Chapter 24

The changing professional role of community nurses

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Introduction

Community nurses work in diverse community settings to provide primary nursing and health care across the lifespan. Traditionally community nurses meet a continuum-of-health needs that range from the management of specific disease/s to broader community development and public health promotion needs. Health promotion and intervention consciously centre on the client who is viewed holistically; thus, care also considers the social conditions and relationships that affect an individual or a population's health status. In recent years the community nurse's role has begun to shift, directing more attention to the provision of disease recovery nursing care for transitioning clients as they move out of the hospital environment and into the community context. Additionally, the community nurse's role has become more focused on the provision of early intervention measures to prevent exacerbations or complications for clients living with chronic illness/conditions to prevent unnecessary hospital (re)admission. These changes to the community nurse's role are the product of a complex blend of issues that are discussed in this chapter.

Background

In the past 30 years community nursing has directed its service to identification of the broad health needs of communities and to developing programs to meet those needs (WHO 1974). Australian community nurses have had two key foci, the provision of primary health care which includes health education, disease prevention and health promotion, and the provision of community-based clinical care (Kemp *et al.* 2005). The primary health care focus has meant community nurses work within a philosophical framework that considers the social, political, economic and environmental determinants of health (WHO 1978). The early years of community health nursing were focused on understanding particular health problems and the methods of

preventing and controlling them within the local community context. Thus promoting health meant considering issues such as the provision of nutritious food, safe drinking water and sanitation, and preventing infectious diseases via immunisation (Tablot & Verrinder 2005). Consideration was given to the local social, political, economic and environmental issues that might be contributing to disease and illness (WHO 1978). When providing health services regard was given to access, affordability, availability and acceptability of services as the essential principles underpinning service provision (WHO 1978).

In the 1970s community health policy language referred to the client as 'stakeholder' – one who has a vested interest in the outcome of the policy. This contrasts with current policy language which increasingly speaks of the client as 'consumer' – one who devours resources (van Loon 1998). This shifting language is indicative of a changing focus within Australian community health from health promotion and disease prevention within the community, which was the priority in the 1970s, to the current focus on disease intervention and clinical service delivery within a community setting. Contemporary community nursing is caught in this ideological juxtaposition, using a philosophy developed for a broad community-based perspective on health, yet being required to provide nursing services that are underpinned by an acute care approach of individualised, biomedical and disease focused care.

Currently, community nurses are being asked to assist clients and their carers/families to self-manage their health situation within their home environment. This help includes locating and liaising with appropriate support services; advocating for clients and increasingly brokering health information and services to help clients attain the skills they require to maximise the self-management of their illness/condition. Community nurses now meet a comprehensive range of health needs within varying practice contexts such as community health centres, general practice rooms, nursing clinics, public health units, schools, universities, local councils, faith communities, rural and remote communities, tele-health across multiple jurisdictions, and importantly in the client's home.

Issues affecting the community nursing role

There are several issues that are forcing the community nurse role to evolve and change to meet altering needs. Some of these issues are discussed in other chapters so they are not addressed here, but other key issues affecting the contemporary community nurse's role are discussed next.

Changing social demographic

Along with many other developed countries, Australia has a vastly improved life expectancy. With high life expectancy variables factored into population projections, life expectancy is predicted to increase to 92.2 years for men, and

95.0 years for women by the year 2050–51 (ABS 2004). As mortality rates continue to drop and the post-Second World War 'Baby-Boomers' approach retirement age, the demand for health and community services is likely to escalate. Concurrently, Australia's birth rates have dropped so children are projected to make up a smaller part of Australia's future population as the people over 65 years olds increase (ABS 2004). Such a major demographic change will impact on economic, social and health policy, as the aged require housing, income support, provision of health and disability services and community care (Rowland 2003).

While it cannot be assumed that all older persons will have increased health needs, the data indicates that the age-specific prevalence of profound disability (requiring supportive care) increases from about 5% at age 70 years to 50% at age 90 years (Giles *et al.* 2003). Couple this fact with the propensity for Australian retirees to move away from major capital cities to quieter coastal towns around Australia, and the provision of community nursing services, is likely to become a logistical challenge. This issue is further compounded by the fact that many seniors do not have, or have access to, an extended family for various reasons including geographic distance; increased divorce; couples choosing not to have children; changing attitudes to caring for the elderly within the family; and the growth of two income families who do not have the time to provide intensive and extensive supportive care. Thus the scene is set for a growth in demand of health and community care services and a decrease in the capacity to meet these community care needs.

To effectively situate Australian community nursing for a viable and helpful future, organisations will have to redesign care and service options to improve the continuity of care, avoid service duplication and assist clients to become better at self-managing their illness/condition while promoting healthy ageing. Even with the best intentions regarding quality health and community care it is most probable that cost rationalisation will occur and decision-making may be more affected by economic imperatives and the availability of services to meet demands within budget constraints.

Changing acuity and complexity of clients

An ageing population will bring an increase in complexity of care demands. In 1998 the National Survey of Disability, Ageing and Carers undertaken by the Australian Bureau of Statistics (ABS 1999) estimated that 3.6 million Australians (19%) had some form of disability. Of these, 2.8 million (78%) had a core activity restriction – in self-care, mobility or communication – caused by their disability (ABS 1999). The number of older people with profound disability is projected to increase by 70% over the next 30 years. The key conditions leading to the restriction of core activity in older Australians will be musculoskeletal, nervous system, circulatory and respiratory conditions and stroke (Giles *et al.* 2003). Therefore it is likely that community nurses will see more people with complex comorbid conditions that impact their ability to self-care.

Changing data needs

As the demand for resources increases, nurses will have to collect more data to justify budgets, and resources will have to be shifted and allocated to where they are most needed. This will require skills in the operation of software and hardware devices to collect client data and nursing data sets from which management decisions will be made enabling services to remain responsive.

Changing health funding

It is likely that some nursing services will attract a limited quantity of Medicare provider numbers. Billing systems will have to be initiated that can itemise accounts. This will require reliable, secure, easy-to-use and accurate transaction systems that enable providers to claim payments directly from Medicare Australia and the various private health funds, so nurses are not constrained in meeting their client needs by copious administration requirements.

Changing value systems

There are diverse value systems employed by people of varying cultures, races, ethnicities and religions within multicultural and Indigenous Australia. In community nursing these values influence how each person in the nurse/client interaction views the person, the community, health, disease, illness, wellness and the role of professionals in the sickness/wellness situation. One's values are impacted by one's belief systems. Value clashes may occur between individuals holding differing beliefs. These clashes also occur between generations and can lead to miscommunication between nurses, workers, family and clients.

The tension between cultural values is highlighted in a study undertaken on the management of comorbid diabetes and alcohol-related disease in Indigenous Australian communities (De Crespigny *et al.* 2004). The Aboriginal health workers were struggling to get clients to self-manage their medication and control their blood glucose levels. Some of their clients were managing their diabetes by drinking more or less alcohol. After discussion it became apparent that the clients did not see their alcohol misuse as a health issue. They were accustomed to living with illness and feeling unwell. In fact, feeling ill had become the norm for many of the Indigenous clients. Drinking alcohol was a social pastime that brought a sense of connection and belonging that was valued highly and regarded as important for the client's mental and social health. Therefore controlling one's blood glucose level was less of a priority when it jeopardised one's capacity to engage in communal social activities. Here we see two different value systems in tension. The health professionals problematise the diabetes and prioritise its management. Their Indigenous

clients did not place the same priority on disease management, preferring to prioritise the social connection they received from their communal drinking activities.

Community nurses need cultural competence because they make clinical decisions based on multiple social factors. They must be able to negotiate and align their value systems while promoting quality self-management. Such cultural brokering is increasingly important in multicultural Australia, as the post-war migrants age and community nurses experience more variations in perspectives regarding health and illness. It is important that future community nurses are culturally aware if Australia is to remove disparities in health outcomes for Indigenous Australians and people from culturally and linguistically diverse backgrounds.

The values generated by a health service may clash with those of the nurse and the client. For example, the acute care sector has increased specialisation that focuses on the person at a micro-system level. Even single systems are subdivided into specialties. In the community such specialisation is less helpful for the client who wants to live as an integrated, functioning and relational whole. Such fragmented and individualised perspectives of the person are foreign to many cultures and especially Indigenous Australians who hold a holistic understanding of the person and health. The future community nurse has to recognise these values, understand the impact they have on health outcomes, and be able to negotiate a care plan that enables communication and effective outcomes of care within these conflicting value systems.

Most community nurses work from a primary heath care philosophical position with its whole person wellness focus. On the other hand the acute care sector works from a biomedical perspective with a compartmentalised view of the person and his/her disease/condition. The increase in intensive episodic care within the community setting has brought with it a clash in perspectives between sectors of the health system and has created its own tension within community nursing services. Community nursing services with a strong community health focus note this tension when communicating and liaising with community nurses working in general practice and acute/restorative care such as 'hospital at home' services, who struggle to understand the relevance and use of a primary health care approach to nursing practice (Kemp *et al.* 2005).

There are also intergenerational value clashes that can lead to miscommunication within the community nursing team, and between workers and clients. The South Australian Department of Health (Department of Health – Nursing Office 2006a, 2006b) released a discussion paper highlighting the generational differences in the nursing workforce between the largest contingent of 'Baby Boomers' who commenced nursing in the 1970s to mid-1980s; those nurses in 'Generation X' who commenced nursing in the mid-1980s to 1990s; and the most recent entrants, 'Generation Y' or 'Millenials' who commenced nursing in the 2000s. Each generation holds different values regarding work. For example, many Baby Boomers are in leadership roles and are willing to forgo their personal lives for work. They are intensely focused on sacrificing for the good of the client and the respect of colleagues (Department of Health – Nursing Office 2006a: 2). Generation X nurses are largely

unimpressed by authority figures. They are self-reliant and independent, unwilling to perform activities that they see as unreasonable and quite prepared to challenge authority in that process (Department of Health – Nursing Office 2006a: 2). Millenials have grown up in a time of unprecedented luxury and convenience. They are accustomed to change, living life at a fast pace and with instant solutions to problems. Millenials have lived with ready access to information so they are technologically competent, absorbing and translating knowledge quickly (Department of Health – Nursing Office 2006a: 2–3). Millenials want to make immediate impact in their workplace. They are emotionally confident and want tangible rewards for meaningful work (Department of Health – Nursing Office 2006a: 6). With such varied generational values regarding work, it is not difficult to see how there is potential for tension and miscommunication between the generations within their professional roles.

Community nurses value the fact that they are doing worthwhile work that is making a difference in someone's life. They are motivated by their capacity to help clients and influence quality outcomes for them (van Loon & Kralik 2006). Factors that enable these values are esteemed and those that constrain these values are perceived as barriers that create frustration. How the various value systems conflict or conform will impact on employee satisfaction. Thus understanding values will be central to the community nurse's professional role and integral to quality client outcomes.

A recent study found community nurses valued organisational support and structures that sustained their accountability and organisational trust (van Loon & Kralik 2006). The nurses valued excellence as a practice and organisational norm. The importance of collegiality was unanimous. The nurses were not interested in competition and wanted a work climate that involved reciprocal exchange; constructive feedback; mutuality; sharing of information; participation and development of all team members enabling them to work within their scope of professional practice. The nurses enjoyed working in teams that had a refined sense of loyalty, agreed purpose, mutual stimulation and shared motivation as they worked towards achieving their agreed clinical goals. These community nurses valued a safe, transparent and open work environment where criticism was not taken personally, rather healthy debate was encouraged, facilitated and moderated. When the nurse's, the client's and the organisation's values aligned the potential for creative synergy was enhanced and this in turn affected the quality of care, morale and intrinsic motivation for all concerned in the caring experience (van Loon & Kralik 2006).

Changing the design of health and community care

Future health and community care systems will need to be responsive. Community nurses value the time they can spend with a client and when this is compromised motivation diminishes quickly and workplace morale suffers (van Loon & Kralik 2006: 48). If organisations are going to retain staff and

maintain viable services within tight budgets significant reorganisation of the nursing and community care workforce will be required.

Increasing autonomy and the provision of accompanying responsibility statements and matching accountability mechanisms are likely to produce a flattened organisational structure that may be more economical. Such changes will require the development of detailed evidence-based guidelines, lucid policies and protocols that can ensure uniform quality care across an organisation. Such autonomy is likely to be embraced by Generation X and Millenial nurses who are likely to be eager to take on such a challenge (Department of Health – Nursing Office 2006a).

Health care is likely to be opened to market forces because services will need to be provided in the most cost-effective way to meet growing demand. Governments will not be able to carry the financial burden alone. For example, dying is not a 9 a.m.–5 p.m. business, yet very few community palliative care services offer a 24-hour hospice-at-home type of service, due to the cost constraints. Will community nurses be able to provide such services, using the support of carers and trained volunteers and having access to a network of specialists with broader knowledge and skills? Should governments and services employ professional nurse case managers or nurse practitioners who manage and broker high-quality, cost-effective, value-for-money services for clients? If so, such care managers must be provided with clearly designated responsibilities and the accompanied authority to make clinical decisions, or the service will fail. What care tasks can be provided by different workers? Does all 'nursing' care need expensive, highly qualified professionals or can nursing services be provided by someone who is trained, credentialed, monitored and supported?

These discussions are taking place in the boardrooms of health services throughout the world. They indicate a future professional role for case/care management that moves across the health care continuum, interfacing with allied health services and volunteer community support structures. This is likely to become part of the community nurse's professional role and raises the vexed issue of professional boundaries and role delineation. It is becoming increasingly difficult to define what professional knowledge is particular and unique to which health professional and who should be responsible for what aspects of client care in the community. This also surfaces issues about how to credential and supervise carers in a climate of increasing litigation. Is the risk worth the money saved? Very large studies (19,000 nurses) in the USA clearly indicate that maintaining a professional credentialed workforce saves money, improves client outcomes and decreases adverse events while increasing client and nurse satisfaction (Aiken *et al.* 2003, 2002; Cary 2000; Needleman *et al.* 2002).

What is of concern to many organisations is the importance of good client assessment to detect signs of complications early, so that timely interventions can be initiated for the client, or so that the nurse/carer knows when to refer the situation on to another professional. It is well known that many adverse medical events could have been avoided if appropriate and timely referral had occurred (Wilson *et al.* 1995). A major cause of adverse events is the

failure of communication between caregivers, because the authority gradient hinders communication and teamwork (Leape 2005). Such system failures need to be addressed when redesigning care. The future professional role of the community nurse will rely on excellent assessment skills that are grounded in a sound knowledge base and outstanding capacity for communicating that knowledge across the health care continuum. This will require a concentrated effort in developing the research and knowledge base of community nursing practice and then ensuring that this knowledge is transferred to practice via efficient and fluid structures, policies, processes and guidelines.

Whatever redesign is undertaken it is likely that generalist community nurses will be central to the platform of care activities, enabling clinical expertise to stay accessible to the client. Nurses will have a broad knowledge base so they can move laterally across an organisation/system and perhaps even between several services. Instead of being promoted 'up' the career ladder and 'away' from direct client care, the future community nurse is likely to have her/his job profile enlarged, or shifted for a time, and be paid additionally for those activities (Department of Health – Nursing Office 2006b).

It is important to realise that economics does not figure highly when community nurses select where they want to work (Department of Health – Nursing Office 2006b). What is most important to community nurses is their capacity to help their clients and influence quality outcomes for them (van Loon & Kralik 2006). Consequently, these factors should be taken into careful consideration when redesigning a health/care service.Again we see that changing workplace requirements will require excellent communication and leadership skills to foster multidisciplinary integration.

Changing scope of practice

Along with most of the developed countries, Australia is experiencing a shortage of nurses in the workforce. With the expected decline in the numbers of younger people in Australia, the community nursing sector will have to recruit and retain staff in a highly competitive job market, to perform in a demanding career that operates in a resource pressured environment. Planning for these changes needs to occur now, if a crisis is to be averted. Expanding the professional nursing role to improve autonomous decision-making, and expansion or evolution of the scope of community nursing practice is critical to Australia's capacity to meet these demands.

The scope of nursing is the practice for 'which nurses are educated, authorised and deemed competent to perform' (Department of Education Science and Training 2002; Queensland Nursing Council 2005). Managing changes to the scope of nursing practice will become essential if an organisation is to be responsive and grasp opportunities to provide their service in a competitive marketplace. Managing the scope of practice involves identifying the enabling factors that provide the authority, the capacity, the knowledge and the opportunity for community nurses to practice.

There is likely to be new contexts and positions within the scope of community nursing practice. One recent example is the addition of faith community nursing or parish nursing which formally commenced in the USA in the 1980s and in Australia in 1996 (van Loon 1999). Faith community nurses provide access to health promotion and illness prevention activities, health education and counselling tailored to specific disease needs, referral, advocacy and care management services in the context of a faith community (van Loon 2001). A faith community can include individual churches, parish clusters, faith-based aged care, hospitals, schools or health and social welfare agencies. Currently, most Australian faith community nurses are working in Christian faith communities; however, internationally there are nurses from other faiths working in this community nursing role (van Loon 2005). They embrace a holistic perspective of the person, providing culturally sensitive care to a specific cultural or geographic community that the auspicing faith community serves. These community nurses use a primary health care approach that partners with other health professionals, services and lay people (van Loon & Carey 2002). Differing care contexts will give rise to diverse nursing activities and roles that meet the changing needs of Australian society.

Expanding the scope of specialist knowledge and practice in community nursing is likely to develop more advanced practice roles such as nurse practitioner and specialist roles. These nurses are experts in their field who are able to make complex clinical decisions based on advanced educational preparation and appropriate regulation and authorisation (Australian Health Ministers' Advisory Council 2006). The '. . . nurse practitioner role has been introduced to complement and improve access to services and health outcomes' for clients (Australian Health Ministers' Advisory Council 2006: 2). It is not designed to 'replace' or 'take over' other health professional roles (Australian Health Ministers' Advisory Council 2006).

Professional roles include autonomy over practice with concomitant responsibility, authority and accountability. Therefore broadening the scope of community nursing practice must be accompanied by appropriate policy, legislation, business opportunities and risk management strategies if nurse practitioner roles are to provide the best outcomes for clients and the Australian health system. How this accountability is established is currently the cause of debate in nursing. In many professions accountability is achieved via self-regulation to a predetermined, documented standard. The nursing profession has a discreet body of knowledge over which it exercises control. It seeks to organise and impart this knowledge to a specific standard to all members. As a profession, nursing is developing its body of knowledge via research which provides the evidence base from which professional practice emanates. Nurse practitioners and advanced practice nurses will be expected to be actively involved in development of the research base for their practice (Department of Education Science and Training 2002).

In recent years accountability demands have led to growing pressure for all professions to audit their members to ensure competence remains at the required standard. These demands have been fuelled by the rapidly changing knowledge base and workplace practices of many professional groups in

Australia (Australian Nursing and Midwifery Council 2002). With the increase in litigation many insurers are requesting regular auditing of professionals as part of their risk minimisation strategies. Community nurses in more autonomous advanced practice roles will be subject to stringent audit processes to protect the community and ensure quality health care is provided.

Changing knowledge and skill sets

The future community nurses are likely to be accomplished knowledge workers. They will need to translate theoretical, public policy and research knowledge into practice expeditiously (Breu *et al.* 2001; Daghfous 2004). Put simply, the expanding and evolving knowledge and skill sets of community nurses will mean that nurses are expected to know why they are doing things; know how to do them; be able to perform appropriate activities proficiently; and then know what to do next. The community nurse must know how, when and where to access assistance, from whom to obtain it and what processes must be employed to facilitate access to this help (van Loon & Kralik 2007). The nurse must have sufficient self-awareness to realise when they do not know, so they can ask for help in a timely manner.

Knowledge translation is the exchange, synthesis and ethical application of research findings by knowledge users (Schryer-Roy 2005: 2). As a broker of knowledge the community nurse builds relationships and networks to share and disseminate research. Sound transfer of knowledge may require the translation of research findings into user-friendly language that requires minimal effort for the end user to take up and utilise the knowledge in practice. This is particularly important as health care is shaped by international forces as well as local and national issues (Ketefian *et al.* 2001). This means that the community nurse will attempt to understand what the learner already knows, what the learner requires and how to provide that information in a way that is readily understood with appropriate intent and accurate application. It is important that the messenger with the new knowledge is credible and as such clinical knowledge will be more effectively brokered by community nurses who are specialists in their field (Lavis *et al.* 2003).

Community nurses will have to be able to read statistical and population data and interpret it, so it can inform their practice. They will need to communicate knowledge in multiple formats, 'presenting their case' in various methods to the clients, the organisation, policy makers and the community. Community nurses will have to translate policy directions into current practice and renewed structural formats and do this within a short time frame.

Nurses will most likely be undertaking skills that community nurses may not have been familiar with in the past. Such knowledge has to be understood and mastered. Community nurses must stay on top of new technology pertinent to their clinical field/specialty. They will need a good understanding of computer and information systems that support community care. They will need to ensure that the information their employing organisation uses is

evidence based, researched and current. Each nurse will have to keep abreast with what is current in his/her area of expertise.

Changing clinical leadership function of community nurses

Allegations about a lack of leadership in community nursing are present in the nursing literature (Kemp *et al.* 2005; Rout 2000; Smith 2000). It is also argued that professional community nurses will have increased clinical leadership in their role. Leadership can be defined as the activities of an individual that are visionary, and critical in directing and sculpting clinical practice (Davidson *et al.* 2006: 182). Leadership differs from management, which is the planning and organisation of services. Leadership is demonstrated by 'unifying people around values and then constructing the social world for others around those values and helping people get through change' (Stanley 2006). Community nurses in clinical leadership positions enact their role underpinned by a strong value base of compassion for clients and passion for community nursing (van Loon & Kralik 2006). These qualities enable the clinical leader to lead with purpose that is based on meaningful values (George 2003).

Future clinical leaders in community nursing will need to be able to quickly up-skill new nurses in community care processes so the nurses are not at risk when practising autonomously in the community. The community nurse must understand the unique nature of their work environment to effectively partner with the client and his/her support persons/systems. There are subtle nuances to caring for clients within their own home context that need to be understood. New competencies will evolve and some of these are likely to include areas such as teaching, project management, marketing, business management, finance, policy and guideline development, information technology, interdisciplinary communication and conflict management (van Loon & Kralik 2006).

A study by van Loon and Kralik (2006) found that the qualities of an effective clinical leader in community nursing could be grouped into four categories:

1. *Personal qualities* that include internalised values and character traits such as trustworthiness, respect, good communication, confidence, flexibility, integrity, justice, acceptance, caring, discernment and refined emotional and social intelligence.
2. *Behavioural qualities* include the responses and actions the clinical leader demonstrates such as responsibility, respect, innovation, creativity, motivation, self-awareness, responsiveness, accountability and support to followers.
3. *Knowledge-related qualities* are the specific merits relating to professional wisdom, information exchange, knowledge management and brokering, and clinical competence. The qualities expressed include advanced/expert clinical knowledge, reflective practice and the ability to translate knowledge and develop oneself professionally.

4. *Role-specific qualities and behaviours* include a client/person-centred perspective, professionalism, role modelling, mentoring, teaching, learning, evaluating, acting as a resource person, an advocate, a people manager and a change agent.

The future community nurse role

In the future the generalist community nurse role will probably involve more comprehensive personal and environmental health and developmental assessments. The nurse will have to know when to consult with and refer to other care support services as he/she provides long-term case management and care brokering services to clients. This will involve comprehensive care planning so clients can self-manage where possible. It is likely that community nurses will have to communicate and negotiate care across a variety of health and social services, both paid and voluntary. The nurse will work to negotiate goals and employ agreed care activities, monitoring progress and designing, and coordinating care as needed. This care will be supported by new and portable technology, available to the nurse and the client in the home, which is likely to be leased from specialist monitoring/intervention services for a fee. Thus nurses will require an extensive knowledge of available technology, equipment and community-based services, and the client's eligibility for subsidised services via government subsidy schemes or medical insurance items.

It is likely that generalist community nurses will be able to call on nurse specialists or nurse practitioners who will have provider numbers and limited prescribing rights. These nurses will perform various investigative tests, treatments and interventions and will create specific care pathways for clients in specialist areas such as mental health, disabilities, continence, diabetes, wound/stomal care, palliative care, drug and alcohol management, dementia care, aged care, sexual health – HIV/AIDS, notifiable conditions, immunisation, Indigenous health, paediatrics, oncology, cardiac care and renal care. The knowledge base for these positions will be refined to specific and detailed understanding of current clinical pathways based on evidence-based diagnostics, treatments/interventions/therapies, monitoring and evaluation processes.

Consequently, future community nurses will have to develop a range of clinical, leadership and management competencies to perform their professional role. These are summarised in Table 24.1.

Conclusion

The Australian community nurse's role is changing rapidly. The future community nurse will be providing complex care in diverse community settings using cutting edge technology to provide primary nursing and health care across the lifespan. The changing social demographic in Australia will cause care to be provided to many older people with higher acuity and complex comorbid health needs. The number of older people with profound disability

Table 24.1 Competencies nurses need for effective clinical leadership in the community

Clinical skill and knowledge competencies of community nurses	• extensive clinical experience (especially in specialist portfolios) • advanced clinical skills/knowledge/competence specific to one's field of practice • actively contributes to clinical care planning, policy and clinical care delivery • involved with broad professional groups and networks • utilises up-to-date and research/evidence-based knowledge for practice • excellent problem-solving skills • works collaboratively, in partnership with clients and multidisciplinary team • evaluates care outcomes • culturally sensitive when planning care • able to develop policy and guidelines • holds suitable academic qualifications • undertakes clinical audits/evaluation • understands the benchmarking process for development of clinical practice benchmarks, performance criteria, measurement/scoring mechanisms to demonstrate achievement of client care goals • manages clients with multiple comorbidities and complex care needs • evaluates care and explication of outcomes of nursing • develops ways to demonstrate attainment of primary heath care indicators • excellent in client assessment, diagnosis and classification of disease
Leadership competencies of community nurses	• influences colleagues regarding clinical care • thinks creatively or laterally • thinks strategically • is intuitive regarding leadership of colleagues • demonstrates vision and direction to the organisation regarding clinical activities • articulates what is leading edge in his/her discipline • translates knowledge in a pragmatic manner • demonstrates and role models best practice • navigates a clinical course that promotes best practice • empowers others to follow • maintains a perspective that is mindful of resources (care is cost-effective) • collegially supports colleagues • is professionally committed, has direction, trust and respect of colleagues • demonstrates collaborative team-building skills • has refined interpersonal skills • utilises negotiation and conflict resolution skills • encourages community building skills • is able to work with other organisations • understands shared governance across partnerships • presents knowledge and skills with clarity and ease • prioritises processes, auditing and provision of feedback regarding clinical care • plans for succession by training leaders in his/her discipline • has skills in teaching, coaching, mentoring, presentation skills using multiple methods to communicate knowledge • utilises appropriate information technology • is involved in 'big picture' directions, e.g. visioning and futures thinking regarding health policy, regulation, strategic processes, risk management, etc.
Management competencies of clinical leaders in community nursing	• directs policy – drives knowledge and practice in their specialty or sphere of influence in the organisation • acts as change agent, understands change management theory • undertakes strategic planning • reads and uses population profiling data to map services • is able to utilise research and statistics e.g. census data to plan clinical services • manages time well for self and others • applies for and/or makes a case for funding • understands health economics – especially payout systems for clients and for organisation • scopes future trends to see where organisation might make a difference • scans environment for business • has sound project management skills • has business management knowledge (contracts, budgets, laws) • knows how to 'market' services, and 'sell' organisation's services to other professionals and clients in a competitive health market

impacting their ability to manage self-care is projected to increase. So the stage is set for the demand for resources to increase. Nurses will need to justify budgets and resource allocations. Thus community nurses will have to collect data and be able to interpret it, so they can make a case for funding and clinical care management decisions so community services can shift resources and remain responsive to client needs. Arguing the case in a competitive funding environment will require an accurate research and knowledge base with accompanying efficient and fluid structures, policies, processes and guidelines to provide quality, accessible, affordable care.

These changes are likely to cause some concern as the values that motivate individuals and services will agitate. The redesign of health and community care will be ongoing as client and community needs and economic demands dictate who can be cared for, how often and with what types of services. The future is likely to see the expansion of the scope of community nursing practice. Alongside that will be the need for generalist and specific knowledge and skill sets that will be administered by nurses who are accomplished knowledge workers, effective clinical leaders, culturally competent individuals and excellent care brokers. This changing role will provide interesting challenges and exciting opportunities.

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