



# **Guiding Principles and Theoretical Orientation for Community Health Nursing**



# SECTION 1

## SECTION OUTLINE

- CHAPTER 1:** Reflecting on Providing Care to Clients in the Community
  - CHAPTER 2:** Respect for an Ethical and Cultural Context for Care in the Community
  - CHAPTER 3:** The Vision for the Alliance for Health Model
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## CHAPTER OUTLINE

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## OBJECTIVES



1. Define the types of nursing interventions, focused on families, groups, and communities that are useful in community health nursing practice.
2. Identify the role of the community health nurse in supporting the core functions of public health.
3. Explain the value of the *Healthy People* project for improving nursing systems of care delivery, education, and research.
4. Define the meaning of incorporating distributive or social justice in the definition of community health nursing care delivery, education, and research.

## KEY TERMS



Accreditation  
Assessment  
Assurance  
Client  
Community

Community health nursing  
*Healthy People*  
Home care services  
Justice

Nursing  
Nursing of special interest  
Policy development

Public health nursing  
Public health nursing practice  
Reflective practice



# CHAPTER 1

## Reflecting on Providing Care to Clients in the Community

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### REFLECTION

*A moral being is one who is capable of reflecting on his past actions and their motives—of approving of some and disapproving of others.*

—Charles Darwin (1809–1882)



## Introduction

This chapter introduces a number of important concerns in providing care in the community. Reflective practice is a concept that the community health nurse (CHN) uses to ensure the delivery of comprehensive care in the community. Nursing in the community is different from the acute care approach in hospitals and other acute care settings. The difference in the role of the CHN begins with an examination of the core functions of community health nursing and public health. The core functions of assessment, policy development, and assurance provide guidance for the performance of nursing in the community.


In addition, the paradigm of providing care requires a special understanding of the concepts central to nursing practice in the community. In community health nursing practice, the concepts of client, nursing, health, environment, and caring as informed by distributive or social justice take on special meaning. As in other settings, the key to providing quality nursing care in the community is role competence. The CHN must demonstrate competence in meeting the needs of clients in a number of settings in the community. Role competence is augmented by the legal and voluntary guidelines in place to support the systems of care management. In addition, the essentials of education and credentialing in the community inform nurses about how best to prepare themselves for safe and effective nursing practice. Role competence is a concern of CHNs over the course of their entire careers.

A brief historical overview of some of the important aspects of the development of community health nursing practice is also provided here. History informs the nurse of where the profession has been, with an eye toward how to create better and more efficient systems of care for the future. The chapter ends by reflecting on nursing's future as outlined by two important documents. This reflection on the possibilities for nursing's future in community health begins by examining the Institute of Medicine (IOM, 2011) guidelines for the future of nursing and the Quality and Safety Education for Nurses (QSEN) competencies (Cronenwett et al., 2007).

## Providing Care in the Community Using Reflective Practice

Providing care to clients in the community through **reflective practice**, or the way nurses provide care, has many challenges in community health nursing. Nursing in the community is unique because at any one time the nurse may be caring for clients (patients) who are young and old, are sick or well, and are making different levels of progress on their path to health and wellness. The CHN continuously reflects upon how all parts of the nursing process relate to the care of individuals, families, other groups, and the community as a whole (American Nurses Association [ANA], 2010a, 2010b), and takes steps to create best practices in care delivery, using ethical and culturally appropriate guidelines.

Definitions of **community health nursing** from the perspective of the ANA, and the American Public Health Association (APHA), Public Health Nursing Section, are helpful in identifying the focus of community health nursing. The Association of Community Health Nursing Educators (ACHNE) provides guidance to educators in the field. For the purpose of this discussion, public health nursing is a component of community health nursing, with a specialized focus on promoting wellness in communities, or among populations.



**Reflective practice:** Practice in which the nurse considers how all parts of the nursing process relate to the care of individuals, families, other groups, and the community as a whole.

**Community health nursing:** The provision of nursing care for collectives of people, bound in relationships that are called families, other groups, aggregates, and communities.

### ANA Definition of Nursing

**Nursing** is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations (ANA, 2010b).

### ANA Standards and Scope of Public Health Nursing Practice

The ANA Standards and Scope of Public Health Nursing Practice are based upon the ANA definition of nursing and act as a guide the role and “expectations of the professional role within which all public health registered nurses should practice” (ANA, 2010a, p. vii). “**Public health nursing** is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences” (APHA, Public Health Nursing Section, 1996).

### APHA Definition of Public Health Nursing Practice

**Public health nursing practice** is affected by biological, cultural, environmental, economic, social, and political factors. As part of the healthcare system, public health nursing practice responds to these factors through working with the community to promote health and prevent disease, injury, and disability (APHA, 2010).

### ACHNE Guidelines of Community Health Nursing

The ACHNE makes available to nurse educators suggestions and plans to implement and evaluate community/public health nursing (C/PHN) baccalaureate nursing curricula relevant for meeting the needs of the public in the twenty-first century. The C/PHN designation identifies the nurse generalist within the specialty. The *Essentials* document provides recommendations of core knowledge, values, and competencies that should be in the curriculum (ACHNE, 2009).

**Nursing:** The protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

**Public health nursing:** “The practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences” (APHA, Public Health Nursing Section, 1996).

**Public health nursing practice:** A part of the healthcare system that responds to biological, cultural, environmental, economic, social, and political factors through working with the community to promote health and prevent disease, injury, and disability.

Providing nursing care to clients in the community involves meeting specific personal and professional responsibilities. The CHN, like nurses who work in acute care settings, cares for clients in a personal and professional way. The CHN, however, has the additional responsibility of caring for the client in the community setting, which adds a

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unique twist to the care provided. As identified by the various professional associations related to community health nursing, the CHN has the privilege and responsibility to care for the community as a whole.

## Reflecting on the Essentials: Core Functions of Nursing in the Community

Three core functions are related to the work nurses perform in the community. Although considered core functions of public health, these three functions—assessment, policy development, and assurance—have meaning for the CHN in all settings. The nurse becomes fluent in these three functions so as to provide safe and effective care to the community as the client of nursing care.

### Assessment

The first aspect of **assessment** that is significant for the CHN is monitoring health status. This is an ongoing activity that continuously alters the picture of health in a community. In addition, the CHN investigates the outcome of assessment. The CHN, using the nursing process, diagnoses and further explores problems and concerns in the community. Working with members of the community, the nurse better understands the significance of problems from the perspective of the community's experience of living with various challenges. The CHN,

in conjunction with other professionals and laypersons, identifies the healthy and less healthy patterns of behavior in the community.

### Policy Development

**Policy development** begins with the process of interacting with the community. The CHN actively informs the community of concerns, educates the members of the community of their choices, and empowers them to act. The CHN, after establishing a therapeutic relationship with the community, mobilizes community partnerships for change. Change efforts are molded into policies and plans to support the evolution of healthy communities. The nurse is active in moving policies into the legal system for protection of the health of the people living in the community (Milstead, 2008).

### Assurance

**Assurance** relates to the public's perception that the providers of health care and the systems of care management are operating in their best interest. The CHN can participate in assurance by fostering linkages between people and services, and monitoring the interaction closely so that people get their needs met. On a larger scale, the CHN has a part in monitoring the competence of professionals working in the community, and participating in the enforcement of laws and regulations to support health in the community.

## Reflecting on a Guiding Paradigm of Community Health Nursing Practice

The CHN approaches nursing care from a special perspective. The guiding paradigm of nursing practice—that is, the unique relationship between (and among) the concepts

**Assessment:** The community health nurse's practice of monitoring health status, investigating outcomes, and using the nursing process to diagnose and further explore problems and concerns in the community.

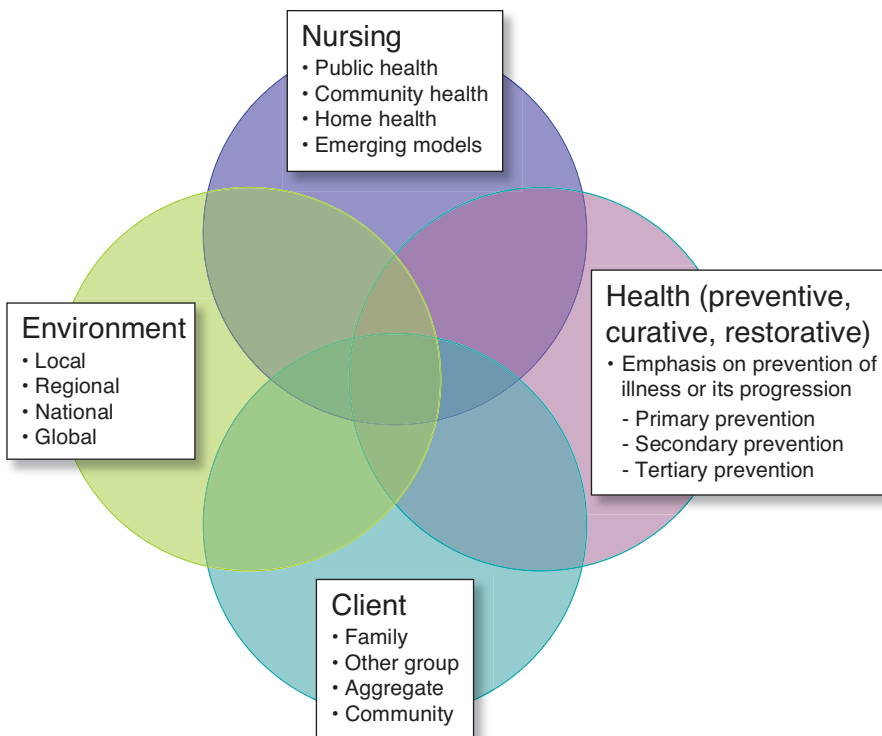
**Policy development:** A process in which the community health nurse interacts with the community, mobilizes community partnerships for change, and molds policies and plans to support the evolution of healthy communities.

**Assurance:** Efforts directed at enhancing the public's perception that the providers of health care and the systems of care management are operating in their best interest.

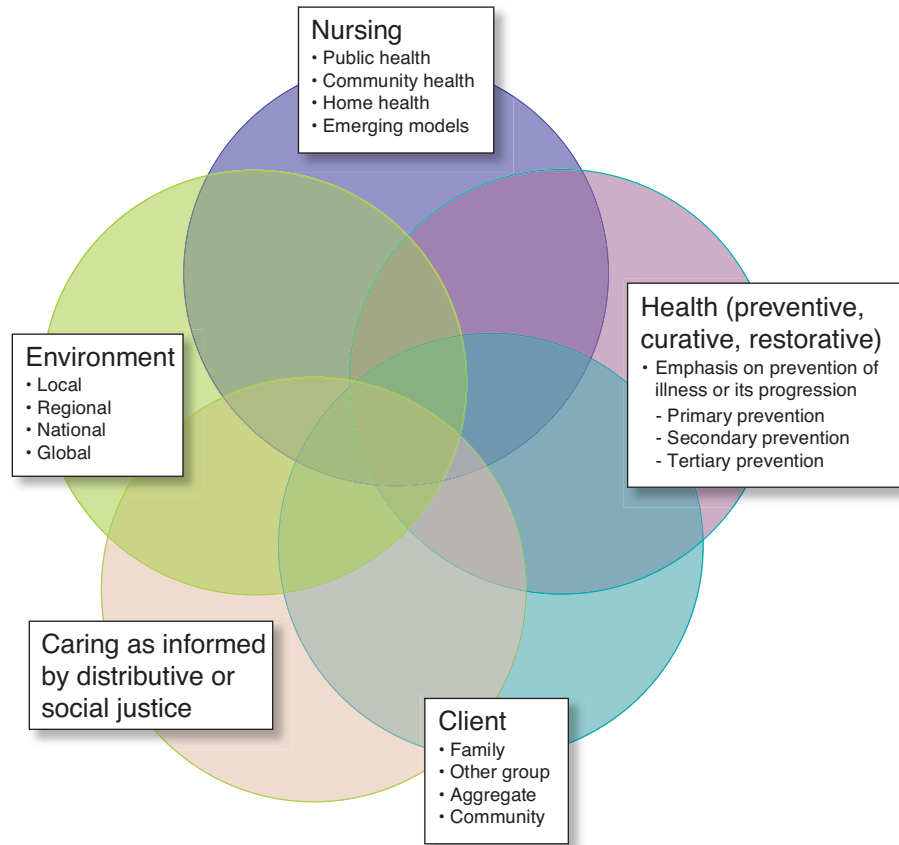
of nursing–health–client–environment and distributive or social justice—gives substance to the roles and responsibilities of the community health nurse (ANA, 2010a, 2010b). The relationship between these concepts is referred to as a paradigm because it attempts to grasp or represent the concepts central to nursing’s development as a profession. **FIGURE 1-1** provides a representation of the concepts that traditionally define community health nursing.

Some nursing scholars suggest that a major concept has yet to be explicated in the paradigm of nursing—namely, the concept of caring as informed by distributive or social justice. If this idea has merit, it suggests that knowing caring informed by justice is as critical as knowing the concepts of nursing, health, client, and environment. **FIGURE 1-2** depicts the addition of this fifth concept in the nursing paradigm.

Nursing in the community has a somewhat different relationship with the concepts of health, client, and environment, and a unique relationship with social justice. The emphasis on understanding health relates to the prevention of illness as well as the progression of illness. This approach focuses on health promotion, the antithesis of high-technology hospital-to-home care. The emphasis on the recipient of care (client) reflects the many different collectives of individuals who make up families, other groups, aggregates, and communities. The influence of the environment on the practice of community health nursing defines the location of practice as local, regional, national, and even global in nature. Community/public health nurses partner with communities, states, nations, organizations, and groups in addition to individuals in assessment and policy development (APHA, 2010). These environments’ impact on the client’s health has local, regional, national, and global significance.



**Figure 1-1** Concepts that help define community health nursing.



**Figure 1-2** A fifth essential concept that helps define community health nursing.

As stated earlier, nursing in the community focuses on the meaning of health in terms of both prevention and progression of illness. Primary, secondary, and tertiary prevention (of illness) strategies are all part of the drive to keep clients as healthy as possible, as reflected in their health choices, and are discussed later in this text. The meaning of health also reflects the ability of the client to find meaning and quality of life in his or her state of health and wellness.

Nursing in the community involves caring for collectives of people, bound in relationships that are called families, other groups, aggregates, and communities. Many nursing strategies move beyond physical care of individuals, as the required interventions may include teaching, counseling, referral, and lobbying for the needs of collectives. An acute care nurse in the hospital may teach an individual client and his family about diabetic foot care. A CHN may identify an aggregate of 30 diabetic clients and teach them about diabetic care at a parent–teacher meeting, as a group.

## Client

The client, patient, or recipient of CHN interventions may be an individual or a collective of individuals. Collectives may be a dyad or pair, a family, or another group. These collectives may make up an aggregate, if they are loosely associated, or a community, if their collective ties are stronger. **FIGURE 1-3** reflects the various meanings of the concept of **client**. Clients may be individuals, bond in pairs or families, or form other groups to meet their needs. Aggregates may be collectives of similar people such as an

**Client:** The individual or collective of individuals who are the focus of community health nursing.



aggregate defined by gender, race, religion, or income. If the aggregate becomes a close, well-functioning group, we refer to it as a **community**. Communities are described by geography, special interest, or special belief.

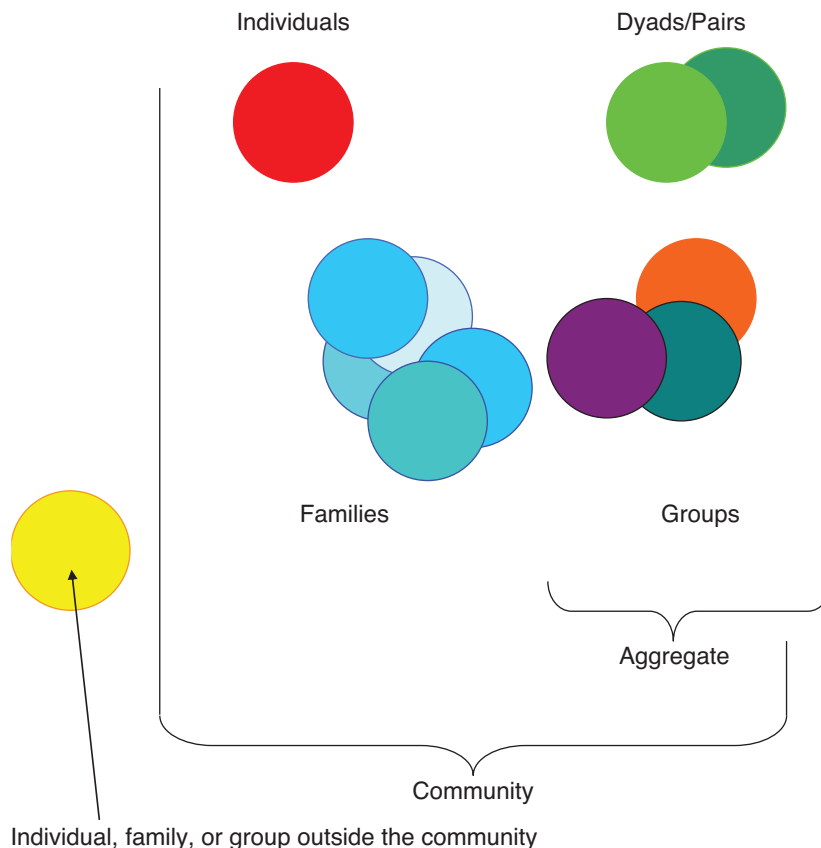
Some individuals, for various political or psychological reasons, place themselves outside of a community (the yellow circle in Figure 1-3). The behavior of some individuals is so disruptive to the community that the community or society restricts their participation in the community. Examples of clients who are not in touch or have restrictions on their interaction with their communities may include some mentally ill persons, political prisoners, and persons convicted of serious crimes.

## Nursing

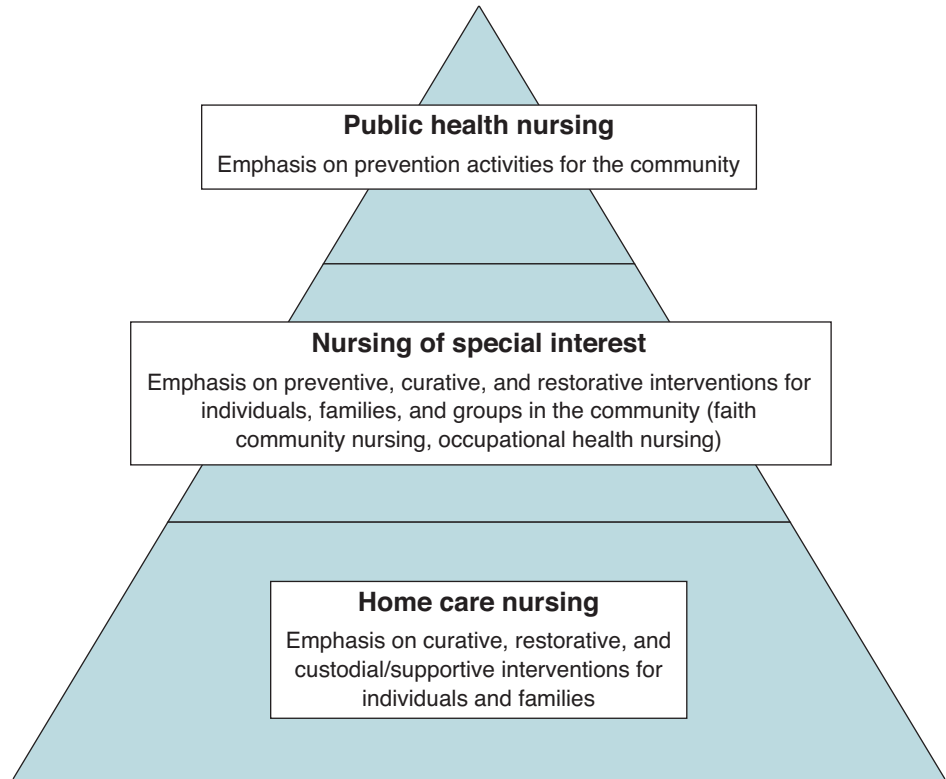
Nursing in the community comprises blended practice—that is, an amalgam of strategies used to provide care that is preventive, curative, restorative, and custodial/supportive. This type of care is provided within three subspecialties of community health nursing: public health nursing, nursing of special interest, and home care nursing. **FIGURE 1-4** represents the three types of community health nursing. The pyramid shape reflects the largest amount of services being offered as **home care services**. These services mirror hospital-based acute care services, which are centered on disease or system dysfunction. These curative, restorative, or custodial/supportive services are provided to individuals and families where they live.

**Community:** A collective of individuals that becomes a close, well-functioning group, and that may be described by geography, special interest, or special belief.

**Home care services:** Curative, restorative, or custodial/supportive services that are provided to individuals and families where they live.



**Figure 1-3** Meanings of “client.”



**Figure 1-4** Community health nursing includes various nursing specialties working in the community.

#### Nursing of special interest:

Provision of services to individuals, families, and groups in the community that are curative and restorative in nature.

**Nursing of special interest** relates to services provided to individuals, families, and groups in the community that are curative and restorative in nature. Examples include parish (faith community) nursing and occupational health nursing. These types of nursing are designated as “special interest” because in one example they serve a faith community, and in the other an occupational aggregate.

**FIGURE 1-5** provides a futuristic, theoretical example of how resources might be altered to provide a majority of public health services, with an emphasis on prevention. This would represent a preferred future where the prevention of illness would be more important than the treatment of illness by society.

## Health

The concept of health is personal. Each person has his or her own journey; each client has his or her own potential for obtaining health and wellness. In general, the types of health-related services nurses provide are preventive, curative, restorative, and custodial/supportive. The CHN provides these services so that clients can achieve a high level of wellness when confronted by serious threats to their physical, psychological, emotional, and spiritual health (Centers for Disease Control and Prevention [CDC], 2010; U.S. Census Bureau, 2010). A more in-depth study of the range of preventive health and nursing services is provided later in this text, as well as the discussion of nursing’s role in implementing *Healthy People 2020*, a national agenda for meeting the United States’ healthcare needs.

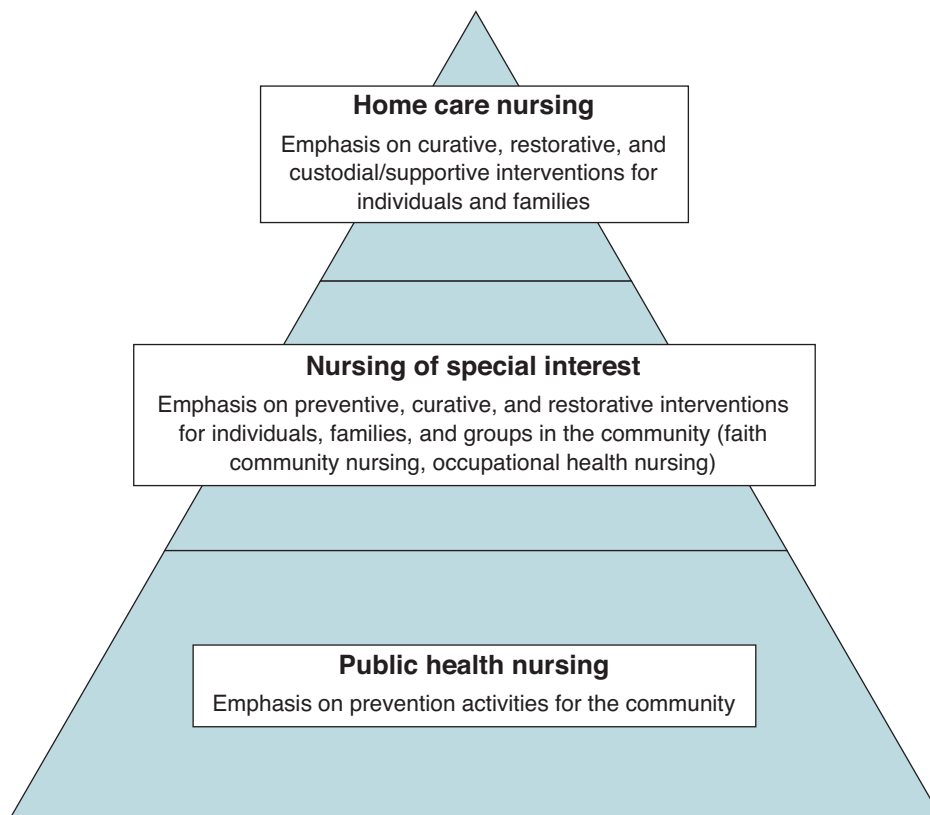
## Environment

The local environment of care delivery (i.e., where care is delivered) occurs in, for example, hospitals, nursing homes, clinics, rehabilitation settings, and locations where people reside or live. The political environment of care delivery occurs on a national and global stage where important decisions are made about who will receive care, which types of services will be available, and who will provide services to society. **Table 1-1** provides a structure through which to examine the relationship between the concepts of client, nursing, health, and environment as they relate to community health nursing.

## Caring as Informed by Distributive or Social Justice

**Justice** is an ethical concept that suggests that there is a fair way to allocate resources (Rawls, 1971). Justice requires the existence of a transparent way of meeting the needs of persons with various threats to their health in the community, and of distributing medical goods and services fairly. The CHN needs to participate in creating a just culture, in which the needs of clients are met in a way that maximizes their potential and properly reflects the ethical principles of the profession (Lackman, 2009; Mayer & Cronin, 2008).

**Justice:** An ethical concept that suggests that there is a fair way to allocate resources.



**Figure 1-5** Theoretical emphasis on resource allocation if primary prevention were valued by society.

**TABLE 1 - 1**  
Relationship Among the Concepts of Health–Nursing–Client–Environment in the Community

Focus of Health Outcomes	Characteristic of Nursing Model of Care Delivery	Client Focus of Care Delivery	Environment Settings of Care Delivery
Preventive outcomes	Public health nursing	Aggregates and communities	Local, regional, national, and global settings
Curative outcomes	Acute care nursing	Individual and family	Hospitals and skilled nursing settings
Curative outcomes	Home care (acute and subacute) nursing	Individual and family	Home and assisted living settings
Restorative	Rehabilitation nursing	Individual, family, group, and aggregates	Short-term rehabilitation, home, and assisted living settings
Custodial/supportive	Rehabilitation nursing	Individual, group, and aggregates	Long-term care settings

## The Nursing Social Contract as a Mandate to Develop and Maintain Role Competence

Nurses serve at the pleasure of society. Society gives nurses “permission to act” because the profession of nursing has established guidelines to promote the provision of safe and effective nursing care. Nurses, taking this social mandate to heart, are responsible for monitoring their personal skill in providing safe, preventive, curative, restorative, and end-of-life care to people of all ages (ANA, 2011a, 2011b). Nurses in the community have the unique challenge of providing care where people live and congregate outside of acute care settings. Central to the idea of providing safe and effective care in the community is the meaning of professional role competence.

Nurses working in the community have the responsibility for monitoring their own competence to meet the needs of the public. A more detailed discussion of how nurses develop and maintain role competence in community health nursing is offered later in this text. Role competence is possible, in part, through adherence to the guidelines required for the systems of care delivery in the community, and the educational and credentialing expectations that guide nursing practice in the community.

## Legal and Voluntary Guidelines for Providing Care in the Community

The provision of health care in the community is regulated by federal, state, and city laws and regulations. Of particular concern are agencies that seek reimbursement from Medicare and Medicaid for services rendered. Agencies are licensed by each state to provide

### ANA's Official Position on Professional Role Competence

The public has a right to expect registered nurses to demonstrate professional competence throughout their careers. ANA believes the registered nurse is individually responsible and accountable for maintaining professional competence. The ANA further believes that it is the nursing profession's responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards for regulation of practice to protect the public. The employer is responsible and accountable to provide an environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other key stakeholders (ANA, 2011a).

services according to specific criteria. The Department of Health and Human Services (DHHS) is a federal agency that oversees government healthcare programs such as Social Security, Medicare, and Medicaid. The Health Resources and Services Administration (HRSA) and the Office of Prepaid Health Care Operations and Oversight (OPHOO) are both parts of DHHS. The Health Care Financing Agency (HCFA) is the federal agency responsible for the oversight of Medicaid and Medicare. The federal agency HRSA is part of the U.S. Public Health Service, within DHHS, responsible for developing primary healthcare services and resources, for the health of mothers, infants, and children, and those persons with special needs (National Center for Health Statistics, 2010).

**Accreditation** is a voluntary process by which a healthcare organization is evaluated by an objective body of its peers on particular standards. The process utilizes established standards so that a specific level of quality is provided. Accreditation bodies monitoring quality in the community include the Community Health Accreditation Program (CHAP), The Joint Commission (an agency often associated with accreditation in acute care settings), and the National Committee for Quality Assurance (NCQA). These organizations, and others, are involved in the accreditation process on national and international levels.

**Accreditation:** A voluntary process by which a healthcare organization is evaluated by an objective body of its peers on particular standards.

## Essentials of Education and Professional Credentialing for Community Health Nursing

Nurses working in the community are expected to be educated, for the most part, with a baccalaureate of science (BS) degree in nursing. These nurses often maintain a caseload of clients, and work fully as a member of the healthcare team in the community. Pre-baccalaureate-educated registered nurses, with associate degree preparation, usually provide more supportive services to BS-prepared nurses and nurses with advanced practice credentials.

Nurses seek graduate education in community health nursing (MS, MSN degree) to assume leadership roles in a variety of institutions. Some nurses working in the community seek master's-level preparation in public health (MPH degree) to complement

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their employment goals. Doctoral preparation may include completing a doctor of philosophy (PhD degree) to conduct research, a doctor of public health (DrPH degree), or a doctor of nursing practice (DNP degree) for participation in advanced clinical practice in public health and nursing (Buerhaus, Straigler, & Auerbach, 2009).

In addition to formal education, nurses can participate in the process of certification to demonstrate expert clinical practice. The American Nurses Association Credentialing Center and other specialty nursing organizations provide credentialing services for this purpose. The CHN should consider seeking certification in areas that support his or her career goals. For example, nurses in the community may become certified in a specialty such as diabetes care or psychiatric nursing because it fits their role in the community. Certification in

community health nursing as a specialty is also available; it demonstrates competence in general or advanced practice.

The guidelines required for the systems of care delivery in the community, and the educational and credentialing expectations that guide nursing practice in the community, were not developed in a vacuum. The long and rich history of nursing in the community is a key aspect of how community health nursing is practiced today.

## A Historical Context for Providing Care in the Community

Although a thorough historical overview of how nurses have provided care in the community is beyond the scope of this text, the history of nursing in the community must be respected. The identification of key historical aspects is important to provide evidence of the evolution of healthcare services, so that the community health nurse can better understand those systems that are currently in place. History allows the nurse to review past patterns of care delivery with attention to how they can be improved (Donahue, 2011).

Caring for the sick is as old as humankind. From the beginning of civilization, people have made attempts to relieve the myriad of afflictions that brought pain, agony, suffering, and death to society. Early on, care was mostly palliative because there were no answers to the many questions posed in diagnostic medicine and nursing. The little care that could be provided took place in the home or community. It was much later on that the notion of providing care in hospitals or other places outside of the home developed. After the emergence of hospitals and other care facilities, various economic variables served to promote today's return to providing an increasing amount of care in the home and other community settings (Fungiello, 2005).

The earliest people viewed illness and death as part of the natural phenomena of life, and later as the work of the supernatural beings who were angry or displeased with them. They believed that the sickness and suffering experienced by individuals was caused by wrathful gods and evil demons. Both death and recovery were often looked upon as magical in nature. These beliefs and practices gave rise, in part, to the custom of priests and religious orders serving as healers and formal caregivers.

As awareness of the relationship between hygiene and sickness evolved, efforts turned toward the development of sanitariums and other facilities to provide care. Epidemics (plagues) were a major source of illness, and when these scourges broke out, there was virtually no way to stop them other than to let them run their natural course. Today, the eruption of new and or mutated communicable disease continues to threaten human life (Hays, 2009).

It was not until the eighteenth century that any formal health interventions toward community health were noted. Although the study of community health problems dates back to ancient Greece and Rome, the first indication of government interest in the recording or investigation of disease or issues relating to sanitation occurred during the eighteenth century.

## Eighteenth Century

The eighteenth century was notable for the beginning of the sanitary revolution that began to take hold in Europe, especially in England and then ultimately in colonial America. During this time, surveys, geographical mapping of diseases, and sanitation investigations and commissions were commonly undertaken by regional governments. As cities grew during this era, slums grew along with them, as did the concomitant problems associated with the inner-city environment, such as high morbidity and mortality rates.

In England, as a result of the Industrial Revolution, people began to flock to cities for work. This wave of immigration created slums and quickly spread infectious diseases. The most significant healthcare discovery during that time was the 1796 discovery of inoculation by Edward Jenner (1749–1823). At that time, the vast majority of the English population was afflicted with smallpox to some degree. Jenner realized that those persons who worked with cattle had milder and fewer cases of smallpox, and this observation led him to an understanding of the idea of immunity, a concept previously unknown in science. At the same time, immigration of colonists to America and the rush to large cities in America as part of industrialization in that country ensured that communicable disease also became an American healthcare problem.

## Colonial America

Crossing the Atlantic Ocean did not improve the quality of available health care. In early America, hospitals comprised either almshouses for the poor and indigent or pesthouses for those persons with contagious diseases. Most care of the ill and most births took place at home, with care being provided by physicians or lay midwives. Institutions, by comparison, were often created to keep the impoverished away from the general public rather than to serve their needs.

The medical profession, still without the benefit of antiseptics and antibiotics, could do little to help those afflicted with disease. Treatment remained crude, as did methods for sanitation and hygiene. Physicians in America had no formal education; instead, skill and training in health care were acquired in an apprentice system. Hospital nurses were responsible for nothing more than general cleaning, scrubbing floors and pots, and doing the laundry. Many nurses were illiterate, disinterested, and totally untrained persons working in hospitals.

Infectious disease remained the major healthcare problem, especially smallpox, which was estimated to affect one in five people, including President George Washington. Later, it was yellow fever that brought terror to the colonies. The first hospital in America was located in Philadelphia, and was established at the urging of Benjamin Franklin. It was his belief that the general public had a responsibility to the poor, sickly, and needy immigrant populations. Franklin wrote a petition seeking permission to build what was to become Pennsylvania Hospital (1751). Later, New York Hospital was built under a charter granted by King George III in 1770 and opened in 1790. Its stated pur-



Copper engraving (c. 1656) of Doctor Schnabel, a plague doctor in seventeenth-century Rome, with a satirical macaronic poem ("Vos Creditis, als eine Fabel, / quod scribitur vom Doctor Schnabel") in octosyllabic rhyming couplets.

*Die Karikatur und Satire in der Medizin: Medico-Kunsthistorische Studie von Professor Dr. Eugen Holländer, 2nd ed. (Stuttgart: Ferdinand Enke, 1921), Fig. 79 (p. 171).*



Upon returning to London, Nightingale was asked to turn her efforts to the needs of England. In 1859, she published a 77-page text entitled *Notes on Nursing: What It Is and What It Is Not*. This text, which addressed issues of prevention and general good health, was an immediate best seller. In her classic work, Nightingale stressed the need for hygiene, good food, sunlight, sanitation, sewerage, and attractive and comfortable surroundings for healing.

According to Nightingale, nurses were to be sober, educated, well trained, cleanly dressed, and, above all, kind and caring to their charges. Nightingale always stressed the importance of prevention as well as prompt and efficient care. Perhaps the most famous quote attributed to her is the description of nursing that identifies two major components of nursing: health nursing and sick nursing. Health nursing was “to keep or put the constitution of a healthy person in such a state as to have no disease,” and sick nursing was “to help the person suffering from disease to live and regain a state of wellness” (Dolan, 1968; Klainberg & Dirschel, 2010).

Nightingale’s work filtered across the Atlantic Ocean and became the basis for the modern nursing movement in the United States—a movement also driven by the horrors of war and the healthcare needs created by war. Military nursing today remains an important factor in caring for society. During this time, Florence Nightingale encouraged nurses to be assigned to work in the community with physicians in a local dispensary, a practice that has been referred to as the forerunner of community health nursing.

### *The Civil War*

The Civil War created the impetus for the improvement of health care in the United States. The catastrophic number of wounded and mutilated soldiers that resulted from the Civil War created the need to provide health care for the troops wounded in battle. More than 2,000 untrained nurses participated in the Civil War, but that number was not nearly enough. If wounded soldiers survived their immediate injuries, they were then susceptible to various infections and diseases.

Seeing the inhumanity of the Civil War and outraged by its atrocities, Clara Barton, trained as a teacher and often referred to as the “American Florence Nightingale,” became a national heroine as her reputation spread throughout the country. Founder of the American Red Cross, Barton began her one-woman crusade against the horrors of war after she witnessed many of them. Like Nightingale, Barton delivered lanterns to surgeons so that they could continue to treat and operate throughout the night. She brought food, clean bandages, and blankets, but mostly—like Nightingale—she brought caring, kindness, and the knowledge that she could help save the lives of the young men in battle. Untrained but not unskilled, Barton proved to the military leaders of the day that her presence, and those she brought with her, would be a help and not a hindrance to the war effort.

### *Immigration to the United States*

New York City has always been a major disembarkation point for immigrants who were seeking to start new lives in the United States. In this sense, its experience is reflective of that of other cities that have served as ports of disembarkation, such as New Orleans and Miami. New York City has also been a place where economically deprived people have lived in large numbers, bringing their own unique set of healthcare needs to be tended. Historically, their presence has posed a dilemma, as the city has often had insufficient resolve or resources to address these needs, which have differed with every new wave of immigrants.



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The late 1800s saw a shift in U.S.-bound immigration patterns. Originally, most immigrants came from England, Ireland, and Germany, largely in reaction to the economic and political conditions found in Europe at that time. That influx was followed by a wave of immigrants from southern and eastern parts of Europe. Jewish and Italian immigrants moved into the slums previously occupied by their German and Irish predecessors. Little attention or consideration was given to light, air, or sanitation in the densely populated tenements, creating a slum environment filled with discontent and unrest. It was the extremes of poverty, illiteracy, ignorance, misery, wretchedness, disease, filth, crime, corruption, depravity, and human degradation that allowed the political structure of the cities to become so corrupt, and planted the seeds for the social reform movement of the 19th century.

### *Nursing in Early American Communities*

In the United States, trained nurses visiting at the homes of the sick first appeared in 1813. The Ladies Benevolent Society was the first to organize women in Charleston, South Carolina, to visit the sick poor. In 1819, the Hebrew Female Benevolent Society of Philadelphia organized a visiting nurses' organization comprising volunteer nurses who visited the sick. In 1839, the nurses' society of Philadelphia assigned female home visitors to care for the sick at home; in 1877, the first educated nurses were sent to care for the sick poor at home; and in 1885, Lillian Wald was closely associated with the establishment of the Visiting Nurses Association.

Perhaps an even more important and profound development during this era was the beginning of the social reform movement and the spirit of advocacy that the settlement workers brought to the consciousness of wealthy Americans. Most of these settlement workers themselves came from the privileged class, but they informed and ultimately interested their peers in the problems and plight of the poor. Social reformers were inspired with a sense of unrelenting mission to bring about change; although they worked on several of large cities' problems at the same time, the common thread among all of these endeavors was the belief that the most important task was education.

### *Lillian Wald, Mary Brewster, and Lavinia Dock*

Born in 1867, Lillian Wald, influenced by family relatives who were physicians, came to New York and entered the New York Hospital School of Nursing (Kalisch & Kalisch, 1978). Wald trained for the standard three years, graduating in 1891. She then went to work at the Juvenile Asylum for a year, but left this position after becoming unhappy and frustrated by her lack of medical knowledge. This frustration brought her to the

Woman's Medical College in New York. During her time there, she and another nurse, Mary Brewster, were asked to go to the Lower East Side of New York to lecture to immigrant mothers about how to care for their sick children and family members.

Together, Wald and Brewster began a district nursing service in New York City. They moved into the neighborhood that they were planning to serve because they felt it would help people in the community view them as friends and be more willing to confide their problems. Years later, in 1895, Wald and Brewster opened the Nurses' Settlement at 265 Henry Street, working with other nurses including Lavinia Dock. It was Wald who first used the term "public health nurse." She put a preface on Florence Nightingale's term "health nursing" to signify that these nurses would be concerned directly with the needs of the people in general.

By 1900, as many as 20 district nursing organizations with more than 200 nurses were operational; most were found in large cities, although some did exist in small communities. Nursing also expanded



Knitting class at the Henry Street Settlement, New York, NY (1910).

Courtesy of the Library of Congress. Photographed by Lewis Wickes Hines.

into school and occupational settings. School nursing rapidly became an integral and indispensable part of the health care of the young, while occupational health nursing served those in the workplace.

## Twentieth Century: Establishment of Community Service

Nursing can and should be viewed as one of the earliest forms of community service. It is related to the strong, perhaps instinctive, desire to preserve and protect the members of one's own group. As civilization grew, this notion was extended to include other groups, tribes, clans, townspeople, and ultimately strangers. It could be argued that the earliest form of nursing was that which took place in the community.

It was during the beginning of the twentieth century, in a time characterized by the enormous and persistent demands of immigration and infectious disease, that American nursing had the foresight, intuition, and historical experience to move into community-based care. Always aware that social context was important to the health care of its population, nurses fed the hungry in neighborhood soup kitchens and tended to the needs of schoolchildren with immunizations, growth scales, and hygiene classes. When the sick could not get to the physician's office, the community health nurse came to the client.

With the dawn of the new century, perhaps the greatest reforms in nursing occurred in relation to public health. The knowledge and information nurses needed to provide care in the community far outstripped anything they had learned in nursing school. It was out of necessity that the specialty of the public health nurse emerged as an essential service. Originally the term "public health nursing" was used more often than "community health nursing," although for a while they were thought to be interchangeable. Community health nursing is the result of the ever growing and changing needs of a rapidly changing society. Community health nursing, influenced by reforms in public health, education, and societal needs, is a direct reflection of the growth and change in the modern world.


Today, the ANA uses the term "community nursing" to encompass the care provided by those nurses who work in public health, schools, industry, and other community-based clinics, services, and organizations. The twentieth century saw many gains in the general health of the public, and the twenty-first century began with a focus, in part, on the high cost of health care. Today, a major reevaluation of how healthcare dollars are spent is under way. Concerns about healthcare costs pose threats to government programs such as Medicare, hospital stays are becoming shorter, and there is a possibility that caps on spending will be placed on health care for special interest groups such as the elderly. New problems in healthcare financing are emerging, in part because some people are unable to pay for care due to inadequacies in insurance coverage or lack of any coverage at all.

## Health Care in the Twenty-First Century

A priority of twenty-first-century health care relates to healthcare insurance issues and the individuals, families, and communities who are either uninsured or underinsured. An attempt to provide insurance for all has become a hot-button political

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**Healthy People:** A U.S. federal government initiative that has generated lists of objectives and desired outcomes of health care for the decades 2000, 2010, and 2020.

issue and, at this book's writing, continued to be addressed by the members of the U.S. Congress and the president of the United States. Many factors impinge on the healthcare insurance (and general cost) debate, including the increased cost of basic healthcare services, decreasing government contributions to payment of healthcare services, inconsistent patterns of "length of stay" in healthcare institutions, aging of the U.S. population, and aging of both lay and professional caregivers (Anderson, Rice, & Kominski, 2007).

The United States has, to some extent, implemented a coordinated national response to the many ethical, legal and financial complexities of providing healthcare services. With a focus on health promotion and disease prevention, the **Healthy People** initiative has generated lists of objectives and desired outcomes of health care for the decades 2000, 2010, and now 2020 (Sultz & Young, 2011). The development of objectives is intended to identify important health concerns and specifically address ways to measure progress every 10 years. The resulting objectives focus on interventions that are designed to reduce or eliminate illness, disability, and premature death among individuals and communities. Some identify broader concerns such as the elimination of health disparities, dealing with either social determinates of health, or improving public health services and access to care (National Center for Health Statistics, 2009, 2010).

As previously mentioned, the Patient Protection and Affordable Care Act (Affordable Care Act) became law (P.L. 111-148) in March 2010. The Affordable Care Act (ACA) is complex legislation with a multi-year phase-in process. It is essentially a measure to make health care available to all but a few exempt groups dramatically changing issues that relate to individual responsibility to participate in access, restructuring cost systems to pay for care (including insurance coverage), and redefinition of Medicaid coverage (Kaiser Family Foundation, 2011, April 15). Exempt groups, like incarcerated persons, and Native Americans will receive care from different government programs.

The law, having been challenged as to its constitutionality, was supported, for the most part, by the Supreme Court in June 2012. The court supported the need for individuals to participate in securing health care, but did not fully support the expansion of Medicaid, a joint state–federal venture to provide care primarily for people living in poverty (Kaiser Family Foundation, 2012; *New York Times*, 2012).

In the first two decades of the twenty-first century, increasing attention has been given to healthcare reform. Legislation is dramatically changing the landscape of who can have access to care and how they will obtain it. The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Affordability Act of 2010 call for major changes in healthcare delivery over the next 20 years (Henry J. Kaiser Family Foundation, 2011). **Table 1-2** identifies some reasons why people are for or against the many reform changes.

It is difficult to be "against" the sweeping changes of healthcare reform; after all, many more people will get the care they need to improve their health. A question does surface, however, about how the United States will be able to afford the sweeping reforms. How will the federal and state pool of resources need to be altered to pay for healthcare reform? Is the American public willing to shift money from military spending, education, or public health prevention to provide more acute illness care to the public? What will be the consequences of shifting resources from one set of priorities to another in an effort to realize healthcare reform?

**TABLE 1-2**  
**Rationale for Supporting Healthcare Reform**

1. Americans will have access to quality, affordable health care.
2. The ability for all consumers to purchase affordable health care.
3. Extend much needed relief to small businesses.
4. Expand Medicare to help seniors and people with disabilities afford their prescription drugs.
5. Prohibit denials of coverage based on preexisting conditions.
6. Limit out-of-pocket costs so that Americans have greater security and peace of mind.
7. Require insurers to include children on their parents' healthcare plan until age 26.
8. Increase access for Medicaid to low-income Americans.
9. Provide sliding-scale subsidies to make insurance premiums affordable.
10. Hold insurance companies accountable for how healthcare dollars are spent.
11. Prevent insurance company abuses.
12. Increase and improve preventive care services.

Source: Adapted from Stand Up for Health Care. (2010). *12 reasons to support health care*. Retrieved from <http://www.standupforhealthcare.org/learn-more/quick-facts/12-reasons-to-support-health-care>

## Reflecting on the Possibilities for the Future

Today, healthcare delivery is experiencing turbulent changes in its legal, political, and application settings. Two documents have emerged that may help stabilize the healthcare environment, as participants in this environment reexamine critical issues related to access to care, healthcare financing, and nursing's role in current and future systems of care. The IOM guidelines for the future of nursing (IOM, 2011) and the QSEN competencies (Cronenwett et al., 2007) challenge the CHN to actively participate in the creation of a future for the nursing profession in increasingly complex care delivery systems. The IOM and QSEN documents, discussed in more detail later in this text, provide a common sense of direction for nursing's involvement in keeping the public healthy for generations to come.

## Summary

This chapter introduced a number of important concerns in providing care in the community. Reflective practice was introduced as a concept that the CHN uses to ensure the delivery of comprehensive care in the community. Nursing in the community is different from the acute care approach to care used in hospitals and other acute care settings, with the major difference in care being related to the core functions that guide nursing practice in the community.

The functions of assessment, policy development, and assurance link the work of nurses in the community with that of other healthcare providers. The needs of the pub-

lic require continuous assessment. The public must engage in policy development to secure the health services they need. Communities can proceed to get their needs met when they feel assured that services and personnel will be available to the community.

The paradigm of providing care in the community requires a special understanding of the concepts central to community health nursing practice. In community health nursing practice, the concepts of client, nursing, health, environment, and distributive justice take on special meaning. As in other settings, the key to providing quality nursing care in the community is role competence.

The CHN needs to participate fully in the process of community engagement, so as to demonstrate competence as a provider of nursing care to the community. This chapter linked the idea of role competence with legal and voluntary guidelines for providing care from a regulatory perspective, and the essentials for professional education and credentialing that support community health nursing practice.

A brief historical overview of some key aspects of the development of community health nursing practice was presented in this chapter as well. Of particular importance is the link between the history of yesterday and the history that is being made today, in the context of healthcare reform. The process of deciding who will receive the care that they request or require, and who will provide it, is central to the ongoing development of community health nursing as a discipline in the service of the public's health.

The chapter ended with a beginning reflection upon the possibilities for nursing's future in community health by introducing the IOM guidelines for the future of nursing and the QSEN competencies, developed to improve community health and all other types of nursing care.

## REFERENCES

- American Nurses Association (ANA). (2010a). *Nursing: Scope and standards of practice* (3rd ed.). Silver Spring, MD: Author.
- American Nurses Association (ANA). (2010b). *Nursing's social policy statement: The essence of the profession*. Silver Spring, MD: Author.
- American Nurses Association (ANA). (2011a). *ANA's official position on professional role competence*. Retrieved from <http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingEducation.aspx>
- American Nurses Association (ANA). (2011b). *Definition of nursing*. Retrieved from <http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing.aspx>
- American Public Health Association (APHA). (2010). *Definition of public health nursing practice*. Retrieved from <http://www.apha.org/membergroups/sections/aphasections/phn/about/defbackground.htm>
- American Public Health Association (APHA), Public Health Nursing Section. (1996). *The definition and role of public health nursing*. Washington, DC: Author.
- Anderson, R. M., Rice, T. H., & Kominski, G. F. (Eds.). (2007). *Changing the U.S. health care system: Key issues in health services policy and management* (3rd ed.). San Francisco, CA: John Wiley & Sons.
- Association of Community Health Nursing Educators (ACHNE). (2009). *Essentials of baccalaureate nursing education for entry level community/public health nursing*. Wheat Ridge, CO: Author.
- Buerhaus, P. I., Staiger, D. O., & Auerbach, D. I. (2009). *The future of the nursing workforce in the United States: Data, trends, and implications*. Sudbury, MA: Jones and Bartlett.
- Centers for Disease Control and Prevention (CDC). (2010, June 25). Summary of notifiable diseases—United States, 2008. *Morbidity and Mortality Weekly Report*, 57(54).
- Charles Darwin. (n.d.). *BrainyQuote.com*. Retrieved from <http://www.brainyquote.com/quotes/quotes/c/charlesdar392807.html>

- Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchel, P., ... Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook*, 55(3), 122–131.
- Dolan, J. A. (1968). *History of nursing*. Philadelphia, PA: W. B. Saunders.
- Donahue, M. P. (2011). *Nursing the finest art: An illustrated history* (3rd ed.). Maryland Heights, MO, MO: Mosby Elsevier.
- Fungiello, P. J. (2005). *Chronic politics: Health care security from FDR to George W. Bush*. St. Louis, MO: Mosby.
- Hays, J. N. (2009). *The burdens of disease: Epidemics and human response in western history*. New Brunswick, NJ: Rutgers University Press.
- Henry J. Kaiser Family Foundation. (2011). *Health reform source*. Retrieved from <http://healthreform.kff.org/timeline>
- Henry J. Kaiser Family Foundation. (2011, April 15). Summary of the new health reform law. *Focus on Health Reform* (Pub. #8061). Menlo Park, CA: Author.
- Henry J. Kaiser Family Foundation. (2012, January). A guide to the Supreme Court's review of the 2010 health care reform law. *Focus on Health Reform* (Pub. #8270). Menlo Park, CA: Author.
- Institute of Medicine (IOM). (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: Author.
- Kalisch, P. A., & Kalisch, B. J. (1978). *The advance of American nursing*. Boston: Little, Brown.
- Klainberg, M., & Dirschel, K. (2010). *Today's nursing leader: Managing, succeeding, excelling*. Sudbury, MA: Jones and Bartlett.
- Lackman, V. D. (2009). Practical use of the nursing code of ethics: Part II. *MEDSURG Nursing*, 18(3), 191–194.
- Mayer, C. M., & Cronin, D. (2008). Organizational accountability in a just culture. *Urologic Nursing*, 28(6), 427–430.
- Milstead, J. A. (2008). *Health policy and politics: A nurse's guide* (3rd ed.). Sudbury, MA: Jones and Bartlett.
- National Center for Health Statistics (NCHS). (2009). *Health, United States, 2009: With a special feature on medical technology*. Hyattsville, MD: U.S. Government Printing Office. Retrieved from <http://www.cdc.gov/nchs/hus.htm>
- National Center for Health Statistics (NCHS). (2010). *Health, United States, 2010: With a special feature on death and dying*. Hyattsville, MD: U.S. Government Printing Office.
- New York Times*. (2012, July 17). Health care reform and the Supreme Court (Affordable Care Act). Retrieved from [http://topics.nytimes.com/top/reference/timestopics/organizations/s/supreme\\_court/affordable\\_care\\_act/index.html](http://topics.nytimes.com/top/reference/timestopics/organizations/s/supreme_court/affordable_care_act/index.html)
- Rawls, J. (1971). *A theory of justice*. Cambridge, MD: Harvard University Press.
- Sultz, H. A., & Young, K. M. (2011). *Health care USA: Understanding its organization and delivery* (7th ed.). Sudbury, MA: Jones & Bartlett Learning.
- U.S. Census Bureau. (2010). *Statistical abstract of the United States: 2010* (129th ed.). Washington, DC: Author. Retrieved from <http://www.census.gov/statab/overview.html>



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## LEARNING ACTIVITIES



1. Which of the following is the best example of a public health nursing intervention?
  - A. Applying wet-to-dry dressings in the home, three times a week
  - B. Developing a program for an aggregate that demonstrates a changing need for services in the community
  - C. Answering an emergency crisis phone line for abused women
  - D. Attending risk-reduction meetings for recovering alcoholic adolescents in a shelter
2. Which of the following nursing interventions is most important to implement, from a public health perspective?
  - A. Installing handrails for senior adults in a nursing home
  - B. Instructing neighbors in a community to create a "Safety Watch"
  - C. Monitoring toxic emissions from a clean water plant
  - D. Implementing statewide screening for scoliosis
3. Which term is used by the American Nurses Association to encompass the work done by nurses in areas such as industry, schools, and community-based clinics?
  - A. Public health nursing
  - B. Community nursing
  - C. Community-based health care
  - D. Community-focused nursing
4. John Snow was famous for his discoveries in 1854 in London related to a disease outbreak associated with which of the following pathogens?
  - A. *Escherichia coli*
  - B. Yellow fever
  - C. Cholera
  - D. Bubonic plague
5. The discoveries of John Snow helped to bring about an increase in which of the following health-related ideas?
  - A. A civic understanding and moral commitment to the betterment of people's lives through economic, social, and environmental reform
  - B. A commitment of the government to reduce taxes on health care
  - C. The need for health insurance for all citizens of London
  - D. The understanding that there needed to be more control by the police in enforcing health laws
6. The focus of *Healthy People 2020* is related to which of the following ideas?
  - A. Economic provision of low-cost health care for all citizens
  - B. Development of objectives and outcomes intended to identify and address important health concerns in society
  - C. Healthcare reform that will require health insurance for all
  - D. Development and implementation of required healthcare services for citizens of every state in the United States
7. Which of the following statements made by a nurse reflects the idea that a major change is necessary in the delivery of nursing care in the community?
  - A. "The amount of home care services needs to be increased."
  - B. "Special interest groups need to provide services that are missing in the community."
  - C. "There is too much regulation in the care that is provided to people in the community."
  - D. "Nurses need to help people learn the value of preventive services."



8. Which of the following is an example of nursing services sponsored by a special interest group?
- A. State monitoring of safe drinking water
  - B. A diabetic foot-care program offered in a large, regional nursing home
  - C. A variety of health screening events taking place in a collection of houses of worship
  - D. Bereavement counseling provided after the death of domestic pets
9. A nurse is discussing the core functions of public health. Which of the following activities relates to assessment?
- A. Meet with members of the community to explain services
  - B. Evaluate the competencies of the home care staff
  - C. Review laws on communicable disease prevention
  - D. Monitor proper seatbelt use in children
10. A nurse is discussing the core functions of public health. Which of the following relates to assurance?
- A. Families feel safe in their communities.
  - B. Groups have a place to meet for their planned activities.
  - C. People believe that the care is safe and available.
  - D. Individuals decrease their use of emergency departments for routine care.

## ADDITIONAL QUESTIONS FOR STUDY

1. Visit the website of *Healthy People* and compare the goals of *Healthy People 2020* with those of *Healthy People 2000*. Write a brief paper describing what you see as the differences, if any, between these goals. What would you like to see incorporated into *Healthy People 2030*?
2. Identify a health-related problem in the community and examine the core functions of public health. For each aspect, explain how the core function relates to the problem.
3. Define the terms associated with the community health nursing paradigm. Compare your definitions with those of your classmates, and expand your definitions based on their ideas.