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An exploratory study of the learning needs of community staff nurses

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Community staff nurses account for a significant proportion of the community nursing work-force, yet little attention has been paid to their training and education. This study explored the views of a range of different community nurses ($n = 68$) working in one inner-city community trust with regard to the skills and learning needs of community staff nurses. In addition to the community staff nurses ($n = 28$), the views of the health visitors ($n = 15$), district nurses ($n = 19$) and nurse mangers ($n = 6$) within the trust were explored. The study utilized three methods, namely semi-structured interviews, focus groups and a postal questionnaire, with the data from each being triangulated. This paper focuses on the learning needs of community staff nurses. The findings suggested the need for a practice-based, integrated approach to the education and training of these nurses informed by the needs of patients, the individual nurse, the nursing team, the organization and the wider community. A period of induction into community-based nursing is recommended to facilitate the transfer from a hospital-based to a community-based staff nurse's role.

Key words: community staff nurses; induction; integrated learning; needs led; training and education

Introduction

Community nursing is a branch of nursing which involves a broad range of practitioners working across the clinical grading scale. Whereas in the past the majority of community-based nursing was undertaken by what are now termed 'specialist-level practitioners' (i.e., those who have undertaken specialist education in district nursing or health visiting), other registered nurses are now being increasingly deployed in the community. Although such nurses have been used for some time in district nursing, they are now in the majority rather than the minority (Audit Commission, 1999), and in many areas they are now also being introduced to health-visiting teams (Cowley, 1993). Much of this expansion is being driven by 'skill-mix exercises', which are often introduced in response to cost pressures (Lightfoot *et al*., 1992). In this study, these nurses were identified as community staff nurses, although it is acknowledged that this is not a universal term and that elsewhere a range of other titles, such as assistant nurses, associate nurses or even primary care nurses, is in use. Community staff nurses are therefore an important and growing element of the community nursing work-force, undertaking a significant proportion of community-based nursing care, a trend which is set to continue both with the expansion of primary care (Gerrish *et al*., 1998) and with the move towards integrated nursing teams (Carnwell and Macfarlane, 1999; Knott, 1999).

It is important to recognize that community staff nurses are not a homogenous group. Although the number of new nurses working in the community is increasing, there are also significant numbers who have worked as community staff nurses or as district-enrolled nurses for a number of years. Indeed, many community staff nurses may have developed a particular expertise within their team. This diversity is expressed in the range of clinical grades at which community staff nurses are appointed, which extends from 'D' to 'F', although

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the majority are on D or E grades (Audit Commission, 1999). Each set of community staff nurses therefore has very different educational needs, and perhaps also different career aspirations. Following recent changes to preregistration nurse education, there are now also significant differences in the educational experiences of these nurses, with the majority of newer recruits being either diplomates or graduates, thus reinforcing the diversity of needs (Maben *et al*., 1997). However, despite this diversity, the majority of community nurses by definition of their role within community-based practice are in the phase of primary practice (term used after United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), 1990), meaning that they are still broadening their experiences and developing their expertise *vis-à-vis* community nursing (Smith and James, 1996). Thus with the current focus on the need for continuous professional development (UKCC, 1990; 1992; 1994; Department of Health, 1999a) and the promotion of the concept of the lifelong learner (Department of Health, 1997), community staff nurses need to be able to access effective education and training programmes. Furthermore, nurses who are transferring from hospital- to community-based practice may require special support (Maben *et al*., 1997).

Any discussion of training must be related to the skills required of community staff nurses. Another element of this study found that community staff nurses required a wide range of skills, reflecting the breadth of nursing activity in the community (reported in another paper). The 12 broad areas of skills identified are briefly described below:

- interpersonal and communication skills, encompassing an awareness of their interactions with patients, therapeutic communication and basic counselling, effective communication with other professionals, written communication and advocacy;
- skills in health promotion/education, ranging from screening activities to health profiling;
- skills in managing specific clinical conditions, such as leg ulcers, incontinence and diabetes (see Table 9);
- skills in clinical decision making, in particular that they should be able to assess, plan, implement and evaluate care in the home environment;
- specific clinical skills, which are presented in a long list of discrete tasks ranging from blood taking to bladder scanning (see Table 10);
- caseload management skills, including caseload analysis and prioritising, seen in the context of a supporting role rather than as a replacement for the specialist practitioner as the overall caseload manager;
- team management skills, including human resource management, deputising for the specialist practitioner, role and resource awareness, and administration and clerical work;
- personal management skills such as time management and prioritisation were identified, reflecting the perceived lack of structure in the community compared to hospital settings;
- skills in inter-agency working, including an awareness of other services and their mechanisms of referral;
- teaching skills in relation to patients, students, colleagues and other professionals;
- skills in research, audit and quality assurance, although these topics were not often mentioned, and little detail was provided as to what these activities entailed;
- social issues, including a diverse range of skills such as having an awareness of the impact of poverty, having a knowledge of welfare and benefits, having a knowledge of NHS policy and social policy, and the need to be racially and culturally aware. Note that due to data limitations this category of skills was somewhat ill-defined, and requires further work in defining the subcategories within it.

Although many of the skills identified reflected recent developments within community nursing (e.g., the introduction of 'advanced' clinical programmes in areas such as leg ulcer and continence management), the most commonly identified requisite for effective practice was communication skills. In addition to the range of skills, it was also reported that community staff nurses needed to be flexible and adaptable in their practice. It was also found that there were significant differences in the role and skills of community staff nurses compared to those working in hospital settings.

The continuing development of community staff nurses is important in three ways: firstly, in supporting the effectiveness and efficiency of community nursing care in a range of different settings; secondly, in helping them to adjust to community-

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based practice; and thirdly, in ensuring that they fulfil their needs for professional development. However, despite such imperatives, the education and training of community staff nurses have received relatively little attention (Closs, 1995), so this exploratory study has attempted to contribute to the knowledge base.

It is first necessary to clarify the terms 'education' and 'training' briefly within the context of this study. 'Education' is an overarching term concerned with the promotion of human learning and understanding. 'Training' is a distinct educational approach which is directed towards and defined by the mastery of a specific task through the acquisition of the skills and knowledge necessary to fulfil that task (Bradshaw, 1989). The focus of this study was on all of the educational activities, including specific training, which aimed to enhance role-related learning for community staff nurses. Although skills 'training' was the main educational modus currently on offer to community staff nurses, other educational processes which might help community staff nurses to assimilate the principles of community nursing practice and to develop strategies to ensure their ongoing learning were also of interest.

Methods

The data were collected using three methods, namely semi-structured interviews, focus groups and a postal questionnaire. Each data collection tool addressed the same topic areas, namely the skills required of and the education and training for community staff nurses. Respondents were also asked to comment on the current education and training programme available to them and how it might best be developed. The content of the schedules was developed with reference to the published literature, an expert panel consisting of a wide range of community-based practitioners and educationalists, and the existing training programme for community staff nurses in the study trust. The interview schedule was piloted with four community nurses, two staff nurses and two specialist practitioners (one health visitor and one district nurse), following which the schedule was revised and shortened.

The structured interview schedule utilized both open and closed questions. The interviews were undertaken by two researchers in health centres throughout the trust. The interviews lasted from 30–120 minutes and were contemporaneously recorded by the interviewer directly on to the interview schedule, providing a written account of what was said. (Although tape-recorded interviews would have generated more in-depth and fuller accounts, they would have involved more man hours in transcription and analysis than project resources allowed.) The postal questionnaire was an edited version of the interview schedule, with the 22 items of the interview schedule becoming 17 items to permit written self-report. The items which were removed from the interview schedule were those which insisted on more expansive responses.

Focus groups were used to complement the questionnaire and interview data, as it has been suggested that they can generate other issues and perspectives (Kitzinger, 1995). Four focus groups were proposed to consist of community staff nurses, health visitors, district nurses and community nurse managers. The groups were run by two researchers – one facilitating and the other again contemporaneously recording what was said in order to provide a written account of the discourse within the group. The groups were facilitated using an explicit schedule that covered the same topic areas as the interview schedule and questionnaire. Thus participants were asked to brainstorm and discuss those topic areas and to try and reach a consensus. In addition to the written record maintained by the second researcher, flip charts were used, on to which the agreed comments were written for all to view.

Population and sample

The study was conducted in one inner-city community NHS trust. All of the community staff nurses (grades D, E and F) within that trust were included. Most of the community staff nurses worked within the district nursing service, and a small minority worked with health visitors. The views of specialist practitioners (district nurses and health visitors) in whose teams the majority of community staff nurses worked were also identified as being important, in addition to those of community nurse managers.

Therefore the population of interest to the study was identified as consisting of all of the community nurses working within the trust (n = 196). For the interviews, a sampling frame was developed from

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which a random stratified sample was drawn (n = 39). Stratification was based on grade, length of time employed within the trust, and geographical location. The response rate of those wishing to participate was poor (47%, n = 18), and the stratification criteria were not met. The low response rate was attributed to low staffing levels and high workload demands during the data collection period. The questionnaire was sent to all of the nurses who were working in the trust who had not been interviewed (n = 178), and a response rate of only 15% (n = 27) was achieved. This low response rate introduced the possibility of sample bias, because there might have been a number of nurses who felt unable to participate. Focus groups were held with district nurses (n = 10), health visitors (n = 7) and community nurse managers (n = 5). A community staff nurse focus group was not held because these nurses could not meet due to their workload pressure. The background data of respondents for each method and the demographic profile of respondents are shown in Tables 1 and 2, confirming the heterogeneity of this population, which was discussed earlier. Ethical principles were observed throughout the study: participation was based on informed written consent, and the anonymity and confidentiality of all respondents were maintained.

Data analysis

A large volume of data was generated in the form of written interview, questionnaire and focus group responses. These data were subjected to content analysis, from which data categories were identified. The content analysis followed a nine-step process adapted from that described by Feher Waltz *et al*. (1984). The data were considered at the 'manifest' level (Fox, 1982), with no attempt being made to identify any hidden meanings within the data – 'latent' analysis. All of the data within the written transcripts were coded, with each code corresponding to a specific data category. The content analysis was undertaken by two researchers, and the coding was checked by both and any differences were discussed (although the degree of concordance was not assessed statistically). The content analysis generated two distinct types of data, namely 'themes' and 'discrete items'. Themes are simply sentences which are used to describe a phenomenon observed within the text (Kerlinger, 1973), with those sentences being based on abstractions gained through a process of continuous review and development typical of inductive analysis (Strauss and Corbin, 1990). In practical terms this involved locating, linking, organizing and describing the observations and comments made by respondents. Discrete items, on the other hand, are self-descriptive and were usually identified in response to specific questions. The output of each data collection tool was examined individually and then triangulated (Denzin, 1989). The process of triangulation involved the merging of all of the data categories generated from each tool into a collective pool of categories. There was a very high degree of convergence between the questionnaire and the interview, with very few categories being unique to each. However, the health visitor and manager focus group data generated a number of specific data categories that were not found elsewhere in the data set. The focus group represented the only source of the management perspective. The volume of response for each data category was measured in terms of the number of respondents and the number of responses (i.e., how often a given category was identified), although all of the relevant data were

Table 1 Data sources

	Community staff nurses (CSN) D, E and F grades	Health visitors (HV)	District nurses (DN)	Community nurse managers (CNM)	Total
Interviewed	12	4	2	—	18
Completed questionnaire	15	4	7	—	26
Focus group	—	7	10	5	22
Total number	27	15	19	5	61
Sample (% of total population)	30.4	23	49	NA	—

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Table 2 Demographic data: summary of interviews and questionnaires only

	CSNs	DNs and HVs
Grade breakdown	9 × D 13 × E 4 × F (Missing data = 1) Modal grade: E	8 health visitors 9 district nurses
Average length of time in the community	Mean 3.27 years Median 2.25 years	Mean 7.8 years Median 6 years
Average length of time in current post	Mean 12.89 months Median 9.5 months	Mean 2.57 years Median 1.83 years
Professional educational background	RGN 20 RN diplomate 5 RN graduate 2	Data not obtained

included even if the observation was only associated with one respondent.

Results

The findings are derived from the content analysis of the interview transcripts, the questionnaires and the focus group transcripts.

The current education and training programme

The current training and education programme was based on a range of unrelated short courses or study days, some of which were mandatory (e.g., fire training). A full list is shown in Table 3. Respondents were asked a number of questions about the current education and training programme, in particular how they acquired their existing skills, and what they thought were the strengths and weaknesses of the current programme.

Mechanisms through which skills are currently acquired

Community staff nurses identified a number of mechanisms through which they acquired their skills (see Table 4). In addition to study days, observational and experiential learning featured quite consistently in their responses. Prior experiences were also regarded as being important.

Strengths and weaknesses of the programme

The strengths and weaknesses associated with the trust programme are listed in Tables 5 and 6. The lack of time available for education and training was the most commonly identified problem with the current provision.

Perceptions of the current programme

Community staff nurse respondents were asked whether or not they had undertaken any of the opportunities as detailed on the list of current provision, and were then asked to rate each item as either desirable or essential (see Table 3). District nurses and health visitors were asked to rate the content as either desirable, essential or non-applicable (see Table 7). The three main findings from this exercise were as follows.

1) Specific clinical activities such as wound care, drug administration and the management of anaphylaxis were identified as most essential.
2) The majority of the programme was regarded as either essential or desirable, with few topics being regarded as non-applicable, suggesting that most of the current programme was relevant. Indeed, there was a high degree of consistency between the current programme and the core skills identified by the study (as described earlier), although training in communication skills was notable by its absence.
3) There were some differences in the perspectives of health visitors and district nurses, with

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Table 3 Current training rated by all CSNs as either 'essential' or 'desirable' (n = 27): all proportions are expressed as percentages

Skill	Essential	Desirable	NA	Non-response
Wound management	100.0	—	—	—
Anaphylaxis	92.86	3.57	—	3.57
Resuscitation	89.29	3.57	—	7.14
Physical assessment of health	85.71	10.71	—	3.57
Drug administration	85.71	7.14	—	7.14
Health promotion	85.71	10.71	—	3.57
Continence care	78.57	21.43	—	—
Pressure sores prevention	64.29	28.57	7.14	—
Reflective practice	60.71	25.0	7.14	7.14
Family assessment of need	60.71	35.71	3.57	—
Information technology training	60.71	21.43	3.57	14.29
Syringe drivers	60.71	25.0	7.14	7.14
Healthy ageing	60.71	25.0	3.57	10.71
HIV and AIDS	53.57	28.57	10.71	7.14
Venepuncture	53.57	28.57	14.29	3.57
Assertiveness training	53.57	28.57	7.14	10.71
Male catheterization	53.57	35.71	3.57	7.14
Domestic violence	42.86	39.29	10.71	7.14
Protecting vulnerable adults	39.29	39.29	10.71	10.71
PREP guidance	35.71	32.14	25.0	7.14
Child protection	32.14	50.0	10.71	7.14
Management and team leadership	25.0	53.57	14.29	7.14
Immunizations	25.0	39.29	17.86	17.86
IV management and drug administration	25.0	39.29	25.0	10.71
Haemoglobinopathies	21.43	39.29	28.57	10.71
Child health promotion	17.86	10.71	67.86	3.57
Promoting positive parenting	17.86	21.43	53.57	7.14
Social policy	14.29	50.0	14.29	21.43
Breastfeeding	14.29	28.57	42.86	14.29
Nursing in primary care (ENB A56)	10.71	17.86	57.14	14.29
Cervical screening	10.71	14.29	64.29	10.71
Emotional effects of childbirth	7.14	21.43	60.71	10.71
Research and audit skills	7.14	17.86	67.86	7.14

health visitors not unsurprisingly rating family health-related training more highly than the district nurses.

Education and training: the future

Respondents were asked to identify how the education and training of community staff nurses could be best developed in terms of both content and format.

Content

A number of areas were suggested which were largely consistent with the core skills identified in the introduction (see Tables 8, 9 and 10). However, there was a significant tailing off in the volume of responses relating to education and training compared to those made with regard to skills which may be attributable to respondent fatigue or to a flaw in the interview schedule. In addition, many respondents made comments to the effect of 'everything I said before' when asked about the content of the learning programme.

An area of educational need that was not identified previously was role awareness (i.e., community staff nurses needed education and training to appreciate their role, to understand and relate to the roles of others, and to be prepared for the different context of care in the community). It was suggested that community staff nurses should be given an outline of their role during their induction:

> You need training to understand your role.
> (CSN)

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Table 4 Mechanisms whereby skills are currently acquired

	CSNs only	
	Respondents (n = 26)	Responses
Study days	17	21
Observation/support of colleagues	12	14
Prior experience	16	22
On-the-job learning	12	13
Impact of pre-registration training	2	2
Input from specialists or specialist centres	3	3
Outside life experiences	1	1
Community training (e.g., DEN)	1	1
Journals and published research	4	4
Reflection on practice	1	1

Table 5 Strengths of current provision

	CSNs only	
	Respondents (n = 14)	Responses
Develops skills quickly	5	5
People are encouraged to update	4	4
Accessibility (ease of booking)	4	5
Courses are well taught	2	2
Distance learning	1	1
Brochure detailing course availability	1	1
Some components are mandatory	1	1
Courses well publicized via email	1	1
Courses are relevant	1	1
A good range to choose from	1	1
Funding is available	1	1
Regular updates	1	1

Format

The large volume of data categories relating to programme format were grouped into three areas, namely structure, process and outcome (see Table 11).

1) *Structure*. The need for the programme to be adequately resourced was the most commonly identified category. The amount of time available to staff for learning was of particular concern. It was felt that the programme's structure should be co-ordinated so that it integrated a whole range of readily accessible learning opportunities, facilities and methods. The need to develop the learning environment was also seen as important in terms of both the provision of practical facilities (e.g., libraries and journal stock) and the development of practice-based learning resources (e.g., the teaching skills of community practitioners themselves):

> If there is a shortage of staff we can't do any studying.
>
> (CSN)

2) *Process*. The idea that the programme should be based on the needs of the community/patient population was introduced. Audit was also mentioned as a means of identifying educational priorities. Respondents emphasized the need for flexibility and diversity in educational methods (see Table 12), and importantly that the programme should seek to integrate theory and practice through practice-based education. The need for effective training needs analysis at both individual and team levels was also identified, with clinical supervision and reflective practice being seen as particularly useful for this process. It was recommended that the programme needed to foster ongoing/continuous learning:

> Reviewing what has happened and reflecting on it is a good way of learning.
>
> (CSN)

> It needs to be lifelong learning, showing people how to learn.
>
> (HV)

3) *Outcome*. Reflecting the aspirations identified in the process categories, it was suggested that a key outcome of the programme should be the development of learning skills (i.e., learning to learn), and similarly that learning outcomes should be linked to patient outcomes. It was argued by a number of respondents that education and training should be accredited, and linked to career

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Table 6 Weaknesses of current provision

	Total		CSNs	
	Respondents (n = 29)	Responses	Respondents (n = 22)	Responses
No time available (no staff to cover)	18	19	14	15
Cancellation of sessions	6	6	4	4
Problems with access	6	6	5	5
Insufficient resources to fund courses	4	4	3	3
A lack of cohesion (*ad hoc*)	3	4	1	1
Not focused to needs of specific grades	3	3	2	2
Not enough training and education available	2	2	1	1
Links to practice unclear	2	2	1	1
Lack of experienced staff to mentor CSNs	2	2	1	1
Lack of knowledge of what is available	2	2	2	2
Lack of clinical supervision	2	2	2	2
Some courses are too far away	2	2	2	2
No routes for those not wishing to become specialist practitioners	2	2	1	1
Not integrated into career development	1	1	1	1
Courses too short	1	1	1	1
Too reliant on the motivation of the individual	1	1	1	1
Poor dissemination of information	1	1	1	1
Insufficient updates	1	1	1	1
No clear rationale for undertaking courses	1	11	0	0
Unequal opportunities	1	1	0	0

development, advancement and financial reward. The importance of evaluating the programme was also raised, and it was suggested that such an evaluation might consider the impact on patient care, staff moral and staff retention:

> You need a contract with trust so you know the more you learn the better your chance of getting on.
>
> (CSN)

Different perspectives on the training and education of community staff nurses

Although there was a high degree of consistency between the comments made from within each community nursing group, there were also some differences.

The views of community staff nurses

When asked, community staff nurses identified a number of features which they would like to see developed. First, an organized structured formal induction programme covering the core skills required for their role and any mandatory training was regarded as important. It was suggested that the induction should enable practitioners to go to their posts 'up and running'. One respondent suggested an internship model in which newly appointed community staff nurses could rotate through a number of clinical placements to gain a grounding in community-based practice. Secondly, it was suggested that community staff nurses would value a programme which was ongoing and which ensured that they maintained up-to-date practice. Thirdly, the respondents wanted the programme to augment their clinical skills and competencies so that they would feel confident in clinical situations. In addition, they wanted the opportunity to undertake specialist studies to reflect areas of interest. Many respondents regarded education and training as being a mechanism through which they could achieve personal and professional fulfilment. Fourthly, the development of a link between education and training and the career structure was regarded as important, with the development of skills being acknowledged and rewarded. For some, access to specialist practice education was identified as being important, while

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Table 7 Current training rated by all DNs and HVs as either 'essential' or 'desirable' (n = 17): all proportions are expressed as percentages

Skill	Essential	Desirable	NA	Non-response
Wound management	88.89	0	5.56	5.56
Anaphylaxis	88.89	5.56	0	5.56
Resuscitation	83.33	11.11	0	5.56
Physical assessment of health	83.33	5.56	0	11.11
Drug administration	77.78	11.11	5.56	5.56
Health promotion	77.78	11.11	0	11.11
Continence care	72.22	22.22	0	5.56
Pressure sores prevention	72.22	11.11	11.11	5.56
Reflective practice	72.22	22.22	0	5.56
Family assessment of need	66.67	16.67	5.56	11.11
Information technology training	66.67	27.78	0	5.56
Syringe drivers	61.11	11.11	22.22	5.56
Healthy ageing	61.11	22.22	5.56	11.11
HIV and AIDS	55.56	33.33	5.56	5.56
Venepuncture	50.00	27.78	16.67	5.56
Assertiveness training	50.00	33.33	11.11	5.56
Male catheterization	44.44	27.78	22.22	5.56
Domestic violence	44.44	50.00	0	5.56
Protecting vulnerable adults	44.44	38.89	5.56	11.11
PREP guidance	44.44	50.00	0	5.56
Child protection	38.89	27.78	27.78	5.56
Management and team leadership	38.89	44.44	5.56	11.11
Immunizations	33.33	38.89	22.22	5.56
IV management and drug administration	27.78	44.44	22.22	5.56
Haemoglobinopathies	27.78	55.56	5.56	11.11
Child health promotion	22.22	27.78	38.89	11.11
Promoting positive parenting	22.22	11.11	55.56	11.11
Social policy	22.22	72.22	0	5.56
Breastfeeding	16.67	27.78	44.44	11.11
Nursing in primary care (ENB A56)	16.67	72.22	0	11.11
Cervical screening	11.11	22.22	61.11	5.56
Emotional effects of childbirth	11.11	22.22	55.56	11.11
Research and audit skills	11.11	72.22	5.56	11.11

others identified the need for options for those practitioners who were not interested in becoming specialist practitioners (i.e., health visitors or district nurses).

The views of district nurses

Interestingly, the views of the district nursing respondents did not deviate significantly from the views of the community staff nurses and, like the community staff nurses, they identified the importance of having a comprehensive induction to prepare new staff nurses.

The views of health visitors

The comments of health visitors reflected their concerns about the use of community staff nurses in the health visiting skill mix. Health visitors were concerned that they would spend much time developing, training and supervising community staff nurses who might leave after a short period of time, so that their investment would not yield an equal return with the diversion of time from their core work. There was also concern that a heavy concentration of educational resources for community staff nurses would be at the cost of developmental opportunities for health visitors and district nurses.

The views of community nurse managers

In the community nurse managers' focus group a number of specific points were made. The managers stressed the need to link the skills of and

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Table 8 Content of training and education provision: respondents' suggestions

	Respondents (n = 36)	Responses
Communication	12	12
Health promotion and education	11	11
Clinical decision making	5	6
Managing specific clinical conditions	see Table 9	
Specific clinical skills	see Table 10	
Team management	8	13
Role-specific training	2	3
Inter-agency/professional working	4	6
Teaching	3	5
Research, audit and quality assurance	2	3
Social issues	5	5

Discussion

The findings of this project raise many issues in relation to the education and training of community staff nurses.

The current education and training programme

As was identified in the introduction, community staff nurses are a diverse group with different educational and practice experiences and learning needs. This was echoed by the findings of this study, with many respondents having developed some of their skills prior to entering the community. It may be more appropriate and efficient therefore to identify the needs of each individual practitioner, building on their previous experiences, rather than adopting an approach which is too uniform. It was clear that practitioners learn and acquire skills from a variety of sources, and that formal education and training represent only one possible mechanism for this. It would seem that a great deal of learning takes place 'on the job', and therefore any development of education and training needs to take this into account. Furthermore, it may be important for trusts to consider the ways in which they facilitate such learning within the everyday working environment. Indeed, the need for effective work-based learning has been emphasized within the recent Department of Health (1999a) report which outlines the way forward for continuing professional development:

Table 9 Specific clinical conditions/problems

	HVs and DNs		CSNs		Total	
	Respondents	Responses	Respondents	Responses	Respondents	Responses
Wound care/TV/leg ulcer management	5	7	6	8	11	15
Diabetes	4	4	7	7	11	11
Continence	4	4	4	5	8	9
Hypertension and CHD	1	1	1	1	2	2
Stress management	1	1	1	1	2	2
Palliative care	1	1	3	5	4	6
HIV and AIDS	0	0	2	2	2	2
Infection control	0	0	1	1	1	1
Respiratory care (asthma)	0	0	2	2	2	2
Dermatology	0	0	1	1	1	1

education programme for community staff nurses to the development of care packages/programmes and the setting of standards. The manager group also identified the possibility of rotational posts in an apprenticeship model. They believed that community staff nurses should have acquired basic skills and adjusted to community-based practice within their first 6 months in post. The managers also identified resource and staffing problems as a major problem in providing effective educational support. However, they felt that they could do little about the current shortage of nurses.

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Table 10 Specific clinical tasks/activities

	HVs and DNs		CSNs		Total	
	Respondents	Responses	Respondents	Responses	Respondents	Responses
Venepuncture	4	5	6	8	2	3
Catheterization	2	2	4	4	2	2
IV drugs/central lines	1	1	3	4	2	3
Ear syringing	1	1	3	3	2	2
Immunization and vaccination	1	1	2	4	1	3
Pharmacology and drug administration	0	0	2	2	2	2
Syringe driver	0	0	2	2	2	2
Child abuse protection	2	3	2	3	0	0
Parenting skills support	1	1	1	1	0	0
Domestic violence	1	1	1	1	0	0
Child health surveillance	1	1	1	1	0	0
Family planning	0	0	0	0	0	0

> An important principle of CPD [continuing professional development] is that it includes more than going on courses. All health organisations need to develop a learning culture with work-based learning at the heart of this.
>
> (Department of Health, 1999a: 5)

This report also highlighted the importance of multidisciplinary learning in the work place.

It was interesting to observe the high degree of consistency between what respondents identified as being important skills, what they wanted in terms of training and what was available in the current provision. This suggested that the content of the current programme complemented the skills required, with skills in communication being the only notable absentee. However, despite this, the current provision was seen to be failing community staff nurses in a number of ways, with such failings being largely attributable to a general lack of resources. The main problem was accessibility, which was restricted due to resource limitations. Even where nurses had secured training places they often had to cancel due to a lack of staff cover. The problem then becomes self-compounding, with poor training opportunities leading to poor recruitment and retention, which further restrict the learning opportunities of the existing staff. Such difficulties must ultimately also be reflected in the quality of care that is available to patients. Many of the failings of the current provision echoed the criticism levelled at training programmes for nurses by Hicks and Hennessey (1997), who suggested that most programmes were constructed on an *ad hoc* basis, reflecting tradition, the assumptions of the local managers, and financial convenience. Clearly, policy makers and service commissioners need to see the provision of a properly resourced education and training programme for community nurses as integral to providing effective health care, and not as a luxury 'add-on' item.

In addition, it is interesting to note the low priority that is given to research and audit skills within the current programme, despite their potential contribution to the attainment and assurance of high-quality care (Audit Commission, 1999; Department of Health, 1999b). The failure to recognize the importance to continuing development of an understanding of research may indicate some of the barriers which need to be overcome if community nursing is to implement evidence-based care (Kitson *et al*., 1996). Indeed, the Audit Commission (1999) noted the limited use of evidence-based protocols within district nursing practice.

The future education and training of community staff nurses

Notwithstanding the importance of resources, the findings of this study suggested that it is the format for education and training rather than the content which was in greatest need of revision. From these data a framework to reform the format for the education and training of community staff

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Table 11 Suggested format of training provision

	DNs ($n = 9$)		HVs ($n = 8$)		CSNs ($n = 25$)		Total ($n = 42$)	
	Respondents	Responses	Respondents	Responses	Respondents	Responses	Respondents	Responses
Structure								
Need for resources	4	7	3	6	9	10	16	23
Accessibility and co-ordination	0	0	1	1	3	3	4	4
Developing the learning environment	4	6	2	2	13	16	19	24
Link to the evidence base of practice	0	0	1	1	4	4	5	5
Process								
Education to be driven by needs of community/patients	2	2	0	0	0	0	2	2
Training needs analysis of individuals and teams	6	11	4	7	18	25	28	43
Clinical supervision/mentor	4	9	4	9	12	17	20	35
Educational approach needs to be integrated with practice	4	4	1	1	11	17	16	22
Flexibility and diversity in the educational approaches employed	6	13	4	5	15	21	25	39
Programme needs to be ongoing	3	5	2	2	9	13	14	20
Learning linked to practice	2	2	0	0	6	6	8	8
Outcome								
Programme needs to be accredited	1	2	0	0	1	1	2	3
Programme needs to be evaluated	0	0	1	4	0	0	1	4
To link the education programme to career development	0	0	0	0	6	12	6	12
Development of clinical skills	0	0	1	1	16	20	17	21

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Table 12 A broad range of educational approaches is required

	Total (n = 44)		CSNs (n = 27)	
	Respondents	Responses	Respondents	Responses
Eclectic (i.e., something from everything)	37	75	23	49
Classroom-based/formal courses	24	33	18	26
Use of in-house specialists and specialist centres	24	32	18	25
Self-directed learning	15	19	13	17
Multidisciplinary	15	15	12	12
Nurse educationalists	14	19	8	11
Needs to include external courses, ENB, etc.	3	3	2	2
Theoretical	2	2	2	2
Practice based			14	17
Practice-based lecturer	2	2	1	1
Research dissemination	2	2	2	2
Opportunities to look at practice in other areas	2	2	2	2
Audiovisual materials	1	1	1	1
Peer based	1	1	0	0
Career breaks/sabbaticals	1	1	0	0

nurses within the study trust was developed. This is depicted in Figure 1.

The framework addresses the structure, process and outcome factors that were identified. The success of the framework requires that certain structural conditions be met, in particular that practice is evidence based and driven towards reflecting the conditions necessary to establish clinical governance (Department of Health, 1997; 1998; 1999b). It also emphasizes the need to establish an educational infrastructure to support and facilitate learning in practice. The framework is based on the premise that the process of education and training should be needs driven. Thus the skills required should be related to the context of the community staff nurse's role, with reference to the health needs of the population served and to the objectives of the community nursing and wider primary care teams. The main objective should be the development of a validated learning plan based on training needs analysis to identify priority areas for skills development both for individual practitioners and for the team as a whole (Shepherd, 1994). The learning plans should relate the needs of the individual to the needs of the team and to patient care reflecting the skills categories set out earlier. Importantly, the plan should also detail the educational resources which are available to develop the identified skills. The learning plan should then be externally validated both by the trust and by an academic body, to ensure that the learning plan is in tune with the wider aspirations of the organization and that the necessary resources are available. As one respondent put it, a *contract* would be created between the practitioner and the trust. Academic validation would advise on the best way of fulfilling the learning plan and provide the appropriate accreditation so that the staff nurses gain academic credit for their learning. This reflects the view of Smith and James (1996), who called for a greater partnership between higher education and trusts in meeting the professional development needs of community nurses.

A common shortcoming of much educational and training investment is the failure to evaluate outcomes. Within the proposed framework, outcome evaluation is integral so that the following questions should be addressed. Have the identified learning objectives been fulfilled both for the individual and for the team? What has been the impact on patient care? Has there been any improvement in staff morale, recruitment and retention? Although the proposed framework is broad and in need of further development and validation, it could provide the way forward for the study trust and other similar organizations. Existing models for training needs analysis could be incorporated within this framework. For example, Shepherd's (1994) sequential training needs analysis model

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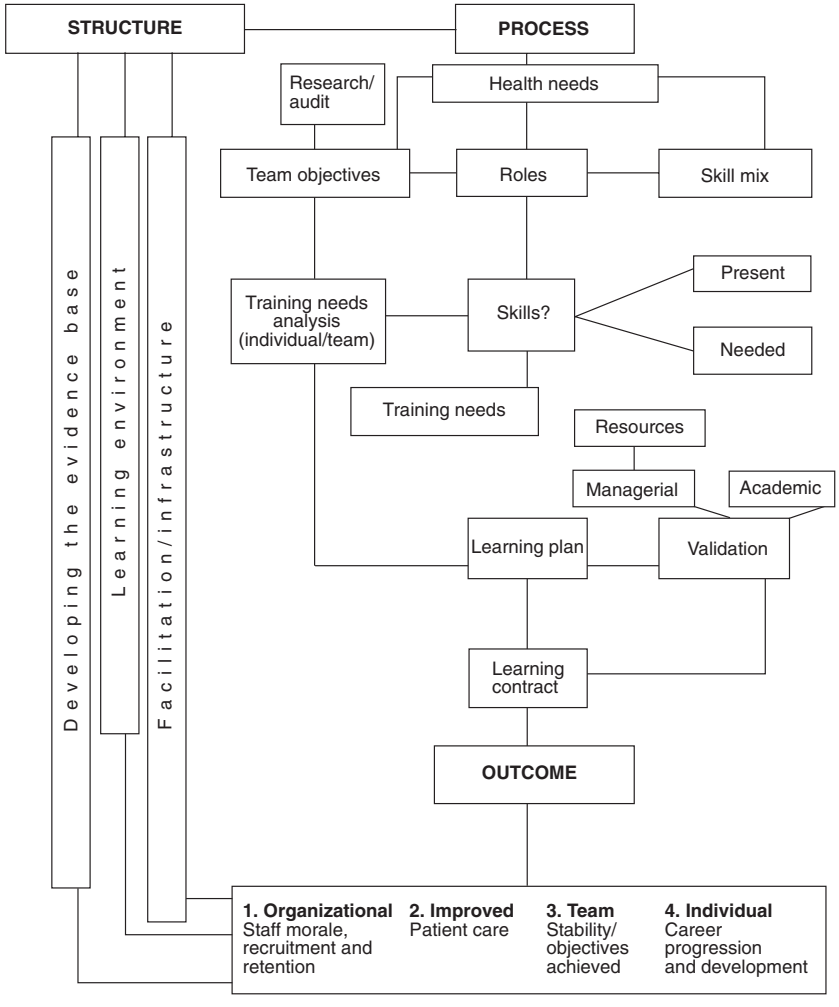

Figure 1 A framework for the training and education of community nurses.

describes mechanisms whereby individual and organizational needs can be identified.

The proposed framework meets many of the conditions for effective training needs analysis prescribed by Lancombe and Maggs (1991), namely that the organization should be clear about its goals and objectives, those goals should be well communicated and embraced by all in the organization, the process should engender a feeling of being valued, there should be an assessment of client/patient satisfaction, there should be recognition that practitioners have learning needs other than those of the organization, and distinctions should be made between perceived and real needs. The latter point alludes to Hicks and Hennessey's (1997) other major criticism of training programmes, which they asserted were frequently based on 'wish lists' of wants rather than on systematically determined needs. They proposed a psychometrically developed questionnaire to overcome the inherent bias of identifying training needs in which professional 'whim' supplants the real training requirements (Hicks and Hennessey, 1997), although it is unclear whether this approach has proved effective in practice. Farley and Fay (1988) have cautioned that such objective measures need to be balanced by more subjective approaches. The framework also appears to fulfil

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many of the criteria set out in the recent government policy statement on continuing professional development (Department of Health, 1999a), which are summarized in Box 1.

Box 1 Continuing professional development guidelines (Department of Health, 1999a)

- Purposeful and patient centred
- Targeted at identified educational need
- Educationally effective
- Part of a wider educational development plan in support of local and national service objectives
- Focused on the development needs of clinical teams, across professional and service boundaries
- Designed to build on previous knowledge, skills and experience
- Designed to enhance the skills of interpreting and applying knowledge based on research and development

The findings of this research have also highlighted the education and training issues for nurses entering community-based practice. Supporting registered nurses in making the transition from hospital- to community-based practice is critical if competent, effective practice is to be ensured. The suggestion from the findings of an organized induction programme to assist this transition is clearly useful. However, it is important to consider what this might incorporate. Strategies to support this transition can be found in the North American literature, where this issue seems to be equally pressing (Culley *et al*., 1996; Chalmers *et al*., 1998). Murray (1998) has argued that role theory might prove helpful in informing this process, and she suggested that nurse educators could help by highlighting the differences between hospital and community practice, developing mentoring and 'buddy' schemes, providing feedback about performance, developing educational strategies which promote self-efficacy and foster autonomy, and revising the undergraduate curricula so that nurses are better prepared for work in the community. In relation to the latter point, questions must be asked about the way in which the Project 2000 curriculum meets this need in the UK (Maben *et al*., 1997). Again, it seems that a facilitated learning environment plays a key role in supporting this change in practice culture, and perhaps the link lecturer or lecturer practitioner models might provide this support (Malone, 1999).

Study limitations

Any interpretation of the findings of this study needs to be tempered with reference to a number of limitations in both method and process.

- This was a small study undertaken within one inner-city trust. The extent to which the views of the nurses within the trust can be generalized or transferred to other trusts is unknown.
- The poor response rate, particularly for the questionnaire, introduces the possibility of respondent bias, which could swing either towards those who were most disenfranchized or towards those who had more invested in the process. Given that most respondents gave full, balanced and very constructive accounts, the emphasis is likely to be on the latter.
- The validity of the study would have been enhanced if the findings had been taken back to the respondents for validation. Unfortunately, time constraints precluded this option.

Conclusion

The training and education of community staff nurses are important if they are to develop the skills necessary to underpin high-quality community nursing services. The continued neglect of their training is not sustainable with the increasing use of community staff nurses as care deliverers in the home setting. The current provision in the study trust was perceived to be external to practice, and failed to deliver in a consistent and coherent way. Although a lack of resources and staffing problems seem to be in part responsible for this, the lack of a systematic approach to the organization of the training and education programme also contributed to the situation. The findings of this study suggested that what is required is a co-ordinated, integrated and properly resourced strategy for

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education and training, which addresses the needs of practitioners, patients, the wider community, the trust, and other primary care agencies. The study has proposed a framework by which this might be achieved. In addition, there is a need for training to support practitioners who are entering community-based practice via internship. The Audit Commission (1999) has highlighted the urgent need for community nursing provision to redefine its focus and therefore its skills base. The learning needs of community staff nurses can no longer be neglected if the aspirations of clinical governance (Department of Health, 1999b) are to be achieved and effective lifelong learning is to be promoted among nurses working in primary health care.

References

Audit Commission 1999: *First assessment: a review of the district nursing service in England and Wales*. London: Audit Commission.

Bradshaw, P. 1989: *Teaching and assessing in clinical nursing practice*. London: Prentice Hall.

Carnwell, R. and **Macfarlane, M.** 1999: Integrating a primary care nursing team: one approach. *Community Practitioner* 72, 252–56.

Chalmers, K., Bramadat, I. and **Andrusyszyn, M.** 1998: The changing environment of community health practice and education: perceptions of staff nurses, administrators and educators. *Journal of Nursing Education* 37, 109–17.

Closs, J. 1995: Community PREP. *Nursing Standard* 9, 22–23.

Cowley, S. 1993: Skill mix: value for whom? *Health Visitor* 66, 166–68.

Culley, J., Courtney, J., Diamond, L. and **Bates, E.** 1996: A continuing education program to retain registered nurses for careers in client-focused community health care. *Journal of Continuing Education in Nursing* 27, 267–73.

Denzin, N. 1989: *The research act*, 3rd edn. New York: McGraw-Hill.

Department of Health 1997: *The new NHS: modern, dependable*. London: HMSO.

Department of Health 1999a: Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare. London: The Stationary Office.

Department of Health 1999b: *Saving lives: our healthier nation*. London: The Stationary Office.

Farley, J. and **Fay, P.** 1988: A system for assessing the learning needs of registered nurses. *Journal of Continuing Education in Nursing* 19, 13–16.

Feher Waltz, C., Strickland, O. and **Lenz, E.** 1984: *Measurement in nursing research*. Philadelphia, PA: F. A. Davis.

Fox, D. 1982: *Fundamentals of research in nursing*, 4th edn. London: Prentice Hall.

Gerrish, K., Ross, B. and **Thompson, V.** 1998: Reviewing responsibilities. *Journal of Community Nursing* 12, 1–5.

Hicks, C. and **Hennessey, D.** 1997: Identifying training objectives: the role of negotiation. *Journal of Nursing Management* 5, 263–65.

Kerlinger, F. 1973: *Foundations of behavioural research*. New York: Holt-Rinehart-Winston.

Kitson, A., Ahmed, L., Harvey, G., Seers, K. and **Thompson, D.** 1996: From research to practice: one organizational model for promoting research-based practice. *Journal of Advanced Nursing* 23, 430–40.

Kitzinger, J. 1995: Introducing focus groups. *British Medical Journal* 311, 299–302.

Knott, M. 1999: Integrated nursing teams: developments in general practice. *Community Practitioner* 72, 23–24.

Lancombe, K. and **Maggs, C.** 1991: *Processes for identifying the CPE needs of nurses: an evaluation*. Project Paper 5. London: English Nursing Board.

Lightfoot, J., Baldwin, S. and **Wright, K.** 1992: *Nursing by numbers? Staffing levels for district nursing and health visiting services*. York: University of York.

Maben, J., MacLeod Clark, J. and **Jones, K.** 1997: Primary health care nursing and Project 2000: challenges and incompatibility? *Nursing Times Research* 2, 38–45.

Malone, M. 1999: The potential for lecturer practitioners in primary care. *British Journal of Community Nursing* 44, 272–76.

Murray, T. 1998: Using role theory concepts to understand the transition from hospital-based nursing practice to home care nursing. *Journal of Continuing Education in Nursing* 29, 105–11.

Shepherd, J. 1994: Training needs analysis model for qualified nurse practitioners. *Journal of Nursing Management* 2, 181–85.

Smith, M. and **James, S.** 1996: Professional development support for community nurses. *Nursing Standard* 11, 34–36.

Strauss, A. and **Corbin, J.** 1990: *Basics of qualitative research: grounded theory procedures and techniques*. London: Sage.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1990: *The Report of the Post Registration and Education Project*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1992: *Scope of professional practice*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1994: *The future of professional practice – the Council's standards for education and practice following registration*. London: UKCC.

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