by government, professional organisations, community nursing staff, unions and extended across other nursing roles (Brookes et al. 2004, Madsen 2009, Bennett and Robinson 2005, Terry 2012). The contemporary community nursing role needs to be considered as part of this process, including the impact of nurse specialist positions on community nursing and how to integrate these into community nursing practice and the potential for the

development of enhanced role options such as possibly advanced community nurse practitioners.

In addressing the needs of community nurses, a further factor is the diversity of the role itself. Community nurses work with a diverse range of clients in very diverse settings which in turn requires a high level of diversity of knowledge and skills. This diversity means that community nursing is an extremely complex type of nursing which cannot simply be broken down into a specific skill and knowledge set.

Consequently, it is impossible to be prescriptive in terms of service delivery or policy and procedure development determining community nursing practice. This diversity can be seen not only as a complicating factor but also as strength of the service as community nurses, like some of those in this study, often develop new, innovative, and client centred approaches to meet the specific health needs of the communities they service.

Rather than decreasing the degree of diversity as has been a focus of past governments, consideration should perhaps be given to embracing this diversity and tailoring options to suit individual service needs rather than only focussing on across the board solutions. There needs to be the development of sound critical thinking and risk assessment and analysis skills within the community nursing role, which given the diversity of the role is an important aspect of best practice community nursing in the future.

It should be noted that the advantage of using phenomenology approach in this study is to deeply understand the inner voice of the participants about their own personal experiences from which thoughts and feelings manifest. While this approach downplays the significance of research generalization which is normally seen in quantitative research, it provides a 'different illuminative side of the research story' that is complementary to quantitative research findings. This is an important contribution of this study.

Conclusion

Community nurses are a central workforce for the care of people within the community, particularly within rural areas where other services are not always present. The role community nurses take is less well defined and influenced by a diverse number of responsibilities and many extrinsic factors. Given the increasing influence of many of these factors further research in this area is required to examine the exact roles and levels of integration between specialist and generalist community nursing roles while exploring and more clearly defining the role of the contemporary community nurse in Australia. This paper has highlighted that consideration should be given to embrace community nursing diversity which is an important aspect of best practice for future community nursing.

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