

# BMJ Open Workplace health and safety issues among community nurses: a study regarding the impact on providing care to rural consumers

Daniel Terry,<sup>1</sup> Quynh Lê,<sup>2</sup> Uyen Nguyen,<sup>2</sup> Ha Hoang<sup>2</sup>

**To cite:** Terry D, Lê Q, Nguyen U, *et al.* Workplace health and safety issues among community nurses: a study regarding the impact on providing care to rural consumers. *BMJ Open* 2015;**5**:e008306. doi:10.1136/bmjopen-2015-008306

► Prepublication history for this paper is available online. To view these files please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2015-008306>).

Received 29 March 2015  
Revised 10 June 2015  
Accepted 22 June 2015



CrossMark

<sup>1</sup>The Department of Rural Health, The University of Melbourne, Shepparton, Victoria, Australia

<sup>2</sup>The Centre for Rural Health, University of Tasmania, Launceston, Tasmania, Australia

#### Correspondence to

Dr Daniel Terry;  
[d.terry@unimelb.edu.au](mailto:d.terry@unimelb.edu.au)

#### ABSTRACT

**Objectives:** The objective of the study was to investigate the types of workplace health and safety issues rural community nurses encounter and the impact these issues have on providing care to rural consumers.

**Methods:** The study undertook a narrative inquiry underpinned by a phenomenological approach. Community nursing staff who worked exclusively in rural areas and employed in a permanent capacity were contacted among 13 of the 16 consenting healthcare services. All community nurses who expressed a desire to participate were interviewed. Data were collected using semistructured interviews with 15 community nurses in rural and remote communities. Thematic analysis was used to analyse interview data.

**Results:** The role, function and structures of community nursing services varied greatly from site to site and were developed and centred on meeting the needs of individual communities. In addition, a number of workplace health and safety challenges were identified and were centred on the geographical, physical and organisational environment that community nurses work across. The workplace health and safety challenges within these environments included driving large distances between client's homes and their office which lead to working in isolation for long periods and without adequate communication. In addition, other issues included encountering, managing and developing strategies to deal with poor client and carer behaviour; working within and negotiating working environments such as the poor condition of patient homes and clients smoking; navigating animals in the workplace; vertical and horizontal violence; and issues around workload, burnout and work-related stress.

**Conclusions:** Many nurses achieved good outcomes to meet the needs of rural community health consumers. Managers were vital to ensure that service objectives were met. Despite the positive outcomes, many processes were considered unsafe by community nurses. It was identified that greater training and capacity building are required to meet the needs among all staff.

#### Strengths and limitations of this study

- Community nurses experience many workplace health and safety issues within daily practice that may lead to dissatisfaction, poor mental health, absenteeism and staff turnover, and this study highlights that many practices and processes remain unsafe among community nursing services.
- It also highlights that community nurses have developed strategies to prevent workplace health and safety, despite inadequacies within current quality improvement and pastoral care systems.
- It is recognised that improved policy and greater training and capacity building regarding workplace health and safety are required to address current inadequacies.
- The advantage of using qualitative research is to better understand the lived experience, the challenges they encounter and gain greater insight into community nurses as they work and live in rural Tasmania. The strength of the study is that the interviews were giving voice to the community nurses. It was perceived by the participants that it was a vital opportunity for them to tell their story and that someone was actually listening. In many cases, the community nurses were speaking candidly with the researchers.

#### INTRODUCTION

In Australia, over 25% of healthcare professionals work in rural areas. These health workers are more vulnerable to occupational injury, work instigated disability, and are at higher risk of experiencing prolonged work absence due to workplace health and safety (WHS) issues.<sup>1</sup> In many cases, this is due to 'risk factors such as heavy workloads, long hours, heavy on-call demands, high stress levels, limited support and workplace violence.'<sup>1</sup>

It has been suggested that the greater demand of the health workforce in rural areas is due to a number of intrinsic and

extrinsic rural challenges. These include poorer health outcomes and lower life expectancy within the rural population.<sup>2</sup> Also there are higher rates of violence, disability, poisoning and accidents in rural communities. In addition, rural healthcare delivery systems are often different in terms of resources availability and models of care than larger urban healthcare systems.<sup>1-3</sup>

This diversity of delivery systems, delayed health-seeking and poorer overall health in rural areas has implications for community nurses.<sup>3</sup> Community health nursing is recognised as a synthesis of public healthcare and nursing applied to protect and promote the health of population and fundamental to maximise the health of individuals, families, groups and communities.<sup>4 5</sup> However, in rural and remote contexts, community nurses play a generalist role due to smaller populations and clients with a broad range of medical conditions. In addition, their nursing practice in rural areas has developed to be more around crisis management rather than preventative care. Rural community nurses are also often described as being 'multispecialist' in knowledge and skills to care for a diverse population and client needs.<sup>4 5</sup>

WHS seeks to protect the safety and health of all individuals in the work environment from exposure risks and hazards resulting from work.<sup>6 7</sup> Within health, nursing and community nursing, stressors related to WHS issues are evident within daily practice. These stressors may include poor quality of care, dissatisfaction with employment and healthcare workload. Other critical stressors include cognitive, physical, behavioural and emotional stressors within the healthcare workplace.<sup>8 9</sup>

In addition to the day-to-day demands of health practice, community nurses may experience inadequate staffing levels, frequent overtime, on-call duties, violence in the work place, limited opportunities for career development, professional isolation, concerns for personal safety, and limited management support and supervision.<sup>10</sup> These factors may lead to occupational stress and high staff turnover and are outlined in greater detail.

### Stress and burnout

Stress is a common issue in community nurse populations which leads to nurses having a greater likelihood of taking time away from work.<sup>11 12</sup> Factors such as emotional demands, staffing problems, work pressure, responsibilities and expectations, social issues, poor management and safety concerns can be linked with psychological distress and emotional exhaustion. Other reasons leading to stress, particularly in rural areas, may include lack of replacement staff and the inability to take leave for personal, medical or professional development.<sup>5 12-14</sup>

### Workload

Stress and difficult workload management tend to relate to excessive work, rather than challenging care situations. Increased workload has shown to adversely impact

the quality of attention community nurses give to their patients which leads to dissatisfaction and guilt.<sup>15</sup> Furthermore, it was shown that community nurses worked without regular breaks, with the majority experienced busy schedules seeing clients. Newman and Berens,<sup>11</sup> in their study, indicated that 90% of community nurses stopped for lunch, however the timing of their lunch was at odd times, while 10% did not stop and ate in the car between clients. In most cases, no time was allocated or taken for morning or afternoon breaks.

### Environment

An additional impact on workload is that community nurses have to travel long distance to and from each client's house that may often be time-consuming and exhausting. To add to their difficulties, the road conditions in these areas are not always well developed or maintained.<sup>16</sup> Both the geography and climate of rural areas can increase the vulnerability of rural healthcare workers. In some cases, weather-related illness and injury lead to high levels of absenteeism from work.<sup>17</sup>

### Physical injury

In addition to environmental hazards, physical hazards are experienced by community nurses, such as smoke, chemical, mechanical and exposure to biological infectious agents that increases the risk to safety.<sup>18 19</sup> The most common physical injury among community nurses related to musculoskeletal disorders include soft tissue and surrounding structures that occur in the neck, shoulder, elbow, hand, wrist, lower back, ankles and feet. A study conducted by Newman and Berens<sup>11</sup> revealed that 48% of all community nurses experienced an injury within their workplace that led to being absent from work from 1 to more than 5 days.

### Violence at work

In Australia, it was revealed that 86% of remote area nurses reported experiencing violence or aggression at work in the previous 12 months, compared with 43% of urban nurses. They also reported receiving limited or delayed support following critical incidents, such as violence. However, there is no indication if working in rural healthcare settings has an impact of healthcare workers being at a higher risk of workplace violence.<sup>10</sup>

Workplace violence in the health sector is destructive and has a negative impact on the professional and personal lives of healthcare workers, but also on the quality and coverage of care provided. This leads to deterioration of quality of care provided to clients with degeneration of working environment. These factors lead to reduction in health services available to the rural population as more nurses and a propensity to leave the profession.<sup>4 5 13</sup>

Although nurses in general experience many WHS challenges, much of the literature has focused on remote area nurses and there is little evidence that

focused specifically on WHS among rural community nurses.<sup>12</sup> On this basis, this study aimed to investigate the types of WHS issues rural community nurses encounter and its impact on providing care to rural consumers. To achieve this aim, the study sought to address a number of objectives, which included identifying the key WHS issues that community nurses encounter; highlighting the impact WHS issues play on nursing practice and provision of care; and what strategies community nurses develop and use to overcome the WHS issues in their practice.

## METHODS

The research examined the WHS issues that are encountered by rural community nurses using a narrative inquiry that was underpinned by a phenomenological approach. This study drew on phenomenology as it allows a more developed understanding of the complexities concerning the discourse of community nurses working in rural Tasmania. Phenomenology is a philosophy where reality is viewed to be constructed from our own experiences and beliefs.<sup>20–22</sup> Phenomenology is the study of the everyday subjective experiences of an individual's lived world, where meaning is shaped and produced continuously.<sup>23–25</sup> Qualitative data were collected using semistructured interviews with 15 community nurses.

### Setting

The research was conducted in the north, northwest, and northeast of Tasmania, a small island state of the southeast coast of mainland Australia that has a population of over 500 000 people and a rural population of 35%.<sup>26</sup> The study sites included 13 publically funded community nursing services with 10 in the north and northeast and 6 community nursing services located across the northwest of the state. These services employ approximately 36 full-time equivalent staff provided across approximately two-thirds of the state where 50.2% of the population live.<sup>26</sup>

### Participants

Participants were experienced, registered nurses working in rural areas of north and northwest Tasmania. As the main purpose of the qualitative research was to provide an understanding of WHS issues within the rural community nursing workforce, it was not deemed necessary to recruit a large number of participants. Currently, 56 community nurses were identified working across the two rural regions in full-time and part-time capacities. Merriam<sup>27</sup> suggests “to discover, understand, and gain insight...one needs to select a sample from which one can learn the most.” Therefore, a sample of 10–15 participants was considered to not impact the quality of the research project as the focus was on the richness and depth rather than on the breadth of information obtained.

To achieve the aims of the study, those community nurses who worked exclusively in rural areas and

employed in a permanent capacity were invited to participate in the project. Owing to the nature of the subject of work health and safety issues and the impact that ‘speaking out’ may have on each nurse, it was felt that community nurse participation needed to be made directly with each nurse that was working in the area and that their participation was purely voluntary and they were fully cognisant regarding the confidentiality of their participation.

### Procedure

All directors of nursing across the study area were approached for their support to the study in 2013 with additional communication occurring in 2014. Each nurse unit manager or community nursing staff who met the inclusion criteria were contacted, with 13 of the 16 community nursing services consenting to participate in the study. All community nurses from the 13 sites were individually approached regarding the study and those that expressed a desire to participate in the project were interviewed. On receipt of their individual consent, an interview was arranged at a convenient date and time.

### Data collection

Data were collected face-to-face or via phone between August and October 2014 using semistructured interviews. Semistructured interviews were used as they allow for flexibility within the interview, which can ensure probing of further data which may not have been on the interview schedule.<sup>23</sup> This flexibility also allows no specific ordering of the questions to occur, which may be required.<sup>23</sup> The interviews were collected over an extensive time due to the busy schedules that community nurses maintained. At times interviews were conducted within lunch hours, after work and as requested by nurse managers, not in peak nursing times. Owing to large distances or busy schedules, phone interviews were conducted with four community nurses, while the remainder were undertaken face-to-face.

The interview schedule was based from a previous study by the authors who examined general health workforce and health service needs among community nurses in Tasmania; however, the schedule was specifically developed to examine WHS issues rather than general workforce needs.<sup>12</sup> Each participant was interviewed once by UN with interviews lasting between 30 and 90min. Face-to-face interviews were held in a public place and were audio recorded with the permission of the participants. Similarly, permission was gained to audio record phone interviews over loud speaker within a private office of the university. The interviews were collected by a female registered nurse with interview training that was not a community nurse to reduce any bias.

### Data analysis

The interviews were transcribed verbatim into Microsoft Word and then crosschecked by first and second researchers against audio recordings for anomalies or

errors. Each participant was assigned a numerical code such as 'Nurse 3' or 'Nurse 6' and so on to maintain confidentiality. The data were then imported to NVivo V.10 software to assist with qualitative analysis. Throughout this process any hardcopy data were stored in a locked, secure location identified within the University, while electronic data were stored in a restricted folder located at the University. Access to the hardcopy or electronic data is restricted to the designated Archives Officer where a registry of project data is held.

Both face-to-face and phone data were then analysed to systematically identify recurring themes and experiences arising from the interviews by DT.<sup>28 29</sup> To achieve this, the autocoding function of NVivo V.10 collated data based on question headings. Grouped data will be subject to double-checking to ensure the integrity of the data. Additionally, thematic analysis of data was undertaken to identify key patterns and trends in the data and to compare expressed views. In the first stage, broad categories will be identified within an overall schema, and in the second stage, a detailed series of hierarchical nodes and subnodes were developed. Data were coded and, where necessary, extra nodes will be built into the schema. A number of quotations are included in the paper to illustrate and support the accounts emerging from the textual responses.

### Quality criteria and trustworthiness

Qualitative research has been recognised, nowadays, as making a valuable contribution to improve healthcare practice and policy, but needs to establish different standards of rigour than quantitative studies.<sup>30</sup> Conventionally, the terms used to measure the quality or rigour of research are reliability and validity. Some argue that validity and reliability are important in qualitative research,<sup>31</sup> others argue that the reliability concept is misleading in qualitative research.<sup>32</sup> The quality of a study should be assessed within a framework suitable to its paradigm.<sup>33</sup> For instance, the terms reliability and validity are crucial criteria for quality in quantitative paradigms while the terms credibility, transferability, dependability and confirmability are more suitable standards for judging quality and trustworthiness in qualitative paradigms.<sup>34 35</sup> Nevertheless, the translation and development of criteria to assess the quality of qualitative research are still a disputed issue.<sup>36</sup> In this study, credibility was enhanced by the adoption of research methods successfully utilised in previous comparable projects,<sup>5 11–14 17</sup> frequent debriefing sessions between the research team and the advisory group, and researchers' reflective commentary. Participants were also offered the opportunity to check their interview transcripts and reflect on situations where they did not understand or they need to decide what to do, etc. In addition, to validate the findings, the major themes were presented to study participants and asked for responses to the major ideas. Additional literature was reviewed to

provide perspective on emerging understanding. Sufficient contextual information about the fieldwork sites is provided to enable the reader to make a transfer to new situations that match study situations as judged by closeness of descriptive findings. Dependability and confirmability of findings were tested by re-reading the data to determine the depth of evidence available for each of the final themes analysed by the research team.

### Ethics considerations

The project received no external funding. Participants provided written consent after being informed of the study through a plain language statement and prior to their participation.

### RESULTS

The participants comprised 15 community nurses, including 13 women and 2 men aged between 40 and 60 years. Ten nurses were from the northern region, three nurses from the northwest Tasmanian region, one from the east coast and one from the west coast of Tasmania. The community nurses had worked an average of 8.8 years with the least experienced working in a community setting for 3 years, while the most experienced had been working in the role for 31 years as indicated in [table 1](#).

The role, function and structures of community nursing services varied greatly from site to site. For example, some nurses were sole practitioners working largely in isolation, others worked in small teams with other community nursing staff, while others worked with enrolled nurses or carers. In addition, some community nursing services were predominantly centre based with staff rarely providing nursing care in client homes, while

**Table 1** Demographics of community nurses

Variables	n (%)
Sex (N=15)	
Male	2 (13.3)
Female	13 (86.7)
Age groups, years (N=15)	
30–39	1 (6.7)
40–49	3 (20.0)
50–59	10 (66.6)
60–65	1 (6.7)
Location of community nurse (N=15)	
In a large rural town	1 (6.7)
In a small rural town	12 (80.0)
Remote town	2 (13.3)
Years of experience in community nursing (N=15)	
1–5	1 (6.7)
6–10	2 (13.3)
10–15	4 (26.6)
16–20	2 (13.3)
21–25	1 (6.7)
26 or more	5 (33.4)

others worked predominantly in the community with minimal or no centre-based service provision.

A number of key WHS themes were identified from the interview data that centred on geographical, physical and organisational environment issues as highlighted in [table 2](#) and discussed in detail below.

### Geographical environment issues

Among many community nurses, there were a number of WHS issues that centred on geography that were highlighted and included concerns around large travel distances and working in isolation.

#### Driving large distances

Driving was considered the greatest hazard within the workplace with major driving issues including great travel distances, long travel times, road condition and the impact that weather played in road safety. Other issues included encountering wildlife when driving, lack of full attention while driving due to looking for client addresses particularly in rural and remote areas, or lack of concentration due to thinking about workload and prioritisation. One nurse stated driving was stressful due to “just being on the road with other cars and trucks... one day, I even had a kangaroo jump off the bank in front of the car” (Nurse 5, 53 years old, woman).

Beyond other drivers and wildlife, the weather had an impact on staff safety. Some examples that were highlighted included extreme weather such as wild winds

causing trees to fall across roads, flooding that impacted access to client homes, extreme hot and cold weather, fog, frost, and rain or snow causing slick and icy roads. These types of conditions not only posed a palpable risk to community nurses' WHS, but also put them under pressure when service delivery had been compromised due to road closure and alternative longer routes were required to see clients.

Although driving was considered stressful, nurses felt there was a level of acceptance concerning driving. For example, one nurse stated “you just accept it. If you have to go out to remote areas, then you just go. That is what we do” (Nurse 5, 53 years old, woman). Another participant stated that it was the current process of vehicle use and mitigating vehicle theft and damage that left her, as a person, feeling vulnerable. In her case, as with her colleagues, work vehicles were returned more than 30 km from her workplace, to a city compound each night, which posed personal safety concerns.

After dark, sometimes I'm the only one there [at the compound]...I have to physically open and shut the gate by myself...I always ring my husband and say I'm on my way if I'm late so he knows...it is not safe. (Nurse 4, 45 years old, woman)

#### Working in isolation

The concern of working in isolation and being vulnerable were echoed among other participants. Within this

**Table 2** Coding used within thematic analysis of community nurses

Themes	Subthemes	Clusters
Geographical environment issues	<ul style="list-style-type: none"> <li>▶ Driving large distances</li> <li>▶ Working in isolation</li> </ul>	<ul style="list-style-type: none"> <li>▶ Road condition</li> <li>▶ Travel times</li> <li>▶ Weather</li> <li>▶ Wildlife</li> <li>▶ Lack of attention</li> <li>▶ Personal safety</li> <li>▶ Remoteness</li> <li>▶ Poor phone reception</li> <li>▶ Vulnerability</li> </ul>
Physical environment issues	<ul style="list-style-type: none"> <li>▶ Client behaviour</li> <li>▶ Home condition</li> <li>▶ Animals</li> <li>▶ Smoking issues</li> </ul>	<ul style="list-style-type: none"> <li>▶ Unpredictable clients</li> <li>▶ Aggression and violence</li> <li>▶ Poor home condition</li> <li>▶ Fire hazard</li> <li>▶ Clutter</li> <li>▶ Poor bathrooms and beds</li> <li>▶ Equipment risk working alone</li> <li>▶ Aggressive animals</li> <li>▶ Poor infection control</li> <li>▶ Passive smoking</li> </ul>
Organisation environment issues	<ul style="list-style-type: none"> <li>▶ Vertical and horizontal violence</li> <li>▶ Workload, burnout and work-related stress</li> </ul>	<ul style="list-style-type: none"> <li>▶ Manager and staff violence</li> <li>▶ Bullying</li> <li>▶ Extremes of workload</li> <li>▶ Documentation</li> <li>▶ Dealing with the dying</li> <li>▶ Dealing with client families</li> </ul>

study, it was shown that community nurses were working on their own in client's homes that were quite remote. In these rural areas, mobile or cell phone coverage is often temperamental or non-existent. Nurses reported frequent dropout areas especially in very remote areas away from town centres. They were concerned for their safety when being out working on their own and losing communication with the administration staff. One nurse stated "a big problem is communication. When you use a mobile phone...it probably will not work. There is usually no signal and that is big a problem" (Nurse 2, 47 years old, woman).

Another nurse shared her experience where she was made aware of the client's history of violence and who was living in a remote area of Tasmania. She said "anything could have happened and no one would have known until the end of the day...I was completely vulnerable" (Nurse 3, 49 years old, woman). Another example was shared by another community nurse who was working on one of the remote islands of Tasmania, when she received an after-hours telephone call through the night from a client who requested a home visit. She said "I didn't feel comfortable going out at night, not knowing the island, the client lived in a quite isolated part of the island and you are really there on your own" (Nurse 1, 57 years old, woman).

### Physical environment issues

Working in isolation can also impact when working in people's homes as nurses may encounter a number of challenges that are not observed within the acute setting. These issues included the condition of the home, access to the home, animals in the home, smoking issues, trip hazards, family domestic issue, falls risk for clients and community nurses, firearms, and tension between community nurses and clients related to home modification, while attempting to negotiate client care.

### Client behaviour

A client's home was highlighted as a unique and 'uncontrolled' work environment that is unpredictable, unable to be prepared and often not well equipped to provide certain types of care adequately. The most common WHS issue within a client's home was working with each individual client and overcoming the issues around poor behaviour. Aggressive behaviour from a client or their family members was the most common cited issue. Six participants stated that they encountered aggression and violence. The most common was verbal abuse or verbal threats and in some cases there was physical aggression. This was demonstrated by one community nurse who stated

I was caring for a lady with dementia...her husband who was her carer didn't understand dementia at all...and it was a very, very difficult relationship. In the end it got so bad that this fellow actually threatened my life. He said

'I'll shoot you'...'Don't come in, I'll shoot you'...he was so frustrated at the whole situation...he couldn't cope. (Nurse 4, 45 years old, woman)

Participants indicated that aggression commonly involved clients with dementia or a mental illness. In these cases when aggression was observed, participants stated that they would communicate with the client, investigate root causes of the situation and offer social support or immediately leave depending on the severity of risk. One nurse stated that

In some cases I would back out immediately and leave the scene, while in other cases I may try to talk the client around and calm them down. It depends on whether anyone else in the house is at risk...I have, on a few occasions managed the situation until the police and ambulance arrived. (Nurse 6, 51 years old, man)

### Home condition

When highlighting a client's home condition, participants said they were 'less than savoury' or 'horrendous'. Various homes were cluttered, filthy and untidy with unpleasant odours. Other homes had poor ventilation, poor lighting or damp floors. In one case, there was a snake found in a client's home and to facilitate greater WHS standards, the client had to keep the area around the home clear of clutter and have the grass cut regularly.

At times bathrooms were too small and beds were too low to provide appropriate and safe care. Manual handling issues included heavy patient lifting and positioning clients that related to the care of palliative care clients and wound care-related activities. For example, one rural community nurse stated "bending over the bed is really hard to prevent if you are caring for someone who is palliative in a double bed" (Nurse 4, 45 years old, woman). At times, it was highlighted that appropriate equipment was unavailable, delivery was often delayed or that the community nurse may be the sole operator of the equipment which may place them at greater risk.

Despite the manually handling issues, and the condition of the home, it was stated that the community nurses always try to improve the manual handling situation or condition of the home for the client and for their own safety. However, one nurse stated

We try and educate people, but often they have lived in this sort of environment for so long. It's a comfortable environment for them and if we go in and start posing our values and judgment too much, it may not work and it is not really what we do. (Nurse 15, 52 years old, woman)

For these specific situations, community nurses would try and educate clients, offer services to help cleaning, wear protective equipment, create a clean zone where possible, and discuss with clients and families how best to provide care through the use of additional equipment.

## Animals

It was recognised that animals such as a dog or a cat may be beneficial for many clients, particularly the elderly, as they provide company and emotional attachment. However, some community nurses did express discomfort when working in home environments where animals were present, such as large barking dogs or dogs that become aggressive when providing physical care to a client. In addition to the safety risk of pets, it was highlighted that animals at times may compromise an aseptic field or impact infection control by sitting on or walking past wound dressing trays, licking a client's wound or due to the owner poor maintenance of the pet's overall needs that impact the health of the owner.

## Smoking issues

Beyond animals, smoking was raised as a significant concern. One participant stated that clients have the right to smoke in their own home, but as the home is also a community nurses' work environment and that it created a "difficult social paradox" (Nurse 8, 52 years old, woman). Participants agreed that passive smoking is dangerous for their health and is a WHS issue that remains difficult to overcome. In many instances, clients were requested not to smoke while the nurse was present but to participants it did not change the environment where cigarette smoke had been building up over time.

Regardless of the issues that community nurses encountered, there were always difficult decisions to be made which by the community nurse, to accept the current risk(s) and continue care or withdraw service. Most participants said before withdrawing service they would propose creative solutions with the client then let them decide whether the service would be continued or ceased.

I have had experience of patient's houses not being safe places to work in and there's ways around that. You'd bring them into the district hospital to deliver wound care or shower them...because their home environment was not conducive to safe practice. (Nurse 9, 55 years old, woman)

## Organisation environment issues

In addition to the geographic and physical WHS issues that community nurses encountered, they also experienced WHS issues that were embedded within the organisations where they were employed. The three key issues that participants highlighted encompassed workload challenges, vertical and horizontal violence and work-related stress.

## Vertical and horizontal violence

Among the participants, there was a mixed response regarding the experience of vertical and horizontal violence in the workplace. Three participants confirmed they got along well with their colleagues, two

highlighted issues with both managers and staff, while three participants shared stories of bullying and harassment from their managers and other staff. One participant indicated that she did not want to discuss the issue, however stated that she was aware of it occurring in her workplace. Overcoming violence, various strategies were attempted to be employed, such as risk assessment and cultural safety techniques yet were all based on experience, advice of other staff and not based on service policy.

When asked about the biggest WHS issue that impacts on their health, three participants emphasised vertical violence that had occurred in various situations as community nurses. The overall detrimental effect was so intense that community nurses required ongoing counselling and psychology consultation for high level of stress, anxiety and depression. They each share similar stories of taking stress leave which led to eventually leaving their respective workplaces. It was indicated that they were not the only community nurses to experience this type of vertical violence, stating that many staff had left the various workplaces and even the profession altogether.

## Workload, burnout and work-related stress

Within the community nursing setting, workload fluctuates throughout the year where there may be higher or lower than normal client numbers. However, this workload may fluctuate week to week and day to day. When busy, community nurses' workload may be very heavy due to time constraints, large amount of documentation or due to taking on extra clients and responsibilities when staff are on leave or sick. One participant suggested that the time required delivering care for clients varied depending on their individual care needs and the impact of overall workload. Some participants shared similar experience where unanticipated situations occur suddenly that may impact their work day even when carefully planned in advance.

You might visit someone and they have had a fall. So your planned 15–20 minutes visit will turn into a couple of hours. You may have to get the ambulance or you would have to wait for their family to come. (Nurse 15, 52 years old, woman)

In addition to the fluctuation of workload, there were other major factors that cause stress and burnout among community nurses and was felt to be a WHS issue if appropriate support was not provided. Caring for palliative clients and encountering confronting situations, such as death and tragedy was the most discussed burnout issue among participants. In many cases, a number of community nurses called it 'compassion fatigue', a common stress factor among community nurse as "we deal with quite gory things a lot of the time and people get burned out" (Nurse 3, 49 years old, woman). This was further reflected by one community

who stated that they had more than nine palliative care clients that required daily care at various times over a period of 18 months.

Despite these challenges, many participants showed strong self-awareness and discussed work–life balance, such as not taking work home or taking a break or time off if necessary. Participants said they would share their stress or concerns with colleagues, managers or loved ones, however not all of them was able to do this. It was highlighted that community nurses would, if possible, organise their workloads to share clients if a nurse was overloaded with palliative clients.

## DISCUSSION

The WHS issues and challenges that were highlighted were many, complex and centred on the ‘environments’ where community nurses were working at the time. It was noted that many of the WHS issues were reflective of the current literature that is focused on remote area nursing and there were many commonalities between the two disciplines. This included working across large geographical areas, working in isolation, driving issues, and poor behaviour from clients and family members. It also encompassed the state of the client’s homes; manual handling issues especially relating to palliative care; workplace issues including conflict, bullying, excessive workload, stress and burnout.<sup>1 5 16 17 37–41</sup>

Despite the consistencies within the literature, the research also revealed that there were key skills that had been developed, emerged or were suggested to meet or at least ‘making do’ the WHS challenges that were encountered. The strategies that were elucidated were often aspirational and included organisational approaches to remove stress. These also included addressing overall workplace demands, a greater focus on improved debriefing systems, and greater awareness of and access to employee assistance programmes. In addition, coping with stress and burnout included seeking social support, planned problem solving, self-controlling, positive reappraisal.<sup>37</sup> Each of these mechanisms were felt to provide more effective management of the emotional demands inherent in the workplace.

Overcoming violence, various strategies were attempted to be employed, such as risk assessment and cultural safety techniques. However, these approaches were often not based on policy and procedure, but on experience and advice sought from other community nurses. In addition, educating staff around violence, its negative consequences was highlighted, but rarely provided to staff. Similarly, implementing zero tolerance as part of the workplace culture was aspirational, yet in many cases it was not consistently occurring in practice. In addition, it was suggested that health services need to work more closely with communities to develop greater safety programmes to address violence between health consumers and healthcare providers.<sup>42</sup>

In terms of strategies to prevent musculoskeletal disorders, it has been suggested a risk assessment to be conducted during the first visit to a client’s home, which was dependent on the service and the assessments that were developed. In addition to assessing and addressing client’s needs, it was felt that community nurses required additional time for thorough WHS assessments and planning with adequate devices and procedures to be in place until care could be provided. Another intervention that was considered to be beneficial was aerobic and strength building exercise training programme for nursing staff.<sup>43</sup>

Beyond the day-to-day WHS issues that many community nurses were encountering and addressing as best they could, it was demonstrated that current approaches to workload issues were inadequate. For example, addressing workload issues included client load being divided between teams or frequent rotation of staff between clients. This addressed driving distance issues and overburden of client contact, however decreased continuity of care among clients. In other circumstances, it was shown that when workload was excessive, nurses would prioritise tasks that may have included cancelling appointments, not completing paperwork in a timely manner or working unpaid overtime to meet the needs of the service. There was great autonomy among staff; however, currently there were poor processes in place to ensure the capable and well-skilled staff are practising safely when providing care in a complex and unforgiving environment.

Overall, there were a number of issues that were highlighted which included chronic underfunding of services; lack of discipline-specific training and access to training for rural community nurses; poor-quality improvement and pastoral care systems; and workforce supply problems, encompassed by poor recruitment, staff relief systems and inadequate orientation of new staff. In addition, it highlights that there is inadequate preparation and capacity of a number of operational managers to appropriately manage systems and support staff to meet the needs of the community in an environment that is centred on WHS practices.

## Limitations

It must be noted that a number of telephone interviews were undertaken, which may have influenced the data that were collected in terms of quality and its depth of information. Face-to-face interactions allow greater probing, clarification and more in-depth data to be gathered from the participants than telephone interview.<sup>23 24 44</sup> However, to undertake face-to-face interviews with these select community nurses was impacted by 5 h travel distances or the inability to meet due to work schedules and commitments of the nurses. As an alternative to no interview, the phone interviews were seen as the best alternative.

Lastly, the role, function and structures of community nursing services varied greatly from site to site and these differences may have influenced the participants’ responses



as they may have encountered quite different WHS challenges. However, the themes that occurred among most community nurses were reported within this paper. In some cases, site-specific challenges, such as dealing with animals that were brought into the community nursing clinic for care, were outside the scope of the paper.

## CONCLUSION

Overall, it was indicative that many nurses were achieving good outcomes to meet the needs of community health consumers. In many cases, managements were assisting their staff to achieve service objectives under the auspice of WHS practices. However, many current processes that were highlighted by participants were considered unsafe, unsustainable, impracticable, and demonstrated a number of underlying issues within the current community health system. Again, it was highlighted that many community nurses and managers were doing their best; however, greater training and capacity building is required to meet the needs among all staff. Meeting the needs of the community was achieved; however, there was a reactive approach among many services and healthcare providers, rather than a proactive approach to ensure both nursing staff and health consumers were safe when providing care.

**Acknowledgements** The authors acknowledge the community nurses who participated in this project and who gave both their time and information. Acknowledgement is also expressed to Tasmania Health Organisations North and Northwest for their support of this study and for allowing their staff to participate.

**Contributors** DT and QL developed the research design, assisted with data collection and developed, wrote and edited the final manuscript. UN undertook the data collection and provided assistance with manuscript development and its initial writing, while HH provided technical advices throughout the research process and wrote and edited the final manuscript.

**Competing interests** None declared.

**Ethics approval** Human Research Ethics Committee (Tasmania) Network (H0013420).

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data sharing statement** No additional data are available.

**Open Access** This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>

## REFERENCES

1. Franche RL, Murray EJ, Ostry A, *et al*. Work disability prevention in rural areas: a focus on healthcare workers. *Rural Remote Health* 2010;10:1–24.
2. AIHW. *Rural health*. In: Welfare AloHa, ed. Canberra: Australian Government, 2013:1–24.
3. Molinari D, Monserud M. Rural nurse job satisfaction. *Rural Remote Health* 2008;8:1055–64.
4. Hunsberger M, Baumann A, Blythe J, *et al*. Sustaining the rural workforce: nursing perspectives on worklife challenges. *J Rural Health* 2009;25:17–25.
5. MacLeod M, Browne AJ, Leipert B. Issues for nurses in rural and remote Canada. *Aust J Rural Health* 1998;6:72–8.
6. Danna K, Griffin RW. Health and well-being in the workplace: a review and synthesis of the literature. *J Manag* 1999;25:357–84.
7. Hilgert J. Future of workplace health and safety as a fundamental human right. *Comp Labour Law Policy J* 2012;34:715–36.
8. Stuart EH, Jarvis A, Daniel K. A ward without walls? District nurses' perceptions of their workload management priorities and job satisfaction. *J Clin Nurs*. 2008;17:3012–20.
9. Salmond S, Ropis PE. Job stress and general wellbeing: a comparative study of medical-surgical and home care nurses. *Medsurg Nurs* 2005;14:301–9.
10. Ellis I, Kelly K. Health infrastructure in very remote areas: an analysis of the CRANA Bush Crisis Line database. *Aust J Rural Health* 2005;13:1–2.
11. Newman B, Berens H. Occupational health-related experiences in rural Tasmania. *Br J Community Nurs* 2010;15:355–9.
12. Barrett A, Terry DR, Lê Q. *Rural community nurses: insights into health workforce and health service needs in Tasmania*. Launceston: University of Tasmania, 2014.
13. Kaasalainen S, Brazil K, Williams A, *et al*. Barriers and enablers to providing palliative care in rural communities: a nursing perspective. *J Rural Community Dev* 2012;7:4–19.
14. Weymouth S, Davey C, Wright JI, *et al*. What are the effects of distance management on the retention of remote area nurses in Australia? *Rural Remote Health* 2007;7:652.
15. Gershon RR, Stone PW, Zeltser M, *et al*. Organizational climate and nurse health outcomes in the United States: a systematic review. *Ind Health* 2007;45:622–36.
16. Wakerman J, Davey C. Rural and remote health management: 'the next generation is not going to put up with this. *Asia Pac J Health Manag* 2008;3:13–18.
17. Opie T, Dollard M, Lenthall S, *et al*. Levels of occupational stress in the remote area nursing workforce. *Aust J Rural Health* 2010;18:235–41.
18. Billay E. *Personal safety of Alberta public health and home care nurses during home visiting [M.N.]*. Ann Arbor: University of Alberta (Canada), 2001.
19. Bushy A. International perspectives on rural nursing: Australia, Canada, USA. *Aust J Rural Health* 2002;10:104–11.
20. McConnell-Henry T, Chapman Y, Francis K. Unpacking Heideggerian phenomenology. *South Online J Nurs Res* 2009;9:6–16.
21. Creswell JW. *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks: Sage Publications, 1998.
22. Carpenter DR. Phenomenology as method. In: Speziale HJS, Streubert HJ, Carpenter DR, eds. *Qualitative research in nursing: advancing the humanistic imperative*. 5th edn. Philadelphia: Lippincott Williams & Wilkins, 2010.
23. Bowling A. *Research methods in health: investigating health and health services*. 2nd edn. Berkshire: Open University Press, 2005.
24. Liamputtong P, Ezzy D. *Qualitative research methods*. 2nd edn. South Melbourne: Oxford University Press, 2005.
25. Greenhalgh T. *Primary health care: theory and practice*. Malden, Mass: Blackwell/BMJ Books, 2007.
26. ABS. *Census 2011 Canberra*: Australian Bureau of Statistics. 2011. <http://www.abs.gov.au> (cited 20 January 2014).
27. Merriam S. *Qualitative research. A guide to design and implementation*. San Francisco: John Wiley & Sons, 2009.
28. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
29. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *Int J Qual Methods* 2008;5:80–92.
30. Dixon-Woods M, Sutton A, Shaw R, *et al*. Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *J Health Serv Res Policy* 2007;12:42–7.
31. Patton MQ. *Qualitative evaluation and research methods*. Thousand Oaks, CA: Sage, 2002.
32. Flick U. *An introduction to qualitative research*. London: Sage, 2006.
33. Healy M, Pery C. Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qual Mark Res* 2000;3:118–26.
34. Guba EG. Criteria for assessing the trustworthiness of naturalistic inquiries. *Educ Technol Res Dev* 1981;75–91.
35. Lincoln YS, Guba EG. *Naturalistic inquiry*. Newbury Park, CA: Sage, 1985;29(2).
36. Atkins S, Lewin S, Smith H, *et al*. Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC Med Res Methodol* 2008;8:21.



37. Hegney D, McCarthy A, Rogers-Clark C, *et al.* Why nurses are attracted to rural and remote practice. *Aust J Rural Health* 2002;10:178–86.
38. Lenthall S, Wakerman J, Opie T, *et al.* What stresses remote area nurses? Current knowledge and future action. *Aust J Rural Health* 2009;17:208–13.
39. Lenthall S, Wakerman J, Opie T, *et al.* Nursing workforce in very remote Australia, characteristics and key issues. *Aust J Rural Health* 2011;19:32–7.
40. McCullough KM, Lenthall S, Williams AM, *et al.* Reducing the risk of violence towards remote area nurses: a violence management toolbox. *Aust J Rural Health* 2012;20:329–33.
41. Opie T, Lenthall S, Dollard M, *et al.* Trends in workplace violence in the remote area nursing workforce. *Aust J Rural Health* 2010;27:18–23.
42. Hegney D, Plank A, Parker V. Workplace violence in nursing in Queensland, Australia: a self-reported study. *Int J Nurs Pract* 2003;9:261–8.
43. Joseph GM, Skinner MW, Yantzi NM. The weather-stains of care: interpreting the meaning of bad weather for front-line health care workers in rural long-term care. *Soc Sci Med* 2013;91:194–201.
44. Minichiello V. Interview processes. In: Minichiello V, Aroni R, Timewell E, eds. *In-depth interviewing*. 3rd edn. Melbourne: Pearson Education, 2008.