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

Centre for Rural Health
University of Tasmania

Suggested Citation:

Barrett, A. Terry, D.R., & Lê, Q. (2014). *Rural community nurses: Insights into health workforce and health service needs in Tasmania*. Launceston: University of Tasmania.

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Executive summary

There have been significant changes in the community nursing role and function since its establishment in the 1850s, with particularly marked changes over the last decade (Boran, 2009). Healthcare is one of the highest spending public sectors of most westernised economies and has undergone greater budgetary restraints recently. These measures have included bed closures, job losses, longer waiting lists and ever increasing costs to access health services, which may contribute to deteriorating health outcomes in the future (Humphreys, 2009). Health remains the object of governments who aim to downsize and cost shift (Oberlander, 2011). It is within this context of the current health climate that this study was conducted.

Specifically, the current Tasmanian government is placed in a situation where the current $1.3 billion health budget needs to find $100 million worth of savings in 2011 -2012, increasing to $150 million by 2014-15 (Giddings, 2011a). It is anticipated this could be achieved through a number of measures which include reducing the duplication in areas such as payroll; reducing expenditure on locums; reforming procurement; and reducing the number of employees up to 2300 full-time equivalent jobs – including frontline services (Brown, 2011; Giddings, 2011a, 2011b; Poskitt, 2011). In addition, a reduction of elective surgery and other services has occurred over this time leading to increased waiting times and delays in diagnosis (Glumac, 2011; Poskitt, 2011).

These changes in medical and surgical care suggest there may be a need to increase the provision of acute health care in community settings, while the implementation of illness prevention and health promotion programs is seen as an urgent priority. It is believed that community nurses are well situated within the community to meet these growing health care needs and implement such programs. In addition factors such as the recent changes in the demographic structure of Tasmania's population and to health policy and management structures further augment the role of community nurses and have altered service delivery expectations.

Previous research has outlined that these and many other factors have placed significant additional workload pressures on community nurses which, when combined with working in rural areas, have the potential to create significant dissatisfaction within the role. In the future this could potentially impact the ability to recruit and retain community nurses in rural areas where they often work in isolation. At times they may feel overwhelmed, stressed and undervalued while undertaking diverse responsibilities in their rural practice. Anecdotally Tasmanian community nurses have indicated this is the case; however there is very limited

research to more accurately identify and quantify the issues which impact their practice in rural Tasmania (Terry, 2012).

This research project aimed to identify the personal and organisational challenges encountered by community nurses working in rural areas in the North and North-West of Tasmania. It also sought to examine and understand the skills, practices and experiences of community nurses when caring for clients in rural community settings where other health care organisations are limited or not always present.

The research adopted a qualitative approach using semi-structured interviews for data collection. Fifteen community nurses were interviewed in total, two from the private sector and thirteen from the public sector. With the exception of the private sector nurses, all worked exclusively in rural or remote areas. Eleven community nurses were from the North of the state, while four were from the North-West.

Data collected from participants provided information in relation to the motivation for working as a community nurse; the skills and experience as community nurses; the benefits and challenges of working in a community nursing role; changes in the expectations of the role; and the future development of the role. Nurses interviewed also provided information on the organisational and personal factors impacting on the provision of community nursing services.

There were a number of variations in the structure of the community nursing service delivery across the North and North-West. Community nursing services ranged from twenty-four hour seven day a week, to Monday to Friday with some after hours and weekend services, while others were day services with no weekend or public holiday cover. The services again ranged from being predominantly centre-based to mostly community based. Others utilised a team approach, while some services were run by a sole practitioner.

The types of service provided were broad with the most common services related to the provision of wound care, palliative care and continence assistance and support. In some areas community nurses were required to provide emergency care and support, while others provided more acute care, such as the administration of antibiotic therapy, de-accessing chemotherapy, Baxter pump therapy, and PICC line management. Alternatively, private sector community nurses were involved in and focussed on the assessment and review of clients. There was evidence that community nurses had 'picked up' aspects of health care when no other services or staff members were available to meet the needs of the community. For example, the provision of foot care or the provision of GP practice nurse services in more isolated areas.

Despite the variations and diversity observed across the rural community nursing services, the nurses discussed high levels of job satisfaction and long-term employment, regardless of any issues or challenges they were encountering. The key motivations for working as a community nurse included:

- The primary health approach and philosophy of care which was valued, and the ability for flexibility in meeting client needs;

- Client autonomy, service appreciation and greater client focus within the service; and

- Practicalities of employment, such as not having to work shifts, "family friendly" hours and their employment being located near to where they lived.

Within the study, it was shown that the most common change being experienced at the time of the study was related to role expectations. There was an expectation to provide increased chronic disease management, and a greater focus on health promotion services while moving the service away from undertaking tasks considered 'non-nursing' such as bathing, showering and monitoring services. Key challenges identified included:

- Coping with altered and increasing expectations of the role and maintaining the knowledge and skills to deal with the diversity of the role;

- Communication and integration with other service providers particularly relating to discharge planning, integration of care and having open dialogue with acute care settings;

- A lack of understanding regarding the role of community nurses and being undervalued;

- Meeting increased workload requirements, role expectations and non-nursing administrative requirements;

- Maintaining boundaries within the rural community nurses were living and working in;

- The emotional stress and pressure of working with palliative care clients;

- Workplace Health and Safety issues associated with working in isolation; and

- Access to training, support, and annual leave due to lack of relief staff.

While a number of key challenges have been identified, nurses felt they were well supported by their managers and well-resourced from a practical perspective to undertake their role. In addition, it was evident the more experienced Community nurses had developed specific strategies or approaches to address these challenges. For example, programs of rotation through Community nursing service areas were established, while volunteer programs and

additional cancer support programs were developed to provide additional support to clients. This was indicative of the nurses using and developing innovation, initiative and self-reliance within the service.

This report provides insight into what was found in the Tasmanian context and then discusses it in the framework of the international literature concerning the health workforce and health service needs of Community nursing. As a result, a number of key recommendations were formulated to address a number of key concerns highlighted. However, it must be noted that due to the small sample size and the diversity in roles and service delivery types it is difficult to make broad generalisations for services outside Tasmania. Nevertheless, five key recommendations are made to enhance and augment the role of community nurses and the service they provide in Tasmania.

Recommendations

The following recommendations have been identified for consideration to augment current and future Community nursing services in rural and more urbanised areas:

1.   Additional resources and services

A need was identified for additional staffing, particularly relief staff; improved communication systems to address workplace health and safety issues; and improved IT resources and systems particularly telehealth facilities to promote access to training and support. Given the diversity between sites consideration may also need to be given to establishing appropriate standard community nursing to patient ratios. Beyond this, additional community support services or processes are required to facilitate out of hours and palliative care support. The issue of after-hours care may become increasingly important if the community nursing role is expected to take on more acute and technical aspects to ease the burden on the acute sector.

2.   Improved training, development and support

Increased training and support is required to facilitate greater attendance at professional training and development activities. 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. Consideration should also be given to additional training and support in instances where community nursing staff have had to pick up additional functions, such as the provision of foot care, and GP nursing services which are not part of the 'normal' community nursing role.

3.   Improved referral and communication processes

The need for improved referral and communication processes was identified as a significant challenge for community nurses and if augmented would positively impact on their practice. A review of the 'TasCare Point' system was suggested as this current process complicated and delayed the referral process.

4.   Review of community nursing paperwork

With reference to the referral and communication processes, community nursing paperwork should be reviewed, streamlined and standardised across the state. The introduction of new paperwork should involve consultation with community nursing staff and consideration of the factors associated with completion of this paperwork such as time requirements and how these will be met.

5.   Enhanced perception of the community nursing role

Lastly, there is a need for the profile of the community nursing role to be increased. This is required to be an across the board process, where the value of the role is recognised and reinforced by government, professional organisations, unions and extended to other nursing roles. 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. There is the potential for the development of enhanced role options such as possibly advanced community nurse practitioners.

Background

Introduction

There have been significant changes in the community Nursing role and function since its establishment in the 1850s, with particularly marked changes over the last decade (Boran, 2009). Healthcare is one of the highest spending public sectors of most westernised economies and has undergone greater budgetary restraints recently. These measures have included bed closures, job losses, longer waiting lists and ever increasing costs to access health services, which may contribute to deteriorating health outcomes in the future (Humphreys, 2009). Health remains the object of governments who aim to downsize and cost shift (Oberlander, 2011). It is within this context of the current health climate that this study was conducted.

Specifically, the current Tasmanian government is placed in a situation where the current $1.3 billion health budget needs to find $100 million worth of savings in 2011 -2012, increasing to $150 million by 2014-15 (Giddings, 2011a). It is anticipated this could be achieved through a number of measures which include reducing the duplication in areas such as payroll; reducing expenditure on locums; reforming procurement; and reducing the number of employees up to 2300 full-time equivalent jobs – including frontline services (Brown, 2011; Giddings, 2011a, 2011b; Poskitt, 2011). In addition, a reduction of elective surgery and other services has occurred over this time leading to increased waiting times and delays in diagnosis (Glumac, 2011; Poskitt, 2011).

These changes in medical and surgical care mean there may need to be an increase in the provision of acute health care in community settings, while the implementation of illness prevention and health promotion programs is seen as an urgent priority. It is believed that community nurses are well situated within the community to meet these growing needs and implement such programs (Terry, 2012). In addition factors such as the recent changes in the demographic structure of Tasmania's population and to health policy and management structures further augment the role of community nurses and have altered service delivery expectations.

When compared to other areas of nursing there has been relatively little research conducted specifically in relation to rural community nursing (Terry, 2012). The research that has been undertaken does however identify some common issues impacting on community nursing which include rurality, demographic factors, factors associated with role definition and delineation, a number of human resource factors and technological issues. A summary of these key issues is outlined in the following discussion.

Rurality

The Australian Institute of Health and Welfare (AIHW) (2013) reports that health outcomes tend to be poorer outside major cities. In addition, there are variations in usage of health services with those living outside metropolitan areas tending to access services later rather than sooner. This has implications for community nurses as it can mean they often have to practice more crisis management when working in rural areas (Molinari & Monserud, 2008). An additional consideration is that rural communities have fewer people living in larger and more remote geographical regions, which impacts health care delivery systems. The more remote the community, the lower the population density, which means rural regions often do not have the critical mass to support public infrastructures that are fiscally sound (Molinari & Monserud, 2008).

Rural communities consequently may have limited, inadequate, and antiquated public infrastructure which may indirectly or directly impact the health of residents and influence health care delivery systems and services in those regions (Bushy, 2002). Consequently, while rural areas have growing numbers of people who are described as vulnerable and with special needs, they are often less able to provide the breadth of services required by these individuals (Davy, 2007). Research by Hanna (2001) reflects this issue with their research of rural community nurses indicating lack of resources, inadequate equipment and facilities, and under-funded environments were key issues (Wakerman & Davey, 2008).

The AIHW (2013) also reveals that rural populations do not have the same level of access to medical and allied health services as metropolitan populations with the number of General Practitioners per capita falling sharply with increased remoteness. In contrast, rural and remote areas are generally well serviced in terms of nursing numbers, having more registered and enrolled nurses per capita than metropolitan areas. This suggests that rural and remote nurses may be required to care for less healthy people in more acute care situations. Many nurses appreciate these challenges as they enjoy the diversity and advanced nature of their practice and the professional autonomy but for others this can create significant stress (Hegney, McCarthy, Rogers-Clark, et al., 2002).

Ageing workforce, clientele and complexities of care

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 nurses being the oldest in Australia at 50.3 years (ABS, 2012). These demographics indicate that a high proportion of the community nursing workforce is likely to retire within the next ten years which will create significant workforce shortages at a time when there are likely to be increasing pressures on services due to the ageing Tasmanian population. Montour et al.

(2009) suggest that these demographic trends pose an immediate threat to the sustainability of rural nursing services. An associated issue will be retaining the clinical expertise of the rural nursing workforce as these older nurses who have often developed extensive knowledge and skills through long term experience working in rural settings begin to retire. Further, rural health facilities are having increasing difficulty recruiting and retaining a nursing workforce and many rural and remote area health services would not be able to provide healthcare without nurses (Hegney, McCarthy, Rogers-Clark, et al., 2002).

In addition to the issues associated with an ageing workforce community nursing services are also likely to be impacted by factors associated with an ageing client profile. This is particularly evident within Tasmania which has the highest average age in the country of 40.9 years (ABS, 2012). Tasmania's population is also ageing at a more rapid rate than that of other states and territories and has experienced the largest increase in median age over the last twenty years rising by 8.1 years from 32.8 years in 1992 to 40.9 years in 2012. Data projections highlight that between 2006 and 2021 the percentage of the Tasmanian population over the age of seventy years is expected to increase from 10.6% to 16.6% (Department of Health and Human Services, 2007). This demographic is further exacerbated in rural areas where younger people have a propensity to migrate to urban areas to find work (Bushy, 2002) and is significant as older people are more likely to live alone and require supports and services (Jarvis, 2007). All of these issues are likely to result in an increased demand on community nursing services in rural areas where health care systems are often already strained.

Role definition and delineation

The community nursing role today is many and varied and includes issues such as post-operative care, leg ulcer and wound care, tissue viability, catheter and bowel care, continence and falls assessment, chronic conditions support, and management and health screening (Davy, 2007). Health promotion is another integral part of the role with community nurses providing advice on dietary and fluid intake, skin care, and mental health promotion. Palliative care and care of the dying is also a substantial part of community nursing practice.

Within the Tasmanian context, community nursing services

> operate within a primary health framework to deliver nursing services that support clients to remain independent and develop a self-management capacity to maintain their health and wellbeing within the home environment. This service works collaboratively with other health care providers to plan and deliver the assessed nursing care required to support clients to remain at home and avoid either a hospital admission or presentation or early admission to residential aged care. (THO, 2013)

In this respect, community nursing services in Tasmania include the following roles and functions as outlined by the Tasmanian Health Organisations (THO) (2013):

- Assessments and development of agreed plans of care;
- Catheter and bowel (continence) management;
- Chronic condition/self-management programs and support;
- Post-acute care following discharge from hospital;
- Health education and promotion;
- Medication management including oral, intramuscular, subcutaneous, intravenous medications including PICC line and port management;
- Palliative care;
- Rehabilitation support; and
- Wound Management.

However, a number of other factors have contributed to changing expectations and focus of the community nursing role. For example, Australia, like other industrialised countries, has developed policy initiatives aimed at reducing costs, improving access, ensuring quality, and improving consumer satisfaction of health care. This health care reform has resulted in changes to where care is delivered and to the types of services provided to clients, which has significant implications for the community nursing role. Increasingly care is being shifted from acute in-hospital care to community-based services and provision of care primarily for acute medical conditions being replaced by ambulatory care services (Terry, 2012).

These factors have resulted in a subsequent need to provide greater complexity of care in community settings which is likely to increase in the future (Kemp et al., 2005).With the shift from acute to community settings there has been an associated emphasis on the promotion of health and prevention of illness in individuals and communities yet this aspect of the community nursing role is being challenged as the previously embraced primary health care model incorporating community based health promotion activities is less achievable as community nurses struggle to provide nursing care that was previously provided in acute settings (Daly et al., 2004).

Nurses have reported that the shift from primary health care to short-term clinical care in Australia is resulting in a loss of a holistic primary care focus. Consequently role tension is developing between the focus on medical care and treatment and on the primary health care roles of health promotion, prevention and education (Kemp et al., 2005). Budget constraints and infrastructure difficulties have resulted in many rural communities already struggling to provide even the most essential health care services, and this shift in the focus of care and

the need to increase preventative services and health promotion programs is creating additional pressure. Bushy (2002) suggests these changes place even greater demands and stress on health care professionals in both urban and rural areas, contributing to burnout and individuals leaving the profession.

As Brookes et al. (2004) outline rural and remote community nurses are, by necessity, generalist due to lower population densities and the need to care for clients with a broad range of medical conditions. Despite needing to be generalists, rural nurses are also often described as needing 'multi-specialist' knowledge and skills to respond to diverse population and client needs and with the shifting focus of care this is increasingly the case (Hunsberger et al., 2009). Community nurses must have the technical and clinical skills to perform crisis assessment and management for populations across the lifespan and for all health conditions, as well as an ability to constantly tailor their practice to meet not only health needs but also to consider the social determinants of health impacting on individual clients and their families (MacLeod et al., 1998).

In rural contexts, these nurses may manage traumas, calm the mentally ill, care for children, stabilize the critically ill, and comfort the dying all in the same shift which is an enormous diversity in client needs and requires very extensive knowledge and skills (MacLeod et al., 1998). These altered role expectations suggest that community nurses may need longer orientation periods, and more specialised training and skills. However, current community health nursing in Australia requires minimal qualifications and there are very few purposely designed training programs and support systems for community nurses which places increased pressure on staff (Davy, 2007).

A further impact on traditional community nursing roles and expectations is the increasing focus on the development of specialist nursing roles in community settings (Brookes et al., 2004). Over the last decade nurses with specialist skills are being introduced to work with clients with specific illnesses or health care needs. There are now specialist palliative care nurses; specialist breast care nurses; specialist diabetes nurses; specialist continence nurses; specialist wound care nurses; and services which outreach from hospitals into the community. Many of these specialist nurses are providing aspects of health care traditionally undertaken by community nurses. McDonald et al. (1997) suggest that there is the potential for the community nursing role to be eroded and downgraded to performing more menial tasks and for this to impact on the job satisfaction of community nurses. This suggests that there may be a need to examine the exact roles and levels of integration between these 'specialist' community based nursing roles and community nurses and to explore and more clearly define the role of the contemporary community nurse in Australia.

Human resource issues

Another factor highlighted within a number of studies is that rural and remote area nurses consistently rate their job satisfaction as high. Generally they report a high level of satisfaction with their scope and context of practice, in some cases more so than their urban counterparts (Hegney, McCarthy, Rogers-Clark, et al., 2002). This was felt to be because community nurses enjoy the autonomy and creativity that is an inherent part of practicing in small rural communities (MacLeod et al., 1998). However, community nurses highlighted they often feel more isolated, experienced more time pressure and received less support. Feelings of burnout were shown to increase with time pressures and were decreased by autonomy, skill variety and task significance. The levels of social support received at work were particularly important in increasing job satisfaction and decreasing burnout (Jansen et al., 1996).

Boswell (1992) states that as the community nurse role functions in a relatively unstructured setting, this has the potential to result in conflicts and situations which can create stress. This was reinforced in research which showed that when nurses were given adequate time to perform their job, their stress levels decreased. Similarly, with higher levels of competency in the required tasks, stress levels also decreased (Boswell, 1992). Respondents felt that quality of care, time, and task requirements were the three most important factors linked to work stress in community nursing. Given the increasing complexity of client care, and the increasing workloads due to the shifting focus of health care these factors are potentially significant in the current changing climate of community nursing.

In other aspects of rural employment, the boundaries between professional work related roles and personal life are nebulous and diffuse. Nurses working in rural areas, much more than those working in urban areas, often have a high profile and are well recognised and trusted members of the community. As a result they can often be accessed by clients when they are 'off duty', at the supermarket, at community activities and in public places. Some nurses see this high public profile as a way to build trust, monitor, follow-up and foster health promotion and to provide opportunities for the implementation of positive health programs and activities. However, it also means that community nurses can often feel that they have no 'down time' and are never off duty (MacLeod et al., 1998). In addition there are often pervasive informal networks which operate and which can present challenges in maintaining individual anonymity and confidentiality within a small community (Bushy, 2002). These factors can impact on retention and recruitment of community nurses to rural areas which is a common concern across rural settings at a national and international level (Bushy, 2002).

In Australia community nurses report that their workloads have been increasing with new and more tasks and more complex workloads. Community nurses are reporting increasing levels of stress associated with the demands of the job and their working environment. This stress and tension has been exacerbated by their lack of control and input into the changes in the health care system and the expectations of their role (Kemp et al., 2005). There have also been alterations in the documentation requirements for nursing staff. With increasing quality improvement processes and reporting requirements of funding bodies there has been a significant increase in administrative loads for nursing staff. Smith (2002) outlines that three to five years ago 15-30% of nursing time was attributed to nursing documentation but this percentage has now increased to 30-50% which is a significant additional workload impact.

Opportunities for education and professional development are essential to nurses' wellbeing and ultimately that of their patients but it is difficult for rural nurses to access education and there are several research papers which suggest that rural nurses have limited access to educational and training programs that are specifically designed for their context of practice (Hegney, McCarthy, Rogers-Clark, et al., 2002). As such, Andrews et al. (2005) found that barriers to accessing education resulted in decreased work satisfaction.

Beyond these major challenges identified, additional research undertaken by Wakerman and Davey (2008) and Hanna (2001) identified the following key issues for nurses working in rural and remote settings:

- Degree of predictability of the role, as rural nurses experience unpredictability in terms of the variety of their practice and work situations;
- Degree of influence, as rural nurses often have limited influence over their work hours and practices;
- Having sole responsibility for patients;
- The high level of diversity of the role and the wide range of skills required;
- Poor systems of orientation, induction and communication;
- Under funded work environments;
- Inadequate levels of pastoral care;
- Quality improvement processes;
- Centralised and sometimes remote management systems not suited to dispersed populations;
- Professional and social isolation;
- Lack of resources, inadequate equipment and facilities;
- Lack of organisational support;

- Limited or absent preparation or cultural orientation to the role;

- Infrequent demand on specific clinical skills making it hard to maintain these skills;

- Limited medical support and allied health support;

- Pressure to extend scope of practice;

- Unmet debriefing needs and confidentiality issues;

- The significant amounts of unpaid work which community nurses often undertake and which is often not recognised;

- Insufficient relief and respite; and

- Feelings of responsibility for the community they serve.

Lastly, personal safety issues were also highlighted in a number of studies. The Working Safe in Rural and Remote communities project surveyed six hundred health professionals, teachers and police in rural and remote Australia and found that workers were most concerned about various forms of workplace violence, working long and unsociable hours and working on your own (Working Safe in Rural and Remote Australia, 2013). Research by Hanna (2001) further outlines personal safety as being a significant issue for rural and remote area nurses and suggests more systematic approaches are required to ensuring the personal safety of nurses working in isolation in remote areas.

Technological issues

Telecommunications, telehealth and bio-technology are expanding at exponential rates and increasingly technology is being used to lessen the isolation experienced by health professionals and to promote the delivery of care outside acute settings. In rural areas it is often nurses who will be using or teaching clients how to use this technology and this use of e-technology and how it will impact on community nursing practice is an additional important issue for consideration (Bushy, 2002). Some countries are increasingly trialling the use of nurse led telehealth clinics to promote access to specialist services and advice for rural clients. Initial research in relation to the use of these has demonstrated some positive results but this approach again has implications for community nurses who may increasingly be expected to adopt this role. This would require specific knowledge and skills to alter practice.

Geographic factors

Distance, travel time, terrain, and transport are common issues that complicate Community nursing service delivery in rural areas. These aspects are often not allowed for in funding or service delivery models. 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 et al., 1998).

The geographic environment of care is also a factor. Community nurses are working in environments which have not been designed specifically for the delivery of health services which can present challenges. Community nurses need to be highly adaptable and skilled in being able to adjust care to the service delivery setting while maintaining appropriate standards of care and optimising health outcomes, often with limited resources. Community nursing service delivery is not simply about a set of skills. 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).

In a community nursing study by McGarry (2003), it was suggested that the client is more in control in the community setting with a greater involvement and influence in their care which impacts on community nursing service delivery. Client families too are often a far greater influence and there are many more factors which impact on the care able to be provided in community settings than in more formal health care settings.

Research conducted by Oberle and Tenove (2000) regarding ethical issues affecting Community nurses identified a number of key ethical issues impacting on community nursing practice including relationship issues, confidentiality, setting boundaries, system issues, and increased exposure to risk. In this study nurses commented on a number of dilemmas including:

- Having to continually make decisions independently while not being sure if these decisions were challenged whether the system would support them;
- Keeping their personal lives separate from their private lives;
- The need to respect the client and their family's views and preferences regarding their care even when they perceived this as not in the best interests of the client's long term health care;
- Balancing client empowerment and autonomy with client dependence;
- Managing client care in the context of the environment and associated family and personal dynamics; and
- Feeling obligated to provide care in often less than ideal or risky environments.

It is evident that the contemporary Community nursing role is subject to a wide range of changes and pressures which have the potential to significantly impact on health service

delivery and health outcomes. It is consequently important to gain a better understanding of these influences and their potential impact and to undertake further research in this area.

Context of study

Community nursing workforce across Australia and in Tasmania

The 2011 nursing and midwifery workforce survey, conducted by AIHW (2011a), highlighted that there were 13,939 nurses working in the field of community health. This includes the areas of community drug and alcohol services, community health care services, Community mental health services, and other Community health care services. The median age of these community nurses was 47.7 years with 26.2% of the workforce aged over 55 years. This was the second highest average age for any area of nursing in Australia second only to nursing management.

In Tasmania, 659 nurses nominated they were working in community health care services (118 of these were working in community mental health services and 22 in drug and alcohol services). The median age for these nurses was 50.3 years, the highest average age of any Australian state or territory with 38.9% of those working in community settings (other than the areas of mental health and drug and alcohol) being over the age of 55 years. Only 4.1% of these nurses were male. The average number of hours worked by nurses working in community settings in Tasmania in 2011 was 32.7 hours and higher than the Australian average of 31.9 hours (AIHW, 2011a).

Community nursing services in Tasmania

Within Tasmania there are both public and private community nursing services. All public community nursing services are funded through the Department of Health and Human Services (DHHS) and managed by the three THOs. These organisations state that

> The function of community nursing services is to deliver nursing services that support clients to remain independent and develop a self-management capacity to maintain their health and wellbeing within the home environment utilising a primary health care framework (THO, 2013).

The THO (2013) further states

> The community nursing role involves working collaboratively with other health care providers to plan and deliver the care required to support clients to remain at home and avoid hospital admission or early admission to residential aged care.

In line with this, public sector community nurses in Tasmania provide a range of clinical and educative services to clients in community settings.

Community nurses have a set base, usually a hospital or a community health centre, and outreach from this providing services across a set geographic region. In the majority of cases community nursing care is provided in client's homes but services are also provided to a greater or lesser degree in clinic or health centre settings depending on the local model of community nursing service delivery. Service structure varies significantly between locations from large teams to sole practitioner services. Similarly the composition of staff within community nursing services also varies significantly with some teams comprising community nurses exclusively and others including enrolled nurses and/or health care assistants (THO, 2013).

Conversely, private sector community nursing services vary from large organisations covering the whole of the state to small owner-operator style services. Private sector community nurses generally have a responsibility for the management of community care packages to clients such as Extended Aged Care in the Home (EACH) and Community Aged Care packages (CACPs) and consequently have a higher degree of management involved in their role although they also provide hands on care to clients with more acute or complex needs. Non-government community nursing services also operate within a set geographic area although these tend to be much larger than those for public sector community nursing services. Private provider community nursing teams usually comprise registered nurses and health care assistants while some also include enrolled nurses (THO, 2013).

Rurality and community nursing

In addition to the varied community nursing services in Tasmania, there is also no one agreed definition of 'rural'. The Australian Government, like other governments have tried to quantify degrees of rurality to enable clearer divisions between areas and to allow for the implementation of specific programs and policies based on rurality. This has resulted in the development of the Australian Standard Geographical Classification - Remoteness Areas (ASGC-RA) which was first introduced in 2001 and subsequently updated on 1st July 2010 (AIHW, 2011b). The ASGC–RA categorises Australia into five degrees of remoteness; 'major cities', 'inner regional', 'outer regional', 'remote' and 'very remote' (AIHW, 2004). As such, the ASGC–RA categorises the majority of Tasmania as being outer regional or remote with the exception of Launceston and Hobart which are classified as inner regional centres (ABS, 2009). The table below outlines the Tasmanian populations living in the various ASGC–RA categories (ABS, 2009).

Table 1: *Australian Standard Geographical Classification - Remoteness Areas classification*

Remoteness Area Classification	Remoteness Area Category	Tasmanian Population	Percentage (%)
RA 1	Major City	-	-
RA 2	Inner Regional	325 487	64.7
RA 3	Outer Regional	167,378	33.2
RA 4	Remote	7,830	1.6
RA 5	Very Remote	2,597	0.5

Note. RA = Remoteness Area. Source: (AIHW, 2011b).

It is suggested that these characteristics result in specific community characteristics which impact on the provision of health care and the practice of health service providers and some health service providers believe this to be a more appropriate approach to defining rurality (Lenthall et al., 2011). Other definitions of rural nursing were originally tied to the presence or absence of medical practitioners (Hegney, McCarthy, Rogers-Clark, et al., 2002). This definition has been broadened with Francis, Mills (2002) page 56) referring to rural nursing as "nurses working outside of major metropolitan areas where patients have reduced access to health services."

For the purposes of this study rural is considered to be all of the areas outlined by the ASGC-RA, as rural and remote within the North and North West Tasmanian Health Organisation areas of Tasmania, excluding Launceston, Devonport and Burnie. Launceston, Devonport and Burnie are classified as outer regional and in these areas community nurses work in larger teams with very differing structures and support levels compared to community nurses working outside these more urbanised centres. If these areas were included it is felt that this may impact on the accuracy of the picture gained of rural community nursing.

Summary

A review of the literature revealed a number of issues which impact on community nursing practices including geographical, demographic, role definition and expectation, workload, and human resource factors. Previous research has shown that expectations of the community nursing role have altered. When this issue is combined with the diversity and isolation of working in rural settings, there is a potential for significant dissatisfaction with the role, which may impact the ability to recruit and retain community nurses.

A lack of a clear professional identity was also raised as an issue for community nursing within the literature, which impacted on the perception of community nursing within the health care sector. Community nursing is an extremely complex discipline within nursing which cannot simply be broken down into a specific skill and knowledge sets. Community nurses work with a diverse range of clients in very diverse settings that requires a high level of knowledge, flexibility and skills. Despite this there is limited discussion on the need for the development of critical thinking and risk assessment and analysis skills for community nurses or the best way that these may be delivered. Due to the diversity of settings and situations in which community nurse's practice it impossible to be prescriptive in terms of service delivery or policy and procedure development determining practice, which are important aspects of best practice, yet within community nursing have had little focus.

While the community nursing role remains diverse by necessity, the development of new roles and services have anecdotally had an impact on the role but there is little information and research in relation to this. For example, many GP practices now have practice nurses who undertake many similar functions as community nurses. There has also been the advent of specific specialist community nursing roles such as breast care nurses, continence nurses, and palliative care nurses and the provision of community based care by hospitals. Similarly in Tasmania there are an increasing number of private providers and overarching program and policy changes such as the implementation of consumer directed care which further impact on the traditional community nursing role. Despite these significant issues job satisfaction has been shown to be very high among the community nursing cohort.

Tasmanian community nurses have anecdotally commented on the factors which impact their work and role; however, there has been very limited research to more accurately identify the issues affecting rural community nursing practice in Tasmania. This research project aimed to examine the personal and organisational benefits and challenges community nurses experience when working in rural and remote areas of Tasmania and to better understand the skills, practices and experiences of community nursing when caring for clients in rural community settings where other health care organisations are little present.

Methods

Aim

The study aims to examine and understand the skills, practices and experiences of community nurses when caring for clients in the rural Community settings where other health care organisations are not always present.

Research questions

The study attempts to respond to the following research questions:

1. What services are being provided by community nurses across the rural areas of North and North-West Tasmania?

2. What are community nursing needs within the community area and how might these be improved?

3. What are the enablers and barriers which community nurses encounter when working in rural communities of Tasmania?

4. What strategies are being used by community nurses to facilitate care and manage the current needs of the community?

Setting

The setting in which the research project was conducted was the North and North West of Tasmania. The larger centres of Launceston, Devonport and Burnie were excluded from the study as they are not classified as rural but as 'outer regional' and within these more 'urban' centres community nurses work in larger teams with very differing structures and support levels compared to their more rural counterparts.

The study sites included thirteen THO public sector community nursing services which currently employ 36.6 (FTE) staff, with the majority being female with only two males identified within the cohort. Ten rural community nursing services are located in the northern THO area and six rural community nursing services are located in the North-West THO region as outlined in Table 2. In addition, there are three non-government community nursing service providers. These include TAS Independent Nursing, Southern Cross Care (TAS) Inc. and RDNS Home Care Limited who employ small numbers of registered nurses. These private providers cover broader areas and which include some urban areas as outlined in Table 3.

Table 2: *Rural community nursing services in North and North West THO areas*

Service	Community nursing No.	Community nursing FTE
THO North area		
Beaconsfield District Health Service	5	3.4
Campbell Town Health and Community Service	1	1.0
Deloraine District Hospital	3	2.5
Flinders Island Multipurpose Centre	1	1.0
George Town District Hospital and Health Centre	4	1.9
Longford Community Health Centre	3	1.6
North Eastern Soldiers Memorial Hospital	4	2.9
St Helens District Hospital	3	1.16
St Marys Community Health Centre	3	1.1
Westbury Community Health Centre	2	1.0
THO North West area		
King Island Hospital and Health Centre	1	1.0
Rosebery Hospital	4 + Agency staff	5.61
Smithton Hospital	5	2.25
Strahan Community Nursing Service	1 + Agency staff	1.0
Ulverstone Community Nursing Service	15	7.18
Queenstown Hospital	1	1.0
Zeehan Community Nursing Service	0	1.0
TOTAL	56	36.6

Table 3: *Non-government community nursing in North and North-West THO areas*

Organisation	Community nursing No.	Community nursing FTE
RDNS Home Care Limited	Unavailable	Unavailable
Southern Cross Care (Tas.) Inc.	2	1.0
Tas. Independent Nursing	2	1.4
TOTAL	4	2.4

Design

The research adopted a qualitative approach using semi-structured interviews for data collection. Data collected from participants provided information about the rural workforce challenges, gaps in services and community nurses' current ability to provide adequate health services to rural communities. They also provided information on the organisational and personal factors impacting on the provision of community nursing services.

Sample

Data were collected from short, semi-structured interviews with 15 community nurses. These participants were experienced, Registered Nurses working in rural areas of North and North-West Tasmania. As the main purpose of the qualitative research was to provide an in depth understanding of rural workforce challenges, gaps in services and community nurses' current ability to provide adequate health services to rural communities, it was not deemed necessary to recruit a large number of participants. As discussed by Patton (1990, p. 169), "The logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research". Also, Merriam (2009, p. 48) suggested "to discover, understand, and gain insight... one needs to select a sample from which one can learn the most". Therefore, the relatively small sample of 15 participants was considered to not affect the quality of the research project as the focus was on the richness and depth rather than on the breadth of information obtained.

Recruitment

To achieve the aims of the study, only community nurses working in a permanent capacity were invited to participate in the project. In the case of public sector community nurses, only those who worked exclusively in rural areas were recruited with a focus on including as many community nurses from as many different sites in the study area as possible. However, as there were no private providers with staff who only worked exclusively in rural settings it was not possible to utilise this same criteria for recruiting private sector community nurses and the nurses interviewed from this sector worked in both rural and urban settings.

To facilitate recruitment, every Director of Nursing across the study area was contacted and information provided to them regarding the project. Permission was then sought to contact either the Nurse Unit Managers responsible for community nursing services or Community nursing staff directly to recruit participants for the project. Thirteen of the sixteen sites granted permission to contact community nursing staff at their site. Community nursing staff were then contacted directly at each site and information regarding the project was provided.

All community nurses expressing a desire to participate in the project were interviewed. All of the sites in the Northern region indicated a willingness to be involved with only three of the six sites in the North West region agreeing to participate. Following contact with community nursing staff and on receipt of their consent to participate in the project, an interview was arranged at a convenient date and time.

Instruments

Participants were interviewed either face-to-face or by phone between September and October 2013. A semi-structured interview process was used involving six key questions (Appendix A). Each interview was between 30 and 90 minutes and was audio recorded with the permission of the participants. Each interview was subsequently transcribed by the interviewer into a Microsoft Word document and each interviewee was provided with a transcript and invited to edit, change or add information to the transcript as required. All data were coded to ensure confidentiality and stored on a password protected computer. The project received approval from the Human Research Ethics Committee (Tasmania) Network (Ref Number: H0013420).

Data analysis

The transcribed raw data were cleaned and imported to NVivo 10 software, which was used for data collation and coding. Data were then thematically analysed to systematically identify recurring themes, behaviour and experiences arising from the interviews. Grouped data were subject to double checking to ensure the integrity of the information. Additionally, thematic analysis of data were done to identify key patterns and trends in the data and to compare expressed views. 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. Data were coded and, where necessary, extra nodes built into the schema. A number of quotations have been included in the report to illustrate and support the accounts emerging from the textual responses.

Results

Introduction

The participants comprised fifteen community nurses, including thirteen females and two males; and thirteen THO employees and two private community nursing service employees. Eleven nurses were from the Northern region and four from the North-West Tasmanian region. The role, function and structures of community nursing services varied greatly from site to site and between public and private providers. For example, some nurses were sole practitioners working largely in isolation, others worked in small teams with other community nursing staff, while others worked with enrolled nurses or carers. In addition, some community nursing services were predominantly centre based with staff rarely providing nursing care in client's homes, while others worked predominantly in the community with minimal or no centre based service provision.

The collective experience of the community nurses was 132.5 years, with an average of 8.8 years. The least experienced community nurse had been working in a community setting for less than twelve months and the most experienced had been working in the community for twenty-five years. Four nurses had been working as community nurses in rural areas for over twenty years and nine for eight years or less.

The qualifications of the community nursing participants were also diverse and included

- seven with no post graduate qualifications;
- one registered as a mental health nurse;
- one with a diploma in Community Health;
- one completing a diploma in Community Health;
- one with a post graduate nursing degree;
- three who had undertaken midwifery training but two let their registration lapse; and
- one who was a registered midwife, registered child health nurse and had a diploma in health science and frontline management.

This variation in qualifications, experience, and service and staffing structure resulted in significant diversity in the roles and functions of the community nurses that participated in the research study. This diversity is likely to have impacted significantly on the issues identified by each participant.

A number of key themes were considered within the data and included the motivation for working as community nurses; services and models of community nursing care; 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. Each of these themes is discussed in detail.

Motivation for being a community nurse

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

Approach and philosophy of the role

This was the most commonly cited motivating factor by participants with ten of the fifteen nurses commenting on this being a factor in choosing to work in the community nursing area. Nurses spoke about wanting to help clients to remain independent; empowering 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. For example, comments included

> *Community health seemed to be probably the way that you had the most opportunity to work with people on their own terms around managing their health and wellbeing. (CN 1)*

> *I liked the contact with the community, to actually go into people's homes, assess their needs and help them resolve health issues... and help them to help themselves. (CN 6)*

> *I loved visiting people in their own home; they were in charge rather than me being in charge and just going into their own home environment and respecting their wishes and then just chipping away slowly at the edges… was really very rewarding. (CN 2)*

These responses regarding motivation demonstrate that the community nurses value a primary health care approach and being able to focus on health promotion, and illness prevention. It is this community based, client centred approach which results in community nurses being well placed to work with clients in community settings to promote and maintain wellness (Brookes et al., 2004).

Practical factors of the role

The second most commonly cited factor for working as community nurses was for practical reasons. Nine of the fifteen nurses highlight 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 outlet 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 rural lifestyle.

Client factors

The third most commonly cited 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 clients 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 one case a nurse stated

> There's real rewards with the family, you get to know the family and the family really appreciate what we do for them and it's totally different… be[ing] involved for such a long time. (CN 8)

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

Job satisfaction

Participants discussed job satisfaction which was universally reasonably high. Four community nurses rated their job satisfaction as seven out of ten, two rated it as eight out of ten, two rated it as eight or nine out of ten, two rated it as nine out of ten, and one rated it as ten out of ten. The remaining four participants did not score their level of job satisfaction, but two provided further insight into their satisfaction with the following comments

> The actual job, much as I don't love the paperwork side of it there's nothing I hate about it and a lot of the job I really love, the most of it, the doing part is great. (CN15)

> I am enjoying the patient care but I'm not enjoying the paperwork and everything that comes with it. (CN6)

A number of nurses did however comment that job satisfaction varied and this was highlighted when one stated

> I'm pretty happy here but then there are days that are absolutely awful because you have your palliative [patients] and it's really gut wrenching when you become involved in the family and it's emotionally draining. But then other days the wounds

> *heal up and people get back to their normal life and the rewards are there because of that. (CN 8)*

Community nursing services and models of care

Although the study included a relatively small number of nursing services, provided primarily by the same organisation, there was significant variation in the type of services provided by community nursing staff and their models of service delivery. The service delivery models varied from services being provided only on Monday to Friday with no weekend cover, other services provided six days a week, while some provided a twenty four hour a day seven day a week service. Staffing structure also varied between sites. For example, the variation comprised of five community nurses working as sole practitioners; four working as the sole responsible community nurse with managerial responsibility for health care assistants or enrolled nurses; and five working in small teams with other community nurses and health care assistants.

The main location for service provision also varied. The majority of public sector services provided mobile services primarily in home and community settings; however, two of the public sector services provided the majority of services in a clinic setting only visiting clients in their homes when absolutely required. Community nurses in the private sector only provided care in client homes.

The types of services provided had some commonalties among all participants with wound care as one of the biggest components of the role. Other activities included provision of palliative care services, medication management, continence management, monitoring and health assessment and referral for other services. There was however some variation in the acuity of services provided at different locations. Four community nurses commented on working with clients with more complex needs, stating that they undertook more acute care activities, such as managing PICC lines, de-accessing chemotherapy, administering antibiotic therapy, changing Baxter pumps, performing venepunctures, and INR monitoring. Two participants commented that this was "a little bit more exciting" (CN 3) and it "has been great, that's been something to update our skills with" (CN 2).

Four Community nurses spoke about the diversity of their role, being a "gamut for everything, a one stop shop" (CN 7) and the role being "quite a variable thing" (CN 1). Community nurses at two sites were required to act as an 'Emergency Department' and provided a particularly diverse range of services as they were required to deal with "anything that comes through the door; chest pain, god forbid a woman in labour, a sick kiddie, that can be anything" (CN14). Participants also spoke of having to adapt or change their practice in line with community needs or their situation.

Two community nurses spoke of working in close conjunction with GP practices which had no practice nurses, so they were required to take on the practice nurse role. One stated "we do all the injections that they want done, BP checks, blood glucose levels, troponins, ECGs, venepunctures, yes all that sort of general GP type work"(CN 4), and "because the GP doesn't have a practice nurse, so we tend to pick up a bit from the GP practice" (CN 14).

One nurse spoke of having a broad role and having to undertake a significant management role, citing

> *It's because we live in an area where there are no resources and it's not financially viable for your non-government organisations to have someone on the ground to manage different pieces of the health service so the Community nurses' role here is quite broad. (CN 1)*

Another participant discussed that

> *in the interests of good health and keeping [someone] mobile and all that sort of thing we do little things, I think everyone does in a remote place, you try and work out a way that they can get around it until something actually official happens... you can't say to someone well I'm not going to cut your toenails while they're growing for twelve months… it's like all the animals that get brought up for treatment sometimes. (CN 4)*

These responses demonstrate that the community nursing role and function has been adapted in some areas to meet specific needs of the Community and reflects the literature which indicates that community nurses often become the "catch-all" in the provision of health services, particularly where there are limited other health care providers (Hegney, McCarthy, Rogers-Clark, et al., 2002). An important consideration in relation to this issue is that community nurses may feel pressured to work outside their scope of practice. Two of the community nurses interviewed stated that they were responsible for providing foot care for clients due to a lack of other available service providers, yet neither of these nurses had received any specialist training or education to provide this service.

The two nurses working in the private sector had a significant management and administrative role incorporated into their positions. One was involved in coordinating federally funded packages of care, undertaking assessments, reviewing packages of care and case management. In addition, they were responsible for the supervision of carers which took up the majority of time although they were required to provide hands-on-care to high level clients with packages of care. The other private sector community nurse was also involved in the management of federally funded packages, but also undertook significant brokerage work and carer education. In comparison with the flexibility of the public sector

community nurses, both private sector nurses only provided care in accordance with formal service delivery agreements.

All community nurses were asked about the health promotion aspect of their role and what, if any, types of health promotion activities they were involved in. Responses varied with some participants being involved in distinct community health promotion activities such as facilitation of the *Stanford Model* chronic disease self-management courses and health promotion activities at local agricultural shows or breast cancer awareness events. Others highlighted the health promotion aspect was mainly one-on-one education with clients and their families.

Other participants stated they just had no capacity to undertake any health promotion activities as part of their role, although all of them considered this an important and valuable component. In addition, three nurses commented on the need for additional resources and support for health promotion activities and health education. They felt this was an important aspect of the role and would like to do more but lacked the resources or time to meet these objectives. One commented

> *We do one to one health promotion with anyone who we're talking to and dealing with but I feel there's lots more I'd like to do in and around the Community... there's lots of different other things that we could do locally in the Community, I'd like even to have the time to get around and talk to people about what do they want to know and what do they feel they need to learn. (CN 15)*

Benefits of community nursing

Each nurse was questioned about the benefits of community nursing and responses are discussed in detail.

Client factors

There were twelve comments in relation to client factors as benefits of community nursing. 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, and 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)

Nursing approach

Nine comments were made in relation to benefits of 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 comment included

It doesn't matter whether the person, who put on the dressing, got it healed or the podiatrist has done the debriding that they wanted to do which worked, it's all about the best outcome working collaboratively as a team and I think that's really important in the Community.(CN 12)

While another 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 7). Community nurses also commented on the benefits of promoting client independence, 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 3).

Autonomy and independence

This was a significant benefit cited with six nurses commenting that they liked to be able to structure their own workload, to have flexibility and no set times to have things completed and being independent and solely responsible for the outcomes of the care they were providing. This was reflected when one nurse stated

Basically I enjoy the autonomy of it. Just me and one client working through some problems, whatever the problems are it didn't matter, it was just me, none of that stuff that really slows you down. (CN 5)

Organisational factors

Beyond autonomy and independence, organisational factors, were cited as being beneficial to Community nursing and included physical resource factors and training and development support. Four nurses commented on the benefits of community nursing forums, which are

one day professional development forums for all community nurses that are held in the north of the state once every quarter. Nurses felt these offered networking and training opportunities and were a valuable resource. Three of the community nurses specifically commented on the level of support provided by their managers as being of significant benefit to their practice. They spoke of being well supported to attend professional development, being provided with flexibility in their work role, management being receptive to new ideas, and being provided with appropriate resources for their role.

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 and 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)*

One more experienced community nurse commented on the fact that they believed the increasing use of personal carers and non-nurses was contributing to clients developing wounds and increased the workload of community nursing. They stated

> *Clients tend to develop wounds unrecognised because staff are not qualified or trained or educated in being able to see the warning signs for an oncoming ulcer or whatever so they don't, and by the time they actually get to the point of finding it it's a couple of stages down where it shouldn't be…They handball them to us to actually fix the problem. (CN 10)*

Three nurses commented on the changes in relation to wound care and management and consultation processes, particularly citing an increasing number of clients with wounds and more structured processes. This included the measuring and photographing of wounds and

increased consultation with staff with a wound care portfolio or wound care expertise. Three nurses also commented that they felt there was an increased expectation that they should be more involved in health promotion activities and chronic disease management.

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 8), "well I think it came from [the manager]" (CN 2) 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 7) scattered with quieter periods.

Challenges of community nursing

In addition to the changes in community nursing service delivery, a number of challenges were outlined. Two areas were identified and categorised into challenges associated with service delivery and challenges associated with service management and structure which is discussed in detail.

Service delivery challenges

The challenges associated with service delivery included service provision issues, communication and integration issues, issues associated with community nursing boundaries, workload and palliative care issues.

Service Provision

Nine nurses commented on the challenges concerning having sole responsibility for decision making and care, with some 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 Community nurses worked in isolation and where there was an expectation to provide emergency services. One nurse commented

> *The only one that still worries me after all these years is a woman who comes in in labour and I just think oh holy shit what are you doing here? I mean we've got very limited stuff here, I've got suction and syntocinon and ergometrine and a delivery tray but I'm not [midwifery] trained. I haven't been anywhere near a woman in labour for probably twenty years and it's not something that I want to go anywhere near. (CN 14)*

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 poorer health outcomes as a result of this; and feeling obligated to the community because of the level of contact and involvement. One nurse commented

> *You do have relationships with them; they are not just someone who you don't really know in the community. Like you can't just leave people, there's no other service so you feel that there's a sense of obligation there that you really need to be there for people (CN 14).*

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. Again, this was a greater issue for nurses working in more isolated areas. One nurse felt that this, at times, compromised client care. This community nurse stated

> *I mean I can't just go up to the shelf and pick a silver dressing. I can't do that whereas for instance someone in [an urban centre]... can have the silver dressing because they can just get a script from the GP, specialist or whoever and just take it down to the pharmacy and you get it. For me [that takes an] extra week. Look, I suppose in some respects patient care sometimes is compromised because of the distance and the isolation. (CN 14)*

Lastly, two community nurses commented on the challenge of 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 with other services

Communication and integration was the second most significant challenge highlighted by community nurses with nine nurses making reference to this issue. The varying challenges associated with communication and integration cited 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 and had varying expectations in relation to service delivery.

Other challenges included the time taken to make referrals and then have these followed up, getting access to services, and receiving feedback on particular issues. In addition, another challenge included not feeling supported by other staff or services and difficulties working

collaboratively for the benefit of clients. Discharge planning was specifically identified as a challenge. One community nurse stated

> *There's no idea of peoples circumstances at home, I mean whether they're going home alone whether they've got a carer and who's caring for who…and how are they going to manage with the type of dressing that they have got on or the fact that the bandage is wrapped round their foot and they can't get their shoe on. At home [how do they]... mobilise to get to the toilet and to get their meals. I mean it's a bit different to lying in a hospital bed where everything is done for them so there's not a lot of thought given to environments, the showers and the baths at home... Do they need to have that equipment in place before they're discharged... and don't send them home on a Friday afternoon for a weekend with no weekend service.(CN 12)*

Boundary issues

In terms of boundary issues due to working in the communities many nurses were also living in, nine nurses discussed this as being a challenge. The following comments illustrated this fact

> *The challenge is living in a small community; the confidentiality is a huge issue. A lot of times like I'll get people come up to me and say do you see so and so she needs something and it's like well I can't really talk about who I do or don't see and because I know everyone and everyone knows me it's difficult to separate that role of health care provider and just [a] person on a Saturday or a Sunday, so that's a challenge separating those roles. (CN 13)*

> *I had a phone call in Launceston yesterday when I was on a day off; somebody's dog had bitten them. (CN 12)*

> *It's challenging sometimes to maintain your professional boundaries as well because with palliative clients you get close to their families and just clients in general but you've just got to remember you're not their friend, you're providing a service, you're a professional. There's got to be some sort of a barrier there. Yes you can bring in a couple of bits of wood but you're not out chopping the wood you have to resource someone to do that so that's a challenge some times. (CN 2)*

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. One community nurse commented

> *I don't know how I draw the professional boundary and the friendship boundary…*
> *but that line is there and I'm not actually even aware that I'm doing it but no it's not a*
> *problem, I seem to just set it, I can't define it.(CN 12)*

While another stated

> *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 know that 'look I am not on*
> *duty now but if you'd like to talk to me later in the week' or refer them to somebody*
> *who they can talk to if they don't want to wait until then. I think initially that was a*
> *wide learning curve, but certainly I have moved on and have fairly clear boundaries, I*
> *don't think you'd survive without that. (CN 1)*

Workload challenges

Seven community nurses commented on increasing paperwork as being a significant challenge, they commented that this was taking considerable extra time and that the time taken to complete an admission had increased significantly. In addition, it was felt there was a lack of consistency in the paperwork between community nursing services, and that the introduction of additional requirements such as those associated with the iPatient Manager (IPM) system had further increased the time factor associated with paperwork.

Participants commented on work pressures which impacted on service provision and the activities they were involved in. This particularly related to the provision of health promotion activities, which five nurses stated they did not have time to do, even though they felt this was an important aspect of service delivery. Nurses also commented on not having time to attend or participate in professional development activities and having a lot of work and too little time to do it. One participant stated "you always need more time, more time to be with people, especially with the palliative cares, you've never got enough time" (CN 3).

Further, two community nurses discussed how they had adapted their workloads to ensure they were more manageable. One community nurse stated

> *It used to be a challenge when I used to try and get to see everyone and I don't do*
> *that anymore, I used to think 'oh I have to see Fred (pseudonym) because I haven't*
> *seen him for a while' and it was silly because you'd go over and then they'd get more*
> *dependent on you. So I don't do that anymore. I feel quite comfortable now making a*
> *phone call and saying I can't come to see you today... I don't feel guilty about that*
> *anymore. I think I've learnt that over the years. (CN 3)*

The private providers also commented on having increasing workloads. One commented on the change to consumer directed care and new Commonwealth guidelines and having to

increase the provision of care to Home and Community Care (HACC) clients. They stated "I don't know where I'm going to find the time to do that" (CN 9). The other private provider had a particularly high workload and stated their service never said no or closed their books. They started work at 7.30am and usually didn't finish until 1.00 or 2.00am and were on call 24 hours a day and every second weekend.

Palliative care challenges

The final service delivery challenge related to the provision of palliative care. Five participants commented on the challenge of caring for palliative clients in their own homes. Comments which were indicative of this included:

> *A big issue, particularly I think for me at the moment is the challenge is the death and dying issues. Because you know people here... you're basically caring for people who you know already... there's a lady at the moment who's a good friend and she's going through palliative care and I've had to look after her at home through community nursing and yesterday she just had to move to the hospital for her last stages so that's really challenging emotionally I think. ...It's people who you know so it's just difficult to do that. (CN 13)*

Similarly, another community nurse stated

> *We've had people just in those last two weeks of dying and a few times last year we did have that and it really got to me much more than I expected. To see young people, sort of middle aged people who are dying there and you see the whole family, it is very stressful and then you go there daily and for months sometimes and that's been a really big challenge for me. (CN 6)*

One of the nurses interviewed did comment that they particularly enjoyed the palliative care aspect of community nursing stating

> *I just loved being involved with the whole family environment and being nurtured in with that family environment too I really found that very rewarding , very special, very special time, very honoured to be allowed to do that. Just the difference to being in the hospital environment where you just don't get that, that same sense of being able to help and making an important impact on their last days of life. (CN 3)*

The challenges associated with caring for palliative care clients was not something discussed within literature regarding community nursing and an area that perhaps warrants further investigation.

Management and structural challenges

In addition to the service delivery challenges, a number of management and structural challenges were identified. These included staffing, workplace health and safety, training and support, and the challenges pertaining to students.

Staffing and occupational health and safety issues

Nine nurses commented in relation to staffing issues, citing factors such as lack of relief staff and working in isolation which did not provide any avenues for debriefing or the opportunity for discussion or self-development through visiting clients with colleagues. A lack of a stable staff structure was also identified, in addition to loss of senior experienced staff resulting in a loss of knowledge and capacity of the service. Beyond these issues, there 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 were cited as challenges. One community nurse commented on a lack of Full time Equivalence (FTE) per head of population and differences in staffing levels between areas as an issue.

In addition to staffing issues, a number of workplace health and 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 the isolation of services and accessing resources, and the 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 needed to travel for the provisions of care were also highlighted by a number of the participants.

Training and support

Eight nurses highlighted that training; professional development and staff support were at times challenges. This related to a lack of training opportunities and difficulty accessing these. This was illustrated by the following comment:

> *Yes we have access to that but again there's the challenge you have to justify that to your manager, you have to be able to get the time off, the money is available there to do stuff but to actually get time off to go and do that. There's no 'you're entitled to so many days a year or whatever' you have to just hope that [management] are supportive of that. [For example], I wanted to go to a palliative care conference earlier this year... [it was] canned because there was going to be no one who could relieve me at all so there are challenges with that. (CN 13)*

An additional issue raised by one of newer community nursing staff was the lack of specific community nursing training or formal preparation for the role, they commented

> *I've probably been flying by the seat of my pants for a fair bit of [my time here]. There was no real transition to move from one to the other, it was basically if you're going to do it, hold your breath, jump and hope for the best. Things have been OK but I think that is something that really needs to be looked at. I think there is a big issue. (CN 13)*

Students

Increasing student loads were also highlighted as a challenge although many nurses recognised the need for students to have appropriate placements and be well supported. Comments included that there was an increasing expectation that they take students and that students added significantly to the community nursing workload and the time taken to complete tasks. One nurse commented:

> *Well I had ten students in five months... [I was] absolutely burnt out and it wasn't fair on the students either... [and] the paperwork got behind because you just can't do it. Then management says well let the students do the paperwork but I know how long it takes me to do an assessment... You still have to guide them through and I can't do something else, I've got to sit there and answer for them and it just takes a long time to do that and when you're busy and I mean they've got to learn I know that but I just find that's quite onerous and exhausting. (CN 12)*

Two nurses also commented on feeling that they had limited time to teach students, one stated

> *There's just not the same knowledge that there was when we were doing hospital training. For example, in those days people would see so many more in their training whereas I've had students in their final year nearly qualified as RNs who've never really seen a wound or a product and wouldn't know what was what and so it's a real challenge for us... because we're trying to teach them what took us three years to learn in the old days we try and cram that into four weeks. (CN 15)*

Future community nursing needs and issues

Many nurses struggled to provide insight into the future needs of community nursing services, however many nurses were reasonably satisfied with their work situations. As previously mentioned, some 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. The key themes which emerged were in relation to resources, training, professional development and support, improved referral and communication systems, additional services, greater recognition and respect for the role and changes to the administrative aspects of the role, which will be further outlined.

Additional resources

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 workplace health and safety 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. (CN 15)*

In terms of physical resources a number nurses stated that they felt well-resourced, 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, 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.

Despite these resourcing challenges, many nurses commented that they felt they were well resourced and reflected comments such as "I think we're really well resourced" (CN 7), and "really I think we do pretty well in that regard in terms of I feel very well supported by my local managers, they've never knocked me back" (CN 15).

Improved training, development and support

Eight community nurses commented on requiring 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 which was reflected in the following comment:

> *It would be just wonderful to be able to Skype people and have more of a meeting using Skype so that we're more involved and also education, I know that in at Launceston community nursing they have regular education on a Wednesday afternoon (and) it would just be fantastic if we could have that on the Intranet so we could sit here in the office but still be part of that. (CN 8)*

Improved referral and communication processes

This issue was identified as a significant challenge for community nurses with six nurses citing the need for improved referral and communication processes and indicating that this improvement would impact significantly and positively on their practice. Comments in relation to this issue included

> *The GPs are very accessible but we have to go in there and talk to their nurses, we have to actually seek them out and the pharmacist, you know they all work very much independently and you really don't get the feeling that we're involved. There can be really poor communication between all the different disciplines and you know you often go to visit a client and they will complain because you should know that because doctor such and such has told me and why don't you know that. (CN 8)*

Further, another community nurse stated

> *More collaboration between organisations, it would be lovely... there's too much territorialism and that would be nice to be able to break that down and be able to work more collaboratively with clients... but I'm not sure that's ever going to be … because I think there's too much competing interest in the dollar value of care that's currently being provided. (CN 10)*

A review of the TasCare Point referral system was suggested by one nurse as they felt this, at times, complicated and delayed the referral process.

Improved perception of the community nursing role

There were challenges identified that were associated with the perception and recognition of community nurses and their role by nurses working in other roles. One nurse stated that she

felt her peers thought that community nursing was "what you did when you had nothing else to do, it wasn't something that had any challenges" (CN 1) and another stating

> *Community nursing must be an easy way to go... [but when] we sponsor university students... they have some of the weirdest perceptions of community nursing before they get to us and when they leave they go 'oh we didn't realise it was going to be so difficult'. They were told it was just like cup of tea and scones, maybe the old district nurse of sixty years ago that was the way they operated, but it's very diverse now. (CN 10)*

Another nurse stated that a significant frustration of the role was "not being appreciated by colleagues, I mean the clients are all very appreciative of what you do for them and that's so rewarding, but I think it's the perceived lack of support because of the lack of understanding of the role of the community nurse" (CN 12).

Six nurses cited a need for more support and understanding, a need for increased value of the role by government, a need for more respect for the position, and a need for other nurses to recognise the value of the role. One nurse commented;

> *We need I think to focus on this role being valued, it is the role for the future, it is the future of nursing in the current climate of the country, the world as far as…continuing to support people in their homes. (CN 1)*

Review of community nursing paperwork

As with referral and communication processes, nurses cited paperwork as being a challenge and this was identified as a future need as well. Six nurses stated that they thought service paperwork should be reviewed, standardised and rationalised. One nurse commented "axe some of the paperwork" (CN7), another "to actually admit a patient you'd need several hours to complete all the paperwork with the patient … but invariably I don't have a few hours" (CN 4) and another made the following comment

> *Some help with the paperwork or streamlining the process or actually probably asking community nurses what works for them because they've got all these new forms coming out and paperwork that has to be filled in… they throw on new bits of paperwork and things and I think we need to be asked what's really relevant. (CN12)*

Additional services

Six nurses highlighted the need for additional services, which primarily focussed on the need for additional out of hours, palliative care support and increased community support services

such as carer support. This need for after-hours services was summarised in the following comments

> *Some form of after-hours service, but that needs to be flexible….. for wound care on weekends, public holidays, medication, Clexane injections is a prime example, they're needing that daily (but) some are needle phobic and they're not happy to be trained and then where do they go, and it's wound care for those heavily exudating wounds or packing of wounds and cavities that really do need to be done. (CN 7)*
>
> *Probably just palliative care clients… I think it would be really good if you had someone who could go in the last two to three days. (CN 11)*

Summary

There were a number of variations in the structure of the community nursing service delivery across the north and North-West. Some community nursing services were 24 hour seven day a week, some were predominantly centre-based, some were predominantly community based, some utilised a team approach and others were sole practitioner. While 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 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 and others were predominantly involved in assessment and review of clients. There was some evidence that community nurses had picked up the provision of aspects of health care when no other services or staff were available.

Community nurses stated they experienced high levels of job satisfaction and many had been in the role long term, despite outlining significant issues and challenges. Community nurses had high levels of commitment to the role and to their clients, demonstrated a willingness to be flexible in meeting client needs and had high levels of motivation. The key motivations outlined for working as a community nurse included:

- The primary health approach and philosophy of care was valued while the role provided the ability for flexibility in meeting client needs;
- Client autonomy, service appreciation and greater client focus within the service; and
- Practicalities of employment, such as not having to work shifts, "family friendly" hours and their employment being located near to where they lived.

The benefits of community nursing and motivations for working in the role included the nursing approach; the clients and their level of autonomy and independence; the diversity of the role; and the work hours. Nurses cited an increased acuity and altered expectations of the role, although they were not always clear where these altered expectations had developed. In addition, many nurses highlighted the difficulty to find time to undertake health promotion activities although they felt this was an important aspect of the role.

The key challenges and issues identified by community nurses included:

- Coping with altered and increasing expectations of the role and maintaining the knowledge and skills to deal with the diversity of the role;
- Communication and integration with other service providers particularly relating to discharge planning, integration of care and having open dialogue with acute care settings;
- A lack of understanding regarding the role of community nurses and being undervalued;
- Meeting increased workload requirements, role expectations and non-nursing administrative requirements;
- Maintaining boundaries within the rural community nurses were living and working in;
- The emotional stress and pressure of working with palliative care clients;
- Workplace Health and Safety issues associated with working in isolation; and
- Access to training, support annual leave due to lack of relief staff.

The data were reflective of the literature with altered role expectations, increasing acuity of clients and at the same time an increasing number of clients affected by chronic diseases, difficulties in obtaining and accessing training and development, workplace health and safety issues, difficulties obtaining relief, and issues associated with the maintenance of professional boundaries being commonalities (Wakerman & Davey, 2008). Future community nursing needs identified by study participants largely reflected these challenges.

While a number of key challenges have been identified, nurses felt they were well supported by their managers and well-resourced from a practical perspective to undertake their role. In addition, it was shown the more experienced community nurses had developed specific strategies or approaches to address these challenges. For example, programs of rotation through community nursing service areas were established, while volunteer programs and additional cancer support programs were developed to provide additional support to clients. This was indicative of the nurses using and developing innovation, initiative and self-reliance within the service.

Conclusion and recommendations

There are considerable factors impacting on the function and structure of community nursing. These include an increasing emphasis on the provision of more acute services in community settings; demographic changes such as an ageing workforce and an ageing clientele; an increasing incidence of chronic disease and a focus on illness prevention and health promotion activities to address this issue; and the increasing development of specialist nursing roles in community settings. In addition there are economic factors placing pressure on the provision of resources and indicating a need to remodel health service delivery systems so they operate more effectively and efficiently. The impact of these factors on community nursing services in Tasmania is not well understood and has been little researched.

This research project aimed to identify the personal and organisational issues and challenges encountered by community nurses working in rural areas in the North and North-West of Tasmania. It also sought to examine and understand the skills, practices and experiences of community nurses when caring for clients in rural community settings where other health care organisations are limited or not always present.

The research adopted a qualitative approach using semi-structure interviews for data collection. Fifteen Tasmanian community nurses were interviewed. Data collected from participants provided information in relation to the motivation for working as a community nurse; the skills and experience as community nurses; the benefits and challenges of working in a community nursing role; changes in the expectations of the role; and benefits for the future positive development of the role. Nurses interviewed also provided information on the organisational and personal factors impacting on the provision of community nursing services.

This study identified key challenges and issues faced by Tasmanian community nurses. These included altered and increasing expectations within the community nursing role; challenges maintaining all of 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 shown 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; a lack of relief staff; inadequate access to ongoing training and professional development; and workplace health and safety concerns.

These issues were largely reflective of previous research and literature. However, this study further identified the emotional stress and pressure of caring for palliative care clients; increasing administrative and paperwork requirements associated with the role; and the impact of having students on placement as significant issues which had not been observed in the literature previously. As a result, a number of key recommendations were formulated to address a number of key concerns highlighted. However, it must be noted that due to the small sample size and the diversity in roles and service delivery types it is difficult to make broad generalisations for services outside Tasmania. Nevertheless, five key recommendations are made to enhance and augment the role of community nurses and the service they provide in Tasmania.

Recommendations

The following recommendations have been identified for consideration to augment current and future Community nursing services in rural and more urbanised areas:

1.   Additional resources and services

A need was identified for additional staffing, particularly relief staff; improved communication systems to address workplace health and safety issues; and improved IT resources and systems particularly telehealth facilities to promote access to training and support. Given the diversity between sites consideration may also need to be given to establishing appropriate standard community nursing to patient ratios. Beyond this, additional community support services or processes are required to facilitate out of hours and palliative care support. The issue of after-hours care may become increasingly important if the community nursing role is expected to take on more acute and technical aspects to ease the burden on the acute sector.

2.   Improved training, development and support

Increased training and support is required to facilitate greater attendance at professional training and development activities. 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. Consideration should also be given to additional training and support in instances where community nursing staff have had to pick up additional functions, such as the provision of foot care, and GP nursing services which are not part of the 'normal' community nursing role.

3.   Improved referral and communication processes

The need for improved referral and communication processes was identified as a significant challenge for community nurses and if augmented would positively impact on their practice.

A review of the 'TasCare Point' system was suggested as this current process complicated and delayed the referral process.

4.   Review of community nursing paperwork

With reference to the referral and communication processes, community nursing paperwork should be reviewed, streamlined and standardised across the state. The introduction of new paperwork should involve consultation with community nursing staff and consideration of the factors associated with completion of this paperwork such as time requirements and how these will be met.

5.   Enhanced perception of the community nursing role

Lastly, there is a need for the profile of the community nursing role to be increased. This is required to be an across the board process, where the value of the role is recognised and reinforced by government, professional organisations, unions and extended to other nursing roles. 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. There is the potential for the development of enhanced role options such as possibly advanced community nurse practitioners.

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Appendix A – Questions for interview participants

Questions for interview participants

STUDY TITLE: Rural Community nurses: Insights into health workforce and health service needs in Tasmania

1. Could you introduce yourself, including years of Community nursing experience and your current qualifications?

2. What was your motivation for working in a Community nursing role?

3. What current services are being provided by your service in this area?

4. What benefits and challenges do you experience when working as a Community nurse in this area of Tasmania?

5. What are some of the needs in the Community which are not being met by current services, particularly among the elderly?

6. Is there anything that you would like to see in the future to assist Community nurses in rural communities in Tasmania? If so, please share.

Appendix B – Ethics approval

20 August 2013

Dr Quynh Le
C/- Rural Health

Sent via email

Dear Dr Le

REF NO: H0013420
TITLE: Rural community nurses—Insights into health workforce and
health service needs in Tasmania

Document	Version	Date
Application Form – Low Risk	-	-
Consent Form for interview participants	Version 1.0	26 Jun 2013
Information Sheet for interview participants	Version 2.0	01 Jul 2013
Information Sheet for different community health centres	Version 2.0	01 Jul 2013
Sample letter to different community health centre	Version 1.0	26 Jun 2013
Advertising Flyer	Version 1.0	26 Jun 2013
Questions for interview participants	Version 1.0	26 Jun 2013
Letter of support THO North	-	10 Jul 2013
Letter of support THO North West	-	22 Jul 2013
Research Protocol	Version 1.0	26 Jun 2013

The Tasmanian Health and Medical Human Research Ethics Committee considered
and approved the above documentation on **04 August 2013** to be conducted at the
following site(s):

    Department of Health and Human Services Tasmania
    University of Tasmania

Please ensure that all investigators involved with this project have cited the approved versions of the documents listed within this letter and use only these versions in conducting this research project.

This approval constitutes ethical clearance by the Health and Medical HREC. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities are required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

All committees operating under the Human Research Ethics Committee (Tasmania) Network are registered and required to comply with the *National Statement on the Ethical Conduct in Human Research* (NHMRC 2007 updated 2009).

Therefore, the Chief Investigator's responsibility is to ensure that:

(1) The individual researcher's protocol complies with the HREC approved protocol.

(2) Modifications to the protocol do not proceed until **approval** is obtained in writing from the HREC. Please note that all requests for changes to approved documents must include a version number and date when submitted for review by the HREC.

(3) Section 5.5.3 of the National Statement states:

Researchers have a significant responsibility in monitoring approved research as they are in the best position to observe any adverse events or unexpected outcomes. They should report such events or outcomes promptly to the relevant institution/s and ethical review body/ies and take prompt steps to deal with any unexpected risks.
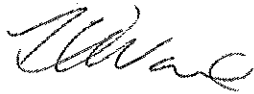
The appropriate forms for reporting such events in relation to clinical and non-clinical trials and innovations can be located at the website below. All adverse events must be reported regardless of whether or not the event, in your opinion, is a direct effect of the therapeutic goods being tested.
http://www.research.utas.edu.au/human_ethics/medical_forms.htm

(4) All research participants must be provided with the current Patient Information Sheet and Consent Form, unless otherwise approved by the Committee.

(5) The Committee is notified if any investigators are added to, or cease involvement with, the project.

(6) This study has approval for 4 years contingent upon annual review. A *Progress Report* is to be provided on the anniversary date of your approval. Your first report is due **04 August 2014.** You will be sent a courtesy reminder closer to this due date.

(7) A *Final Report* and a copy of the published material, either in full or abstract, must be provided at the end of the project.

Should you have any queries please do not hesitate to contact me on (03) 6226 2764.

Yours sincerely

Heather Vail
Ethics Administrator
Office of Research Services
Email: Heather.vail@utas.edu.au
University of Tasmania
Private Bag 01 Hobart Tas 7001