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A Template of Patient-Centred Professionalism in Community Nursing

Eight themes of patient-centred professionalism

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Executive Summary
The study sought to clarify the concept of patient-centred professionalism in community nursing. It did so through a series of workshops with community nurses—both experienced and newly qualifying, members of the public, and other stakeholders in community nursing (including educators, policy developers, and policy implementers). For the purposes of this study, our sample of study participants reflected our understanding of community nursing which includes all registered nurses and health visitors who work in a primary or community health setting.

Five workshops were held, with a total of thirty-four research participants. The community nurses who took part in the study were drawn from all types within community nursing: practice nurses, district nurses, occupational health nurses, mental health nurses and those who called themselves community nurses, nurse stakeholders (managers, educators, policy developers) and members of the public. The workshops took place in South West Wales, and utilized a range of qualitative and quantitative methods to clarify the concept of patient-centred professionalism.

During the course of the workshops, the research participants engaged in exemplar-building activities that endeavoured to disclose, through the Nominal Group Work technique, the key positive and challenging characteristics of patient-centred professionalism from the perspective of established community nurses, newly qualified/qualifying community nurses, members of the public, and other stakeholders, respectively.

Nominal Group Work is a research method that systematically enables key characteristics of the matter under investigation (i.e. the concept of patient-centred professionalism) to be disclosed, refined, and ordered.

The full set of characteristics that emerged from the workshops were synthesized and thematized, and each of the eight themes placed within a template of positive and challenging aspects of patient-centred professionalism. The template structures and presents the themes according to their relative significance, as determined by the ranking preferences of the study’s participants. The themes are:

- The patient
- Nursing ethos
- Community nurse as a person
- Knowledge and skills
- Working relationships
- Service delivery
- Training and information
- Environment

Within the Template, each theme will be described briefly and then in full, following an executive summary of all eight themes.

Taken as a totality, the template clarifies the concept of patient-centred professionalism in community nursing, and situates it within a nexus of perspectives that spans community nurses, members of the public, and other stakeholders.

The full methodology is presented in the Final Report (September 2010), which accompanies this document.
Overview of the eight themes of patient-centred professionalism in community nursing

The following eight themes of patient-centred professionalism in community nursing are presented in the rank order as determined by the study’s participants.

The Patient

Whilst there is consensus amongst patients, community nurses, and nurse stakeholders that the patient should be at the centre of community nursing, this is not self-evidently the case. Many patients see themselves as marginalized in relation to nurses’ concerns about bureaucracy and government policy. Patients are characterized by nurses as complex human beings, who need individual care packages and an holistic approach to care that requires considerable emotional labour from nurses. This can be personally rewarding and a key source of identity and pride for community nurses, but it can also be a source of anxiety, exhaustion, and guilt. There is an essentially reversible power relationship between nurses and patients: patients depend upon community nurses for care, yet since nurses perceive themselves as being “guests” in patients’ homes, patients have the ability to subvert, resist, and withdraw hospitality, and compliance. Overcoming resistance to care and treatment, which is a recurring theme in this corpus of work, is well illustrated by the ambivalence of the patient’s role in the eyes of nurses and stakeholders. Whilst they want patients to take personal responsibility for their ongoing care, they suggest that a symmetry of giving and receiving is difficult to accomplish. Patient care is not straightforward and the communicative aspect requires considerable social and negotiation skills that include showing “respect” for patients and caring with patients as much as caring for patients. Accordingly, the ‘patient’ in ‘patient-centred professionalism’ has multiple identities, many of which contradict or conflict with one another: a recipient and an object of care, a taker of care and a subject of care, and a force of resistance and a focus of negotiation.

Nursing Ethos

A nursing ethos is perceived to exist within the nursing profession. It is instilled during training, and develops in individuals over time, once they are in a community nursing role. Delivering holistic care, for example, is described by patients and professionals alike as being important to the “ethos of nursing.” This involves putting patients at the centre of care, and focusing as much on patient needs as on tasks. Holism, in this respect, can be linked to “patient-centredness”. Newly qualifying nurses feel somewhat conflicted in their professional role as a result of the demands of community nursing, and the ethos around nurse practice, as taught during undergraduate nurse training – attempting to offer holistic care whilst working within an environment of target-driven agendas. Furthermore, the lack of time to deliver care is seen to threaten the ethos of nursing and is a key concern for many. For professionals, some of the core values of the community nursing ethos are trust and empathy, both of which pertain to the longevity of the relationship with patients. However, this runs counter to the nurse managers’ wish to prioritize short-term gains, with a policy environment that neglects the long-term. Giving patients control within the clinical relationship epitomizes a central tenet of the community nursing
ethical, whereby a power-sharing dynamic must be nurtured to ensure greater patient-professional equality in terms of the rules of engagement. Being open with patients is crucial if nurses are to manage successfully their expectations and to share their concerns, and to help patients differentiate between realistic and unrealistic expectations. All study participants point to the increased risks involved in entering patients’ homes, whilst remaining safe is recognized as an essential aspect of the nursing ethos. Although becoming risk-centred as opposed to patient-centred is a temptation to be avoided, many believe that some nurses still take unnecessary risks with respect to their own safety, whilst others are unduly risk averse. Consequently, judgments need to be made regarding the safety of the spaces within which community nurses operate.

**Community Nurse as a Person**

Patients note that the ideal personal characteristics of the community nurse should include: adaptability, empathy, good mediation skills, being intuitive, and being an excellent communicator. “Empathic” and “non-judgmental” are also adjectives that frequently occur in nurses’ conversation as regards patient-centred professionalism, and the acceptance of patients and their circumstances are strongly linked to these positive traits. To enable empathy, community nurses must be able to communicate well and listen to patients, and be able to encourage them to feel comfortable, especially when care is delivered within a particularly intimate situation. Whether these aspects can be taught is questionable, and nurses recognize as particularly dubious those associations made between being caring and being technically proficient. For patients, genuine care should be inherent in the nurse; nursing is a vocation not a job, and empathy is the driving force defining that vocation. Thus, personal characteristics are at least as important, if not more important, than the skills and competencies taught during training, though training can enhance these inherent characteristics. Adequate use of space also plays a large part in nurses’ positive sense of self. Having enough space and a pleasant environment in which to work can be enabling, emphasizing one’s position and allowing professionals to feel proud of their abilities and their position. Personal appearance also plays a large role in shaping the “community nurse as a person”, with professional standards drawing a parallel with appearance – a tidy person can lead to more “credibility as a professional”. Furthermore, wearing a uniform is a clear mark of professionalism, helping nurses to gain the patient’s trust. However, a minority of patients and nurses see uniforms as setting barriers in some contexts (e.g. mental health), making the nurse seem less approachable, able to hide behind a uniform.

**Knowledge and Skills**

Patients and professionals agree that expert knowledge and skill acquisition are dependent on effective training and an acute awareness of patient need and expectation, as well as the ability to recognize other health professionals’ strengths and refer patients appropriately, to react quickly to changing situations, and to reflect on one’s own practice. Optimal patient-centred professionalism, in this context, is about tailoring skills to individual need, approaching patients on their own level, and taking a caring approach in all situations. Patients emphasize that by establishing a rapport with them, and caring about their personal situation, community nurses can be differentiated from hospital nurses, who are often too busy or inured to the patient
condition. This proves to be a strong feature of the community nurse – someone who really cares, and who applies their skill to fulfil patient expectation. Registered community nurses, of all seniorities, regard expert knowledge as enabling – knowing which skills to apply on a case-by-case basis, and which health professionals can provide the necessary support if their skills alone are insufficient. Expert knowledge also lends itself to working independently and in isolation, managing ever-expanding caseloads, and staying patient-focused – being able to “read” patients and adapt to different environments whilst upholding good relations across services. Respect for patient decision-making can improve patients’ quality of life, and encourage them to take control of their own care in the long term. Patient-centred professionalism, in terms of skills and knowledge acquisition, thus ensures compliance in the care relationship, and allows patients to negotiate care pathways. In turn, this builds trust and respect towards more effective communication. The converse is perceived as particularly problematic, alongside the inappropriate use of interpersonal skills, and poor skill management. Devising care packages takes expert knowledge, and patients need to understand what is feasible. Expectations that overreach themselves lead to over-demanding patients and the creation of conflict. Positive social interaction and successful patient-centred working are, therefore, closely aligned to carefully crafted care packages.

Working Relationships

Good working relationships refer to those both within and without community nursing who are reliant on community nurses’ knowledge of the patient and perceived position of authority regarding advice-giving. This is inter-dependent on other health professionals’ response to nurses’ advice, and the respect given to their opinion – working in partnership means taking advice from others, whilst maintaining professional boundaries. Some patients and stakeholders regard the community nurse as being alienated from other community professionals, lacking the necessary tools to deal with all patient care issues or to work across environments. Professionals recognize the advantage of being part of a bigger team; to organize care, to enact personal support, and to build confidence. Thus, good relations can help the lone worker overcome what is often described as the “dumbing down” of the community nurse’s role. Nurses and stakeholders describe GPs inappropriate expectations of the community nurse, and their lack of understanding of the scale and complexity of their workload. GPs often draw on nurses’ strong ethical, emotional, and moral position to ask them to do over and above what should be expected in order to take care of patients, especially, for example, where a child is involved. Relationships with others are dependent on matching different work agendas to drive patient-centred care. Shortages of staff or space influence these agendas, whilst maintaining confidentiality and discussing sensitive issues in shared spaces with high noise levels may hamper effective working. Newly qualifying community nurses perceive others, especially GPs and practice managers, as not seeing the nurse as fully professional, leading to a “them and us” situation. This works against the productive sharing of information and appropriate assessment, which can easily become out of kilter with managing workloads and achieving targets. Newly qualifying community nurses recognize the importance of peer and external support, and the commitment necessary to deal with a wide variety of patient issues, in collaboration with others.
Service Delivery

For a mixed group of community nurses of varying seniorities, good service delivery is tempered by the challenges they face in terms of an “environment of inconsistencies” between policies introduced and available funding to work in accordance with those policies. This creates tensions within the community. Targets are railed against by all professionals. They make nurses appear less accessible and more distracted to others, in their desire to fulfil a policy agenda. For the newly qualifying community nurse, being supported in the workplace by colleagues is a major factor in being able to provide a good service, although this is often lacking, in part as a result of the top-heavy managerial system, and in part from the range of imposed directives. Consequently, for the newly qualifying community nurse, ‘professionalism’ is a term that is market-driven, rather than dependent on good service delivery, whilst ‘patient-centred professionalism’ is a term created “by Government officials” rather than something that resonates with the community nurse. Professionals recommend reconsidering the balance in the delivery of services. In order to work “to the best of one’s ability” one has to be professional. Good service delivery is also hampered by time restrictions, which results in community nurses having to watch the time spent with patients, especially in the patient’s home, whilst recognizing the range of commitments that need to be fulfilled – being in control of day-to-day work schedules is to be praised. Patients commend community nurses for their care and patience, providing vignettes of bad practice of nurses within the hospital, where “bad behaviour becomes habitual”. For professionals, poorly managed time allocation is linked to GPs who are difficult to pin down and who bring unwanted interruptions into the nurse’s work at inconvenient times. Nurses say they work in “organized chaos”, arguing that services should encourage patient self-empowerment. Whilst some patients might like “the sick role”, they should be better supported in helping themselves. Patient-centred professionalism means having services delivered to you by nurses very much in charge of what they do, and the proficiency of those services is dependent on nurses keeping up to date, avoiding duplication, being versatile, respecting others’ ability, sustaining high standards, and working to time.

Training and Information

When judged within its historical context, community nurse training is seen to have lost some of its emphasis on hands-on working, and consequently there is a current emphasis on paperwork over and above the patient. In this situation, training does not fully support patient-focused practice, nor does it preserve notions of patient and professional dignity, nor uphold a strong nursing ethos in line with direct-care provision. Training should ensure professionals appreciate the advantages of working together and using patient information to provide others with a clear account of the patient’s position. However, patient examples of inappropriate care indicate that nurses cannot always answer queries or find the necessary health professionals to support them. Linked to this is having a good bedside manner, good communication skills, and an empathic approach. Being able to make independent decisions about patient assessment, patient safety, and risk is regarded as strongly related to developing basic nursing skills during training that can be honed thereafter through Continuing Professional Development (CPD). These skills include being perceptive about the home environment, working according to nursing’s Code of
Ethics, and information-gathering to inform all patient situations. Community nurses compare themselves to practice nurses, and suggest that for them, the opportunities to undertake CPD in specialist areas or to share experiences with colleagues are limited. The newly qualifying community nurse recognizes that university teaching programmes encourage an holistic patient approach, but say that practice can differ from training quite dramatically, depending on where one is working. Whilst training provides the basic building blocks of the profession, the reality of nursing is of a more nuanced and ambiguous practice that cannot easily be taught. Whereas some aspects of training will never be put into practice, many nursing issues are simply not embedded during training – according to nurses and stakeholders, training does not adequately prepare you for “the reality out there”.

Environment

Widespread agreement amongst nurses of all seniorities indicates that whilst nurses work across and within a variety of environments and contexts, this should not unduly affect patient care. Whilst nurses are conscious of the risky nature of work spaces, assessing and managing risk should not compromise their ability to provide patient-centred care. These are vital skills for the community nurse to master, yet they are largely absent from the skill sets of other health professionals. Space is also an active component of care – especially in the patient’s own home, where there is a wide range of social and physical spaces and situations presenting familiar and unexpected challenges. Patients’ personal space needs to be respected, in terms of maintaining an appropriate distance and not crossing boundaries, especially given the nurses’ engagement with them in their domestic settings, the intimate nature of that engagement, and their exposure that needs constant negotiation. Community nurses stress their non-judgmental attentiveness to the patient environment, unless their safety or the safety of others is compromised. Patients can exert power to influence the rules of engagement within the community, and particularly within their own home, and the nurse considers it a “privilege” to be invited into that space as a “guest,” with the most significant obligation to show the patient due respect, through attentiveness, good time-keeping, and full attention to need. However, whilst constrained by the pressure of time-keeping, nurses frequently need to extricate themselves in a sensitive manner from situations. Lack and limitation of space are recurrent themes, with community environments frequently characterized by lack of facilities, insufficient access to information, equipment and privacy, and ill-suited offices, that hamper work and detract from professional self-identity and status. Given their mobility and inadequate bases, cars can serve as essential work spaces.
Note: The following eight themes are arranged in rank order as determined by the study participants.

Each theme is presented in two forms: a short version for the purpose of concision, and then a fuller version for the purpose of explication.

In the short version, the reader is directed to specific paragraphs in the fuller version (which are numbered for each theme).
1 Theme: The Patient (shorter version)

Study participants considered the theme of ‘the patient’ to be the most important aspect of patient-centred professionalism in community nursing.

1.1 There is a consensus that the patient should be at the centre of community nursing. (para.1)

1.2 Patients feel themselves to be at best marginal, and at worst an obstacle, to the seemingly impersonal functioning of healthcare. (para.1)

1.3 Patients are complex human beings, whose medical needs are bound up with the rest of their lives. (para.2)

1.4 The community nurse’s approach to caring for patients is encapsulated in the notion of holistic nursing. (para.2)

1.5 There is a self-conscious characterization of community nursing as a caring profession. (para.3)

1.6 The emotional labour involved in community nursing can be rewarding and a key source of pride and identity. It can also be a source of anxiety, exhaustion, and guilt. (para.3)

1.7 The ideal relationship between community nurses and patients entails the former giving care respectfully, and the latter taking care willingly. However, this can be very difficult to achieve in practice. (para.5)

1.8 Caring for a patient is not straightforward. It requires a considerable repertoire of social skills. (para.6)

1.9 Community nursing is as much about caring with patients as it is about caring for patients. (para.6)

1.10 The ‘patient’ in ‘patient-centred professionalism’ encompasses a multitude of identities, and holds the centre of attention in community nursing. (para.7)
1 Theme: The Patient (fuller version)

Para 1 There is a consensus that the patient should be at the centre of community nursing, and that this should really go without saying. Hence the fact that this theme repeatedly secured the highest ranking. However, it is not self-evident that the patient is actually at the centre of community nursing. For example, some community nurses are concerned that the focus has come to rest on government policy and bureaucracy, and many patients feel themselves to be at best marginal, and at worst an obstacle to the seemingly impersonal functioning of healthcare: “You can sometimes get treated as the lowest common denominator and can be made to feel like a bad penny turning up” (Member of the Public). This ambiguity largely stems from the fact that the patient is an ambivalent figure. On the one hand, the patient may be regarded as a person in the fullest sense of that term, whose health and wellbeing need to be addressed and cared for on a holistic and enduring basis. On the other hand, the patient may be regarded as little more than the bearer of a particular case, which needs to be dealt with as swiftly and efficiently as possible in order to conserve scarce resources. This ambiguity comes to the fore when either the patient feels as though he or she is being ignored or the community nurse feels as though the patient is resisting treatment. Accordingly, patients want community nurses to show them respect and to care for them as individuals, and community nurses want patients to participate in and take responsibility for their own health and wellbeing.

Para 2 In the community, and especially in their homes, patients are invariably characterized as complex human beings, whose medical needs are intimately bound up with the rest of their lives. Consequently, the community nurse must be sensitive to the specificity of each of their patients, and attentive to the way in which a patient’s health is contextualized and socialized (e.g. within their homes, families, and neighbourhoods). For many, this is encapsulated in the notion of holistic nursing, which engages the whole person and the contexts in which they find themselves. This opens the way to treating the context as well as the person, and reveals the extent to which community nurses need to work closely with a host of other healthcare and social-service professionals.

Para 3 The emphasis on treating the patient as a holistic human being accords with the self-conscious characterization of community nursing as a caring profession, and of the community nurse as a person who cares for other people. This is one of the main reasons why community nursing requires considerable emotional labour, which can be personally rewarding and fulfilling, and a key source of identity and pride, but also a source of anxiety, exhaustion, and guilt, since caring for someone often entails becoming responsible for someone, a process of conflation that is exacerbated over time.

Para 4 It is therefore not surprising that the power relationship between community nurses and patients is essentially reversible. For while patients may ostensibly appear to depend on the care given by community nurses, community nurses are acutely aware of the fact that they are “guests” in patients’ homes, and that patients—and their families and friends—have the on-going ability to subvert, resist, and withdraw both hospitality and compliance.
Para 5  Overcoming resistance to treatment and care is a recurring theme in this study. This is well illustrated by the ambivalent role that many community nurses and stakeholders envisage for patients: the seemingly progressive and pervasive desire for patients to be “empowered” is invariably expressed as a regressive and disciplinary demand for patients to “take responsibility” for themselves, their health, and their circumstances. In many respects, the ideal relationship between community nurses and patients entails the former giving care respectfully, and the latter taking care willing. By all accounts, however, this symmetry of the giving and receiving of care is a difficult and precarious accomplishment, especially in the context of mental health.

Para 6  To care for a patient is therefore not a straightforward instrumental and communicative act that is easily accomplished. It requires a considerable repertoire of social skills. Hence the fact that community nurses place considerable emphasis on notions such as respect for patients, empowerment of patients, and partnership with patients. Community nursing is as much about caring with patients as it is about caring for patients. This explains why community nurses stress the need for them to understand, acknowledge, and appreciate the values, expectations, perceptions, demands, and situation of patients, and for them to negotiate care in relation to these things. However, this is not necessarily regarded as a negotiation between equals, since community nurses presume to know what a patient needs. Consequently, the art of negotiation in community nursing has the express aim of ensuring that patients are compliant.

Para 7  Accordingly, the ‘patient’ of ‘patient-centred professionalism’ has multiple identities, many of which contradict and conflict with one another. They include the patient as a recipient of care and an object of care, the patient as a taker of care and a subject of care, and the patient as a force of resistance and a focus of negotiation. Given this myriad form, all parties agree that the patient holds the centre of attention in community nursing.
2 Theme: Nursing Ethos (shorter version)

Study participants commented on the many similarities between the two themes: the Nursing Ethos and the Community Nurse as a Person. While the former refers to the qualities within the profession that are instilled in community nurses over time, the latter refers to the personality traits that particularly accord with community nursing.

2.1 The delivery of holistic care to patients is tantamount to the notion of a 'Nursing Ethos'. (Para. 2)

2.2 The term holism is synonymous with the notion of patient-centeredness in community nursing. (Para. 2)

2.3 A conflict exists between the demands of community nursing in the "real world" and the ideals of the 'Nursing Ethos' that is ingrained in students through training and education. (Para. 3)

2.4 The role of the community nurse is evolving and now incorporates other practices such as prescribing medication and hitting targets. (Para. 3)

2.5 Lack of time may threaten the community nursing ethos since it directly impinges on the community nurse’s capacity to deliver care to patients. (Para. 4)

2.6 Core values of the community nursing ethos include trust and empathy in the patient-nurse relationship. Short-termism of policy makers impacts on the ability of the community nurse to develop relationships with patients. (Para. 4)

2.7 Giving patients control within the clinical relationship with community nurses is a central aspect of the nursing ethos. (Para. 5)

2.8 Nurses describe themselves as "guests" within the patient’s home; allowing the patient to determine the rules of their engagement. Managing expectations of patients and their families in these encounters is an intrinsic element of the nursing ethos. (Para. 5)

2.9 Assessing risk and remaining safe are integral parts of the nursing ethos. Particularly, nurses have a professional obligation to consider safety as part of patient-centred professionalism and as part of their nursing ethos. (Para. 6)

2.10 A space for retreat, in the way of an office or a community nurse’s car, is considered important. (Para. 7)
2 Theme: Nursing Ethos (fuller version)

Para 1 Many elements that make up the theme ‘nursing ethos’ overlap with elements of the theme ‘community nurse as a person’. Particularly during the Forum Event all study participants commented upon the similarities between these themes. There appeared to be some consensus during the Forum that the theme ‘community nurse as a person’ related to the personal qualities that an individual brings to the profession, whilst ‘nursing ethos’ exists within the profession and develops in individuals over time once in a community nursing role.

Para 2 Delivering holistic care was discussed by all study participants as being centrally important to their “ethos of nursing” and involved “putting the patient at the centre” of nursing care. Holistic care in community nursing was described as care that focuses not merely on the tasks of nursing but also on patients’ and families’ concerns beyond their immediate physical needs. The term holism was also conflated with the term ‘patient centeredness’. For example some study participants explain that “there’s more to giving an injection, it’s about patient centeredness and looking at the patient holistically” (Community Nurse group 1).

Para 3 However, the newly qualifying community nurses described some of the conflicts that exist between the demands of community nursing “in the real world” and the ethos of nursing practice as taught during undergraduate nurse training. For example, the difficulties of delivering holistic care in an operational climate where reaching government-set targets was perceived as being the primary concern. Similarly other study participants commented that they were no longer “community primary health care nurses” but that their increasingly diverse role included such practices as caring for patients, prescribing medication and hitting quality (QUOF) targets.

Para 4 The lack of time to deliver care to patients was also discussed several times. Lack of time was viewed as a threat to the nursing ethos of delivering patient centred community nursing care. Sometimes time pressures were caused by the increasingly diverse roles undertaken by community nurses but also the unrealistic demands made by colleagues such as General Practitioners and the perceived scarcity of staff to deliver the care. A further temporal issue that undermined the nursing ethos of patient-centeredness was the “short-termism” of policy makers and managers. Study participants explained that some of the core values of the community nursing ethos—such as trust and empathy—were dependent on a relationship based on “longevity”. However, policy makers and managers often prioritised short-term gains and created a policy environment that neglected the long-term: “We are constantly trying to meet the agendas of middle managers... [It is] very hard to work holistically” (Newly qualifying Nurse).

Para 5 Giving patients control within the clinical relationship with community nurses was also identified as a central aspect of the community nursing ethos. Seemingly related to this was that community nurses described themselves as guests within the patient’s home and giving patients control (or empowering patients to take control) seemed to be an extension of the community nurse’s status as guests and the patient’s status as host: “the power balance shifts depending on the environment.... In patients’ own homes the power is much more equal”
(Community Nurse); “They determine the rules of engagement” (Community Nurse). The increasing level of expectation with respect to care amongst patients and family members was also discussed. Sharing the control of care and “being open” with patients and families were seen as key ways of managing expectations. Once goal-setting becomes a shared concern, the patient can see more clearly whether or not their expectations are realistic.

Para 6 All study participants discussed how entering the homes of patients increased the risks to community nurses. Subsequently assessing risk and remaining safe were identified as part of the nursing ethos and played an important role in minimising the vulnerability of this part of their role. Study participants discussed how community nurses have a professional obligation to consider safety as part of patient-centred professionalism and that at times newly qualified nurses failed to exhibit sufficient caution - “they don’t know what they don’t know”. However some of the study participants described how some community nurses exhibited tendencies towards being “risk centred” as opposed to “patient centred”. It was suggested that colleagues occasionally managed, or attempted to control, the risks to themselves to such an extent that the patient no longer existed as the focus of their concerns. Community nurses can become overly risk averse, and study participants felt that sometimes judgements regarding safety compromised the ability “to walk in with an open mind”. However, the community nurses’ confidence to go into such different environments was considered a distinct part of their patient-centred professionalism.

Para 7 Interestingly the themes of safety and space were also combined in discussion by some study participants. The benefits of community nurses having their own space to retreat into when they felt the pressures of the job. Having a space of their own (office space in the main) was described as increasing their sense of safety offering a retreat from the hassles associated with the job, and this will be discussed further under the theme “community nurse as a person”.
3 Theme: Community Nurse as a Person (shorter version)

Study participants identified several important characteristics that they believed community nurses should possess, such as being adaptable, a mediator, intuitive and a good communicator. However, being “empathetic” and “non-judgemental” were characteristics that were reiterated amongst all study participants.

3.1 The community nurse has an obligation to the patient to be non-judgemental – accepting people and their homes. (Para. 1)

3.2 The community nurse is expected to be empathetic towards patients. This involves understanding the patient’s needs and wants, as well as “getting on the patient’s level”. (Para. 1)

3.3 Strong communication and listening skills are a pre-requisite of an empathetic community nurse. (Para. 2)

3.4 Open communication between patient and community nurse gives scope for rapport to develop and for patients to feel comfortable even in the most intimate situations. (Para. 2)

3.5 Some of the desirable characteristics expected in a community nurse as a person may be innate and not necessarily able to be taught in training. (Para. 3)

3.6 The personal characteristics of the community nurse are considered by patients to be as least as important, or more important, than the skills and competencies acquired through training. (Para. 4)

3.7 The lack of space which community nurses often have to call their own may make their work more difficult and in impact on their sense of self or personhood. (Para. 5)

3.8 Not having space may be considered by some community nurses as diminished status compared to other healthcare professionals. (Para. 5)

3.9 A lack of space for the community nurse to “belong to” may impact on how the perceived value of nurses as people within an organisation. (Para. 6)

3.10 Appropriate personal appearance and dress can project professionalism to patients. (Para. 7)

3.11 The community nurse’s uniform is considered another means of projecting professionalism, as well as often helping to gain trust of the patient. (Para. 8)

3.12 An organised, clean and tidy workspace, such as a treatment room, may be a display of professionalism to patients. (Para. 9)
3 Theme: Community Nurse as a Person (fuller version)

Para 1 Several personal characteristics were discussed as being important for “good community nursing”, such as being adaptable, a mediator, intuitive, and a good communicator. However, being “empathetic” and “non-judgemental” are key “person characteristics.” They are words that often recurred in discussions within the groups. Being non-judgemental was described by study participants as accepting that people and the homes they live in will occasionally be different to the nurse’s own standards. Empathy was described as “getting on the patient’s level, prescribing care, knowing what the patient needs and wants” and is something which community nurses are “well versed in” (Stakeholder group). Study participants also discussed empathy as being expected of community nurses (more so than doctors) and that being empathic is more important than being formal which could potentially result in an “overly cold” relationship with the practitioner.

Para 2 To enable empathy, community nurses need to be good communicators and be adept at interpersonal communication. Study participants discussed how community nurses could talk to patients and listen to their concerns, which is not always associated with doctors. Community nurses, through communicating openly, allow the public to “feel comfortable” which enables “rapport” to build between community nurse and patient. Such a relationship was seen as useful in situations where the care was particularly intimate, for example with certain tests undertaken on patients by community nurses as part of their role as primary care practitioners.

Para 3 Whether factors such as empathy, communication or being non-judgemental can be taught during community nurse training or were largely innate within people who become community nurses was also discussed at length. Study participants discussed how working holistically with patients demands “good intuition” from community nurses and that intuition and good communication are key to getting a relationship up and running. Professional practice is described as being “part of me, it goes with saying” although other study participants suggested that professionalism comes from community nurses who can “give of themselves” and that those who lack this may be technically proficient but not as “genuinely caring” - a fact which “patients can rumble in a second”. Other study participants also commented that nurses are nice people and “inherently caring”.

Para 4 Study participants discussed how empathy “can’t be taught - it’s the driving force of what nurses are” and “nursing attracts those who are not lured by money but who have passion”. Furthermore, study participants suggested that “good communication”would be difficult to teach someone -how do you teach that?”. Study participants consider training an important facet so that community nurses “know how to deal with people”. Study participants also suggested that the individuals who choose to become a community nurse are following a vocation rather than a career such as medicine. The person or personal characteristics innate within the community nurse are at least as important, or more important, than the skills and competencies that are taught to nurses during their training. However, at the Forum Event, study participants commented that although many elements of being a “good” nurse can be considered inherent within individuals
(“Nurses are a certain kind of person”), training can “enhance those inherent characteristics”.

Para 5 Other things that impact upon and reflect the community nurse as a person are space and appearance. The lack of space that community nurses can call their own, whether within GP practices or health centres, make the work of community nurses more difficult but also seem to have an impact on their sense of self or personhood. Not having adequate space may be considered as a projection of how community nurses and their work sometimes have little status when compared to the work of others; especially medicine. Study participants discussed how “space is important to your position” and that not having one’s own space creates tension with GPs and compounds a “them and us” working culture. In general community nurses feel there is a close relationship between how much they are valued by colleagues and the workspace they are given to work within. Newly qualifying community nurses describe community nursing space as “rubbish” and “poky” often squeezing into cupboard-like spaces that leads to stress.

Para 6 The lack of space therefore seems to impact on the perceived value of community nurses as people within the organisation. Some study participants also described how a lack of space for a team of nurses to meet and talk may lead to individuals feeling “very isolated” and having “no notion of a team around them”. This relationship between space and the community nurse as a person was summed up by study participants who said that “Space makes the professional feel better about themselves, and as a result, feel better about their job and situation within a surgery”. This also links with the notions that nurses having their own space can lead to nurses feeling more secure and nurses “carving out an identity for themselves” (stakeholders).

Para 7 A further theme of ‘community nurse as a person’ is that of “appropriate personal appearance”. Some study participants drew parallels between professional standards and appearance; mainly that a tidy personal appearance can lead to more “credibility” and being more “professional”. Some study participants described how “appearing professional” is important in setting standards for students to follow – “I don’t have to wear uniform but I like to help students with professionalism” and that lots of community nurses look “like they need a good wash and need to improve appearance”. Community nurses with “piercings” (especially students) may be considered to be projecting an unprofessional appearance. However it was also acknowledged that someone with piercings could be a good community nurse but may not be displaying the appropriate and/or relevant “professional image”.

Para 8 Study participants identified wearing a uniform as a mark of professionalism but were surprised by the importance other study participants attached to appearance. There was some discussion of occasions when community nurses hide behind a uniform. Other study participants felt wearing a uniform “helps to gain trust of the patient” although sometimes uniforms may be seen as a barrier in some contexts of care. For example study participants commented that in mental health care situations, a community nurse may be considered more approachable when wearing jeans and polo shirt.
The appearance of the community nurse’s physical work space contributes to projecting a sense of the community nurse as a professional person. For example, “when I went into the treatment room the room looked a tip. I felt we were letting the public and the patient down... I don’t think that’s professional”. Similarly a study participant explained that she felt that she “has to apologise if my office space is not tidy”. 
4 Theme: Knowledge and Skills (shorter version)

The theme ‘knowledge and skills’ encapsulates a wide range of complex notions for professionals and patients alike, including the ability of the community nurse to: recognise other health professionals’ skills and knowledge alongside their own.

4.1 Community nurses are adaptable: they tailor their interaction according to patient need and selectively impart knowledge with patients. (Para. 1)

4.2 Community nurses often possess inherent qualities that develop through training and experience of patient-centred interaction. (Para. 1)

4.3 Establishing rapport with patients and being highly adaptable to patient need within differing environments sets the Community Nurse apart from the hospital nurse. (Para. 2)

4.4 Community nurses are perceived by patients to be more approachable, friendly and professional than hospital nurses. (Para. 2)

4.5 Patients remarked that the Community nurse’s ability to respond to them on and individualised basis demonstrated professionalism. (Para. 2)

4.6 Community nurses recognise that expert knowledge enables them to identify which skills are relevant for different patients. (Para. 3)

4.7 Possessing a mix of skills is a strong element of the role of the community nurse. (Para. 3)

4.8 The ability to work effectively within a wider primary care community setting is beneficial for patients. (Para. 3)

4.9 Community Nurses need to be able to project the ability to “read the patient”. (Para. 3)

4.10 Imparting knowledge and skills to patients is empowering and can improve quality of patient life. (Para. 3)

4.11 Patients commented that community nurses have a responsibility to remain sensitive to patient needs and ailments. (Para. 4)

4.12 At times, poor communication skills impede community nurses in communicating their knowledge and skills to the patient. (Para. 5)

4.13 The community nurse needs specific skills to devise bespoke care packages for patients. This may, at times, conflict with patient expectation of care. (Para. 6)

4.14 Patient centeredness refers to undertaking more than just the task in hand. (Para. 6)
4 Theme: Knowledge and Skills (fuller version)

Para 1 The theme ‘knowledge and skills’ encapsulates a wide range of complex notions for professionals and patients alike, including the ability of the community nurse to: recognise other health professionals’ skills and knowledge alongside their own. Study participants commented on the need for community nurses to refer patients to external agencies as necessary, be alert to different care situations or work environments, think quickly and react appropriately to new or changing situations, listen to the patient and respond to them directly. Study participants were keen to emphasise the high level of skill the community nurse already brought to her job and their commitment and staying power: “it is a vocation and their skill is tailoring interaction with patients to suit individual patient’s need”. This was described as a quality particularly suited to the community nurse, reflecting their adaptability, expert knowledge and effective training. By tailoring skills to individual need, study participants noted that community nurses could approach patients at “the right level”, and they could be “empathic”, an inherent quality that was perceived as something that cannot be taught but that can be developed through the right training in support of optimal patient-professional interaction.

Para 2 Patients emphasised that through the establishment of a rapport with patients, working at the correct professional level and being adaptable, community nurses were distinguishable from hospital nurses. Whilst patients viewed the hospital nurse as overworked, too busy to care appropriately, inured to the patient condition and to their ongoing healthcare needs, and unhappy: “miserable nurses on the hospital floor”, community nurses were: "approachable", friendly and often professional in their approach. This was an identifying feature of ‘professionalism’ for patients – having a community nurse who could provide one-to-one care, who listened to their problems and applied skills that met their personal needs and fulfilled their expectations.

Para 3 Registered community nurses of all seniorities emphasised the fact that expert knowledge enabled them to know which skills were relevant with different patients, when to pass a case on to another healthcare professional for their attention, and when to ask for advise from another nurse. This was a positive application of skills and highlighted that skill-mix was a strong element of their job. Consequently, it was not always in the best interest of patients for community nurses to manage all aspects of their care, when others should be brought in who had distinct expertise. Being in touch with other professional groups or with other nurses suggested a skill at being part of a primary care community. Thus, whilst much work was carried out independently, and in isolation, it was important for community nurses to have a base and to be able to share caseloads, patient issues and personal concerns with others. Specific professional skills that applied to community nurses related to the nurse’s ability to be patient-centred: “you have a role to play; your role is your job title”. Professional knowledge and concomitant skills were reflected in the language that nurses used to work with patients and to understand patient’s needs for information and for advice regarding their ongoing and often complex care pathways, “more educated people may not need to ask as many questions”. Community Nurses also had to project an ability to “read the patient”, to adapt to
different patients’ expectations and different care environments, to know where the nurse’s role ended and other practitioners’ roles began, to fit care provision around others’ workloads and work patterns and to uphold good relationships within primary care practice and beyond. Indeed, building partnerships was at the core of patient-centred professionalism, and was dependent on the knowledge and skills of all involved, respecting each other’s positions and by so doing, enabling trust to be built across the primary care workforce. Well-respected and knowledgeable nurses were able to work openly and honestly with patients and professionals. They could empower patients to take control of their own care and to sustain control during longer-term care: “we are working to the same agenda as patients, sharing care”. Enabling patients to have ownership over their own lives and healthcare needs was seen as encouraging skilled community nurses to let go of certain aspects of their role: “we are just the facilitator for that disease, we want to give them [the patient] respect to take over their own decisions”. By enabling patients, through heightened skills and knowledge, to remain in control of their lives and their bodily needs, community nurses were: “improving the quality of the patient’s life and thus improving concordance”.

Para 4 Patient-centred professionalism, in terms of skill and knowledge acquisition, related to ensuring compliance in the care relationship, and the ability of patients to negotiate their care. To have knowledge was to be able to reflect on one’s own professional position and to enable patients to understand the role of the community nurse: “integrity is a major issue for nurses, which makes us professional”. Study participants remarked that what mattered most to them was knowing that community nurses had full knowledge of their individual cases, recognised them as individuals, and if they had ongoing care needs were able to advise other health professionals about them, whilst having respect for other nurses’ knowledge. If the community nurse was presentable and appeared knowledgeable, then the patient could respect their views and trust their opinions, recognising their ability to translate knowledge into practical skills that could support the patient. Patients recommended that whilst skills were developed over time, community nurses should stay highly sensitised to patients’ ailments. They commented on the ability of the community nurse to become desensitised over time: “being sick and unwell is not a nice position in which to find yourself and nurses need to be seen to care, even if they cannot care for everyone. It is one of the tricks of the trade. You don’t expect them to be saints, but…”

Para 5 The inability of community nurses to communicate their knowledge and skills was seen as a particularly negative quality, as was the inappropriate use of interpersonal skills, misuse and misperceptions surrounding the community nurse’s role, poor management of skill mix and community nurses inability to clarify what community nurses do. Patients reflected that different community nurses’ roles were not clearly delineated from each other, whilst community nurses rarely described the extent of their role or of their knowledge. Newly qualifying community nurses emphasised the importance of knowing patients well: “everyone is an individual”. They also commented on the importance of being able to put the patient at the centre of their role, and to treat the patient at the community nurse’s level. All these aspects, interwoven into the newly
qualifying community nurses' understanding of their skills and abilities, meant respecting the patient and not: “getting above myself”. If skills and knowledge are adapted appropriately, and to meet individual need, then the community nurse’s work: “can only be patient-centred, that is what nursing is as a role”. For the newly qualifying nurse, this incorporates: upholding core values, and having the skill to: “assess the problem, know the solution and see it through. Sometimes circumstances turn against you in that respect, but you can only do the best you can”.

Para 6 All study participants discussed the skills necessary to devise the most appropriate care package for the patient. Registered community nurses complained that patients often forced their expectations of their care package onto the community nurse, even though certain packages were not feasible and, as a consequence, that patients were often over-demanding. Community nurses explained that care packages were often unavailable at the time of the patient’s need and that this could create conflict between patients and professionals, hindering the natural development of trusting relationships. This was linked to the time needed to provide a holistic care package, whereby patients were able to discuss their problems with community nurses and community nurses to address more than just hands-on care issues. Recognising that task-oriented care was not always the most successful approach to working well with patients, professionals described the need for real skill and ingenuity: “you can teach a monkey how to give an injection, it is about knowledge of the complete social interaction necessary for working with a patient in a specific environment to address their specific and personal needs... The patient will notice if she was just like a robot”. In this respect, patients can be seen to be in tune with the community nurse’s limitations, and for them patient-centeredness means applying the skills necessary to undertake more than just the task in hand. As one patient said: “people's expectations are growing, and people are more aware of their rights to have a perfect care package, to have expert professional care".
Theme: Working Relationships (shorter version)

All of the study participants recognised the benefit of good working relationships, both within the community nursing profession and with other healthcare professionals. However, study participants noted that working relationships were not always good.

5.1 Good working relationships between community nurses and other healthcare professionals are essential for the delivery of high-quality care. (Para. 2)

5.2 Community nurses do not always display that they are “inherently caring” in their working relationships. (Para. 2)

5.3 A support team for community nurses could help them to deal more effectively with their working environment. (Para. 3)

5.4 Study participants commented that there are often instances of “dumbing down” of the importance of community nurses by other healthcare professionals. (Para. 3)

5.5 Working closely with social workers was recognised as important for partnership working and for maintaining boundaries within patient care. (Para. 4)

5.6 Good communication within the profession and with other healthcare professionals plays a significant part in the community nurse’s role of duty to care. (Para. 4)

5.7 Sometimes other healthcare professionals may draw on the emotional and ethical morals of the community nurse to take on additional workloads that may be avoidable or more shared. (Para. 5)

5.8 Issues such as unequal access to office space (for example, GP practice) do not help foster good working relationships with other healthcare professionals. (Para. 5)

5.9 Newly qualifying nurses commented that since some healthcare professionals may not consider community nurses as professionals this could have a negative impact on their working relationship. (Para. 6)

5.10 Better systems for the management of patient information would help engender better and more communicative relationships between healthcare professionals. (Para. 6)

5.11 The Community nurse’s need to meet targets and goals can impinge upon the desire and ability to develop a relationship with the patient. (Para. 6)

5.12 Newly qualifying nurses commented that the opportunity to reflect on experiences with their peers and gain advice from team members
demonstrates good working relationships between community nurses. (Para. 7)
5 Theme: Working Relationships (fuller version)

Para 1 All study participants recognised the benefit of good working relationships both within the profession and with other healthcare professionals, although it was highlighted that working relationships were not always good.

Para 2 Some study participants felt that working relationships relied on community nurses having full knowledge of the patient and having the authority to advise other professionals about the care and treatment of the patient. This in turn relied on other healthcare professionals responding and respecting the views and knowledge of the community nurse. It was felt that working relationships within community nursing were not always good. It was commented that you “expect that these people are nice and inherently caring”, but that was not always apparent in their working relationships.

Para 3 Some study participants felt that community nurses needed a support team to help them deal with the working environment or lack of in community nursing. They believed that community nurses did not have the tools to deal with all the issues related to dealing with patients in the community. It was felt that there was a definite advantage in being part of a bigger team in terms of working with other professionals and helping to “moves things along” with the patient. The organisation of individual care- bespoke for each patient was the key to community nursing and that this relied on professional support both peer support and professional supervision. It was noted that a confidence in oneself and of other healthcare professionals was required to benefit from improving the care of the patient. Although good relationships were felt to be advantageous, it was commented that there were instances of “dumbing down” the importance of the community nursing role by other healthcare professionals outside of community nursing.

Para 4 The recognition of the need to involve other healthcare professionals such as social workers was also recognised by study participants. It was reinforced that there was a need to work in partnership and to know who to refer to but that there was also a need to maintain boundaries. It was felt that good communication both within the profession and across other healthcare professionals was essential and that community nurses had a “duty of care to patients, employers and those they worked with”. Study participants agreed and commented that the role had changed drastically, that they had taken on more responsibility and that they worked more in partnership with other professionals.

Para 5 Study participants felt that they were sometimes inappropriately asked to go out on calls to patients but that as a community nurse you felt you had to go. They also commented that GPs did not always appreciate the scale of the workload of community nurses. It was stated that other professionals sometimes drew on community nurses strong emotional and ethical morals, for example where there may be a child involved. This group commented that they didn’t feel part of the GP team. They stated that it wasn’t them and us but that GP teams and community nurses did have different agendas. It was also felt that relationships with other healthcare professionals were sometimes difficult due to shortage of space and that it was difficult to maintain confidentiality or discuss sensitive
issues in shared office spaces, where there were often high noise levels. It was also noted that community nurses often wouldn’t have key access to a GP surgery even though it was necessary to upload patient information on to records. In addition, some community nurses worked more than 25-miles away from GP surgeries where records were held which was felt to impede their ability to do even basic duties. As well as general relationships with other professionals, study participants commented that there was also a need to information share with other professionals. For example, if a patient was a known drug user, it was suggested that community nurses should visit a patient in pairs.

Para 6 The newly qualifying community nurses study participants felt that GPs and practice managers did not see community nurses as professionals. Some study participants felt it was really “us and them”. It was felt that this also affected the relationship with GPs. Study participants made some references to the separation of community psychiatric nursing and other healthcare professionals. Often some patients were seen by both community and mental health nurses. It was felt that better systems for management of the patient and information sharing were necessary in these instances. It was also felt that in some instances there were too many directives coming from senior levels that there was no support to deliver the patient care. It was commented that care should be holistic but that they had to fit in with targets. Study participants agreed that it was difficult to provide holistic care and to assess the patient that required additional help when they constantly had targets and goals to achieve. They also believed that they couldn’t make decisions individually for the patient.

Para 7 The newly qualifying community nurses study participants felt supported by their peers with the opportunity to reflect on their experiences with other team members to gain advice and guidance. Study participants commented that “it was not just a one man band” and that support and advice was needed from both within their profession and with other healthcare professionals. Study participants felt that community nurses had a personal conscience to pick up on other patient issues and that they were instilled with morals and ethics to do this.
6 Theme: Service Delivery (shorter version)

Service delivery was given a middling score of importance in the rank order of the eight themes of patient-centred professionalism in community nursing. For community nurses, delivery of good services was hampered by challenges such as bureaucratic policy and funding constraints.

6.1 Community nurses often feel challenged by an “environment of inconsistencies” that is created when policy imperatives encounter funding constraints. (Para. 1)

6.2 Community nurses are concerned that unattainable targets can impact negatively on their approach to working and their relationship with patients. (Para. 1)

6.3 Community nurses are aware that pressures to meet government targets make them appear less accessible to patients in the community. (Para. 1)

6.4 Newly qualifying nurses are aware that professional support mechanisms benefit and foster the provision of a good service to patients. (Para. 2)

6.5 Newly qualifying nurses commented that a “top heavy system, led by directives and targets” often meant that real support in early stages of a community nursing career was lacking. (Para. 2)

6.6 Newly qualifying nurses considered the most exceptional service they could offer was linked to working holistically. (Para. 2)

6.7 Holistic approach to community nursing involves understanding the whole problem; assessing patient need; understanding complete care packages and making decisions about referrals and discharge. (Para. 2)

6.8 Newly qualifying nurses challenged the notion of patient-centred professionalism – suggesting that it was “market-driven” and a term created by the government. (Para. 2)

6.9 Time and time restrictions impact on the service delivered to patients by the community nurse. (Para. 3)

6.10 Lack of time with a patient can impact on the community nurse’s ability to develop rapport and trust with a patient. (Para. 3)

6.11 Scheduled appointments help community nurses develop clear boundaries and expectations with patients. However, in comparison with the “protected, scheduled time allocation” of appointments that GPs benefit from, community nurses consider their work to be “organised chaos”. (Para. 4)

6.12 For community nurses, service delivery and patient-centred professionalism are synonymous with one another. (Para. 5)
6.13 As a “guest” in a patient’s home, the community nurse often has little control over their clinical encounter with a patient in the domestic environment. (Para. 5)

6.14 For patients, patient-centred professionalism is based around services delivered by community nurses who are “hugely knowledgeable and in charge” and who view nursing as a vocation not just a job. (Para. 6 and Para. 7)
6 Theme: Service Delivery (fuller version)

Para 1 Service delivery was a theme given a middling score of importance in the rank order of the eight themes of patient-centred professionalism in community nursing. For the registered nurses in this study, who represented a wide mix of nurse types and seniorities, what they were able to deliver in terms of good services was tempered by the challenges they faced in terms of what they described as: “an environment of inconsistencies”, between policies made and funding available for them to work in accord with those policies. Community nurses were concerned about the impact of unattainable targets on their approach to working, their workload and their relationship with patients, which in turn impacted on patient communication. Targets were railed against by all professionals, and the community nurses talked at length about the target-driven world in which they found themselves. This environment created tensions within the community, and made them appear less accessible and distracted to other health professionals and patients, in their desire to fulfil Government targets. According to one District Nurse, targets had changed dramatically over recent years: “We are now nurse prescribers, QUOF targets, and a new code of conduct – all this has meant that we are not community primary health care nurses”.

Para 2 For the newly qualifying nurses being supported; be it by a senior community nurse during training, by another health professional in the workplace, or by their own colleagues on courses attended, is a major factor in being able to provide a good service. Support was too often lacking, in part because there were too many managers: “a top heavy system, led by directives and targets that have to be met, rather than led by the community nurse as a holistic worker”. For the newly qualifying nurse, offering an exceptional service was also strongly linked to working holistically, in an environment that was clearly recognised as community-led, without the pressures of targets. This meant having the time to: understand the whole problem, conduct a thorough assessment of the patient’s need and of their home environment, understand care packages that should be developed, clarify whether the patient should be referred on, and make a decision about appropriate discharge, irrespective of the pressure to discharge a certain quota of patients each week. Consequently, some study participants berated the fact that ‘professionalism’ was a term now being market-driven, linked to targets that had to be achieved, and dependent solely on policy directives not on service delivery. According to newly qualifying nurses, community nurses are not working as professionals, and are unable to perform responsibly, because of these restrictions. In the real world: “It is different – you can only act holistically to the best of your ability”. This is not what is “driven in to us during training”. Newly qualifying nurses thought about service delivery in relation to the notion “patient-centred professionalism” and commented: “This is a term created by Government officials. It is a term that does not resonate with community nurses”. Whilst they recognised the need to be both professional and patient-centred, they queried the linkage between the two terms, saying: “There needs to be a balance, you cannot always deliver services but you try to do your best, you have to be professional all the time, you have a duty to carry through what you started”.
Para 3 Time, and time restrictions, was a major element of all group discussions around service delivery. Community nurses commented on having to watch the time they spent during consultations, particularly in the patient’s home, to make sure they could arrive at the next consultation on time. They also emphasised the negative effect that time restrictions could have on their ability to build trust with patients and their families. However, some community nurses thought that keeping to a tight schedule enhanced the development of appropriate barriers between the community nurse and the patient, as the patient became aware that the nurse needed to move on to fulfil other commitments, and thus recognised that time was bounded. According to some study participants, time was there to be respected – by the community nurses who had to provide a competent service of good quality and close communication, delineated by a specific timeframe and in line with what they thought the patient actually needed to know, and by the patients – who had to learn to trust the community nurse in relation to the service they could provide within that timeframe. Providing a timely and appropriate service, also related to the need for community nurses to have privacy built into their day. With clearly defined appointments, during which the community nurse could focus on the patient and the setting, time was under control. Building in to the day some time to oneself also meant community nurses were in control. This was discussed in relation to hospital regimes, where nurses were described as being out of control, and time was seen as uncontrollable, in terms of the delivery of services. Other study participants concurred with this view, praising the community nurse for their care and their patience. Study participants provided a number of vignettes of bad practice within the hospital, and described hospital nurses as often poor carers: “There is nothing to excuse bad caring, behaviour there becomes habitual”.

Para 4 Study participants linked time allocation to other health-professional patient care, with particular reference to the general practitioner, whom they noted was especially difficult to “pin down”. Study participants also remarked that doctors had more “protected time”, making them unavailable to community nurses, and so community nurses often wasted valuable time, throwing their work off course. Lack of availability of general practitioners, when nurses needed to see them, meant standards were easily affected, with unwanted interruptions at inconvenient moments. In considering the services community nurses could offer, some study participants commented that, like community pharmacists, they had a lot of work to do in order to comply with Governmental stipulations. Whilst many of the community pharmacy regimes and workspaces were perceived to be chaotic, what community nurses did was seen by these health professionals as working in “organised chaos”.

Para 5 Study participants discussed the need to enable patients to feel self-empowered and to establish a strongly patient-centred approach to their care, so that patients could feel supported to take control of their own health and ongoing needs. For community nurses, service delivery and patient-centeredness went hand in hand, with health promotion enabling patients to be self-supportive. Community nurses are there to guide patients, irrespective of the fact that some people: “liked the sick role”. Some study participants were emphatic that people could change to lead healthier lives, but noted that patients often wanted to be led. With this in mind, nurses needed to be able to help patients, through
increased focus on patient experience, to overcome their resistance to change. For those who were unable to help themselves, it was important that the professional community nurse recognised this trait: “it is not always the case that patients can change their own health when they want others to do so for them”. In these cases community nurses should apply safe working practices, support patients in their own homes over the long term, and continue with their risk assessment. Offering a service within the patient’s own home meant that nurses were the patient’s “guest”. This was an important role to understand as being invited in to a patient’s home and supporting patients directly, within their own environment, could enhance patient-centred professionalism. In these circumstances, community nurses clearly saw the patient as “in control. It is their home. They can determine the rules of engagement”. Delivering a service within the patient’s home also entailed a particular set of “power dynamics” – as a guest in the patient’s home, the patient was in control of many more aspects of the clinical encounter, and could present their predicament freely and openly within the comfort and security of their home territory. However, on occasion this could bring about tensions between the patient’s expectations and the community nurse’s ability to offer care, but these aspects needed to be negotiated.

Para 6 Patient-centred professionalism, from some study participants’ point of view hinged on having services delivered by community nurses who appeared “in charge”, and who had: “full knowledge of patients, while being able to advise other health professionals”. With these services in place, patients felt they could have respect for nurses’ knowledge. Services had to be delivered by community nurses who appeared interested in the patient and who could refer them on to another health professional if the community nurse could not provide the necessary service. The opposite experience was of community nurses who were “robotic, not having a relationship”, and who were unable to refer the patient on. When services were delivered by community nurses who did not have the appropriate specialisation, they were unable to recognise something was wrong and consequently to undertake their job appropriately. This led to community nurses who could not communicate and interact with patients, could not read the patient’s signs and symptoms, advise the patient where to turn for correct care, or understand the patient’s needs.

Para 7 The newly qualifying nurses mentioned the need for proficient services, stemming from good community nurse training, grounded belief in the provision of appropriate care – this included keeping up to date with the community nurse role, recognising the need not to duplicate services, respecting others’ abilities, and focussing on the patient. Services needed to be delivered in line with the public view that this was not a job but a vocation – provided with dedication and sincerity. According to patients, on occasion services could be deemed: “sloppy”, with patients considered: “an afterthought”, and on other occasions, services were delivered to a high standard. The patient was described as being: “offered reassurance”, when services were delivered to a high standard by community nurses who patients saw as: “semi-doctors”. The public were in agreement that there was a great deal of confusion about the community nurse’s role, and that for services to be delivered efficiently and to time, community nurses needed to
be versatile – to fulfil their role wherever they were placed, and to be able to work to optimal effect, irrespective of setting.
7 Theme: Training and information (shorter version)

The importance of training and information were well recognised and study participants commented that much ‘training’ came from experience of working within community nursing as well as the ability of reflective practice.

7.1 Members of the public suggested that “training had lost something from the younger days” – that there was now too much emphasis on paperwork. (Para. 2)

7.2 Appropriate time and space should be provided for community nurses to gain knowledge and understanding of the work of other healthcare professionals. (Para. 2)

7.3 The ability to act as “gatekeeper” to patients in terms of information or alternative healthcare was considered very important. (Para. 2)

7.4 Having the ability to deal with a wide spectrum of patient needs, yet also recognising that they do not know everything were felt to be real training issues. (Para. 4)

7.5 Assessing the extent of information to impart to a patient is an important aspect of the role of the community nurse. Good communication skills are essential for the community nurse to support and empower the patient. (Para. 5)

7.6 Discretion, judgement and risk assessment during patient encounters are essential. Training to be aware of vulnerability in the patient’s home is necessary. (Para. 6)

7.7 Training focuses on being patient-centred and directs community nurses to recognise when other healthcare involvement is needed. (Para. 7)

7.8 CPD (continuing professional development) is necessary to maintain registration for a community nurse, however time for this training is not scheduled and therefore difficult to commit to. (Para. 8)

7.9 The University teaching programme focuses on providing patients with holistic care, however, it can be different in practice. In the community, care is not routine-like and as such the nature of work for a community nurse can be stressful. (Para. 9)

7.10 Standards set by the NMC are “drilled into you from the beginning of care”. As such training in some areas may be inadequate. (Para. 9)
7 Theme: Training and information (fuller version)

Para 1 Although the benefits of training and information were well recognised, the workshop groups felt that much of this ‘training’ came from experience of working within community nursing as well as the ability to reflect and discuss with their peers rather than academic teaching.

Para 2 Some study participants commented that training was necessary to deal with people to allow community nurses to listen, maintain eye contact and be pleasant- “putting us at ease”. They felt that training had lost something from its younger days. It was felt that historically community nurses were more “hands on” and that nowadays there was too much emphasis on paperwork than the patient. Some study participants also felt that training had changed and that “something had been lost”. They felt that training was necessary to preserve dignity and to use initiative. They also made reference to “bringing back the matron”.

Para 3 Being able to work with other healthcare professionals was felt by many study participants to be a training issue and entailed the community nurse having time and training to gain knowledge that allowed them to work effectively with other professionals. It was also felt that community nurses should be well-informed to impart knowledge and be able to point the patient in the right direction. This was reinforced by other study participants who felt that community nurses should act as gatekeepers and be able to pass the patient more information or alternative contacts. It was felt that community nurses should be experts in the task they are called in for.

Para 4 It was sometimes felt by some study participants that patients were passed on to community nurses “to do the bits that the doctors don’t do”. In these instances some of the study participants felt that the community nurses were sometimes dismissive, didn’t talk much, didn’t know the answers to patient queries and made no attempts to find the answers. These study participants felt that community nurses should be well trained and have the information at their fingertips. They were expected by the public to be experienced in dealing with a wide spectrum of patient needs yet have a recognition that they don’t know everything. Having a good bedside manner and being able to communicate effectively was important to the public but they questioned how this could be taught. Having direction and knowing their own role were felt to be training issues.

Para 5 Some study participants felt that as professionals, the community nurses were required to make judgements regarding the level of information and technical knowledge that they imparted to the patient. As part of the patient assessment they would be required to make an assessment of the patient and judge what was needed for each patient. Inherent in this assessment process was recognition of the community nurses’ own limit. It was felt that the development of specific skills such as communication skills were important to support the best interests of the patient and could help to empower the patient.
Para 6 Some study participants concurred that training in assessment was necessary. Issues regarding discretion and risk assessment were in particular highlighted. They felt that it was the professional obligation of the community nurse to consider safety in the patient assessment as it may impact on the service that could be delivered to the patient. Training to be aware of vulnerability in the patient’s home was considered necessary. It was highlighted in particular that newly qualified community nurses may not be aware of potential safety issues or risks due to their lack of experience. Study participants agreed that part of the patient assessment involved a judgement on safety and patient need and that the nurse needed to “walk in with an open mind”. With experience the NQ group felt that they would be able to judge situations such as abuse much better.

Para 7 The ability to recognise when other healthcare involvement was required was taught as part of the district nursing training: core skills, extended skills, and talking to team leaders. It was noted that patients were at the core of training and that training was focused on being patient centred. Other study participants agreed that “training teaches us” and that experienced community nurses had the knowledge to recognise wider patient issues and the necessity to refer patients on to other professionals if necessary. Part of the community nursing training was learning to assess the patient within their home environment.

Para 8 Community nurses are trained according to the NMC code of conduct and the NMC is responsible for teaching pre- and post-registration students. While CPD is necessary to maintain registration the training is not timetabled, so fitting it in can be difficult. Consequently, it “ends up being in your own time”. Within general practice, however, practice nurses were able to update their training during allocated and protected time. Conversely, within other community settings, such as factories, there was no scope for training. It was also commented that certain government led training such as protection of vulnerable adults was mandatory but that there was limited scope for training in any personal areas of interest or speciality. Reflective practice was felt to be a key to improving knowledge and training. Study participants also commented that there was an opportunity to reflect on experiences with other team members.

Para 9 The newly qualifying group of study participants felt that although the university teaching programme taught you to look at patients holistically, that it could be very different in practice, depending on where you were working. It was felt that in the community, the care was more one-to-one with the focus on the patient. It is not routine. It was discussed that many community nurses experience stress but that this was not taught. Some community nurses attempted to deal with this by job sharing. Many study participants commented that the role had changed with increasing advancements in medicine and treatment. The newly qualifying group of study participants commented that some things are learned in training that may never be used in practice and that community nurses were working to the standards set by the NMC. It was felt that these standards were “embedded, drilled into you from the beginning of care”. Study participants felt that training was inadequate and that University didn’t really prepare you enough for the reality of “getting out there”.

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8 Theme: Environment (shorter version)
Community nursing takes place in a wide variety of environments and contexts, each of which entails its own particular set of opportunities and challenges.

8.1 The environment and context within which community nursing takes place should not affect patient care. (para.1)

8.2 Community nurses are more vulnerable than most other healthcare professionals since they work in the community and people’s homes, both of which are inherently risky environments. (para.1)

8.3 Community nurses need to be flexible and adaptable in order to deliver high-quality patient-centred care to patients regardless of the environment in which they find themselves. (para.1)

8.4 The space within which care is delivered by a community nurse is an active component of care. (para.2)

8.5 Community nurses may need to consider the ways in which the space they are using may inhibit or facilitate the delivery of care. (para.2)

8.6 Whilst community nurses stress their respect and regard for each patient by not being judgemental about a patient’s personal home environment, patients claim that “space impacts on how professionals respond to you.” (para.3)

8.7 Caring for patients in their home environment often means that patients can influence the “rules of engagement” and the “power dynamics with community nurses.” (para.5)

8.8 The relationship between the community nurse and the patient becomes a relationship between “guest” and “host” when encounters occur within the patient’s home. This is very often a very positive social relationship. (para.5)

8.9 The lack and limitations of working space for community nurses were recurrent themes in this research. (para.6)

8.10 A community nurse’s car often serves as a “portable office” due to the extent of mobility involved in the role, and the lack of other appropriate workspaces. (para.7)
8 Theme: Environment (fuller version)

Para 1 While community nurses work in a wide range of environments and contexts, each of which entails its own particular set of opportunities and challenges, there is widespread agreement that this should not unduly affect patient care. They are conscious of the fact that the community is an inherently risky environment within which to operate, and that they are more vulnerable than most other healthcare professionals when they are working alone and in other people's homes. Community nurses therefore need to be flexible, adaptable, and able to deliver the same quality of care irrespective of the environment in which they find themselves. They also need to be able to assess and manage a wide spectrum of risks without unduly compromising their ability to provide patient-centred care. These are vital skills for community nurses to master, and they are skills that are largely absent from the skill-sets of other healthcare professionals.

Para 2 As well as being characterized by considerable diversity, the space within which care is delivered is not a neutral backdrop, but an active component of care. As one patient noted, something as simple as “a phone line can be a lifeline.” This is especially the case within people’s homes, in which community nurses encounter an enormous variety of social and physical spaces and situations, each of which may present familiar or unexpected challenges (e.g. cramped bedrooms, dangerous animals, poor hygiene, dilapidation, and hazards such as smoke-filled rooms). Community nurses frequently need to consider the way in which space may inhibit or facilitate care. They emphasize the importance of an “holistic” regard for patients and their social and physical situations, which often draws them into liaison with other healthcare professionals and social services, and in certain respects blurs the boundaries and expectations of their role. Nevertheless, engaging with patients in their homes generally enhances the capacity of community nurses to deliver care effectively.

Para 3 Community nurses stress that their attentiveness to the patient’s environment should be non-judgemental with respect to the patient’s taste and lifestyle, expect on those rare occasions where the safety of themselves or others is at stake. However, some patients do feel that they are judged by health professionals who enter their homes: “space impacts on how professionals respond to you” (Member of the Public).

Para 4 Community nurses are acutely aware of the need to respect the patient’s personal space. Consequently, the notion of maintaining an “appropriate distance” and “not crossing the boundary” between the community nurse and the patient is an important component of professionalism and the nursing ethos. This notion is especially important for community nurses because of the emotional content of their labour, their engagement with patients in domestic settings, and the often close and intimate relationship that they establish over time with patients. Nevertheless, the fact that community nurses truly care for patients exposes both parties to the pleasure and pain of a caring relationship, not least when the continuity of care-giving is interrupted. Negotiating this exposure is something that community nurses must constantly attend to in practice.
Para 5 Within the community, and especially within their homes, patients potentially exercise a great deal of power. In their homes, patients can strongly influence “the rules of engagement” and “power dynamics” with community nurses. Power and control are often uncertain, and community nurses need to “negotiate” carefully their relationship with patients. At the same time, however, community nurses appreciate the fact that by entering a patient’s home they are also entering into the patient’s life. Accordingly, they regard themselves not simply as health professionals who happen to “visit” patients in the community, but as “guests” within patients’ homes. By casting the relationship between community nurse and patient in terms of “guest” and “host” the ostensible reversal of power is turned into a positive social relationship rather than a site of contestation. Indeed, community nurses regard such an “intimate relationship” as a very important and highly valued privilege: “I am invited into a patient’s home. I feel that there are obligations attached to that notion of being a guest” (Community Nurse). The most significant obligation is to show the patient due respect. One of the most effective ways to do this is through attentiveness. “When in the patient’s home you can devote your full attention to the patient” (Community Nurse). However, although community nurses place themselves at the patient’s disposal for the duration of their visit, they remain constrained by the pressure to keep to time, and frequently need to extricate themselves from situations in as sensitive a way as possible.

Para 6 With respect to space, “lack” and “limitation” were recurrent themes. Community nursing is frequently characterized by a lack of facilities and space, with insufficient access to information, equipment, and privacy. While the lack and limitations of space are keenly felt by nurses working in the community—especially in people’s homes—the lack of a suitable physical and social “base” is equally problematic. Community nurses often find themselves located in small, over-crowded, and ill-suited offices, which can hamper their work and may detract from their professional self-identity and status.

Para 7 Given the mobility of community nurses, and the fact that many have an inadequate “base”, their cars serve not only as a vehicle, but also as an essential work space: “My car becomes my portable office.”