NURS6022 Community Health Nursing

Allender, J.A., & Spradley, B.,W. (2005). Community Health Nursing: Concepts and Practice. Philadelphia, Lippincott, Chapter 18: The Community as client: Assessment and diagnosis, PP.405–427.

- *Describe the meaning of community as client*
    - Community health is a primary mission:
        - Community health directly influences health of individuals, families, groups, subpopulations and populations who are a part of it
        - Provision of most health services occurs at the community level
    - The concept of a community-wide group of people as the focus of nursing service
    - Understanding the concept is prerequisite for effective service at every level of community nursing practice
- *Discuss how a key American value and three myths can undermine a nurse's intention to move beyond an individualistic focus to practice population-based community health nursing*
    - The American value of individualism
        - Individualism – the belief that the interests of the individual are/ought to be paramount
        - Healthcare is dominated by commitment to individual treatment
        - Nurses are first educated to focus on the individual client in clinical nursing; community health practice requires shift in focus to the community
    - The location myth – defines community health nursing in terms of where it is practiced, in a specific setting or location e.g. outside the hospital
        - Silently influences nurses to define their practices based on the location of the service rather than the nature of it
        - Supports the belief that community health nursing emphasises care of individuals
        - Instead, community health nursing focuses on assessing and treating the health needs of the population and aggregates wherever such groups are located
    - The skills myth – states that community health nurses employ only the skills of basic clinical nursing when working with community clients
        - Led to nurses' assumption that their clinical skills are completely adequate for population-focused practice → unaware of sophisticated knowledge and competencies required
        - Community health nurses need skills drawn from the public health sciences in measurement and analysis; skills in social policy based on history and philosophy of public health; and skills in management and organisation for public health
    - The client myth – says that primary clients are individuals and families
        - Prevents nurses from taking a broader focus on the health of aggregates and groups at risk; an approach that is central to community health nursing practice
        - Population-focused practice distinguishes community health nursing from other nursing specialties
- *Articulate specific considerations of each of the three dimensions of the community as client*

- Community is defined as having three features:
    - A location
        - Boundary of community – serve as a basis for measuring incidence of wellness/illness and determining spread of disease
        - Location of health services – use of health services depends on availability and accessibility
        - Geographic features – injury and death from natural disasters; recreational opportunities that promote fitness; extremes of heat/cold/precipitation etc.
        - Flora and fauna – poisonous plants and disease-carrying animals; plants and animals as resources and dangers
        - Human-made environment – housing, dams, farming, waste, air pollution etc.
    - A population
        - Size – the number of people influences number/size of healthcare institutions; size also affects homogeneity of the population and its needs
        - Density – increased density may increase stress; high and low density affect availability of health services
        - Composition – determines types of health needs
        - Rate of growth or decline – rapid growth may place excessive demands on health services; marked decline may signal a poorly functioning community
        - Cultural differences – health needs vary among sub-cultural and ethnic populations; utilisation of services varies with culture; health practices and extent of knowledge affected by culture
        - Social class – class differences influence utilisation of services; class composition influences cost of public health services
        - Mobility – mobility of population affects continuity of care and availability of service to highly mobile patients
    - A social system
        - Health; family; economic; educational; religious; welfare; political; recreational; legal; and communication systems
        - Each system must fulfil its functions for a healthy community
        - Collaboration among the systems to identify goals and problems
        - Undue influence of one system on another may lower community health
        - Agreement on the means to achieve community goals affects community health
        - Communication among organisations in each system affects community health

❖ *Express the meaning and significance of community dynamics*

- Every community has a dynamic or changing quality; affected by three factors:
    - Citizen participation in community health programs
        - Communities where citizens are apathetic about public health issues and rely on health officials to take responsibility require nurses to promote community education and awareness

1. *Because communities differ widely in power structures, do not assume that what is known about one community will be true of another*
2. *The leaders within the health system have different degrees of power and varying spheres of influence; knowledge of these differences is prerequisite to effective community work*
3. *Leaders whose power is limited to health systems often have a network of contacts with similar leaders in other systems; many decisions are made informally via this network*
4. *Power does not automatically flow through established bureaucratic channels*
5. *Beware of leaders who speak authoritatively on issues outside their sphere of power; their power may be more apparent than real*
6. *Leaders from the health system may become key leaders with power that extends beyond the health system*
7. *Learn to distinguish between political, economic, and social power; then use appropriate combination needed to promote community health issues*
8. *Do not overestimate the support of key leaders/power cliques; support is helpful but may still leave much organisational work to be done*
9. *Try to encourage participation in the decision-making process at every level, from average citizen to key leader*
10. *One can assume that leaders in one part of a community are ignorant of needs and problems in other parts of the system. When one contacts such leaders, recognise that they will have to be educated in community health issues.*

    - Participation may be widespread but uninformed/obstructive; citizens may hamper or block development of some programs
    - It is more difficult to work in communities where groups have become polarised by issues (e.g. abortion, fluoridation); assessing the type/extent of citizen participation is a necessary first step in community work
    - Encouraging responsible participation → self-care
  - The power and decision-making structure
    - A key leader may have influence in more than one system but the power will be diffuse; a dominant leader has specific power, but only within a single community system (e.g. a public health official has no power in religious systems)
    - Power and decision-making in any community are complex
    - **Sanders and Brownlee (1979)** suggested several guidelines:
  - Collaborative efforts of the community
    - The nurse must remember that each person has a different level of power and influence within each of their many roles in the community and use this information to enhance collaboration
    - Community collaboration – the ability of the community to work together as a team of citizens to meet an identified need in the community
    - Healthy communities use the skills of community members to enhance the health of the community for all people
    - There are several broad principles underpinning collaboration efforts **(Anderson, Guthrie & Schirle, 2002; Peterson & Alexander, 2001)**

11. *Central to client and community wellbeing is a recognition that public policy issues are beyond the scope of any single person's or profession's jurisdiction and responsibility; community members need to be involved*
12. *Community needs results-based accountability that emphasises programs'/projects' effectiveness as the goal*
13. *Cultural competence is the norm; all programs require respect for ethnic and linguistic identity and the reduction of marginalisation, invisibility and devaluation of people*
14. *Ethical behaviour is fundamental to collaborative relationships*
15. *People work in teams that cross traditional lines of programs, agencies, disciplines, and professions*
16. *Funding strategies need to be decategorised to give more flexibility at the community level ← providing a better way of allocating resources where they are needed.*

❖ *Compare and contrast five types of community needs assessment*

Familiarisation/"Windshield Survey"	○ The most necessary evaluation of a community ○ Involves studying data already available on a community, and gathering a certain amount of firsthand data, to gain a working knowledge of the community ○ Nurses travel around the community; find health, social, and governmental services; obtain literature; introduce themselves and explain they are working in the area; and become familiar with the community ○ Provides a knowledge of the context in which these aggregates (families, groups, populations) exist and may enable the nurse to connect clients with community resources
Problem-Oriented Assessment	○ Begins with a single problem and assesses the community in terms of that problem ○ Commonly used when familiarisation is not sufficient and a comprehensive assessment is too expensive ○ Responsive to a particular need ○ Data collected is used in planning for a community response to the problem ○ E.g. lack of available services and resources for deaf children
Community Subsystem Assessment	○ Focus on a single dimension of community life e.g. the role of churches/religious organisations in the community ○ Can be useful for a team to conduct a more thorough community assessment
Comprehensive Assessment	○ Seeks to discover all relevant community health information ○ Begins with a review of existing studies and all the data presently available on the community ○ A survey compiles all the demographic information on the population ○ Key informants are interviewed in every major system ○ More detailed surveys and intensive interviews are performed to yield information on organisations and the various roles in each organisation ○ Describes not only the systems of a community but also how power is distributed throughout the system, how decisions are made and how change occurs ○ Expensive, time-consuming process → seldom performed
Community Assets Assessment	○ Focuses on the strength and capacities of a community rather than its problems ○ Identifies the capacities and skills of community members, with a focus on creating or rebuilding relationships among local residents, associations, and institutions to multiply power and effectiveness ○ The nurse can become a partner in community intervention efforts, rather than merely a provider of services ○ Three levels: specific skills, talents, interests, and experiences of individual community members; local citizen associations and organisations; and local institutions

❖ *Discuss community needs assessment methods*

Surveys	○ A series of questions used to collect data for analysis of a specific group of area ○ Commonly used to provide a broad range of data that will be helpful when used in conjunction with other sources/if other sources unavailable ○ To plan and conduct community health surveys, the goal should be to determine the variables that affect a community's ability to control disease and promote wellness ○ Survey method involves three phases to ensure adequate design and appropriate collection of data (**Polit & Hungler, 2003)**: ▪ Planning phase ▪ Data collection phase ▪ Data analysis and presentation phase
Descriptive Epidemiologic Studies	○ Examines the amount and distribution of a disease/health condition in a population by person (who is affected), place (where does it occur) and time (when does it occur) ○ Useful for suggesting which individuals are at greatest risk and where/when the condition might occur ○ The choice of assessment method varies depending on reasons for data collection, the goals and objectives of the study, and resources available
Community Forums/Town Meetings	○ Qualitative assessment method designed to obtain community opinions; participants are selected by invitation from the group organising the forum ○ Relatively inexpensive method and results are quickly obtained ○ Drawback is that only the most vocal community members or those with greatest vested interests in the issue may be heard; does not provide a representative voice to others in the community
Focus Groups	○ Designed to obtain opinions in a smaller group of participants ○ Members chosen for the group are homogenous with respect to specific demographic variables ○ Interviewer guides the discussion according to a predetermined set or questions/topics ○ Advantage of efficiency and low cost ○ However, some people may be uncomfortable expressing their views in a group situation

❖ *Describe four sources of community data*

- Primary sources – information gathered by talking to people; directly from the community
- Secondary sources – information from people who know the community well, and the record such people create in the performance of their jobs e.g. health team members, client records
- International sources
    - International data are collected by several agencies e.g. WHO, UN
    - Information from these official sources give the nurse in the local community information about immigrant and refugee populations
- National sources
    - Official and non-official sources of national data that community health nurses can access
    - Official sources develop documents based on data compiled by the government e.g. the US Public Health Service (USPHS), US Bureau of the Census, National Institutes of Health (NIH)

- State sources
    - The most significant state source of assessment data comes from the state health department; this agency is responsible for collecting state vital statistics and morbidity data
- Local sources
    - E.g. local city chamber, city planner's office, health department, hospitals, school districts, universities, and community leaders and key informants
    - Some of these sources compile their own statistics, but all have views of the community particular to their discipline, interest, or knowledge base
    - Some agencies at the local level develop city/country resource directories
    - E.g. working maps that plot where people with known diseases or conditions live

❖ *Discuss the significance of formation of community diagnoses*

- **Neufeld and Harrison (1996)** defined wellness diagnosis as "the statement of a client's [community's] healthful response which nursing intervention can support or strengthen. It should also identify the essential factors related to the healthful response"
- These diagnoses identify the conclusion the nurse draws from interpretation of collected data and describes a community's healthy/unhealthy responses that can be influenced or changed by nursing interventions
- Community health nurses do not limit their focus to problems; they consider the community as a total system and look for evidence of all kinds of responses that may influence the community's level of wellness
- Community diagnoses – nursing diagnoses about a community's ineffective coping ability and potential for enhanced coping; the statements should include the strengths of the community and possible sources for community solutions, as well as weaknesses and problem areas
- The changing diagnosis can be a useful means of encouraging a community toward improved health because it gives community members a clear standard against which to measure progress

❖ *Explain the characteristics of a healthy community*

- **Cottrell (1976)** outlined four important characteristics of a competent/healthy community. A competent community can:
    - Collaborate effectively in identifying community needs and problems
    - Achieve a working consensus on goals and priorities
    - Agree on ways and means to implement the agreed-upon goals
    - Collaborate effectively to take the required actions
- **Cottrell (1976)** suggested several essential conditions for community competence:
    - Commitment of members
    - Self-awareness and awareness of others among groups
    - Clarity of situational definitions
    - Articulateness of various subgroups
    - Effective communication
    - Conflict containment and accommodation

    - Participation
    - Management of relations within the larger society
    - Machinery for effective decision-making
- The healthy community
    - Is one in which members have a high degree of awareness that "we are a community"
    - Uses natural resources wisely while taking steps to conserve them for future generations
    - Openly recognises the existence of subgroups and welcomes their participation in community affairs
    - Is prepared to meet crises
    - Is a problem-solving community; identifies, analyse, and organises to meet its own needs
    - Has open channels of communication that allow information to flow among all subgroups of citizens in all directions
    - Seeks to make each of its systems' resources available to all members of the community
    - Has legitimate and effective ways to settle disputes that arise within the community
    - Encourages maximum citizen participation in decision-making
    - Promotes a high level of wellness among all its members

Nies, M.A., & McEwen, M. (Eds). (2007). Community/Public Health Nursing (pp 237-258). Canada: Sanders Elsevier.

❖ *A critical theory approach to environmental health*

- Critical theory suggests that community health nurses must be aware of environmental obstructions that affect the safety and wellbeing of particular aggregates or deprive them of access to resources necessary in the pursuit for health
- Nurses need to ask critical questions about their clients' work and home environments to help discern the contributions of specific hazards to their health by taking an environmental health history. An environmental health history can benefit the client by:
    - Increasing awareness of environmental/occupational factors
    - Improving timelines and accuracy of diagnosis
    - Preventing disease and aggravation of conditions
    - Identify potential work-related environmental hazards and/or environmental hazards in/around clients' homes
- Environmental health screenings: Adults
    - What kind of work do you do? How long on the job? Types of work exposures?
    - Do you notice health problems you are having while at work/home/in the community?
    - What is the age of your home? Characteristics of heating/ventilation? Do you live near industrial sites or landfill?
    - Recent use of pesticides, solvents, insecticides or weed killers?
    - What kind of hobbies do you have?
    - Has your workplace been treated recently for insects, weed, or other pests?
- Environmental health screenings: Children (Parents or Guardian)

- Where does your child go to school/day care/playground?
- Have any of these places been treated recently for insects/weeds/pests?
- Does your child help with gardening activities?
- What are sources of food, water? Is someone in the household breast-feeding an infant?
- Do parents have any occupational exposure to potential health threats (e.g. lead, pesticides, x-rays)?

- Nurses should listen to what the community believes is a problem, help raise consciousness about environmental dangers, and help bring about change
- Conducting community assessments → learn how community members perceive themselves, their health, and their environmental influences
- Ultimate goal of critical practice of community health nursing is liberating people from health-damaging environmental conditions
- A critical perspective can help nurses plan and implement aggregate level interventions because it emphasises collective strategies for change

❖ *Areas of environmental health*

AREA	PROBLEMS
Living patterns The relationships among people, communities, and surrounding environments that depend on habits, interpersonal ties, cultural values and customs	Drunk driving Second-hand smoke Noise exposure Urban crowding
Work risks Include poor employment environments and potential injury/illness due to working conditions	Occupational toxic poisoning Machine-operating hazards Sexual harassment
Atmospheric quality The amount of protection in the atmospheric layers, the risk of severe weather, and the purity of the air	Gaseous pollutants Destruction of the ozone layer Aerial spraying of herbicides and pesticides
Water quality The water supply's availability, volume, mineral content levels, toxic chemical pollution, and pathogenic microorganism levels	Contamination of drinking supply by human waste Heavy metal poisoning of fish Oil spills
Housing The availability, safety, cleanliness, and location of shelter, including public facilities and individual/family dwellings	Homelessness Rodent/insect infestation Unsafe neighbourhoods
Food quality The availability and relative cost of food, variety and safety of food, and the health of animal and plant food sources	Malnutrition Bacterial food poisoning Disrupted food chains by ecosystem destruction
Waste control The management of waste materials resulting from industrial and municipal processes, human consumption and efforts to minimise waste production	Use of non-biodegradable plastics Poorly designed solid waste dumps Inadequate sewage systems
Radiation risks Health dangers posed by various forms of ionising radiation relative to barrier that prevent human exposure and other life form exposure	Nuclear facility emissions Radioactive hazardous wastes Excessive x-ray exposure