

HOME HEALTH NURSING

A Position Paper Developed by:

The Community Health Nurses' Initiatives Group

of

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DEDICATION AND ACKNOWLEDGEMENTS

This paper is dedicated to all nurses who have chosen home health as their practice focus and who, through their creativity and commitment, identify its possibilities, realize its depth, and celebrate its achievements.



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- Bradson Home Health Care
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Introduction

“Home was a rootedness at the centre of their lives, the centre of caring for themselves and others”¹

Home health nurses’ understanding of the home and family as the centre of their clients’ lives provides the foundation for their practice. Given home care’s cost effectiveness in comparison to institutional care, that understanding also explains the health care system’s continuing focus on, and expansion of home health care services. Since it has been predicted that by 2010, 70% of employed nurses will practice in the community², a comprehensive understanding of home health nursing is imperative in order to attract sufficient numbers of home health nurses, promote their learning and integration of the required practice philosophies, and retain them in the workforce. An appreciation of home health nursing begins with the recognition that it is a unique and diverse practice focus, possessing its own “distinct practice philosophies that include concepts of self-care across the lifespan”³.

Purpose of this Position Paper

The purpose of this paper is to describe home health nursing, identify its associated issues, and stimulate discussion about solutions to those issues. Information in the paper may be used to support activities or initiatives that address the issues such as responding to enquiries from the media, preparing responses to legislative initiatives, or writing letters to the editor. The paper may also be used as briefing material to convey a comprehensive understanding of home health nursing, for example as part of orientation to new home health nurses or students. The content of the paper represents CHNIG’s position regarding the practice and issues of home health nursing.

Separate Position Papers for Public Health and Home Health Nursing

CHNIG gratefully acknowledges the support of members from a wide variety of community practice settings. Practising in occupational health, family practice, parish nursing or as Nurse Practitioners, the diversity of our membership has meant a tradition of celebrating the common roots and shared competencies amongst all nurses working in the community. Accordingly, the decision to prepare and publish separate position papers for public health and home health nursing came about only after considerable thought and debate. The development of the two papers reflects the evolution of home health nursing to a practice that is distinct from public health nursing. CHNIG welcomes the opportunity to work with stakeholders in the development of position papers reflective of the many other areas of community practice.

The Evolution of Home Health from Public Health Nursing

Home health nursing traces its roots in Canada back to the 17th Century when nuns from religious orders such as the Grey Nuns arrived from France and began caring for the poor in Quebec. It has been suggested that this early connection between community nursing and volunteer service has contributed to the persistent underfunding for community health nursing and society’s traditional lack of recognition of the value of home health nursing care or the educational preparation required to fulfil the role⁴. Home health nursing was originally inseparable from public health nursing, as each nurse provided the full continuum of nursing care, including health promotion and disease prevention, hands-on care directed toward the restoration of health, or palliative care. However, over the years, and influenced by the medical model and the emergence of publicly funded home care services operating in an increasingly cost-constrained, business model environment, community health nurses have been increasingly separated into two categories, public health nurses and home health nurses. Home health nurses have since experienced growing pressure to restrict their practice to the provision of specific tasks for the ill client. At the same time, Public Health Nurses have experienced pressure to move away from care focused on individuals, and focus on population health strategies. Expert home health nurses remain committed to the provision of holistic and family centred care, which encompasses health promotion, and disease prevention, takes into account the determinants of health, and works toward the health outcome identified as optimal by the client.

Home Health Nursing Practice

In Ontario, 13% of employed nurses--approximately 6700 nurses in total-- listed home care as their practice setting on their 1999 College of Nurses Annual Payment Form⁵. The majority of those nurses are employed by health service agencies, however they may be in independent practice, or work for Community Health Centres (CHCs), Churches (Parish Nurses), or community service agencies such as Easter Seals or the Red Cross.

The focus of home health nursing is the care of individuals and their families throughout the community in settings that include traditional homes, group residences, school classrooms, shelters, and the street. Also called Visiting Nurses and/or Community Health Nurses, home health nurses are those for whom the scope of practice, in conjunction with the ability to practice holistic nursing in the context of a rewarding nurse-client therapeutic relationship, represents a highly fulfilling practice environment.

Home health nursing has traditionally been considered a generalist practice, involving the expectation that the nurse demonstrate competence and flexibility in caring for clients across the age and illness continuum. Home health nurses provide the full spectrum of care, combining critical thinking, comprehensive assessment, and clinical decision-making with expertise in the nursing management of intravenous infusion therapy (often via central venous lines), complex dialysis regimes, medication delivery via ambulatory pumps, and ventilator dependent clients. Adding to the complexity of home health practice is the challenge of maintaining competence with the above clinical care skills when they may be required sporadically.

In recent years, new opportunities have arisen for home health nurses to combine their generalist practice with the application of specialized knowledge and skills in such areas as home chemotherapy, enterostomal therapy, mental health, continence management, lactation consultation, palliative care and care of children with long-term health needs.

Central to home health nursing is the nurse's understanding that s/he is the "guest in the house"⁶, and the "stranger in the family"⁷, with the resultant willingness and ability to work in collaboration with the client and adapt to an endless variety of client controlled environments. The practice involves the use of a vast array of technology, the need to cope with the full spectrum of traffic and weather conditions, fulfil funder-reporting requirements, and implement strategies to overcome isolation from peers. Acting as the health care team's "eyes and ears", the home health nurse plays a key role in both coordination of care and communication of client status and needs to the members of the health care team. Personal characteristics of home health nurses identified in the literature include independent decision-making, maturity, confidence, independence, diplomacy, creativity and self-motivation⁶.

Expert home health nurses readily describe their sense of privilege and fulfilment in working in a holistic and committed therapeutic relationship with their clients. Their commitment to their chosen practice focus arises from a type of nursing that "takes the nurse to where the person lives in more than the literal sense...[and gives them] the opportunity to come to know the person and family as they really live and to become a meaningful presence actively promoting health and quality of life in family and community patterns of daily living"².

The characteristic enthusiasm of home health nurses has been identified as "work excitement, which in turn has been described as "the energizer essential to nursing care delivery and positive patient outcomes"⁸. High levels of "work excitement" were found to be associated with nurses who had chosen home health nursing because of personal fulfilment.

Public Access to Home health Nurses:

In Ontario, members of the public may access home health nursing care by contacting their local Community Care Access Centre (CCAC), by referring themselves directly to a health service agency, or by having their physician or other health care provider make a referral to the health service agency or CCAC. Ontario's publicly funded health insurance covers the cost of home health nursing services provided to residents who have care needs that meet the funding and eligibility criteria identified by the Ministry of Health and the CCAC. However, if clients require services in excess of those available from the publicly funded programs, out-of-

pocket payment is required.

Educational Preparation

In contrast to public health nursing, there is no legislation which governs the education preparation required of home health nurses. The historical preference by some employers and jurisdictions for Registered Nurses with a baccalaureate degree was influenced by several factors. Firstly, home health nursing's public health roots meant the requirement for an in-depth knowledge of public health science including health promotion and the impact of the determinants of health, the social sciences, nursing science, including family nursing theory, and nursing research concepts^{9,10}. Secondly, preparation for the highly autonomous nature of the role included a comprehensive knowledge base and well developed critical thinking skills. While an outcome of many nursing education programs, such knowledge and skills have traditionally been emphasized within nursing baccalaureate programs, or acquired via a university program that awards a diploma in public health. While historically some employers either insisted upon, or gave hiring preference to Registered Nurses with a baccalaureate degree or post RN diploma in public health nursing, cyclical shortages of home health nurses, the low number of baccalaureate-degree prepared nurses in Ontario (only 28% of Ontario RNs possess baccalaureate degrees⁵), and fiscal realities has meant an increasing number of diploma-prepared RNs and certificate-prepared Registered Practical Nurses (RPNs) in the role of home health nurse. To begin to address gaps in home health nursing competencies, certificate programs have been developed by community colleges and professional nursing associations on such topics as community nursing, family nursing, health assessment and nursing leadership.

Home Health Nursing Competencies

Early documents articulating standards and functions for the community health nurse^{11,12,13} did not differentiate between competencies for the community public health nurse and the home health nurse. However, a growing body of literature depicts home health nursing as specialized nursing practice¹⁴, with its own unique competencies. Those competencies include the ability to work in a highly autonomous manner, within an unstructured environment, and while assuming a high level of responsibility.

Studies found that home health nursing competencies were not automatically possessed by institutionally-based nurses, noting that "there is no evidence in the literature that nurses with acute care skills are equally proficient in a home health setting until the specialized home health nursing skills are added to the repertoire"¹⁴. Further supporting the understanding of home health nursing practice as unique from that of institutionally based practice is the observation that: "the transition from hospital to home care nursing isn't a lateral move"¹⁵. Accordingly, nurses moving from the hospital to home health nursing require support and a comprehensive orientation/preceptorship to their new role.

Home health nurses require proficiency in traditional clinical practice competencies with an emphasis on systematic interviewing, in-depth holistic assessment skills, the ability to judge the appropriateness of options, priorities and resources and to provide client-relevant teaching⁹. Competencies related to identifying and managing personal or client safety risks are also needed¹⁶, as are those in conflict resolution, time management and working with groups.

Conveying empathy and "communicating to seek the client's perspective while not imposing one's own values on the client and family"¹⁷ have also been identified as necessary competencies for home health nurses. Closely related to the above competencies are those identified in another study as "socialization competencies"⁹ which include:

- Recognizing world view differences between client and nurse
- Sensitivity to worth and living conditions of vulnerable client
- Recognizing values of the [Community Home Health Nurse]: "going the extra mile"; greatest good for the greatest number
- Professional behaviours: resourcefulness, progressiveness, self-reliance

A variety of additional competencies have been identified for home health nurses that further depict the complexity and art of their practice. These include⁹:

- Long-term relationship development
- Promoting empowerment and self-efficacy
- Casefinding (For the purpose of this paper, interpreted as identifying and responding to needs of client or others not contained in the referral. E.g. Assessing the leg ulcer of a client's wife and initiating service referral or assisting an elderly man who has fallen down and offering/initiating service referral).
- Managing community resources and [homemaking/unregulated providers]
- Picking up on client cues
- Fostering consumer participation
- Problem-solving with and motivating clients

The information age has introduced yet another important competency for home health nurses—that of a “knowledge navigator”¹⁸, able to assist clients to access and interpret the vast array of information now available electronically. The pre-requisite to this competency is possession of effective computer skills—also necessary as home health nursing agencies increasingly implement computerized patient information and documentation systems.

Mentorship for both students and new home health nurses has been emphasized as an important vehicle for modelling and promoting competency development^{2,14}.

Examples of Home Health Nursing Practice

The following examples are listed to illustrate the general scope and variety of home health nursing practice. First person, detailed accounts of home health nursing care are provided in Appendix One.

Home Health Nurses:

- ***Foster growth and development*** for a child with long-term health needs by providing nursing care in the classroom setting, which may include tube feeding, medication administration and chest percussion/postural drainage. Such care includes communication with the child's guardian, often via notebook or telephone as well as liaison with the child's teacher and/or classroom assistant to provide health teaching and information regarding the child's status and response to treatment.
- ***Respond to trends in society*** such as the increase in homelessness by providing wound care, foot care, counselling or service referral to homeless individuals during street patrols or in settings such as shelters or clinics.
- ***Pioneer innovative roles***, such as that of Parish Nurse. A member of a faith community, the Parish Nurse works from an office site or travels to homes or shelters to provide outreach services to parishioners in the form of holistic counselling and support, clinical care and/or referral to community services.
- ***“Find ways to be comfortable and effective in the homes of others”¹*** while offering respite care via extended hours of nursing care to family members caring for loved ones with chronic illnesses across the age and illness continuum.
- ***Enable “aging in place” and facilitate communal living arrangements*** by providing assessment, counselling, monitoring, personal care or referral services to those in residences for specific populations, such as members of religious orders, developmentally delayed individuals or those with mental health issues.

- ***Support home management*** of health care needs as direct care provider, teacher or coach to clients and their families with specific health needs in areas such as mental health, wound care, intravenous medication administration, post myocardial infarction monitoring, etc.
- ***Identify and apply state-of-the-art knowledge*** in specialty practice areas such as palliative care, mental health, enterostomal therapy, lactation support, continence management, or newborn care.

Conclusion

The expression “a lot bigger than just a job”⁷ has been used to convey the joys and challenges of home health nursing, and explain home health nurses’ commitment to it as a practice focus. While home health nursing shares its knowledge base and philosophy with public health nursing, it has evolved over the years as unique and distinct from other types of nursing practice. It is an essential component of the continuum of health care services and of a safe community. Contemporary issues for home health nursing are outlined in Appendix Two. Addressing those issues is of paramount importance in order to assure continued public access to home health nursing care.

Appendix One: Home Health Nursing Stories

Story One: Caring Across the Continuum of Needs

I once cared for a 45 year old man with Lymphoma who was discharged from hospital after a two-month stay. The referral asked for once weekly visits for two weeks to assess symptom management, but my first visit revealed more pressing issues. This gentleman had a history of drug abuse although he had been employed throughout his life. He had been living in a rooming house, but while he was in hospital the Landlord had vacated the house and locked the doors. Therefore he had no home, no clothes, no money, and no identification. Although he had been estranged from his family, he contacted his father who agreed to let him stay at his house for a maximum of two weeks. The Case Manager and I met with the client and his father and explained the difficulty involved in getting social assistance or housing before identification could be obtained. The father nervously agreed to extend the son's stay. The Case Manager arranged for the Social Worker to visit and the process of obtaining social assistance and identification was begun. I was then able to begin to focus on my client's physical nursing needs. His chemotherapy was resulting in severe nausea and vomiting for well over a week after each treatment. We talked about the chemo and he opted for quality of life versus quantity, especially since he had been told his chances of remission were poor.

Once chemotherapy stopped, he developed severe ascites requiring paracentesis for drainage of between 5 and 12 litres! The ascites reoccurred every two to three days, causing symptoms of dyspnea, and difficulty walking and eating. I would track down the Oncologist by phone, relay the symptoms, and ask to send the client back for a repeat paracentesis. The Oncologist often questioned my assessment, stating: "We just did the paracentesis 3 days ago, he should be ok for a couple of weeks now". I would have to firmly repeat my findings. After 2-3 weeks of this process, I asked the Oncologist if I couldn't just phone the hospital's diagnostic area and ask them to see the client. The Oncologist agreed, stating that he would leave some completed requisitions with the diagnostic unit. I explained to the client that a tube could be inserted into his abdomen which would allow the drainage to be done at home. He was initially reluctant, feeling that he didn't want to spend the rest of his life living with tubes. However, when he continued to require twice weekly trips to the hospital, spending the days in between debilitated by the ascites symptoms, he asked me to see what could be arranged. The Oncologist agreed to the tube insertion. I visited twice daily after the tube was inserted and eventually taught the client how to do the drainage procedure. I spent time with the father as well, as he was very concerned that something would go wrong if a nurse did not do the procedure. I reviewed the procedure in detail and explained that many people were successfully performing such procedures at home. The client began draining himself twice daily, removing 2-3 litres of fluid each time. Being able to do the procedure at home and independently became a positive experience. The client's comfort level, independence, self esteem and sense of personal control increased significantly and he was able to eat better because he did not constantly feel full.

Not long after the ascites management was under control, a lymph node under his arm became very large and painful. I felt that radiation might help, and the Oncologist agreed. The radiation program involved twice daily radiation for three weeks. Again, however there was a great benefit as the abdominal drainage decreased to 250-300 c.c.s a day, and changed in consistency from thick white to clear and thin! His ability to eat further improved, the nausea and vomiting was substantially reduced, his blood pressure stabilized and his energy increased. Now he was able to leave the house for short periods and use public transportation to visit other family members.

As time went on, his pain control needed attention, and I phoned the Oncologist to ask for an increase in the analgesic. I was concerned about the answer to my request, and as the client never did have a family doctor, I made a referral to a palliative care physician service. The client now has easily accessible medical care from an experienced palliative care physician.

Future planning has been addressed through an application to a nearby palliative care unit, because the client felt dying at home would be too much for his father to manage. The rewards of caring for this client were brought home even further to me when the client revealed that the hospital had initially considered discharging him to a nursing home.

Story Two: Promoting Independence and Respecting “The Right to Be At Risk”

My patient was an 82-year-old woman who had suffered a devastating CVA, leaving her with expressive aphasia. Added to that was a long-standing dependence on peritoneal dialysis, requiring four exchanges per day. Despite her inability to verbalize comprehensible words, her fierce determination to be independent resulted in her discharge from hospital to her beloved home of many years, with 24 hour homemaking. The visiting nurses arrived four times a day to perform the dialysis, soon realizing the depth of the communication difficulty. “Alma” was unable to read or nod yes or no reliably, and couldn’t dial numbers correctly. Intense speech therapy was unable to improve her verbalization ability.

Alma was able to say “bacon”, usually repeated three times in sequence. I soon learned that Alma’s tone of voice with “bacon, bacon, bacon” varied according to her needs. For example, after many weeks of 4 visits per day, Alma began saying “bacon, bacon, bacon” with great intensity when the dialysis was performed. I eventually asked Alma if she wanted to do the tasks herself. My reward was a much gentler “bacon, bacon, bacon”, and over time Alma learned to perform the dialysis exchange procedure herself. She then made it clear that she did not want the nurse to visit four times a day. As you can imagine, we were quite concerned about leaving her on her own. How could she get help if needed? We set up a speed dial mechanism connected to the nurse’s office, and after many hours of repeated teaching, Alma was able to use the speed dial correctly. We then set up a system whereby we would phone Alma just after she would have performed the exchange. We were able to tell from the tone of her voice if she needed us to visit—one day the anxiety in her words “bacon, bacon, bacon” was so evident when I phoned that I almost flew to the house to find that she couldn’t do the dialysis exchange because one of the clamps had broken. Alma made it clear she found 24-hour homemaking intrusive and over time the homemaking hours were decreased. She also indicated that she wished as few nursing visits as possible, but she was agreeable to a one visit per day so that we could monitor her vital signs and weight and choose her dialysis bags appropriately. We would help her phone her relatives to ease the loneliness she seemed to convey. One of the nurses took her shopping.

We cared for Alma that way for two years—years in which she was in her familiar surroundings and had as much independence as possible. Years in which she avoided the institutionalisation she dreaded. One day she was not found by the nurse in her accustomed place. She was in bed, having passed away peacefully. I will always feel grateful for knowing Alma and for being able to help her be as independent as possible in spite of such profound physical challenges.

Story Three: Staying the Course: Palliative Care at Home

I was asked to visit a 57 year old man who was so physically fit that he ran marathons! He was a top level executive in an international corporation and had always enjoyed excellent health. He was married, and he and his wife travelled extensively and enjoyed running together. He had two sons—one of whom had graduated from university two years ago, with the second due to graduate in a few months. This was a very happy and accomplished family.

One day he noticed a strain under his arm which he attributed to lifting heavy luggage. When it did not improve, he saw his physician, and eventually received the devastating diagnosis of mesothelioma—a rare tumour of the mesothelium of the lung, usually associated with asbestosis. He was determined to “lick this”, and never lost his unique sense of humour. Nonetheless his disease progressed quickly. When his nursing needs increased, I arranged with a colleague to be my back up, and between the two of us we were able to ensure continuity of care. He soon needed oxygen, and pain control became an issue. Most of our visits were two hours so that we could ensure all needs were covered. We needed to be very sensitive to the timing of our visits, arranging them not to conflict with the visits from the minister, accountant and lawyer that were so important to my patient in order to leave his affairs in order. Despite organizing his affairs, my patient never acknowledged that he was dying and I knew how important it was that I help him and his family to sustain hope. I experienced disapproval from my nursing colleagues who were uncomfortable with my patient’s denial. Yet, not openly acknowledging the severity of his illness was enabling my patient and his family to get through each

day. The majority of my visit was spent just listening to my patient and his family, and directing them to the appropriate supports. My “being there” was important to them.

I was there when he died at home--there to help his wife through those first few devastating moments. There to see the wife in turn help her sons touch their father’s body. It was a privileged time—a time in which I received as much back as I had tried to give.

Story Four: Holistic Care

Working in a different area one Saturday, I found myself in the home of a 67 year old woman with shingles. The shingles were quite severe, with open, raw blisters covering the front and back of her right leg. Her pain was not controlled, and no compresses had been ordered. She had been sent to the Emergency Department at one point, but there were no orders. Her family physician had ordered some fucidin ointment. I was very concerned about her health status. She was skin and bone and therefore at high risk of infection. She had bilateral pedal edema, making ambulation difficult. She had no food and apparently no one to shop for her. She asked me to go and buy her some groceries, which I did. She was not receiving meals-on-wheels.

When I returned on Sunday, I asked her about her thick accent. She told me she was Armenian and that her husband had died 3 years ago. She said: “no one ever asked me about my accent before”. She talked about how lonely she felt and I asked if she was a member of the Armenian church nearby, or would like a visitor from there. She had not known about the church.

She was very concerned about her housing. There had been numerous break-ins in her apartment building and she was afraid. She wanted placement—stating that she couldn’t go out in bad weather, and just couldn’t cope with the apartment.

I revised the care plan to include compresses for the shingles, spending time listening, linking with community supports, and pursuing the desire for placement, and then discussed the care with the nurse due to follow me. The visits reminded me again of the rewards of listening, and of fostering trust.

Story Five: Advocacy and Safe Care versus System Pressure

Tyler was a 14-year-old boy with Down’s Syndrome who lived in a group home. With a mental age of about six years old, Tyler’s affectionate and happy disposition made him popular with other residents and staff. Although at one time his diabetes had been managed with oral hypoglycemics, it was now poorly controlled, and he was referred to the CCAC (Community Care Access Centre) for nursing visits to initiate insulin and monitor his clinical response. He was to receive “insulin by reaction”, twice daily. This meant I was to assess his clinical status, test his blood sugar with a glucometer, choose the dose of insulin (from a range provided by the physician) that corresponded to his status and blood sugar result, and administer the insulin. Referral instructions from the CCAC called for me to teach the group home staff how to measure Tyler’s blood sugar, and inject the insulin. The CCAC visit plan called for a decrease in the twice-daily nursing visits within one week of admission. On my first visit to the group home I was greeted by two very anxious group home staff members demanding to know how often I would be visiting and telling me that they had never given “needles” before and were afraid they would hurt Tyler. They talked about how frightened they were of making a mistake in using the glucometer or in choosing the right amount of insulin. I listened closely and explained that I would work closely with them and keep the health team informed of the needs of both Tyler and his caregivers. I knew that taking a gradual approach to teaching new skills often provides an opportunity to reduce anxiety and build confidence in the learner. However, as the first week progressed, Tyler experienced significant swings in his blood sugars along with several hypoglycaemic reactions. His insulin dose continued to be variable and it was clear his diabetes had not yet been stabilized. I felt strongly that monitoring his clinical status continued to require the knowledge and skills of a Registered Nurse. I requested continuation of twice-daily visits from the CCAC, but was reminded of the plan to reduce visits, and vigorously challenged about the need for twice daily monitoring and why I had been unsuccessful in teaching the staff how to give the insulin. I perceived significant

pressure to reduce visits and lower the cost of Tyler's care to the system. At the same time, the staff remained adamant that assuming any additional responsibility for his care was a burden they would not accept, and I believed that their decision was appropriate from a client safety perspective. Seeking help to manage this conflict, after leaving the home I contacted my agency's Clinical Educator and discussed the situation with her. She fully supported my clinical judgement, but suggested contacting a Practice Consultant at the College of Nurses for additional information and support. The Practice Consultant verified that unregulated care providers (the group home staff) could provide routine activities of daily living (such as insulin injections), but that because Tyler's blood sugar, clinical status and insulin dose were not presently stabilized (i.e. routine) I would not be meeting the standards of practice if I delegated the care at that time. When I presented that information to the CCAC I received authorization to continue visiting twice daily for another two weeks. I was relieved that Tyler could receive the care he needed, but distressed over experiencing such conflict between the needs of my client and the pressures of today's health care system.

Story Six: Community Mental Health

I once cared for a 35 year old woman diagnosed with an anxiety disorder, possibly related to a post-partum depression. She was a teacher, on maternity leave to care for her then six-month-old son. She had experienced three miscarriages prior to the birth of her son who was born by caesarean section.

My client had sought the help of her family physician because she was having episodes of severe anxiety during which she had visions of herself in a coffin, couldn't breathe and thought she was smothering. The vision of herself in the coffin had first happened when she was still in hospital, just after her son was born. The vision was attributed to a medication induced hallucination, but she associated the visions with sleeping and became very afraid to fall asleep. As the anxiety episodes continued she became concerned that something would happen to her, and she became fearful of activities she had previously enjoyed, such as flying. One anxiety episode was so severe that she went to the emergency department of the local hospital, but they found nothing physically wrong. She was afraid that she was losing her mind and agreed to visit a psychiatrist.

She described the visit to the psychiatrist in vivid detail, explaining that she poured out her thoughts while the psychiatrist "wrote and wrote, and never even looked at me". At the end of the visit, the psychiatrist said: "You need drugs and psychotherapy". My client was devastated. Now she felt sure she really was "crazy", but was not comfortable going back to the psychiatrist. Her family doctor then referred her to home care, and I became her primary nurse.

On my first visit, I asked her to tell me about the birth of her son. She chuckled, and explained that two ultrasounds during the pregnancy had said she would have a girl, and since she and her husband were fair-haired, they expected a blonde baby girl. Instead, she gave birth to a red headed son! She recalled her feeling of shock and her worry that her shock was affecting her bonding with her son. I told her that what she was experiencing sounded pretty normal, that in view of the miscarriages, even though she had had a healthy baby, the pregnancy and delivery had been stressful, and that adjustment to parenthood was a significant transition for most couples.

She then spoke about her miscarriages, and I discovered that she had not had any grief counselling. She also mentioned that there had been several deaths in her neighbourhood recently. I thought this lady needed a chance to grieve, and I was pleased when she was receptive to attending a bereavement group. The group was run by the Salvation Army, significant because the client's religious faith had been a life long comfort. On the first night, the husband realized the depth of his wife's grief as she wept throughout the session. As the weeks progressed they both understood how much of a role the miscarriages had been playing in their lives. The sessions ended with a memorial service which was, in my client's words "tastefully done, very meaningful and of enormous comfort". The client felt she had achieved closure of the losses.

I identified the client's interest in relaxation techniques, and loaned her some audiotapes on the subject. She and her husband made new Wills, naming a guardian for their son, and arranged a trip to Florida (by plane!), after which she planned to return to work.

On my last visit to the client, she told me that I had helped her to make the connection between her experiences and her anxiety, and how relieved she had been to hear that what she was going through was pretty normal. She also said how grateful she had been that on my first visit I hadn't written anything down, but just focused on her and her story.

Appendix Two: Contemporary Issues for Home Health Nursing

1. Recruitment and Retention

The 1996 introduction of the managed competition system operating within a business model structure for the administration of publicly funded home care services, including nursing, has destabilized the home health nursing workforce through the elimination of long term, full time positions, the deepening of the disparity in wages, benefits and work hour guarantees between the home health nurse and her/his hospital counterpart, and job insecurity brought about by cyclical, term limited service contracts and agency closures when service contracts are lost¹⁹. During consultation with home health nursing leaders during CHNIG's preparation of its submission to the Nursing Task Force, there was agreement that the managed competition system had decreased visit compensation by approximately 10%. Consequently, many home health nursing employers have reduced wages (which in many cases had been frozen in 1992 as a consequence of the social contract), decreased or eliminated mileage allowance, orientation and education programs, and reduced or eliminated nursing supports such as nurse-managers and clinical educators. Despite these realities, in some agencies, expectations of home health nurses include accountability and responsibility for 24 hour management of their client's visit needs and care outcomes, resulting in extended on-call availability, complex juggling of work and home responsibilities and the blurring of work and off-duty time.

The above conditions have contributed to a rapidly increasing shortage of home health nurses, made more acute by the recent increase in hiring by hospitals at wages and conditions significantly better than those in the community.

The shortage of home health nurses directly impacts both the health care system and individual clients. The system is impacted by waiting lists for nursing services which may delay planned hospital discharges. The client is impacted by reduced access to experienced home health nurses. Communities which do not assure the availability of expert home health nursing care cannot be promoted as safe communities.

2. Erosion of the Home Health Nursing Role and its Associated Autonomy

The reorganization of long term care services into a system of 43 Community Care Access Centres brought with it an increased emphasis on case management services provided by CCAC staff. The Case Manager authorizes the purchase of nursing services from the contracted provider, specifying both the visit frequency and overall care plan. It is important to acknowledge that CCACs are challenged by the expectation that they will respond to ever-increasing service needs and demands within the environment of fiscal restraint that characterizes today's health care system. Given those challenges, there is pressure for the home health nurse to achieve a focused client health outcome (e.g. heal the surgical wound) within the shortest possible timeframe. Nurses have reported situations where their assessment revealed additional client concerns, such as inadequate housing, but were told by CCAC that addressing such concerns was beyond the mandate of the CCAC care. Accordingly, the home health nurse's ability to provide holistic, family centred care is effectively constrained. This restricted focus, in view of home health nurses' long-standing commitment to holistic client and family centred care, and accustomed autonomy of practice has resulted in painful role conflict and confusion, particularly for expert community home health nurses. The response of many nurses has been to provide the range of care activities deemed necessary, even in the absence of funding/remuneration. This results in what has been

termed “invisible nursing care”⁴ and contributes to job dissatisfaction and poor morale.

3. Home Health Placements for Nursing Students

The turmoil associated with the introduction and realities of the managed competition system has been linked to a reduction in the availability of student placements in home health nursing. Reductions are attributed to the closure of provider agencies, start-up pressures for new agencies, a reduced number of experienced nurses in the system, and the agency’s inability to predict or guarantee the volume of client visits during a student rotation. Per-visit compensation systems further complicate student placement in that preceptorship time often reduces the number of client visits the preceptor can make in a given timeframe. Expenses incurred by nursing service agencies that provide student placements are not explicitly recognized in the funding structure. There is concern that nursing students may not acquire an adequate understanding of home health nursing practice because of both the shortage of home health student placements, and the optional nature of such placements. Addressing issues related to student placements is particularly critical at a time when there is a growing shortage of home health nurses. The placements represent an ideal opportunity to provide nurses with a grounding in home health nursing and recruit those who have benefited from a positive mentorship experience and demonstrate an understanding of the unique and comprehensive role of the home health nurse.

4. The need for ongoing research into home health nursing effectiveness and outcomes

Increasingly, policy and funding bodies inform their decision-making with research findings that provide evidence of “best practices”. Of particular relevance is research that studies the link between home health nursing and its outcomes for both clients and nurses. Initially, studies of outcomes (or efficacy) associated with home care services were categorized as inconclusive²⁰ but a 1998 landmark study²¹ on workload and outcomes associated with nursing in the home setting provided evidence of improved client outcomes as a direct result of home health nursing. That study also found that fewer visits and improved outcomes were linked to greater nursing skill as measured by nurses’ registration status (RN/RPN) and education level (diploma/degree). The authors acknowledge the need to replicate and extend their research, objectives vitally important to assuring continued public access to expert home health nurses. Skill mix is another research need associated with home care, particularly as unregulated providers are involved in caring for those with increasingly complex health needs, for example palliative care. Research designed to identify needs and issues associated with demographic realities such as the aging population and associated increase in diseases such as Alzheimer’s is also required. A positive development in the promotion and implementation of home care research initiatives is the recent creation of the Home Care Evaluation and Research Centre of the University of Toronto.

5. Quality of Care in the Community

Quality of care is a central tenet of home health nursing, especially given the managed competition system’s stated commitment to “highest quality, best price”. There is an urgent need to identify and standardize quality indicators, along with their measurement and reporting. The link between service quality and attainment of the community health care accreditation credential also requires study—particularly if such accreditation remains voluntary. At the client-nurse level, there is a need to identify the impact on quality of care resulting from such trends as the increasing dependence on either new graduates or nurses without home health nursing experience, paying nurses on a per-visit basis, shortened orientation programs, and reduced opportunities to meet with colleagues to review client needs and management.

Other factors impacting quality of care include inequities in services resulting from the lack of standardization of CCAC-funded services across the province (e.g. home laboratory services covered by some CCACs but not others, and variations in eligibility and funding ceilings for supplies, services and health care professional visits, sometimes related to program designation such as acute, chronic or palliative), and the financial penalties beginning to be imposed by some CCACs on providers who limit

their intake of new clients when their staffing levels cannot meet client care needs. Issues related to system inequities or lack of standardization have been linked to discussions about the need for home care to be an insured service under the Canada Health Care Act so that the principles of the CHA including universality and accessibility are protected.

Mechanisms to examine, promote and measure quality of care should be evident within provider agencies, including regular review of client outcomes and management, involvement of nurses in management decision-making, and practice support mechanisms such as practice councils nurse educators/managers and inservice programs. Most important is an acknowledgement by funders that focusing on “best price” requires employers to cut programs (such as the previously mentioned orientation program and meeting opportunities), directly impacting their ability to conduct an effective quality promotion and monitoring program.

6. The need for identified home health nursing practice standards and the development of a provincial/national certification process.

Standards of Nursing Practice for Community Health Nurses in Ontario were developed in 1985²². The standards were based on B. Neuman’s Health Care Systems Model, and did not differentiate between the roles of public health and home health nurse. Given the changes to the College of Nurses of Ontario’s Standards of Professional Practice, along with the rapid evolution of both nursing theory, and the roles of public health and home health nurses in the past fifteen years, the standards are in urgent need of revision. CHNIG has begun a process to look at revising the standards, and through its membership in the Community Health Nurses Association of Canada (CHNAC) will also consider the feasibility of a national certification process for home health/public health nursing through the Canadian Nursing Association.

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