Primary Health Care Research and Development 2003; **4**: 137–145

Questions we should ask about community nursing practice

Jean McIntosh

Glasgow Caledonian University, Glasgow, UK

This paper identifies some of the key questions that researchers should address in relation to community nursing practice in the UK. The paper begins with a brief overview of the nature and impact of change within the UK health service and the way this has impacted on community nursing. It argues that the nature and scale of such change means that it is important to investigate any resultant threats to the safety of patients and clients, to the quality of their care and to the capacity of the service to meet health care needs. However given the difficulties associated with identifying links between the quality of care and policy driven change, the author argues that a more appropriate approach would be to focus on investigating the effectiveness of practice and seeking explanations for variation in practice. The paper makes reference to the complex knowledge base used in community nursing practice and acknowledges the challenges for nurses in internalising messages from the social science disciplines in order to strive to achieve effective practice. Drawing on some current research studies the author then highlights the importance of developing a better understanding of the interpersonal skills used in practice. The author then moves on to consider wider issues of practice including delegation, supervision and teamwork, arguing that insufficient attention has been paid to effectiveness in these domains. In concluding, the author makes the case that questions should be pursued in all these areas with a focus on exploring variation in practice so that a broader more theoretically based understanding of what is effective in practice can be achieved.

Key words: research questions; community nursing; interpersonal skills; nursing knowledge

Introduction

This paper aims to identify some of the important research questions that should be asked about current community nursing practice. While the focus is primarily on two groups of community nurses, namely district nurses and health visitors employed within the UK National Health Service (NHS), it is hoped that the points raised are applicable to other members of the primary health care team as well as community and primary care nurses working in other countries.

Many questions that relate to community nursing practice have already been addressed by researchers and a brief reference to some of this work is included in the paper. However this does not mean that there is no longer a need to pursue such questions. Political, organizational, social and demographic change involves constant adaptation on the part of healthcare professionals and the impact on their work and the care they can offer should be kept under constant scrutiny. This paper makes reference to some of the challenges posed by developing research questions in a context of change and goes on to argue that a focus on the effectiveness of care provides a key source of questions. The important contribution to 'effectiveness' of practitioner knowledge and interpersonal skills is emphasized and evidence is drawn from a

Address for correspondence: Jean McIntosh, Glasgow Caledonian University, UK. Email: J.McIntosh@gcal.ac.uk

10.1191/1463423603pc142oa

number of current research studies with which the author has been involved.

Current and future influences on practice – the challenge of change

Over the last 15 years there has been an unprecedented degree of political influence over the NHS with successive governments initiating organisational, managerial and economic reforms. Walby and colleagues have even referred to the British health service as a laboratory of experimentation in changing work patterns (Walby *et al*., 1994). In Primary Care the reforms over the last ten years that have arguably had most recent impact include the GP contract of 1990 with its emphasis on health promotion and disease prevention programmes, GP fundholding, together with the introduction of market principles, and the move to Primary Care Groups and Trusts in England and Local Health Care Co-operatives in Scotland. All this has taken place against a backdrop of a reduction in acute hospital beds and an increase in Day Surgery which both pose a potential additional burden on Primary Care (Baggott, 1998; Goodman, 1998).

A number of writers have commented on such influences on community nursing. Fifteen years ago Ross identified that district nursing was shaped by social, political and economic forces (Ross, 1987: 132). She highlighted demographic change, government emphasis on community care and the failure to redistribute resources from hospital to community among other factors as posing particular pressures. More recently, Latimer and Ashburner (1997) have also identified a number of key reasons for the unrelenting pressure to change in Primary Care and issue a plea for nurses to find ways to exert more influence in the primary care arena. In a critical assessment of the impact of changes in primary care, Sibbald (2000) argues that as a consequence of fundholding, GPs acquired more control over the development of primary care nursing than nurses themselves. This argument is also supported by Williams and others who conclude that such factors as these, together with the role of doctors, the decline in the number of GPs and the expansion of nurse-led services are powerful determinants of the shape of nursing and nursing services (Williams, 2000; Chapple *et al*., 2000; Gardner, 1998a; 1998b).

Underpinning these politically driven changes is of course the vexed question of the funding of the health service and the government's need to pursue cost containment (Baggott, 1998). Nursing salaries account for such a high proportion of the revenue spending that the pressure to expand the workforce by means of skill dilution is considerable. As Klein (2001) has argued, there is also a concern to find ways of lessening the burden of ill health and hence the focus on health promotion and the confident expectation that nurses and especially health visitors will act as the 'front line troops' in the battle to promote healthier lifestyles. It is now acknowledged that the burden of ill health is borne disproportionately by those living in deprived circumstances. As a consequence policy documents now promote the idea that working in ways that promote social inclusion should form part of professional practice (Ranade, 1997; Department of Health, 1999; Scottish Executive Health Department, 2001).

It can therefore be argued that community nursing has partial perhaps even minimal control over its sphere of activity. Working boundaries are shifting, demand for care in the home is expanding, the use of technology is increasing and there are expectations that practice should be modified to include health promotion and socially inclusive approaches. However it has to be acknowledged that none of this is new. The boundaries of work, together with its nature and pace have been changing inexorably for decades. What appears to be different now is that the frequency and scale of change has increased and there is less time for practitioners to adapt their practice. But if these changes are as influential as many writers say they are, what research questions should be posed about practice?

The overarching questions that should be addressed are whether and in what ways these changes pose any threat to the safety of patients and clients, to the quality of their care and to the capacity of the service to meet health care needs? Although these are very important questions, there are a number of difficulties in developing research programmes designed to answer them. First of all there would be considerable challenges associated with ascribing the quality of care or the level of unmet need to one or more of the policy or service changes that are outlined above. The precise influence of such changes on the quality of care could

https://doi.org/10.1191/1463423603pc142oa Published online by Cambridge University Press

be hard to identify because of local variations in the workforce, local variations in social services and voluntary provision and the tradition of adaptability and flexibility common among community nurses and other members of the primary health care team.

The fact that the influence of change is so difficult to assess is of considerable benefit to politicians. The British NHS may indeed be a laboratory of experimentation but the rules of laboratory science with valid and reliable tests and controlled trials cannot be applied. The need to justify policy change on the basis of evidence can be conveniently sidestepped. But identifying the link between politically driven change and the quality of care must concern the professional and academic community because nurses and other health care professionals are accountable to the general public for their practice. What is required is a better understanding of variations in practice and the impact of such variation on patients and clients. While it is acknowledged that differences may arise from necessary adaptation to circumstances and local provision, it is also essential to recognize that variations may arise as a result of prioritising, or resource constraints or changes in the way a service is delivered.

The quality of care

The issue of the quality of care is central to any questions that focus on variation in practice. However the first point to acknowledge is that quality has many facets. Ranade (1997) reminds us that the concept of quality comprises appropriateness, equity, accessibility, effectiveness, acceptability and efficiency. However she points out that some of these are incompatible. For example efficiency may not go hand in hand with acceptability. So how should questions about the quality of the community nursing services be framed? It could be argued that the issue of effectiveness should form the foundation for research questions because what works well for the patient is arguably central to care. To begin with it is important to consider what progress has been made in understanding the effectiveness of community nursing practice.

The types of questions that have been posed in community nursing research have all been important but have not often addressed the effectiveness of many aspects of practice. In district nursing for example, a considerable body of research over a number of years has been devoted to analysing roles, teamwork, skill mix and the impact of new services (Hockey, 1966; McIntosh and Dingwall, 1975; Jenkins-Clarke *et al*., 1998; Chapple *et al*., 2000). These approaches consider important questions but tell us little about practice at the level of individual patient care and how particular approaches are or are not effective. In health visiting, Kendall (1999) has argued that many of the early studies of practice were descriptive in nature and failed to illuminate the relationship between practice and outcome. However in some aspects of patient and client care our understanding of effective interventions has undergone considerable development. For example, in district nursing, there is now a body of sound evidence on the management of venous ulcers (Nelson, 1995; Royal College of Nursing *et al*., 1998). In health visiting there is also evidence of the effectiveness of interventions with mothers and young children (Elkan *et al*., 2000). Unfortunately, however, it cannot be assumed that community nursing practice across the country is consistently based on this evidence.

While the research evidence on the management of venous leg ulcers is considerable, in 1997, the NHS Centre for Reviews and Dissemination published a report which identified that there was widespread variation in practice and evidence of unnecessary suffering and costs due to inadequate management of venous ulcers in the community (NHS, 1997). Two years later in 1999, the Audit Commission published the results of its national review undertaken in England and Wales. This work focused on a number of aspects of practice and service delivery (Audit Commission, 1999). As far as clinical practice was concerned, the researchers investigated two tracker conditions, venous leg ulcers and incontinence. The Commission studied documentation and found that the quality of patient assessment in both areas did not meet available guidelines. The report acknowledges that poor documentation does not necessarily mean poor care but did note that the recorded frequency of change of compression bandages was not in accord with recommendations. This suggests that in this instance variation in practice means that the effectiveness of care and patient safety is being compromised. It is hard to escape the conclusion

https://doi.org/10.1191/1463423603pc142oa Published online by Cambridge University Press

that if there is this level of variation in a clinical procedure that has attracted much research attention, then there will be variation in other areas of care that remain relatively under or poorly researched. It is interesting to note that Kenrick and Luker's 1995 textbook on clinical district nursing practice was produced precisely because the evidence base for the most common nursing procedures had not been previously brought together (Kenrick and Luker, 1995).

It is therefore essential to explore variation in practice more vigorously, whatever the reason for variation. If variation occurs in response to different family, geographical or socio-economic contexts or in response to individual patient differences then it can be inferred that community nurses are testing out and confirming the value of different approaches to care because they are differentially effective under different conditions. This process of testing out and confirming of effectiveness may indicate that community nurses are learning experientially or employing necessary adaptations to suit varying circumstances. These processes need to be made more explicit. They need to be shared, debated and systematically tested. The same applies to variations in practice that arise from resource constraints or organisational change. However an equally important focus for attention ought to be where variation in practice stems from a lack of awareness of effective approaches to care, or difficulty in gathering, appraising or synthesising evidence in a usable way or indeed an absolute lack of evidence on which to base care. In response to these situations research questions should be asked regarding how to develop the evidence base for practice, how best to disseminate it through education and continuing professional development.

It has to be acknowledged of course that the term 'evidence base' is contentious and several researchers in this field have put forward cogent arguments testifying to the problematic nature of evidence (Kendall, 1999). As Closs and Cheater (1999) have pointed out, critics of the evidence-based movement have argued that it undervalues professional judgment and ignores patient preferences. There may also be dangers in using so called evidence based guidelines as Appleton (1997) has shown in her investigation of guidelines for identifying and prioritising families requiring extra health visiting support. However it is clear that there is an increasing number of clinical procedures that are evidence based and that the use of such evidence would benefit patients and clients if consistently used. But it is also the case that clinical procedures cannot be divorced from the other aspects of patient care and the all important relationship between nurse and patient that is, as Robinson has said, a key variable in the achievement of a client centred approach (Robinson, 1998: 102). Closs and Cheater sum it up well when they say 'evidence-based practice is not simply a pragmatic, logical process, involving access to and the subsequent use of, best research evidence. There is an interplay of multiple factors that influence decisions about patient care; an amalgamation of evidence, context, expert practice/experience and patient's preferences' (Closs and Cheater, 1999: 15). This suggests that effective practice depends on much more than the available evidence. It depends also on a broad range of different types of professional knowledge. Therefore in seeking an understanding of variation in practice we need to look beyond the evidence base for practice and focus on the knowledge base for practice, with the caveat that much knowledge is provisional and to some extent culturally and contextually bound.

Practitioners' knowledge and skills

Currently there are a number of resources to guide the delivery of health and nursing care. For example clinical guidelines for practice, clinical protocols, clinical standards and best practice statements (NHS National Institute for Clinical Excellence, 2001; The Nursing and Midwifery Practice Development Unit, 2002). It is therefore relatively straightforward to establish how to undertake those clinical procedures for which a knowledge of basic sciences is required. However caring involves much more than the performance of clinical procedures and community nurses' knowledge base depends substantially upon the social sciences, predominantly sociology and psychology. It is from these disciplines that theories pertaining to society, communities and the individual are drawn. But how do these theories inform practice? Many of them undergo modification and refinement over time. Sometimes they are refuted and therefore can be regarded as only provisional. They can offer an understanding to support practice but do not necessarily provide a template for action.

https://doi.org/10.1191/1463423603pc142oa Published online by Cambridge University Press

The problem is that community nurses have to internalize the messages from these theories and then find ways to shape practice accordingly. For example in learning how to care for a patient with an ulcerated leg, district nurses may have considered theories of compliance and concordance; theories of adult learning and research evidence about the association between capacity to learn and stress or illness. But these theories and evidence have to be synthesised and used in different contexts with patients who range from the scrupulous follower of a nurse's advice to those who adjust bandages or dressing because of pain, discomfort or for other reasons. So while the knowledge base for the application of a compression bandage is more or less unequivocal, the knowledge base for engaging patients' co-operation and trust and offering information is diffuse in terms of its theoretical sources. These sources will not be specific to this group of patients and their situations and the theories themselves may be in a state of evolution. Nevertheless 'knowing how' to give this holistic care to patients is central to achieving effective practice. This 'know how' is sometimes referred to as procedural knowledge and in many domains of community nursing is gained experientially (Bryans, 1998).

In situations where there are no exact templates for action, procedural knowledge can only develop through trial and error or experiential learning (Schön, 1983). However it is essential to adopt a critical stance towards experiential learning because there are few areas in which it has been tested. It is therefore not known whether the theoretical understandings that inform practice are being translated in an effective way. This has important implications for the research questions that we should ask about practice and an example of the insights that can be gained is demonstrated in Bryans' (1998) doctoral work.

Bryans used video-taped simulation and interview to explore the assessment practice of district nurses (Bryans, 1998, Bryans, 2000). Assessment of course depends crucially on interpersonal skills which are developed largely through experiential learning. In her study Bryans identified two clear approaches to the process of assessment, a patient-focused approach and a nurse-agenda led approach. The patient-focused approach was characterised by a sense of collaboration and reciprocity, an acknowledgement of patient feelings, advice that was specific for the patient, rather than generalised and a careful checking of the judgments that the nurse made. It was found that patients responded to this style of assessment by asking questions, volunteering information and responding positively to the nurses' suggestions, advice and information.

In contrast, the nurse-agenda led approach to assessment was characterized by a nurse-question, patient-response style of communication with a less collaborative tone. Patients' feelings were not explicitly acknowledged, advice and information given to the patient was generalized rather than patient specific and the nurse alone decided on the nature of the patient's needs and the care to be offered. Patients responded by being less open and positive, sometimes even rejecting advice. Bryans concludes that these findings are of particular interest with regard to the procedural knowledge used in assessment. In particular it can be seen that if patient needs are only partially identified then nursing judgments about need may be flawed and there are major consequences for the plan and therefore the effectiveness of nursing care that follows.

Other researchers have identified similar results. For example Kendall showed in a study of health visitor-client interaction that there was 'little convergence between the health visitor and client agenda with limited opportunity for mothers to participate in the discussion' (Kendall, 1999: 34). In addition, Besner working in Canada demonstrated that her sample of public health nurses visiting postpartum mothers focused on the provision of information, that the clients were passive recipients of this information, that actions were problem focused rather than client-centred and that plans of action were standardized rather than tailored. Despite this there was a high level of client satisfaction with the service (Besner, 2000).

The findings from these studies demonstrate how important it is to develop a better understanding of the intricacies of the interpersonal skills used by community nurses and the way in which relationships between nurses and patients or clients are developed and sustained. It is also important to consider the potential for theories drawn from a number of other disciplines to inform the nature and content of nurse patient communication. These points apply equally to other members of the primary health care team.

The importance of focusing on interaction and the development of relationships has been

https://doi.org/10.1191/1463423603pc142oa Published online by Cambridge University Press

emphasized in a number of recent doctoral studies. For example Holloway (2000) used Bandura's theories incorporated into a minimal intervention with patients identified as problem drinkers (Bandura, 1991). This minimal intervention only took 15 minutes and Holloway demonstrated the effectiveness of this approach within her study. Secondly Worth's (1999) doctoral work on comparing district nursing and social work assessment identifies many of the interactional challenges faced by practitioners. For example she states that 'Observed assessments and interview data suggested that the balancing of an older person's need for space, privacy and self-determination with the need for a professional response to identified risk forms a perpetual dilemma for practitioners in the conduct of assessment. The tendency to be over-protective in minimising risk is perceived as a feature of inexperienced practice; practitioners learn to live with an acceptable degree of risk' (Worth, 1999: 119). Finally the doctoral work of Atkinson (2000) on single homeless men offers a valuable insight into the knowledge and skills required for effective practice in a socially excluded group. The study demonstrated the need for the district nurse to develop different strategies to engage with the men in order to gain their trust, identify both physical and psychiatric illness and offer appropriate care or referral. The level of unmet need uncovered during the course of the study clearly demonstrated the value of the role of proactive generalist using particular methods of communication.

In addition to the focus on practice at the level of the individual patient or client, it is also important to consider practice at a wider level. Little is known about the effectiveness of practice at the level of the team, the practice population or the entire community. So as working boundaries shift and roles are re-defined, how is the effectiveness of need identification and care giving affected across different groups of patients and clients? Is there a risk that whole groups of individuals, such as the frail elderly, or certain groups of mothers will receive sub-optimal care because they are visited or seen predominantly by nursing auxiliaries or health care assistants or invited to have their child and maternal health checks in a busy clinic environment? These are uncomfortable questions but they need to be asked.

In considering practice at this level the reference to whole groups of individuals means that we are confronting questions about appropriateness and equity. But are questions in this arena about practice or are they about service delivery? It could be argued that as 'practice' constitutes the day to day actions and decisions that are undertaken on the basis of expert knowledge, then this must include the management of the team, delegation, supervision of junior and untrained colleagues, and the overall balance of the caseload. How should research questions be framed to account for these wider consequences within practice?

The key activities of delegation and supervision of the practice of junior colleagues are undertaken in the UK by community nurses who are qualified as registered nurses and who possess a specialist community qualification. They delegate work to, and supervise the practice of, members of the nursing team who range from staff nurses with registration as a nurse to health care assistants or nursing auxiliaries. The latter group has no formal nursing qualification and varies in terms of educational preparation, with some members gaining national vocational qualification while others have only a short in-service preparation. Given this range of educational preparation for practice, delegation and supervision are fundamental to ensuring that quality of care is achieved by the whole team. Yet these aspects of practice have received relatively little research attention.

In a recent study of district nursing teams, it was possible to identify the supervision strategies that community nurses use to ensure that team members give safe patient care that is of an acceptable standard (McIntosh *et al*., 2000). The importance of the skills involved in assessing the competencies of junior and unqualified colleagues cannot be over-estimated. The knowledge and skill base of nursing auxiliaries is growing with the expansion of training opportunities, their own experiential learning and the allocation of a wider remit (McIntosh *et al*., 2000). However researchers in the field of psychology have demonstrated that the degree and level of experiential learning depends substantially on the motivation to self evaluate and this in turn depends on a critical body of knowledge (McIntosh *et al*., 1999). This suggests that there are limits to the capacity of some individuals to learn experientially in a way that is consonant with effective care and patient safety. Assessing and supervising colleagues is therefore a complex task and we need to ask questions about the nature

of the skills involved and whether current practice in this area is achieving effective care.

Using research in practice

This paper has made only passing reference to the challenges involved in interpreting research and using it in practice. It is acknowledged that the issue of research utilization will generate a wide range of research questions. Many other writers have written eloquently and at length on this subject and it is not the intention here to repeat their arguments (Kenrick and Luker, 1996; Bryar, 1999). What should be emphasized though is the importance of continuing to pose questions about research utilisation. This paper has emphasised the importance of questions that we need to address in developing interpersonal skills. It has been argued that these questions need to be pursued in such a way as to incorporate existing theories relevant to caring for patients and clients, together with accumulated practice wisdom derived from experiential learning. If these questions become the subject of research investigations then it has to be acknowledged that the implementation of findings from such investigations will present us with some interesting challenges and a range of further questions. For example what is the best way to demonstrate the shortcomings of a nurse agenda-led assessment approach to a practitioner who uses it? What strategies of practice development can be used to promote such a fundamental change in understanding and communication style? Sensitive approaches to change management and education will require to be planned, tested and evaluated.

Conclusions

In this paper there has been only brief mention of those aspects of community nursing practice that exemplify the 'hands-on' activity such as compression bandaging or care of pressure areas. The majority of these aspects of practice require knowledge of basic sciences such as anatomy, physiology, or pharmacology in order to give care safely. Insofar as knowledge in any of these fields is advancing, then there will be scope for asking questions about practice. What is of equal importance though is to ask questions about nurse-patient communication, the theories that underpin it, what knowledge has been gleaned experientially and what role these factors play in achieving effective practice. The same plea could be made for all other members of the primary health care team.

In parallel, a range of questions about team working, delegation, and supervision need to be addressed. This paper has argued that these questions could be pursued by exploring variation in practice so that the effects of policy, context and individual differences can be identified. Pursuit of practice questions in these domains would have a number of benefits. They would add to our developing understanding of what is effective; they would help to critically appraise care based on experiential learning; they could help to extend that experiential learning by testing it; they could make some of the less visible skills of community nurses more tangible and more directly linked with patient outcomes. There is a potentially important policy dimension to this latter point. A broader more theoretically based understanding of what is effective ought to provide a stronger basis upon which community nurses can argue for the retention or extension of the boundaries of their work. This might serve to extend community nurses' control over their professional domain.

There are undoubtedly certain difficulties in pursuing the sorts of questions that this paper has identified. In the first place in depth study of practice at the individual, team and population level is methodologically challenging. In addition, while qualitative studies using innovative methods such as simulation, guided recall and non-participant observation can yield valuable insights, the merits of transferability are recognised in political and other circles much less than the merits of generalisability. Secondly there is a lack of support for nursing research in general and in particular a fairly narrow range and limited pool of available funding. Thirdly the questions are focused exclusively on the input of a single professional group at a time when researchers and practitioners are being urged to engage in partnership and multidisciplinary working. Of course there is a case for looking at the totality of patient experience and the contribution of all those who contribute to it. But this will not assist in developing an understanding of the effectiveness of community nursing practice, or build a portfolio of evidence for practice. Community Nursing contact with patients is arguably

https://doi.org/10.1191/1463423603pc142oa Published online by Cambridge University Press

more frequent, more sustained and is more holistically focused than any other group of professionals. The impact of such contact is potentially very powerful. The right to ask questions about community nursing practice as a discipline must be defended. The pursuit of such questions must be fully supported as a potential foundation for policy.

References

Appleton, J.V. 1997: Establishing the validity and reliability of clinical practice guidelines used to identify families requiring increased health visitor support. *Public Health* 111, 107–13.

Atkinson, J. 2000: *Nursing homeless men: a study of proactive intervention*. London: Whurr Publishers Ltd.

Audit Commission 1999: *First assessment. A review of district nursing services in England and Wales*. London: Audit Commission.

Baggott, R. 1998: *Health and Health Care in Britain*, 2nd edition. Basingstoke and London: Macmillan Press Ltd.

Bandura, A. 1991: Self-efficacy mechanism in physiological activation and health promoting behaviour. In Madden, J., editor, *Neurobiology of learning, emotion and affect*. Englewood Cliffs, NJ: Prentice-Hall, pp. 229–270.

Besner, J. 2000: Public health nursing: a comparison of theoretical and actual practice. *Primary Health Care Research and Development* 1, 91–102.

Bryans, A. 1998: The nature and application of professional knowledge in community nursing assessment. Unpublished PhD thesis. Glasgow Caledonian University.

Bryans, A. 2000: Providing new insight into community nursing know-how through qualitative analysis of multiple sets of simulation data. *Primary Health Care Research and Development* 1, 79–89.

Bryar, R.M. 1999: Using research in community nursing. In McIntosh, J., editor, *Research issues in community nursing*. Basingstoke: Macmillan Press Ltd, pp. 6–28.

Chapple, A., Rogers, A., Macdonald, W. and **Sergison, M.** 2000: Patients' perceptions of changing professional boundaries and the future of 'nurse-led' services. *Primary Health Care Research and Development* 1, 51–59.

Closs, S.J. and **Cheater, F.M.** 1999: Evidence for nursing practice: a clarification of the issues. *Journal of Advanced Nursing* 30, 10–17.

Department of Health 1999: Saving Lives Our Healthier Nation. Cm 4386. London, Stationery Office.

Elkan, R., Robinson, J.J.A., Blair, M., Williams, D. and **Brummell, K.** 2000: The effectiveness of health services: the case of health visiting. *Health and Social Care in the Community* 8, 70–8.

Gardner, L. 1998a: Nurse-led primary care Act pilot schemes: threat or opportunity? *Nursing Times* 94, 52–3.

Gardner, L. 1998b: Does nurse-led care mean second-class care? *Nursing Times* 94, 50–1.

Goodman, C. 1998: The purchasing and provision of district nursing in GP fundholding settings: a case study. Unpublished PhD thesis, University of Hertfordshire.

Hockey, L. 1966: Feeling the pulse: a study of district nursing in six areas. London, The Queen's Nursing Institute.

Holloway, A. 2000: An evaluation of self-efficacy and minimal intervention for potential problem drinkers in a general hospital setting. Unpublished PhD thesis. Glasgow Caledonian University.

Jenkins-Clarke, S. Carr-Hill, R. and **Dixon, P.** 1998: Teams and seams: skill mix in primary care. *Journal of Advanced Nursing* 28, 1120–6.

Kendall, S. 1999: Evidence-based health visiting – the utilisation of research for effective practice. In McIntosh, J., editor, *Research issues in community nursing*. Basingstoke: Macmillan Press Ltd, pp. 29–52.

Kenrick, M. and **Luker, K.A.** Eds. 1995: Clinical nursing practice in the community. Oxford: Blackwell Science.

Kenrick, M. and **Luker, K.A.** 1996: An exploration of the influence of managerial factors on research utilisation in district nursing. *Journal of Advanced Nursing* 23, 697–704.

Klein, R. 2001: *The new politics of the NHS*, 4th edition. Harlow: Prentice-Hall.

Latimer, J. and **Ashburner, L.** 1997: Primary care nursing: how can nurses influence its development? *NTresearch* 2, 258–67.

McIntosh, J., Lugton, J., Moriarty, D. and **Carney, O.** 1999: Exploring district nursing skills through research. In McIntosh, J., *Research Issues in Community Nursing*. Basingstoke: Macmillan Press Ltd, pp. 70–91.

McIntosh, J., Moriarty, D., Lugton, J. and **Carney, O.** 2000: Evolutionary change in the use of skills within the district nursing team: a study in two Health Board areas in Scotland. *Journal of Advanced Nursing* 32, 783–90.

McIntosh, J. and **Dingwall, R.** 1975: Teamwork in theory and practice. In Dingwall, R. and McIntosh, J., editors. *Readings in the Sociology of Nursing*. Edinburgh, Churchill Livingstone, pp. 118–34

NHS Centre for Reviews and Dissemination 1997: 'Compression therapy for venous leg ulcers. *Effective Health Care Bulletin*, 3.

NHS National Institute for Clinical Excellence 2001: Pressure ulcer risk assessment and prevention. London, National Institute for Clinical Excellence.

Nelson, E.A. 1995: Management of leg ulcers. In Kenrick, M. and Luker, K.A. editors, *Clinical nursing practice in the community*. Oxford: Blackwell Science, pp. 70–85.

Nursing and Midwifery Practice Development Unit, NHS Scotland 2002: Pressure ulcer prevention best practice statement. Edinburgh, The Nursing and Midwifery Development Unit.

Ranade, W. 1997: *A future for the NHS? Health care for the millennium*. Edinburgh: Addison Wesley Longman Ltd.

Robinson, J.J.A. 1998: The social construction through research

of health visitor domiciliary visiting. *Social Sciences in Health* 4, 90–103.

Ross, F. 1987: District nursing. In Littlewod, J., editor. *Recent advances in nursing: community nursing*. Edinburgh: Churchill Livingstone, pp. 132–60.

Royal College of Nursing Institute, Centre of Evidence-Based Nursing, University of York, School of Nursing, Midwifery and Health Visiting, University of Manchester 1998: Clinical guidelines for the management of patients with venous leg ulcers.

Scottish Executive Health Department 2001: Caring for Scotland. The strategy for nursing and midwifery in Scotland. Edinburgh, Scottish Executive.

Sibbald, B. 2000: Primary care: background and policy issues. In Williams, A., editor, *Nursing, medicine and primary care*. Buckingham: Open University Press, pp 14–41.

Schön, D. 1983: The reflective practitioner. How professionals think in action. New York: Basic Books.

Walby, S., Greenwell, J., Mackay, L. and **Soothill, K.** 1994: Medicine and nursing: Professions in a changing Health Service. London: Sage.

Williams, A. editor, 2000: *Nursing, medicine and primary care*. Buckingham: Open University Press.

Worth, A. 1999: An ethnographic study of assessent of the needs of older people by district nurses and social workers. Unpublished PhD thesis, Glasgow Caledonian University.

https://doi.org/10.1191/1463423603pc142oa Published online by Cambridge University Press