



chapter 2

Community-Based Care

KeyTERMS

community
community-based nursing
complementary and
 alternative medicine
cultural competence
cultural encounter
cultural self-awareness
cultural skill
epidemiology
home visits
outpatient clinics
primary prevention
secondary prevention
telephone consultation
 services
tertiary prevention

LearningOBJECTIVES

After studying the chapter content, the student should be able to accomplish the following:

1. Define the key terms.
2. Differentiate community-based nursing practice from acute care settings.
3. Describe nursing roles in community-based health care.
4. Explain the difference between primary, secondary, and tertiary health care and give an example of how each may be provided in the community.
5. Identify at least three barriers to cultural competence.
6. Outline strategies for integrating elements of alternative/complementary therapies and scientific health care practice.



WOW

To recognize diversity in others and respect it, we must first have some awareness of who we are.

Nursing in the United States began as **community-based nursing**. Self-trained women cared for the sick and dying, assisted women in laboring and birthing, and provided health education to those without access to it. Community-based nursing is the application of the nursing process in caring for individuals and families in **community** settings. The focus of community-based nursing is illness-oriented care of individuals and families throughout their life cycle. Its goal is to help people manage acute or chronic health conditions in community and home settings. It emphasizes all levels of prevention (i.e., primary, secondary, and tertiary), but focuses more on secondary and tertiary levels. Secondary health care typically refers to relatively serious or complicated care that has historically been provided in the acute care setting. Examples of community-based secondary care include outpatient surgery for complex procedures that would have been previously done in the hospital setting (cholecystectomy, hysterectomy, appendectomy), chemotherapy, radiotherapy, magnetic resonance imaging (MRI), and angiography. Tertiary health care encompasses the management of chronic, complicated, long-term health problems that is now delivered in the community setting. Centers for cardiac rehabilitation, home health care for bed-bound elderly people, home care for respiratory-dependent people, and hospice care for the terminally ill are a few examples of tertiary health care community settings.

Preventive health care serves people of all ages and at all levels of health. Improving access to health care means bringing health services that support a continuum of care to people where they live.

Nurses are essential in each of these community-based settings and for each level of care described. Nursing practice in the community is similar to that within the acute care setting because assessing, performing procedures, administering medications, coordinating care services and equipment, counseling patients and their families, and teaching clients and their families regarding their care are all part of the care administered by nurses in the community.

During the past several years, the health care delivery system has changed dramatically. The health care business is focused on controlling costs, sometimes at the expense of patient care. To control costs, people are spending less time in the hospital. Patients are being discharged “sicker and quicker” from their hospital beds. The health care system has moved from reactive treatment strategies in hospitals to a proactive approach in the community. This has resulted in an increasing emphasis on health promotion and illness prevention within the community.

Concepts of Community

Because community-based nursing care is part of the continuum of health care services, it is important for nurses to understand the concepts of community. Often community is defined as a collection of people sharing common characteristics, interests, needs, resources, and environments that interact with one another. The common features of a community may be common rights and privileges as members of a designated city or common ties of identity, values, norms, culture, language, or social support. Women are caregivers to children, parents, spouses, and neighbors, and provide important social support in these roles. A person can be a part of many communities during the course of daily life. Examples would be area of residence (home, apartment, shelter), gender, place of employment (organization or home), language spoken (Spanish, Chinese, English), educational background or college student status, culture (Italian, African-American, Indian), career (nurse, business woman, housewife), place of worship (church or synagogue), and community memberships (Women’s Garden Club, YMCA, Women’s Support Group, school PTA). In community-based nursing, the community is the unit of service. In community-based settings, the providers of care are concerned not only with the clients who present themselves for service, but also with the larger population of potential or at-risk clients.

Community-Based Nursing

The health needs of society and consumer demand brought about community-based and community-focused services. The movement from an illness-oriented “cure” perspective in hospitals to a focus on health promotion and primary health care in community-based settings has dramatically changed employment opportunities for today’s nurses. This shift to emphasizing primary care, and outpatient treatment and management will very likely continue. As a result, employment growth in a variety of community-based settings can be expected for properly trained nurses.

The 2000 National Sample Survey of Registered Nurses (USDHHS/DON 2001) found the following trends in registered nurse (RN) employment settings:

- The percent of RNs working outside the hospital setting is 40.1%.
- RNs employed in community-based settings showed a 36% increase between 1992 and 2000, which was largely the result of an increase in nurses working in home health care and managed care organizations.

Community-based settings include ambulatory care, home health care, occupational health, school health, and hospice settings (Table 2-1). Clinical practice within the community may also include case management, research, quality improvement, and discharge planning. Nurses with advanced practice and experience may be employed in areas of staff development, program development, and community education.

Nurses must be educationally and experientially prepared to provide care in very diverse settings. The goals of Healthy People 2010 to increase quality and years of healthy life and to eliminate health disparities are attainable through community-based health care activities and interventions. The focus of health initiatives today shifts the emphasis of health care to the people themselves and their needs, reinforcing and strengthening their capacity to shape their own lives. This shift of emphasis away from dependence on health professionals toward personal involvement and patient responsibility gives nurses the opportunity to interact with individuals in a variety of self-help roles.

Table 2-1 Community-Based Practice Settings

Setting	Description
Ambulatory care settings	<ul style="list-style-type: none"> Doctor's offices Health maintenance organizations (HMOs) Day surgery centers Freestanding urgent care centers Family planning clinics Mobile mammography centers
Home health care services	<ul style="list-style-type: none"> High-risk pregnancy/neonate care Maternal/child newborn care Skilled nursing care Hospice care
Health Department services	<ul style="list-style-type: none"> Maternal/child health clinics Family planning clinics Sexually transmitted infection programs Immunization clinics Substance abuse programs Jails and prisons
Long-term care	<ul style="list-style-type: none"> Skilled nursing facilities Nursing homes Hospices Assisted living
Other community-based settings	<ul style="list-style-type: none"> Parish nursing programs Summer camps Childbirth education programs School health programs Occupational health programs

Nurses in the community-based arena are well positioned to be the primary force in identifying the challenges and implementing changes in women's health for the future.

Community-Based Nursing Roles

Many nurses find the shift from acute care to community settings a challenge. However, nurses working in community-based settings share many of the same roles and responsibilities as their colleagues in acute care settings. For example, nursing assessment and interventions are practiced in a variety of community settings. As nurses build their experiences in community-based settings, they will also develop their roles in case management, patient education, collaborative practice, counseling, research, and advocacy for individuals and families. See Table 2-2 for examples of these roles. The nurse who implements these roles in the community demonstrates a caring and comprehensive client-centered nursing practice.

Community-Based Nursing Interventions

Nursing interventions involve any treatment that the nurse performs to enhance the client's outcome. Although certain nursing interventions are universal in most settings, the ones described in Box 2-1 are particularly prevalent in community-based practice.

Community-Based Nursing Challenges

Despite the positive benefits achieved by caring for families within their own home environments and community, challenges also exist. Clients are being discharged from acute care facilities very early in their recovery course and present with more health care needs than in the past. As a result, nursing care and procedures in the home and community are more complex and time-consuming for the nurse. An example of this would be a high-risk woman discharged from the hospital after childbirth by cesarean with a systemic infection, pelvic abscesses, deep vein thrombosis in her leg, and anorexia. The home health nurse would be making **home visits** to administer heparin and antibiotics intravenously rather than to spend time educating her about child care and follow-up appointments. In the past, this woman would have remained hospitalized for this therapy, but home infusion therapy is now cheaper and allows the client to be discharged sooner.

This demand on the nurse's time may limit the amount of time spent on prevention measures, education, and addressing the family's psychosocial issues. Families may need more time with the nurse to meet all their issues and concerns. With large client caseloads, nurses may feel stretched to spend the time needed and still meet the time restrictions dictated by their health care agencies. To maximize a home care visit, the nurse should plan the tasks to be accomplished (Box 2-2).

Table 2-2 Community-Based Nursing Roles

Role	Example
Direct care provider	Involves the direct delivery of care including client assessment, taking vital signs, medication administration, and changing dressings—for example, a nurse working in an OB/GYN office practice completing prenatal assessment of pregnant client
Educator	Teaches individuals, families, and groups about health maintenance, threats to health, and relevant lifestyle choices that impact health—for example, a home health nurse instructing parents how to care for their high-risk newborn after discharge
Case manager	Coordinates support services for the elderly, assists with insurance issues, arranges transportation for the disabled, and coordinates home visits to high-risk pregnant clients—for example, a home health nurse coordinating home care with several community services
Collaborator	Works with family, teachers, physicians, and social workers for clients with complex or chronic health problems to deliver the most comprehensive, effective, cost-conscious care—for example, a community health nurse partnering with various disciplines to bring care to a preterm infant with multiple health care needs
Advocate	Acts on behalf of the client to ensure they receive necessary care and services—for example, a clinic nurse advocating on behalf of a substance-abusing pregnant woman to receive appropriate treatment for her addiction
Counselor	Assists clients to use problem-solving techniques to decide on the most appropriate course of action for them by listening objectively, clarifying, and offering guidance—for example, a nurse working with couples in a genetic counseling clinic
Researcher	Shares current research findings with new mothers—for example, a school nurse working in community education who shares research findings about the importance of vaccinations for public health in the local high school teenage pregnancy program

BOX 2-1

COMMUNITY-BASED NURSING INTERVENTIONS

- *Health screening*—detects unrecognized or preclinical illness among individuals so they can be referred for definitive diagnosis and treatment (e.g., mammogram or Pap smear)
- *Health education programs*—assisting clients in making health-related decisions about self-care, use of health resources, and societal health issues such as smoking bans and motorcycle helmet laws (e.g., childbirth education or breast self-examination)
- *Medication administration*—preparing, giving, and evaluating the effectiveness of prescription and over-the-counter drugs (e.g., hormone replacement therapy in menopausal women)
- *Telephone consultation*—identifying the problem to be addressed; listening and providing support, information, or instruction; documenting advice/instructions given to concerns raised by caller (e.g., consultation for a new mother with a newborn with colic)
- *Health system referral*—facilitating the location, services offered, and telephone number for contacting that agency (e.g., referring a woman for breast prosthesis after a mastectomy)
- *Instructional*—teaching an individual or a group about a medication, disease process, lifestyle changes, community resources, or latest research findings concerning their environment (e.g., childbirth education class)
- *Nutritional counseling*—demonstrating the direct relationship between nutrition and illness while focusing on need for diet modification to promote wellness (e.g., Women, Infants, and Children [WIC], counselor interviewing an anemic pregnant client)
- *Risk identification*—recognize personal or group characteristics that predispose one to develop a specific health problem and modify or eliminate them (McCloskey & Bulechek, 2000; e.g., genetic counseling of 42-year-old pregnant woman at risk for a Down syndrome infant)

BOX 2-2

HOME CARE VISITATION PLANNING

- Review previous interventions to eliminate unsuccessful ones.
 - Check previous home visit narrative to validate interventions.
 - Communicate with previous nurse to ask questions and clarify.
 - Formulate plan of interventions based on data received (e.g., client preference of intravenous (IV) placement or order of fluids).
- Prioritize client needs based on their potential to threaten the client's health status.
 - Use Maslow's hierarchy of needs to set forth a plan of care.
 - Address life-threatening physiologic issues first (e.g., an infectious process would take precedence over anorexia).
- Develop goals that reflect primary, secondary, and tertiary prevention levels.
 - *Primary prevention*—Have the patient consume adequate fluid intake to prevent dehydration.
 - *Secondary prevention*—Administer drug therapy as prescribed to contain and treat an existing infectious process.
 - *Tertiary prevention*—Instruct the client on good hand-washing technique to prevent spread and future secondary infections.
- Bear in mind the client's readiness to accept intervention and education.
 - Ascertain the client's focus and how they see their needs.
 - Address minor client issues that might interfere with intervention (e.g., if the client is in pain, attempting to teach her about her care will be lost; her pain must be addressed first before she is ready to learn).
- Consider the timing of the visit to prevent interfering with other client activities.
 - Preschedule all visits at convenient times per client if possible.
 - Reschedule a home visit if a client event comes up suddenly (e.g., if the client has a favorite soap opera to watch, attempt to schedule around that event if at all possible).
- Outline nursing activities to be completed during the scheduled visit.
 - Know the health care agency's policy and procedures for home visits.
 - Consider the time line and other visits scheduled that day.
 - Research evidence-based best practices to use in the home (e.g., if the client is fatigued, be able to be flexible to accommodate her needs and allow for periods of rest so that she may conserve her energy).
- Obtain necessary materials/supplies before making the visit.
 - Assemble all equipment needed for any procedure in advance.
 - Secure any equipment that might be needed if a problem occurs (e.g., bring additional IV tubing and a catheter to make sure the procedure can be carried out without delay).
- Determine criteria to be used to evaluate the effectiveness of the home visit.
 - Revisit outcome goals to determine the effectiveness of the intervention.
 - Assess the client's health status to validate improvement.
 - Monitor changes in the client's behavior toward health promotion activities and disease prevention (e.g., verify/observe that the client demonstrates correct hand-washing technique after instruction and reinforcement during the home care visit).

Nurses making home care and community visits have fewer resources available to them when compared with the acute care setting. Intervention decisions have to be made in isolation at times. The nurse must possess excellent assessment skills and the ability to communicate effectively with the family to be successful in carrying out the appropriate plan of care needed.

Nurses interested in working in community-based settings must be able to apply the nursing process in a less structured or controlled environment compared with the hospital. Nurses must be able to assimilate information well beyond the immediate physical and psychosocial needs of the client in a controlled acute care setting, and deal with environmental threats, lifestyle choices, family issues, different cultural patterns, financial burdens, transportation problems, employment hazards, communication barriers, limited resources, and client acceptance and compliance.

Although opportunities for employment in community-based settings are plentiful, a baccalaureate degree may be required for many positions. Many public health departments will hire only nurses with a bachelor of science in nursing (BSN) degree. Previous medical/surgical experience in an acute care setting is typically sought by home health agencies before hiring a nurse, because they must function fairly independently within the home environment.

The nurse must also be familiar with and respectful of many different cultures and socioeconomic levels when visiting clients in their homes. The nurse must remain objective in dealing with such diversity and demonstrate an understanding and appreciation for cultural differences. Home-based interventions must be individualized to address the cultural, social, and economic diversity among clients within their own environment (Littleton & Engebretson, 2005).

Community-Based Nursing Care for Women and Infants

A woman's reproductive years span half her lifetime, on average. This is not a static period, but rather one that encompasses several significant stages. As her reproductive goals change, so do a woman's health care needs. Because of these changing needs, comprehensive community-centered care is critical. These services should include

- Contraceptive services
- Abortion services
- Infertility services
- Screening for sexually transmitted infections and cancer of the reproductive system
- Preconceptional risk assessment and care
- Maternity care (including prenatal, birth, and postpartum/newborn care)

Prenatal Care

Early, adequate prenatal care has long been associated with improved pregnancy outcomes (March of Dimes, 2005). Adequate prenatal care is a comprehensive process in which problems associated with pregnancy are identified and treated. Basic components of prenatal care are early and continuing risk assessment, health promotion and medical and psychosocial interventions, and follow-

up. Within the community setting, several services are available to provide health care for pregnant women. These are highlighted in Box 2-3.

Although many families living in affluent neighborhoods have access to private prenatal care, some are unaware of the various community resources available to them within their communities. Most public health services are available for consultation, local hospitals have "hot-lines" for questions, and public libraries have pregnancy-related resources as well as Internet access. Nurses can be a very helpful "link" between needs and resources for all women regardless of their economic status.

Technologically advanced care for high-risk pregnancies has proved to improve maternal child outcomes. Between 1980 and 2000, the LBW infant mortality rate declined from 694 per 1000 to 422 per 1000, and by 2000 declined to approximately 250 per 1000 live births (Iyasu et al., 2002). Widespread use of better high-technology care has been credited with this decline. The idea of regionalized high-risk care was promulgated by the American Academy of Pediatrics in the late 1970s. The goal was to promote uniformity nationwide, covering the prenatal care of high-risk pregnancies and high-risk newborns. Advanced technology found in level III perinatal regional centers along with community-based prenatal surveillance programs has resulted in better risk-adjusted mortality rates (Mackey & Alexander, 2003; Schwartz et

BOX 2-3

MATERNAL AND INFANT COMMUNITY HEALTH CARE SERVICES

- State public health prenatal clinics provide access to care based on a sliding scale payment schedule or have services paid for by Medicaid.
- Federally funded community clinics typically offer a variety of services, which may include prenatal, pediatric, adult health, and dental services. A sliding scale payment schedule or Medicaid may cover costs.
- Hospital outpatient health care services offer maternal-child health services. Frequently they are associated with a teaching hospital in which medical school students, interns, and OB/GYN residents rotate through the clinic services to care for patients during their education process.
- Private OB/GYN offices are available for women with health insurance seeking care during their pregnancies. Some physicians in private practice will accept Medicaid patients as well as private patients.
- Community free clinics offer maternal-child services in some communities for women with limited economic resources (homeless, unemployed).
- Freestanding birth centers offer prenatal care for low-risk mothers as well as childbirth classes to educate couples regarding the birthing process. Most centers accept private insurance and Medicaid for reimbursement services.
- Midwifery services are available in many communities where midwives provide women's health services. They usually accept a multitude of payment plans from private pay to health insurance to Medicaid for reimbursement purposes.
- WIC provides food, nutrition counseling, and access to health services for low-income women, infants, and children. WIC is a federally funded program and is administered by each state. All persons receiving Aid to Families with Dependent Children (AFDC), food stamps, or Medicaid are automatically eligible for WIC. An estimated 45% of the infants born in the United States are served by WIC (USDA Food and Nutrition Service, 2004; Fig. 2-1).
- Childbirth classes offer pregnant women and their partners a series of educational classes on childbirth preparation. Women attend them during their last trimester of pregnancy. Some classes are free and some have a fee.
- Local La Leche League groups provide mother-to-mother support for breast-feeding, nutrition, and infant care problem-solving strategies. All women who have an interest in breast-feeding are welcome to participate in the meetings, which are typically held in the home of a La Leche member.



● **Figure 2-1** A trained registered nurse screens a pregnant woman at a WIC clinic. If the woman meets income and nutritional eligibility requirements, she may receive vouchers to purchase nutritious foods. (Photo by Joe Mitchell.)

al., 2000). For example, fetal monitoring and ultrasound technology have traditionally been used within acute care settings to monitor the progress of many high-risk pregnancies. However, with the increased cost of hospital stays, many services were moved to outpatient facilities and into the home. The intent was to reduce health care costs and to monitor women with complications of pregnancy in the home rather than in the hospital. Home-versus-hospital care has the potential to produce cost savings. Such services offered in the home setting might include

- Infusion therapy to treat infections or combat hydration
- Hypertension monitoring for women with pregnancy-induced hypertension
- Uterine monitoring for mothers who are high risk for preterm labor
- Fetal monitoring to evaluate fetal well-being
- Portable ultrasound to perform a biophysical profile to assess fetal well-being

Care During Labor and Delivery

The nine months of pregnancy are all about choices: cloth or disposable diapers, breast-feed or bottle feed, doctor or midwife, where to give birth—at a birthing center, at home, or at a hospital. Deciding where a woman chooses to give birth depends on her pregnancy risk status. For the pregnant women identified as high risk as a result of medical or social risk factors, the hospital is the safest place for her to give birth. Potential complications can be addressed because medical technology, skilled professionals, and neonatal services are available. For low-risk women, a freestanding birthing center or a home birth is an option.

Birthing Center

A *birthing center* is a cross between a home birth and a hospital. Birthing centers offer a “homelike” setting but with close proximity to a hospital facility in case of com-

plications. Midwives often are the sole care providers in freestanding birthing centers, with obstetricians as backups in case of emergencies. Birthing centers usually have fewer restrictions and guidelines for families to follow and allow for more freedom in making laboring decisions. The cost and the cesarean section rate are much lower when compared with a hospital (Ramsey, 2004). The normal discharge time after birth is normally measured in hours (4–24 hours), not days.

Birthing centers provide an alternative to parents who are not comfortable with a home birth, yet who do not want to give birth in a hospital. Advantages of birthing centers include nonintervening obstetric care, freedom to eat and move around during labor, ability to give birth in any position, and the right to have any number of family and friends attend the birth. Disadvantages are that some centers have rigid screening criteria, which may eliminate healthy mothers from using birth centers; many have rigid rules concerning transporting the mother to the hospital (e.g., prolonged labor, ruptured membranes); and many have no pediatrician on staff if the newborn has special needs after birth (Cooper, 2004).

Birthing centers aim to provide a relaxing home environment and promote a culture of normality. Birth is viewed as a normal physiologic process, and most centers use a nonintervening view of labor and birth. The range of services for the expectant family often includes prenatal care, childbirth education, intrapartum care, and postpartum care, including home follow-up and family planning (Fig. 2-2). One of the hallmarks of the freestanding birthing center is that it has the ability to provide truly family-centered care by approaching pregnancy and birth as a normal family event and encouraging participation of all family members. Education is often provided by centers, encouraging families to become informed and self-reliant in the care of themselves and their families (ICEA, 2001).

Home Birth

For centuries women have been having babies in their home. Many feel more comfortable and relaxed when giving birth in their own environment. Home births are recommended for women with low-risk pregnancies and no labor complications. Many women who want no medical interventions and a very family-centered birth choose to have a home birth. Advantages of home birth include

- Incurring the lowest cost
- Laboring and delivering in the privacy, comfort, and familiarity of home while surrounded by loved ones
- Maintaining control over every aspect affecting the woman’s labor (e.g., positions, attire, support people)
- Allowing labor to progress normally, without interference and unnecessary interventions
- Having continuous one-on-one care given by the midwife throughout the childbirth process
- Establishing a trusting relationship with the nurse midwife (APA, 2003)



● Figure 2-2 Birth centers aim to provide a relaxing home environment and promote a culture of normality, while offering a full range of health care services to expectant family. (Photos by Gus Freedman.)

Disadvantages of having a home birth include

- Limited anesthetic pain medication
- Danger to mother and baby if an unanticipated emergency arises (placenta abruptio, uterine rupture, cord prolapse, or a distressed fetus). The time it takes to get to the hospital could be detrimental.
- The necessity of an emergency backup plan for a doctor on standby and a nearby hospital should an emergency occur (Ramsey, 2004)

Nursing Management

The choice between a birthing center, home birth, and hospital depends widely on the woman's personal preferences, her risk status, and her distance from a hospital (30 minutes away). Some women choose an all-natural birth with no medications and no medical intervention, whereas others would feel more comfortable in a setting

in which medications and a trained staff are available if needed. Presenting the facts (pros and cons) to women and allowing them to choose in collaboration with their health care provider is the nurse's role. Safety for the low-risk childbearing woman is paramount, but at the same time nurses must protect the right to choose birth options and continue to promote family-centered care in all maternity settings.

Postpartum and Newborn Care

Recent reforms in health care financing have reduced the hospital stays significantly for women after giving birth. Community-based nursing is part of an effort that extends care beyond the hospital setting. When new mothers are discharged from the hospital, most are still experiencing perineal discomfort, incisional pain, and uterine cramping. Furthermore, they are fatigued, constipated, and unsure

about their feeding and caring for their newborn without consultation. These new mothers need to be made aware of available community resources, which might include telephone consultation by nurses, **outpatient clinics**, and home visits.

Telephone Consultation

Many hospitals offer **telephone consultation services** by their maternity nurses. The discharged mother is given the phone number of the nursing unit on the day of discharge and is instructed to call if she has any questions or concerns. Because the nurses on the unit are familiar with her birth history and the newborn, they are in a good position to assist her in adjusting to her new role. Although this service is usually free, not all families recognize a problem early or use this valuable informational resource.

Outpatient Clinics

Outpatient clinics offer another community-based site for the childbearing family to access services. Usually the mother has received prenatal care before her birthing experience and thus has established some rapport with the nursing staff there. The clinic staff is usually willing to answer any questions or concerns she may have concerning the health of herself or her newborn. Appointments usually include an examination of the mother and newborn, and instructions about umbilical cord, care, and nutritional issues for both mother and infant.

Home Visits

Home visits offer similar services as a scheduled clinic visit, but in addition provide the nurse an opportunity to assess the family's adaptation/dynamics and the home environment. During the last decade, hospital stays averaged 24 to 48 hours or less for vaginal births and 72 to 96 hours for cesarean births (CDC, 2004). Federal legislation went into effect in 1998 that prohibited insurers from restricting hospital stays for mothers and newborns to less than 2 days for vaginal births or 4 days for cesarean births (CDC, 2004). These shortened stays have reduced the educational opportunities for new mothers to learn to care for themselves and their newborns.

Postpartum care in the home environment should include

- Monitoring the physical and emotional well-being of the family members
- Identifying potential or developing complications for the mother and newborn
- Bridging the gap between discharge and ambulatory follow-up for mothers and their newborns (Lynch et al., 2001)

Because hospital stays are reduced, high-risk newborns are also being cared for in community settings. High-tech care once was reserved exclusively for the hospital. Now, however, the increasing cost of complex care and the preva-

lence of managed care have forced high-technology equipment into the living rooms of high-risk infant's homes. Families have become "health care systems" by providing physical, emotional, social, and developmental home care for their technology-dependent infants. A few conditions that would persist or continue after discharge might include

- Preterm infants with ongoing oxygen dependency, strictures and bowel obstructions, or retinopathy
- LBW infants needing nutritional or hypercaloric formulas and adjunct feeding devices (e.g., tube feeding or gastrostomy)
- Hydrocephalus
- Cerebral palsy

Examples of home technology equipment may include

- Renal dialysis
- Mechanical ventilation for bronchopulmonary dysplasia
- Electronic apnea monitoring for preterm infants
- Home oxygen equipment
- IV infusions for antibiotics
- Hyperalimentation
- Respiratory nebulizer
- Phototherapy
- Suction equipment

All family members must work together to provide 24-hour care. Family members must negotiate with insurers for reimbursement of durable medical equipment, to troubleshoot equipment problems, and to make sure they manage inventories of supplies and equipment. In addition, the parents or caretakers must be able to assess the infant for signs of illness; determine the problem; decide when to call nurses, pharmacists, and physical therapists; and interpret and implement physician prescriptions. Technology in the home requires nurses to focus on the family "home care system" to provide total care to the infant.

Nurses can play a key role in assisting families with successful adaptation by guiding preparedness and increasing their confidence in caring for their infants at home. This adaptation begins with the hospital discharge nurse. This nurse can help prepare the family to care for their infant by providing instruction and hands-on experience within a supportive environment until their confidence increases. Family members should be active participants in the transition-to-home plan. Recognition of parental needs and addressing each area in the discharge plan will ease the transition home.

The home health nurse can further assess the family's preparedness through several brief questions:

How well prepared are you to take care of your infant's physical, emotional, and technologic equipment needs?

How well prepared are you obtain the home services you need for your infant?

How well prepared are you manage the stress of home care?

These simple questions convey the nurse's concern for the infant and family while obtaining a thorough assessment of the family learning needs.

Once preparedness has been assessed, the nurse can intervene as necessary. For example, if the caretakers do not judge themselves to be prepared to maintain machinery, technology, medication, or developmental therapy, then the nurse can demonstrate the care to the family. The nurse can also assist the family to anticipate the common problems that might occur, such as running out of supplies, having enough medication or special formula mixture to last throughout the weekend, and keeping backup batteries for powering machines or portable oxygen. The outcome of the preparedness assessment and intervention is that safety of the infant is established and maintained.

Nursing of families who are using complex home care equipment requires caring for the infant and their family members' physical and emotional well-being as well as providing effective solutions to problems they may encounter. Home health nurses need to identify, mobilize, and adapt a myriad of community resources to support the family in giving the best possible care in the home setting. Preparing families for high-technology care before hospital discharge, with home health nurses continuing and reinforcing that focus, will help ease the burden of managing high-technology equipment in the home.

Women's Health Care

Community-based women's health services have received increased emphasis during the last few decades simply because of economics. Women use more health care services than men, make as much as 90% of health care decisions, and are the majority of the population (CDC, 2001). Women spend 66 cents of every health care dollar, and 7 of the 10 most frequently performed surgeries in the United States are specific to women (Breslin & Lucas, 2003). Examples of community-based women's health care services that can be freestanding or hospital-based include

- *Screening centers* that offer mammograms, Pap smears, bone density assessments, genetic counseling, ultrasound, breast examinations, complete health risk appraisals, laboratory studies (complete blood count, cholesterol testing, thyroid testing, glucose testing for diabetes, follicle-stimulating hormone [FSH] levels), and electrocardiograms
- *Educational centers* that provide childbirth education, preconception classes, women's health lectures, sibling preparation classes, instruction on breast self-examinations, breast-feeding, and computers for research
- *Counseling centers* that offer various support groups: genetics, psychotherapy, substance abuse, sexual assault, and domestic violence
- *Surgical centers* that provide plastic surgery, urologic and gynecologic surgeries, abortion, liposuction, and loop electrode excision

- *Wellness centers* that make available stress reduction techniques, massage therapy, guided imagery, hypnosis, smoking cessation, weight reduction, tai chi, yoga, and women's fitness/exercise classes
- *Alternative/wholeness healing centers* that provide acupuncture, aroma therapy, biofeedback, therapeutic touch, facials, reflexology, and herbal remedies
- *Retail centers* that offer breast pump rental and purchase, baby scales, nursing clothes and supplies, breast prostheses, and lactation consultants

Women have multiple selections regarding services and settings, and have many choices regarding health care providers. In the past, most women received health care services from physicians such as obstetricians, gynecologists, and family physicians. Today, nurse midwives and nurse practitioners are becoming more prevalent in providing well-women care.

Nurses who work in community-based settings need to be familiar with the many health issues commonly encountered by women within their communities. All nurses who work with women of any age in community-based settings, including the workplace, schools, practitioner offices, and clinics, should possess a thorough understanding of the scope of women's health care and be prepared to intervene appropriately to prevent problems and to promote health.

Levels of Prevention in Community-Based Nursing

The concept of prevention is a key focus of community-based nursing practice. Prevention means to ward off an event before it occurs. The emphasis on health care delivery in community-based settings has moved beyond primary preventive health care (e.g., well-child checkups, routine physical examinations, prenatal care, and treatment of common acute illnesses) and now encompasses secondary and tertiary care.

Primary Prevention

The concept of **primary prevention** involves preventing the disease or condition before it occurs through health promotion activities. It encompasses a vast array of areas, including nutrition, good hygiene, sanitation, immunization, adequate shelter, smoking cessation, family planning, and the use of seat belts (Matteson, 2001). Primary preventive interventions for women are directed by four goals. These goals include

1. Maintaining balance, perspective, and priorities in life to improve ability to cope with life stress in effective ways and to handle multiple roles
2. Developing and maintaining healthy relationships to prevent abuse
3. Developing and maintaining a healthy sense of self to deal effectively with the role changes of the life cycle

4. Developing and maintaining physical health and preventing illness by eating a balanced diet, using safety precautions, practicing safe sex, preventing osteoporosis, and not smoking or drinking (Clark, 2003)

Prevention of NTDs, which include anencephaly and spina bifida, is an example of primary prevention. NTDs arise from improper development of the neural tube during embryogenesis. Anencephaly is incompatible with life. Spina bifida can range from mild to severe with associated morbidity, which may include paraplegia, bladder and bowel incontinence, and mental impairment. The worldwide incidence of fetal NTDs ranges from 1 to 8 per 1000 live births and varies considerably geographically. In the United States, approximately 2500 babies are born each year with NTDs, about 6 in every 10,000 live births (Wald, 2004). Primary prevention of NTDs by all pregnant women taking folic acid supplementation between 0.4 to 0.8 mg daily 3 months before and 3 months after conception reduces the risk of first occurrence of NTD by 50% or more (Wald, 2004). All women of childbearing age should be advised to take 4 mg folic acid daily as soon as they plan to become pregnant and continue throughout the pregnancy to prevent this devastating condition.

Secondary Prevention

Secondary prevention is the early detection and treatment of adverse health conditions. Pregnancy testing, blood pressure readings, cholesterol levels, fecal occult blood, breast examinations, mammography screening, hearing and vision examinations, and Pap smears to detect cancer or sexually transmitted infections are examples of this level of prevention. Such interventions do not prevent the start of the health problem but are intended to detect it and start treatment early to prevent further complications (Anderson & McFarlane, 2000).

Consider the benefits of secondary prevention related to HIV infection. Without intervention, an estimated one in four HIV-positive women in the United States will transmit HIV perinatally. This means approximately 1750 HIV-positive infants would be born each year, with lifetime estimated medical costs of \$282 million. The estimated cost of secondary prevention (counseling, testing, and AZT) is \$68 million. This represents a savings of \$114 million in health care costs. This estimate excludes lifetime productivity savings and quality-of-life improvements related to HIV infections averted (CDC, 1999).

Tertiary Prevention

Tertiary prevention is designed to reduce or limit the progression of a disease or disability after an injury. The purpose of tertiary prevention is to rehabilitate or restore individuals to their maximum potential (Sorrell & Redmond, 2002). Tertiary prevention measures are supportive and restorative. Two areas in which tertiary prevention are particularly warranted for women include

sexually transmitted infections and abuse. Tertiary prevention efforts would focus on minimizing and managing the effects of chronic sexually transmitted infections such as herpes, HIV infection, and untreated syphilis. With regard to abuse, tertiary prevention would involve working with women who have suffered long-term consequences of violence. The focus of the nurse would be to maximize the woman's strengths, to heal from the trauma and loss, and to build support systems. These examples represent the essence of the tertiary level of prevention.

The Nurse's Role in Community-Based Preventive Care

Women's health needs are many and varied. All health professionals have a special role in health promotion, health protection, and disease prevention. Community-based nurses provide health care for women at all three levels of prevention. This care often involves advocacy for services to meet the particular needs of women.

Much of community nursing involves prevention, early identification, and prompt treatment of health problems, and monitoring for emerging threats that might lead to health problems. For example, a nurse could help reduce the incidence of AIDS by taking the following steps:

- *Primary*—educating clients on the practice of “safe sex”
- *Secondary*—urging testing and counseling for clients who practice “unprotected sex,” as well as providing referrals and follow-up for clients who test positive for HIV
- *Tertiary*—providing care and support, advocacy, case management, and other therapeutic interventions to slow disease progression and keep viral counts down

Nurses who work with clients in community settings are frequently in a position to assist in identification, management, treatment, and prevention of health problems. As a result, these nurses need a general understanding of the basic principles and concepts of **epidemiology**. Using an epidemiologic approach can provide nurses with the language to describe and analyze health concerns in population-based care. Epidemiology is the study of factors that influence the frequency and distribution of disease, injury, or other health-related events, and their causes, for the purpose of establishing programs of prevention and control (O'Toole, 2003). Its ultimate goal is to identify the underlying causes of a disease, then apply findings to disease prevention and health promotion. Epidemiology uses research and statistical data collection to find answers to the following questions:

Who in the population is affected by the disease, disorder, or injury?

What is the occurrence of this health problem in the community?

Can the causative factors and risk factors contributing to the problem be determined? (Hitchcock et al., 1999)

Healthy People 2010 (US Department of Health and Human Services, 2000a) was written based on epidemiologic principles. This report presents health statistics and data, describes health threats, discusses interventions, and sets goals and objectives directed toward prevention and management (McEwen, 2002). A few examples of objectives demonstrating epidemiologic concepts that address women's health needs are presented in the accompanying box "Healthy People 2010."

Cultural Issues in Community-Based Care

The population in the United States has a mix of cultural groups, highlighted by ever-increasing diversity. The Center for Immigration Studies (2004) reports that the US immigration population has reached 33 million, with people arriving from every corner of the world. One million immigrants come to the United States each year, and more than half are of childbearing age. Latin America accounts for more than 50% of immigrants to the United States. By the year 2050, people of African, Asian, and Latino backgrounds will make up one half our population (Hawke, 2004).

The nursing population in the United States does not begin to approximate the diversity in the general population. According to the US Department of Health and Human Services (2000b), 12% (or 324,000) of the 2.7 million RNs in the United States identify themselves as being from racial/ethnic minority backgrounds. This stands in contrast to 30% of the general population, which

describes themselves as being from a racial or ethnic minority (Mattson, 2003).

This growing diversity has strong implications for the provision of health care. For years nurses have struggled with the issues of providing optimal health care that meets the needs of women and their families from varied cultures and ethnic groups. In addition to displaying competence in technical skills, nurses must also become competent in caring for clients from ethnic and racial backgrounds. Adapting to different cultural beliefs and practices requires flexibility and accepting others' viewpoints. Nurses must really listen to clients and learn about their beliefs of health and wellness. To provide culturally appropriate care to diverse populations, nurses need to know, understand, and respect culturally influenced health behaviors. Table 2-3 lists selected beliefs and behaviors from various cultures that may help nurses understand their childbearing patients.

Characteristics of Culture

Culture is complex and not easily dissected. It can be thought of as a fabric with many interwoven colored threads. Each colored thread represents one aspect of culture—values, worldview, time orientation, personal-space orientation, language, touch, and family organization. Understanding one's values is key to understanding their behavior, because behavior generally reflects values. A culture's worldview helps its peoples understand how life fits into the "big picture" and allows them to make sense of that which is knowable (e.g., evil, disease, natural disaster).

It is very important for nurses to research and understand cultural characteristics, values, and beliefs of the various people to whom they deliver care so that false assumptions and stereotyping do not lead to insensitive care. Table 2-4 provides a comparison of common cultural characteristics, values, and beliefs. Time orientation, personal space, family orientation, and language are discussed in the following paragraphs.

Time Orientation

The strict concept of time that organizes American health care service is not shared by many other cultures around the world, where a more relaxed attitude toward time prevails. Time measures productivity in many health care settings and nurses can get angry or frustrated when women from different cultures arrive late for appointments and do not seem to be concerned about their "lateness."

Personal Space

Personal space, which is an appropriate distance between conversing people, varies widely between cultural groups. Overall, this distance is generally closer between people of the same gender and wider when the interaction involves people of the opposite sex. Touch is incorporated in cultures with close distance zones (Hispanic, Mediterranean, Eastern Indian, Middle Eastern) and is not used in cultures

HEALTHY PEOPLE 2010

Objectives for Women's Health Needs

- ✓ **Goal:** Reduce pregnancies among adolescents from 72 pregnancies to 46 pregnancies per 1000
- ✓ **Goal:** Reduce AIDS among adolescents and adults (incidence) from 19.5 new cases to 1 new case per 100,000
- ✓ **Goal:** Reduce fetal and infant deaths during the perinatal period from 7.5% to 4.5% per 1000 live births
- ✓ **Goal:** Increase the proportion of women with health insurance from 87% to 100%
- ✓ **Goal:** Reduce the percentage of cases of osteoporosis from 10% to 8%
- ✓ **Goal:** Reduce cervical cancer deaths per 100,000 women from 3 to 2
- ✓ **Goal:** Reduce lung cancer deaths per 100,000 women from 45 to 41
- ✓ **Goal:** Reduce pregnancy complications per 100 deliveries from 32 to 20

Source of data: US Department of Health and Human Services. (2000). *Healthy people 2010* (conference ed.). Washington, DC: Government Printing Office.

Table 2-3 Selected Cultural Beliefs and Behaviors during the Childbearing Period

Topic	Belief or Behavior
Pregnancy	A pregnant woman is considered ill or weak. (Latino) Pregnancy is a “hot” condition, so meat should be avoided and sodium intake increased. (African-American) Drinking milk during pregnancy may result in a large baby and hard labor. (Asian) “Cold” foods, including vegetables, should be avoided during pregnancy. (Chinese) A pregnant woman’s workload should be reduced. (Native American) Planning for the infant prior to delivery defies God’s will. (Arab)
Birth	Pain speeds delivery so pain relief should be avoided. (African-American) Emotional expression during labor is expected. (Arab and Italian) Labor can be stimulated by the use of herbal preparations. (Latino) Changes in the moon’s phase may trigger labor. (African-American) Delivery should take place in a squatting position. (Asian) The pregnant woman’s mother-in-law should attend her during delivery. (Chinese) Women will want to wear their headscarves during labor and birth. (Muslim)
Conception	Pregnancy is more apt to happen during monthly menses. (African-American) Infertility is perceived as failure to fulfill family role expectations. (Chinese) Herbs can be used to “heat” the womb to increase the chances of conception. (Latino) Islam forbids exposing a developing fetus to alcohol and drugs. (Muslim)
Contraception	Pregnancy should be avoided by abstinence. (Chinese, Filipino, Latino, Catholic) A wife who asks her husband to use a condom marks herself as a prostitute. (Latino) Charms and ceremonies may prevent conception. (Native American) An ice water and vinegar douche slows sperm and kills them. (African-American) Islam forbids permanent sterilization for both men and women. (Muslim)
Menstruation	Menstruation opens one up to infection. (African-American) One must avoid sex during menstruation and wear shoes to prevent poisons from entering the body. (African-American) Avoiding hot, spicy food can alleviate menstrual cramping. (Latino) Exposure of an infant to a menstruating woman may cause an umbilical hernia. (African-American, Latino)
Postpartum	Bathing should be avoided after delivery. (Mexican) Outside visitors should be discouraged after delivery. (Korean) Drinking cold water after delivery should be avoided. (Asian) Beef and seafood cause itching at the episiotomy site. (Asian)

Modified from Clark (2003) and Moore and Moos (2003).

with more distanced personal space (North American, Muslims, Native Americans) (Moore & Moos, 2003).

Family Orientation

Families may be patriarchal (male/father centered), matriarchal (female/mother centered), or egalitarian (equal). Patriarchal family orientation is most common throughout the world. Health care workers need to know which type of family organization is present to be able to relate to family dynamics and to understand who will be making health care decisions for all family members (Fig. 2-3).

Language

Language barriers can complicate communication between nurses and patients from different cultures. There are more than 6000 languages and dialects spoken around the

world today. Types of language barriers that impede communication include foreign languages; different dialects and regionalisms; and the use of idioms, slang, and street talk (Munoz & Luckmann, 2005). A skilled interpreter can assist nurses to overcome the anxiety and frustration produced by language barriers. In addition, Box 2-4 provides guidelines to help nurses establish a therapeutic relationship with people of different cultures speaking a different language.

Culturally Competent Nursing Care

Cultural competence is defined as the knowledge, willingness, and ability to adapt health care to enhance its acceptability to and effectiveness with patients from diverse cultures (Clark, 2003). Cultural competence is a dynamic

Table 2-4 Comparison of Common Cultural Characteristics, Values, and Beliefs

American Characteristics (Anglo-European)	Other Contrasting Cultures' Characteristics
Individualism	Family focus (Asian)
Independent	Interdependence (Hmong)
Obsession with personal hygiene	Not concerned with body odors or frequent bathing (Zimbabwe)
Emphasis on youth	Value of elders (Japanese)
Health care decisions made by women	Decisions made by elders (Indian)
Time is precise	Time is flexible (Northern Europe)
Technology oriented	Confidence in natural systems (Latinos)
Direct eye contact valued	Direct eye contact violates privacy (Navajos)
Reliance on biomedical remedies	Traditional healers, folk medicine (Chinese)
Active participation of fathers at birth	Taboo against presence of father (Africa)
Childbearing cycle can be hazardous	Childbirth is normal, natural (Cherokee)
Disbelief in supernatural phenomena	Strong belief in "evil spirits" (Hispanics)
Independent during postpartum	Dependent for 40 days (Mexican)

Sources: Steefel (2003), Levine et al. (2004), and Moore and Moos (2003).

process during which nurses obtain cultural information and then apply that knowledge. Nurses must look at patients through their own eyes and the eyes of patients and family members. Nurses must develop nonjudgmental acceptance of cultural differences in clients, using diversity as a strength that empowers them to achieve mutually acceptable health care goals (Kersey–Matusiak, 2000). This cultural awareness allows nurses to see the entire picture and improves the quality of care and health outcomes.

Cultural Self-Awareness

The first step of the journey toward cultural competence is **cultural self-awareness**. Nurses need to become aware of, appreciate, and become sensitive to the values, beliefs, customs, and behaviors that have shaped their own culture. It is only through this self-exploration that they can then look beyond their own culture and "see" patients from different cultures. During this process, nurses should examine their own biases and prejudices toward other cultures. Without being aware of the influence of their own cultural values, nurses may have a tendency to impose their own beliefs, values, and patterns of behavior on other cultures. The goal of self-cultural awareness is to help nurses become aware of how their background and their clients' backgrounds differ (Habel, 2001).

An example of the first step in achieving cultural awareness is to explore your "preunderstandings" of diverse cultures based on your history and culture, and know this is how you form your prejudices. It is important to be aware that in many cultures pregnancy and

childbirth are primarily taken care of within a woman's domain in the home setting. Expecting a husband to help or support his wife during labor is contrary to the traditions of some cultures. Awareness that this cultural norm is different from the nurse's own frame of reference prevents the "labeling" of culturally diverse husbands as disinterested in the childbirth process and prevents you from forming prejudices.

Cultural Knowledge

The second step is gaining cultural knowledge about various worldviews of different cultures. Some of the ways nurses can acquire knowledge are by reading about different cultures, attending continuing education courses on different cultures, accessing Web sites, and attending cultural diversity conferences. The goal of cultural knowledge is to become familiar with culturally/ethnically diverse groups, worldviews, beliefs, practices, lifestyles, and problem-solving strategies.

An example of the second step in gaining cultural knowledge is to know that touch is not welcome by many cultures. For example, Hmong women are not comfortable with vaginal examinations, which traditionally are not performed in their culture. The genitals are considered to be a private area of the body, with the only exposure occurring during the sexual act with one's husband (Levine et al., 2004). For nurses working with Hmong women, cloth covering and positioning to promote privacy are needed to demonstrate understanding of their culture.



● **Figure 2-3** It is important for nurses to recognize family dynamics when providing health care to patients. Many different family structures exist and influence patient needs. (A) The traditional nuclear family, which is composed of two parents and their biological or adopted children. (B) The extended family, which includes the nuclear family, plus other family members such as grandparents, aunts, uncles, and cousins. (C) Gay and lesbian families comprise two people of the same sex sharing in a committed relationship, with or without children. (Photos by Gus Freedman.)

BOX 2-4

GUIDELINES FOR COMMUNICATING WITH CLIENTS

- Convey empathy by experiencing what that person is experiencing. Example: If that client has just been told she has breast cancer, mentally place yourself into “her shoes” and “feel” her feelings at that time.
- Show respect by valuing that person and viewing them as special. Example: Address all patients with a formal title to retain their individuality and demonstrate personal respectfulness.
- Build trust by having confidence or faith in that person. Example: Be honest about what can be done to “fix” the problem and do not promise anything more to patients than you can deliver.
- Establish a rapport by initiating social, friendly conversation first. Example: Ask questions about the client’s homeland, about how long she has lived in the United States, and about family before asking health-related questions.
- Listen actively by giving verbal and body language clues that you are interested in that person and her problem. Example: Use eye contact, an open posture, and sit at the same level to promote open communication between parties.
- Demonstrate genuine interest by using words of concern and demonstrating a caring attitude that shows you are interested in their total well-being. Example: Using a “concerned facial expression” when listening to a patient’s problems conveys interest in that patient as an individual (Munoz & Luckmann, 2005).

Cultural Skills

The third step toward becoming culturally competent is acquiring **cultural skills**. This step involves learning how to do a competent cultural assessment. Nurses who have achieved cultural skills can individually assess each client’s unique cultural values, beliefs, and practices without depending solely on written facts about specific cultural groups. Principles of cultural assessment include the following:

- View all cultures in the context they were developed.
- Examine underlying premises for cultural beliefs and behaviors.
- Interpret behavior within the context of the particular culture.
- Recognize the potential for intracultural variation (Bowers, 2000).

An example of the third step in acquiring cultural skills can be demonstrated in asking all postpartum women what they would like to drink, rather than bringing them cold juice or water. Many cultures (Latinos and Asians) that

prescribe to the theory of cold (yin) and hot (yang) consider cold drinks harmful after birth—a cold state. These mothers need to restore balance by taking warm drinks. To add confusion to nurses, hot and cold actually refer to the property rather than the temperature of a substance, which is all the more reason to ask rather than assume what women want to drink after birth (Steeffel, 2003).

Cultural Encounter

The final step in the journey to becoming culturally competent is a **cultural encounter**. This involves participating in cross-cultural interactions with people from culturally diverse backgrounds. Cultural encounters may include attending religious services or ceremonies and participating in important family events. Although nurses may have several friends in different cultural groups, they are not necessarily knowledgeable about the group as a whole. In fact, the values, beliefs, and practices of the few people nurses encounter on a social basis may not represent that specific cultural group for which they provide care. Thus, it is important to have as many cultural encounters as possible to avoid cultural stereotyping (Salimbene & Gerace, 2003; Fig. 2-4).

An example of the final step (cultural encounter) in achieving cultural competence would be to participate in a culturally diverse group discussion to work on changing policies and procedures within the health care unit. Invite several cultural brokers that represent diverse cultures to discuss specific childbirth practices that affect the childbearing health care setting. A cultural broker is someone who is fluent in the language and is knowledgeable about the value systems, customs, mores, and daily living experiences of the population served. The ultimate goal is to facilitate a more positive experience for all cultures.



● **Figure 2-4** Cultural encounters help nurses develop an understanding and appreciation for people from culturally diverse backgrounds. Caring for women and children in Guatemala provided rich opportunities for a group of American nurses to develop cultural competence.

ConsiderTHIS!

Our medical mission took a team of nurse practitioners into the rural mountains of Guatemala to offer medical services to people who had never had any. One day, a distraught mother brought her 10-year-old daughter to the mission clinic, asking me if there was anything I could do about her daughter's right wrist. She had sustained a fracture a year ago and it had not healed properly. As I looked at the girl's malformed wrist, I asked if it had been splinted to help with alignment, knowing what the answer was going to be. The interpreter enlightened me by saying that this young girl would never marry and have children because of this injury. I appeared puzzled at the interpreter's prediction of this girl's future. It was later explained to me that if the girl couldn't make tortes from corn meal for her husband because of her wrist disability, she would not be worthy of becoming someone's wife and thus would probably live with her parents the rest of her life.

I reminded myself during the week of the medical mission not to impose my cultural values on the women for whom I was caring and to accept their cultural mores without judgment. These silent self-reminders served me well throughout the week, for I was open to learning about their lifestyles and customs.

Thoughts: What must the young girl be feeling at the age of 10, being rejected for a disability that wasn't her fault? What might have happened if I had imposed my value system on this patient? How effective would I have been in helping her if she didn't feel accepted? This incident ripped my heart out, for this young girl will be deprived of a fulfilling family life based on a wrist disability. This is just another example of female suppression that happens all over the world—such a tragedy—and yet a part of their culture, on which nurses should not pass judgment.

Barriers to Cultural Competence

Barriers to cultural competence can be grouped into two categories: those related to providers and those related to systems (Mazanec & Tyler, 2003). When health care providers lack knowledge of their patients' cultural practices and beliefs or when the provider's beliefs are different than those of the client, the provider may be unprepared to respond when the patient expresses unexpected health care decisions. System-related barriers occur when most agencies have not been designed for cultural diversity, want everyone to conform to the established rules and regulations, and attempt to fit everyone into the same mold.

If nurses are to meet the needs of all their patients and families, they must understand that cultural competence does not mean substituting one's own cultural identity with another, ignoring the variability within cultural groups, or even appreciating the cultures being served. Instead, a respect for difference, an eagerness to learn, and a willingness to accept that there are many ways of viewing the world will distinguish nurses who integrate cultural

competence into their daily practice from those who give “lip service” to it (Gonzalez et al., 2000).

Complementary and Alternative Medicine

The use of **complementary and alternative medicine** (CAM) is not unique to ethnic culture groups. Interest in CAM therapies continues to grow nationwide and will affect care of the childbearing and child-rearing families. CAM use spans people from all walks of life. Overall, CAM use is seen more in women than men, and in people with higher educational levels. Prayer specifically for health reasons was the most commonly used CAM therapy (NCCAM, 2004a). Research indicates that more than 42% of adults use some form of alternative practice, and one in three pregnant women use CAM therapies, some of which may be potentially harmful (Ranzini et al., 2001).

Types of Complementary and Alternative Medicine

CAM includes diverse practices, products, and health care systems that are not currently considered to be part of conventional medicine (NCCAM, 2004b). Complementary medicine is used *together with* conventional medicine, such as using aromatherapy to reduce discomfort after surgery. Alternative medicine is used *in place of* conventional medicine, such as eating a special natural diet to treat cancer instead of undergoing surgery, chemotherapy, or radiation that has been recommended by a conventional doctor.

Integrative medicine combines mainstream medical therapies and CAM therapies for which there is some scientific evidence of safety and effectiveness (NCCAM, 2004b). These include acupuncture, reflexology, therapeutic touch, meditation, yoga, herbal therapies, nutritional supplements, homeopathy, naturopathic medicine, and many more used for the promotion of health and well-being (Youngkin & Davis, 2004). See Table 2-5 for selected CAM therapies and treatments.

The theoretic underpinnings of alternative health propose that health and illness are complex interactions of the mind, body, and spirit. It is then surmised that many aspects of patients’ health experiences are not subject to traditional scientific methods. This field does not lend itself readily to scientific study or to investigation, and therefore is not easily embraced by many hard-core scientists (Sorrell & Redmond, 2002). Much of what we consider to be alternative medicine comes from the Eastern world, folk medicine, and religious and spiritual practices. There is no unifying basic theory for the numerous treatments or modalities, except (as noted previously) that health and illness are considered to be complex interactions among the body, mind, and spirit.

Nursing Management

Because of heightened interest in complementary treatments and their widening use, anecdotal efficacy, and growing supporting research evidence, nurses need to be sensitive to and knowledgeable enough to answer many of the questions patients ask and to guide them in a safe, objective way (Tryens et al., 2004). Traditional remedies need to be integrated with mainstream medicine

Table 2-5 Selected Complementary and Alternative Therapies

Therapy	Description
Aromatherapy	Use of essential oils to stimulate the sense of smell for balancing mind, body, and spirit
Homeopathy	Based on the theory of “like treats like”; helps restore the body’s natural balance
Acupressure	Restores balance by pressing an appropriate point so self-healing capacities can take over
Feng Shui (pronounced fung shway)	The Chinese art of placement. Objects are positioned in the environment to induce harmony with chi.
Guided imagery	Uses consciously chosen positive and healing images, along with deep relaxation to reduce stress and to help people cope
Reflexology	Uses deep massage on identified points on the foot or hand to scan and rebalance body parts that correspond with each point
Therapeutic touch	Includes balancing energy by centering, invoking an intention to heal, and moving the hands from the head to the feet several inches from the skin
Herbal medicine	The therapeutic use of plants for healing and treating disease and conditions
Spiritual healing	Praying, chanting, presence, laying on of hands, rituals, and meditation to assist in the healing process

Adapted from Littleton and Engebretson (2002).

when patients are taking modern drugs. Many patients who use complementary or alternative therapies do not reveal this fact to their health care provider. One of the nurse's most important roles during the *assessment* phase of the nursing process is to encourage clients to communicate their use of these therapies to eliminate the possibility of harmful interactions and contraindications with current medical therapies. When assessing clients, it is important to ask specific questions about any nonprescription medications they may be taking, including vitamins, minerals, or herbs. Clients should also be questioned about any therapies they are taking that have not been ordered by their primary health care provider.

A few common *nursing diagnoses* that might be applicable for clients using CAM are as follows:

- Deficient knowledge regarding the benefits of CAM
- Deficient knowledge regarding the potential risks linked with CAM
- Ineffective health maintenance related to traditional medicine

Nurses who treat patients who practice CAM may want to consider some of the following tips:

- Be culturally sensitive to nontraditional treatments.
- Acknowledge and respect different beliefs, attitudes, and lifestyles.
- Keep an open mind; standard medical treatments do not work for all women.
- Accept CAM and integrate it if it brings comfort without harm.
- Provide accurate information, not unsubstantiated opinions.
- Advise clients how they can best monitor their condition using CAM.
- Discourage practices only if they are harmful to the client's health.
- Instruct the client to weigh the risks and benefits of CAM use.
- Avoid confrontation when asking clients about CAM.
- Be reflective, nonjudgmental, and open-minded about CAM.

The nurse can offer clients the following guidelines:

- Do not take for granted that because a substance is a natural herb or plant product, it is beneficial or harmless.
- Seek medical care when ill.
- Always inform the provider if herbs are being used.
- Avoid taking herbal remedies if you are pregnant or lactating.
- Be sure that any product package contains a list of all ingredients and amounts of each.
- Frequent or continual use of large doses of a given CAM preparation is not advisable.
- Possible harm may result if therapies are mixed (e.g., vitamin E, garlic, and aspirin all have anticoagulant properties).

- Research CAM through resources such as books, Web sites, and articles (Clark et al., 2003).

Nurses need to remember that when they provide guidance to women concerning CAM therapies, stress to them that they check with their health care provider before taking any "natural" substance. The use of complementary therapies is widespread, especially by women desiring to alleviate the nausea and vomiting of early pregnancy. Ginger tea, sea-bands, and vitamin B₆ are typically used to treat morning sickness (Gaffney & Smith, 2004). Although these may not cause any ill effects during the pregnancy, the fact that most substances ingested cross the placenta and have the potential to reach the growing embryo, it is imperative to emphasize to all pregnant women that it is better to be safe than sorry. Women at risk for osteoporosis are seeking alternative therapies to hormone replacement since the release of data from the Women's Health Initiative (WHI) study placed doubt on estrogen. Some of the alternative therapies for osteoporosis include soy isoflavones, progesterone cream, magnet therapy, tai chi, and hip protectors (Kessenich, 2004). In addition, menopausal women seek CAM therapies to reduce the incidence of hot flashes. Once again, despite many "natural herbs" claims, most of the therapies have not undergone scientific inquiry and thus could place the woman at risk if mixed with traditional medicines.

A large increase in the use of CAM has occurred during the past decade. This situation has precipitated many issues, including the safety and true value of many of the therapies. Nurses must educate themselves about the pros and cons of CAM and be prepared to discuss and help their patients make sense of it all. Expanding our consciousness by understanding and respecting diverse cultures and CAM will enable nurses to provide the best potential treatment for patients and their families entrusted to our delivery of community-based care.

KEY CONCEPTS

- Community-based nursing uses the nursing process in caring for patients within community settings and applies primary, secondary, and tertiary prevention levels.
- Health care delivery has moved from acute care settings out into the community, with an emphasis on health promotion and illness prevention.
- Nurses have a variety of job opportunities in ambulatory care settings, home health care, occupational health, school health, hospice, and others.
- The goals of Healthy People 2010 to increase quality and years of healthy life and to eliminate health disparities are attainable through community-based health care activities and interventions.
- Nursing interventions in community-based settings include those of health screening, education, medication administration, telephone consultation,

nutritional counseling, and acting as referral agent, counselor, and researcher.

- The goal of epidemiology is to identify the underlying causes of a disease, then apply findings to disease prevention and health promotion.
- Cultural competence is a dynamic process during which nurses obtain cultural information and then apply that knowledge.
- Steps to gaining cultural competence include cultural self-awareness, cultural knowledge, cultural skills, and cultural encounters.
- The field of complementary and alternative health and medicine is almost entirely community based.
- Nurses must educate themselves about complimentary/alternative therapies to be able to advise patients in community-based settings who use them.

References

- American Pregnancy Association (APA). (2003). *Birth choices: care providers and labor locations*. [Online] Available at www.americanpregnancy.org/planningandpreparing/birthingchoices.html.
- Anderson, E. T., & McFarlane, J. (2000). *Community as partner* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.
- Bowers, P. (2000). *Cultural perspectives in childbearing*. [Online] Available at <http://nsweb.nursingspectrum.com/ce/ce263.htm>.
- Breslin, E. T., & Lucas, V. A. (2003). *Women's health nursing: toward evidence-based practice*. St. Louis, MO: Saunders.
- CDC. (2004). *Longer hospital stays for childbirth*. National Center for Health Statistics. [Online] Available at www.cdc.gov/nchs/products/pubs/pubd/hestats/hospbirth.htm.
- CDC. (2001). *New study profiles women's use of health care*. [Online] Available at www.cdc.gov/od/oc/media/pressrel/r010725.htm.
- CDC. (1999). *Status of perinatal HIV prevention: US declines continue*. Division of HIV/AIDS Prevention. [Online] Available at www.cdc.gov/hiv/pubs/facts/perinat1.htm.
- Center for Immigration Studies. (2004). *Current numbers*. [Online] Available at www.cis.org/topics/currentnumbers.html.
- Clark, C. C., Colbath, J. D., & Reitz, S. E. (2003). *A complementary potpourri*. [Online] Available at <http://nsweb.nursingspectrum.com/ce/ce199.htm>.
- Clark, M. J. (2003). *Community health nursing: caring for populations* (4th ed.). Upper Saddle River, NJ: Prentice Hall.
- Cooper, T. (2004). Changing the culture: normalizing birth. *British Journal of Midwifery*, 12, 45–50.
- Gaffney, L., & Smith, C. A. (2004). Use of complementary therapies in pregnancy: the perceptions of obstetricians and midwives in South Australia. *Australia and New Zealand Journal of Obstetrics and Gynecology*, 44, 24–29.
- Gonzalez, R. I., Gooden, M. B., & Porter, C. P. (2000). Eliminating racial and ethnic disparities in health care. *American Journal of Nursing*, 100, 56–58.
- Habel, M. (2001). *Putting patient teaching into practice*. [Online] Available at www.cyberchalk.com/nurse/courses/nurseweek/nw0650/c6/references.htm.
- Hawke, M. (2004). Mosaic of diversity. *Nursing Spectrum*. [Online] Available at <http://community.nursingspectrum.com/MagazineArticles/article.cfm?AID=11786>.
- Hitchcock, J. E., Schubert, P. E., & Thomas, S. A. (1999). *Community health nursing: caring in action*. New York: Delmar Publishers.
- ICEA. (2001). ICEA position statement and review: the birth place. *International Journal of Child Education*, 17, 36–41.
- Iyasu, S., Tomashek, K., & Barfield, W. (2002). Infant mortality and low birth weight among black and white infants—United States, 1980–2000. *MMWR*, 51(27), 589–592.
- Kersey–Matusiak, G. (2000). An action plan for cultural competence. *Nursing Spectrum*. [Online] Available at <http://nsweb.nursingspectrum.com/ce/ce255.htm>.
- Kessenich, C. R. (2004). Alternative therapies in osteoporosis. *Nursing Spectrum*. [Online] Available at <http://nsweb.nursingspectrum.com/ce/ce282.htm>.
- Levine, M. A., Anderson, L., & McCullough, N. (2004). Hmong birthing: bridging the cultural gap in a rural community in northern California. *AWHONN Lifelines*, 8, 147–149.
- Littleton, L. Y., & Engebretson, J. C. (2002). *Maternal, neonatal, and women's health nursing*. New York: Delmar.
- Lynch, A. M., Kordish, R. A., & Williams, L. R. (2001). *Maternal–child nursing: postpartum home care*. In Rice, R. (Ed.), *Home health nursing: concepts and application* (3rd ed., pp. 379–398). St. Louis: Mosby.
- Mackey, M. C., & Alexander, J. W. (2003). Program management of high risk pregnancy: outcomes and costs. *Disease Management Health Outcomes*, 11, 1–6.
- March of Dimes. (2005). *Why prenatal care?* March of Dimes Birth Defect Prevention Foundation. [Online] Available at www.modimes.org.
- Matteson, P. S. (2001). *Women's health during the childbearing years: a community-based approach*. St. Louis: Mosby.
- Mattson, S. (2003). Cultural diversity in the workplace. *AWHONN Lifelines*, 7, 154–158.
- Mazanec, P., & Tyler, M. K. (2003). Cultural considerations in end-of-life care. *American Journal of Nursing*, 103, 50–58.
- McCloskey, J. C., & Bulechek, G. M. (2000). *Nursing interventions classification (NIC)* (3rd ed.). St. Louis: Mosby.
- McEwen, M. (2002). *Community-based nursing: an introduction* (2nd ed.). St. Louis: Saunders.
- Moore, M. L., Moos, M. K. (2003). *Cultural competence in the care of childbearing families*. March of Dimes nursing module. White Plains, NY: Educational Services of March of Dimes.
- Munoz, C. C., & Luckmann, J. (2005). *Transcultural communication in nursing* (2nd ed.). Clifton Park, NY: Delmar Learning.
- National Center for Complementary and Alternative Medicine (NCCAM). (2004a). *The use of complementary and alternative medicine in the United States*. [Online] Available at <http://nccam.nih.gov>.
- National Center for Complementary and Alternative Medicine (NCCAM). (2004b). *What is complementary and alternative medicine (CAM)?* [Online] Available at <http://nccam.nih.gov>.
- O'Toole, M. T. (2003). *Encyclopedia & dictionary of medicine, nursing & allied health* (7th ed.). Philadelphia: Saunders.
- Ramsey, L. (2004). Birthing options: birthing center, home, and hospitals. *PageWise*. [Online] Available at http://nncn.essortment.com/birthingoptions_rikm.htm.
- Ranzini, A., Allen, A., & Lai, Y. (2001). Use of complementary medicine and alternative therapies among obstetric patients. *Obstetrics and Gynecology*, 4(Suppl. 1), S46.
- Salimbene, S., & Gerace, L. M. (2003). *Cultural competence for today's nurses—culture and women's health*. [Online] Available at <http://nsweb.nursingspectrum.com/ce/m29a-1.htm>.
- Schwartz, R. M., Muri, J. H., Overpeck, M. D., Pezzullo, J. C., & Kogan, M. D. (2000). Use of high-technology care among women with high-risk pregnancies in the United States. *Maternal Child Health Journal*, 4, 7–18.
- Sorrell, J. M., & Redmond, G. M. (2002). *Community-based nursing practice: learning through student's stories*. Philadelphia: FA Davis.
- Steeffel, L. (2003). No cookie cutter approach to postpartum culture care. *Nursing Spectrum*. [Online] Available at <http://community.nursingspectrum.com/MagazineArticles/article.cfm?AID=9717>.
- Tryens, E., Coulston, L., & Thush, E. (2004). *Understanding the complexities of herbal medicine*. [Online] Available at <http://nsweb.nursingspectrum.com/ce/ce290.htm>.
- Turnock, B. J. (2001). *Public health: what it is and how it works* (2nd ed.). Gaithersburg, MD: Aspen Publishers.
- USDA Food and Nutrition Service. (2004). *WIC: the special supplemental nutrition program for women, infants and children*. [Online] Available at www.fns.usda.gov/wic/aboutwic.
- US Department of Health and Human Services. (2000a). *Healthy people 2010*. [Online] Available at www.healthypeople.gov.
- US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2000b). *National sample survey of RNs final report*. [Online] Available at www.hrsa.gov.

US Department of Health and Human Services, Division of Nursing, Bureau of Health Professions (USDHHS/DON). (2001). *The registered nurse population: national sample survey of registered nurses, March 2000*. Washington, DC: Government Printing Office.

Wald, N. J. (2004). Folic acid and the prevention of neural-tube defects. *New England Journal of Medicine*, 350, 101–103.

Youngkin, E. Q., & Davis, M. S. (2004). *Women's health: a primary care clinical guide* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Web Resources

Acupuncture, www.acupuncture.com
Alliance for Hispanic Health, www.hispanichealth.org
American Botanical Council, www.herbalgram.org

American Holistic Nurses Association, www.ahna.org
American Nurses Association, www.nursingworld.org
Association for Women's Health, Obstetrics, and Neonatal Nursing, www.ahonn.org
Center for Immigration Studies, www.cis.org
Centers for Disease Control and Prevention, www.cdc.gov/mmwr
Cross-Cultural Health Care Program, www.xculture.org
DiversityRx, www.diversityrx.org
Herb Research Foundation, www.herbs.org
National Center for Homeopathy, www.homeopathic.org
NIH Complementary and Alternative Medicine, www.altmed.od.nih.gov/oam
Office of Minority Health, www.omhrc.gov
The Holistic Health Center, www.forholistichealth.com
Transcultural Nursing Society, www.tcns.org

Chapter WORKSHEET

● MULTIPLE-CHOICE QUESTIONS

1. A nurse with cultural competence is one who is
 - a. Well versed in the customs and beliefs of his or her own culture
 - b. Open to the values and beliefs of other cultures
 - c. Knowledgeable about various cultures and able to apply it in treatment settings
 - d. Active in establishing policies to address care for diverse cultures
2. Which prevention level includes early diagnosis, screening, and treatment?
 - a. Primary prevention
 - b. Secondary prevention
 - c. Tertiary prevention
 - d. Community prevention
3. The Anglo-European culture in the United States tends to emphasize
 - a. Youth, technology, time as precise
 - b. Value of elders, spiritual phenomena, belief in fate
 - c. Flexible time, confidence in natural systems, family focus
 - d. Independence, extended family, folk medicine
4. A pregnant client asks the nurse about taking an herb to boost her energy levels. An appropriate response by the nurse would be to
 - a. Discourage it because she is pregnant and it might be harmful
 - b. Encourage her taking it because she will probably feel better
 - c. Make no comment because it might be culturally oriented
 - d. Tell her to double her prenatal vitamins to improve her energy
5. When talking about CAM therapies with a patient, which of the following would be a nonjudgmental question to ask?
 - a. “Are you practicing alternative medicine?”
 - b. “You’re not taking anything that we don’t know about, are you?”
 - c. “What activities are you doing to promote wellness for yourself?”
 - d. “Are you playing it safe and staying away from herbs?”

● CRITICAL THINKING EXERCISE

1. As a nurse working in a women’s health clinic serving a culturally diverse population, you are concerned that many of the client’s cultural beliefs are not being addressed, and thus the clients are not keeping their scheduled appointments. Many of the nurses that work there seem to feel that the clients should adopt Western cultural values and beliefs, and leave their own cultural beliefs behind now that they live in the United States. You are planning to address this concern at the next staff meeting.
 - a. What resources would you use to research this topic before the meeting?
 - b. What information will you present to address the nursing staff’s attitudes toward their culturally diverse clientele?
 - c. What steps would you take to help the nursing staff to become culturally competent?

● STUDY ACTIVITIES

1. Form a panel discussion group representing at least three different cultures. Ask each panel member to describe predominant health care practices based on their cultural background and compare them with those of the United States.
2. Accepting cultural differences with an open mind and heart, expressing a willingness to work with others from different cultures, and keeping a flexible attitude describes _____.
3. Select one of the Helpful Informational Resources websites to explore cultural diversity. After reviewing the website, answer the following questions: Would this resource be helpful for nurses to learn about the various cultures with which they interact in their practice? Why or why not?
4. Arrange for a visit to a community health center that offers services to various cultural immigrants. Interview the staff concerning strategies used to overcome communication barriers and different health care practices.