

THE FAMILY HEALTH NURSE CONTEXT, CONCEPTUAL FRAMEWORK AND CURRICULUM

HEALTH21, the health policy framework for the European Region of WHO introduces a new type of nurse, the Family Health Nurse, who will make a key contribution within a multidisciplinary team of health care professionals to attainment of the 21 targets for the twenty-first century set out in that policy. Based on the competencies derived from the WHO definition of the multifaceted role of the Family Health Nurse, a curriculum has been designed which will prepare qualified and experienced nurses for this new role. The curriculum places emphasis on the integration of theory and practice. The content is described in seven modules. Teaching, learning and assessment strategies are based on andragogic principles of adult educational theory and will use a variety of methods. To help clarify the scope of the role of the Family Health Nurse, sample care scenarios, focusing on the care of different families, are included in Annex 1. Successful completion of the educational programme will lead to a postgraduate academic award and the specialist qualification of “Family Health Nurse”.

EUROPEAN HEALTH21 TARGET 2: EQUITY IN HEALTH

By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all Member States, by substantially improving the level of health of disadvantaged groups

EUROPEAN HEALTH21 TARGET 3: HEALTHY START IN LIFE

By the year 2020, all newborn babies, infants and pre-school children in the Region should have better health, ensuring a healthy start in life

EUROPEAN HEALTH21 TARGET 4: HEALTH OF YOUNG PEOPLE

By the year 2020, young people in the Region should be healthier and better able to fulfil their roles in society

EUROPEAN HEALTH21 TARGET 5: HEALTHY AGING

By the year 2020, people over 65 years should have the opportunity of enjoying their full health potential and playing an active social role

EUROPEAN HEALTH21 TARGET 6: IMPROVING MENTAL HEALTH

By the year 2020, people's psychosocial wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems

EUROPEAN HEALTH21 TARGET 8: REDUCING NONCOMMUNICABLE DISEASES

By the year 2020, morbidity, disability and premature mortality due to major chronic diseases should be reduced to the lowest feasible levels throughout the Region

EUROPEAN HEALTH21 TARGET 15: AN INTEGRATED HEALTH SECTOR

By the year 2010, people in the Region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system

EUROPEAN HEALTH21 TARGET 18: DEVELOPING HUMAN RESOURCES FOR HEALTH

By the year 2010, all Member States should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health

EUROPEAN HEALTH21 TARGET 19: RESEARCH AND KNOWLEDGE FOR HEALTH

By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

KEYWORDS

NURSING – trends
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PROFESSIONAL-FAMILY RELATIONS
EDUCATION, NURSING – trends
CURRICULUM – nurses' instruction
EUROPE

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1. Context

HEALTH21: the health for all policy framework for the WHO European Region (1) was approved by the WHO Regional Committee for Europe in September 1998, following extensive consultation with all 51 European Member States and other major organizations. It sets out 21 targets for the twenty-first century. These targets articulate the aspirations of the regional policy. They are intended to provide a framework for action within each Member State, in order that it can bring its own health policies and strategies into line with those of HEALTH21.

1.1 Development of human resources for health

Target 18 of the policy document deals with the development of human resources for health and states: “By the year 2010, all Member States should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health” (*I*: 198).

Within the multidisciplinary team of health care professionals, whose contribution will be essential to securing the health care outcomes envisaged in the policy targets, two groups are singled out. These are the professions of medicine and of nursing. Specific reference is made to the qualifications of physicians and nurses working in primary health care settings, as they are stated to be “at the hub of the network of services” required to achieve the goal, aims and targets of the policy. The key elements of the role of the family health physician and of the Family Health Nurse are outlined in the policy document, which stresses that they need to be educated and trained in such a way as to ensure that they acquire the necessary underpinning knowledge and skills.

2. The Family Health Nurse in the context of HEALTH21

The present paper focuses on the educational preparation of a new type of nurse, the Family Health Nurse. It is important to bear in mind that it does so within the context of the HEALTH21 policy, the “one constant goal” of which is “to achieve full health potential for all”, through the attainment of two main aims. These are: “promoting and protecting people’s health throughout the course of their lives; and reducing the incidence of and suffering from the main diseases and injuries”.

Underpinning the policy, its goal and aims are three very important basic values, which form the ethical foundation of HEALTH21. These are:

- “health as a fundamental human right;
- equity in health and solidarity in action between countries, between groups of people within countries, and between genders; and
- participation by and accountability of individuals, groups and communities and of institutions, organizations and sectors in health development” (*I*: 3–4).

2.1 Definition of the role of the Family Health Nurse

The Family Health Nurse will: “help individuals and families to cope with illness and chronic disability, or during times of stress, by spending a large part of their time working in patients’ homes and with their families. Such nurses give advice on lifestyle and behavioural risk factors,

as well as assisting families with matters concerning health. Through prompt detection, they can ensure that the health problems of families are treated at an early stage. With their knowledge of public health and social issues and other social agencies, they can identify the effects of socioeconomic factors on a family's health and refer them to the appropriate agency. They can facilitate the early discharge of people from hospital by providing nursing care at home, and they can act as the lynchpin between the family and the family health physician, substituting for the physician when the identified needs are more relevant to nursing expertise." (1: 139)

This multifaceted role ensures that the Family Health Nurse will be in a position to contribute significantly to reaching 20 of the 21 targets in HEALTH21, the exception being target 17, which is focused exclusively on the role of governments (see Annex 1).

The WHO European Regional Adviser for Nursing and Midwifery, speaking to the European Forum of Nursing and Midwifery Associations and WHO, saw the Family Health Nurse as having a role along the whole continuum of care, including health promotion, disease prevention, rehabilitation and providing care for those who are ill or in the final stages of life (2). While the title "Family Health Nurse" suggests that the focus of the nurse is only on people who live within families, as this concept is generally understood, the role embraces much more than that and includes all people in the community, whether they are living with others or alone, whether they have a home or are homeless and/or marginalized in some way, and it also includes the community itself. The Family Health Nurse will also have important roles to play, in empowering communities and working in partnership with them to foster their own resources and potential, and to find their own solutions to issues of concern.

HEALTH21 points out that "families (households) are the basic unit of society where health care providers will be able not only to address patients' somatic physical complaints but also to take into account the psychological and social aspects of their condition. It is important for PHC [primary health care] providers to know the circumstances in which patients live: their housing, family circumstances, work, and social or physical environment may all have a considerable bearing on their illness. Unless care providers are aware of these circumstances, presenting symptoms may be misinterpreted and conditions may go unrecognized and untreated. The result may be unnecessary diagnostic and treatment procedures, thus increasing costs without helping to address the real problems." (1: 121)

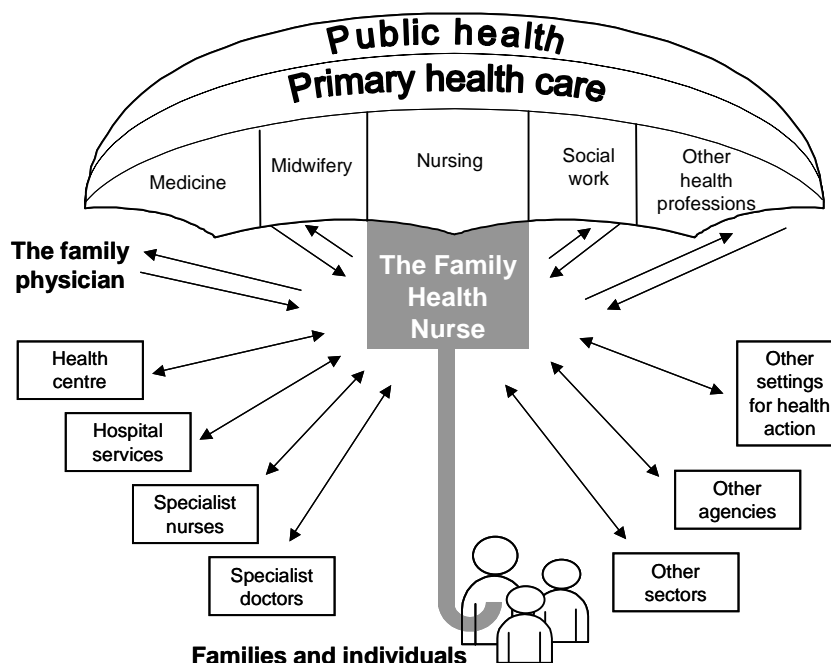
It is anticipated that the Family Health Nurse will be responsible for a defined group of "families".

2.2 The Family Health Nurse – a new concept?

The role and functions of the Family Health Nurse as described above contain elements which are already part of the role of several different types of community nurse who work in primary health care across the European Region. A recent survey undertaken by the WHO Nursing and Midwifery Programme found several different models of community nursing provision in operation. Both roles and titles varied, and the same title, for example "public health nurse", described very different roles in different countries (3). What is new in the concept of the HEALTH21 Family Health Nurse is the particular combination of the various elements, the particular focus on families and on the home as the setting "where family members should jointly take up their own health problems and create a 'healthy family' concept" (4).

The position and role of the new Family Health Nurse can be depicted, as shown in Fig. 1, under the “umbrella” of public health and primary health care, and within the context of the integrated health sector described in target 15 of HEALTH21: “By the year 2010, people in the Region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system.” (1: 119)

Fig. 1. The Family Health Nurse under the “umbrella” of public health and primary health care



3. The Family Health Nurse course and curriculum

3.1 The aim of the course and curriculum

The aim of the curriculum is to prepare the Family Health Nurse for practice in the role as defined in HEALTH21 and in section 2.1 above. The aim will be achieved by means of a competency-based and research-based curriculum.

3.2 Structure, length and mode of delivery

The course will be modular, of 40 weeks' duration, and the preferred mode of delivery is full time. Flexibility to deliver the course in part-time mode or with elements by distance learning should be open for negotiation, depending upon each Member State's resources.

3.3 Entry requirements

In HEALTH21, the question of whether the family health physician would possess the necessary skills to function in that role “straight after graduating from medical school” is noted to be currently a matter of debate in several countries, and a similar question arises in relation to the

Family Health Nurse. Would she or he be able to function in the lynchpin role envisaged in HEALTH21 directly after graduating from nursing school? For the time being, therefore, the Curriculum Planning Group (Annex 3) has taken up the position set out below.

Course participants will be nurses who have successfully completed an initial nursing education programme, as described in the WHO regional strategy for nursing and midwifery education entitled *Nurses and midwives for health. A WHO European strategy for nursing and midwifery education (5)*, or its equivalent. They will therefore be qualified to work in hospitals or in the community. They should have a minimum of two years' post-qualifying experience and have completed a period of three months' work experience on attachment to a family in their home and community setting. This period should, in due course, be under the supervision of a qualified Family Health Nurse. In the interim, while there is no critical mass of such nurses, a qualified community nurse should undertake this supervision.

Informed consent will need to be sought from the family, and the appropriate legislation and regulations should specify the rights of both the family members and of the nurse. It is intended that nurses will continue their professional relationship with the family throughout the duration of the Family Health Nursing course, so that they can test out the theoretical content of the course in the reality of practice within the family life course and health/illness experiences.

3.4 A conceptual framework for family health nursing

A conceptual framework provides a way of understanding and organizing the key concepts of practice and of the education programme which prepares the student for that practice – in this case, that of family health nursing. Such a framework gives direction and focus, and it makes visible the values and goals of the activity.

To describe the role of the Family Health Nurse and to guide the curriculum presented in this document, the Curriculum Planning Group drew on systems theory, interaction theory and developmental theory (6,7). Systems theory provides a useful way of representing and analysing the complexities of a situation – and health care is a very complex matter. Interaction theory encourages consideration of the nurse/patient relationship, the nurse/family relationship and the concepts of partnership and teamwork which are central to the philosophy of primary health care. Developmental theory is important in aiding understanding not only of individual human beings but also of the development of the family, in the context of the major life course events that are faced by all people and which vary in intensity and impact, depending on many complex factors.

These three theories are combined in the conceptual model which is depicted in Fig. 2 and 3 and exemplified in the portfolio of care scenarios (Annex 2).

Fig. 2 indicates how Family Health Nurses and the families with whom they work may be viewed as systems operating within a context or environment. Many elements in the environment (stressors) impinge both positively and negatively on these systems, strengthening or threatening their existence and integrity. Health is viewed as the dynamic equilibrium which is maintained between one of the systems, i.e. the family or the individual, and the environment. The systems change and develop over time, never being static. The work of the Family Health Nurse is an interactive activity, in which nurse and family are partners. The goal of the nurse's activities is to maintain, and over time if possible to improve, the family's equilibrium or health status by helping the family to avoid or to cope with stressors or threats to health.

Fig. 2. The family and the Family Health Nurse as systems in an environment

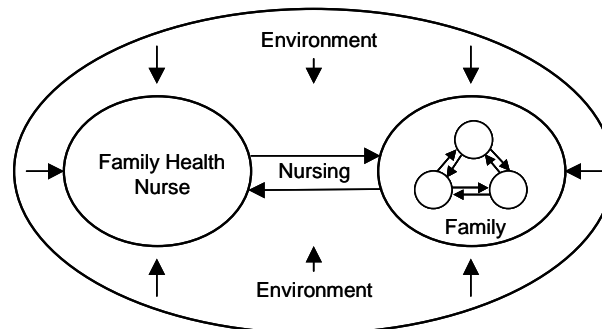
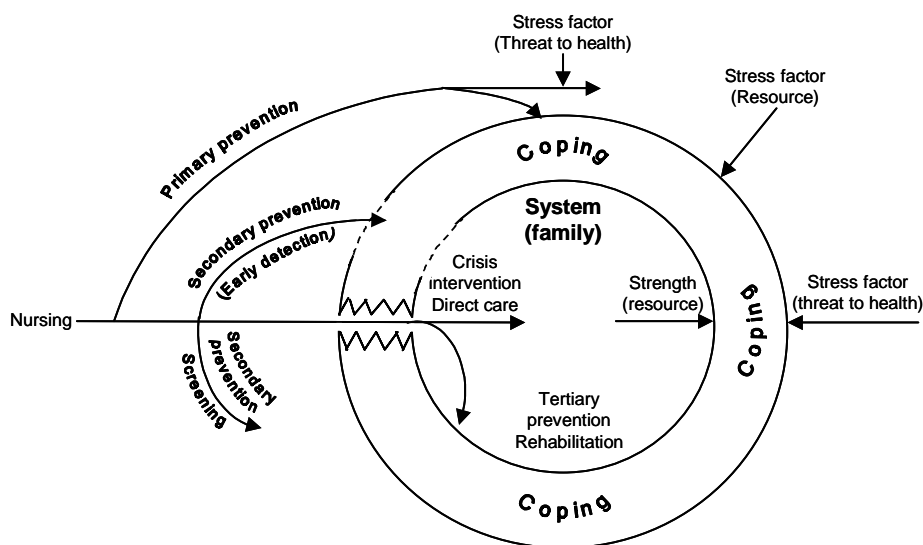


Fig. 3 depicts the four major types of intervention by Family Health Nurses – primary, secondary and tertiary prevention, and crisis intervention/direct care. At the level of primary prevention, they assess the possible presence of harmful stressors or threats to health and work pro-actively to prevent these from impinging on the family. They may help the family build up their “resistance resources” (7) by providing health education and support, and by assisting them to mobilize other resources, monitoring the integrity of the system pro-actively by identifying potentially harmful stressors. At the level of secondary prevention, they may become actively involved in screening and vaccination programmes. Because of their expert knowledge of their particular caseload of families, they will detect the onset of health problems at an early stage, prompting quick action to minimize disruption of the individual and the family and calling on other relevant expert resource personnel as necessary, acting in their key lynchpin role as described in HEALTH21 and in section 2.1 above. In tertiary prevention, they are involved in rehabilitation and rebuilding the family’s “resistance resources”. The fourth mode of intervention, the provision of direct care, is the traditional role of the nurse when the family’s or individual’s coping mechanism has been breached, for example by illness. Here, the Family Health Nurse works in partnership with the family or individual to achieve, as appropriate, cure, rehabilitation, palliation and/or support.

Fig. 3. Family health nursing: helping the family to maintain health and cope with threats to health

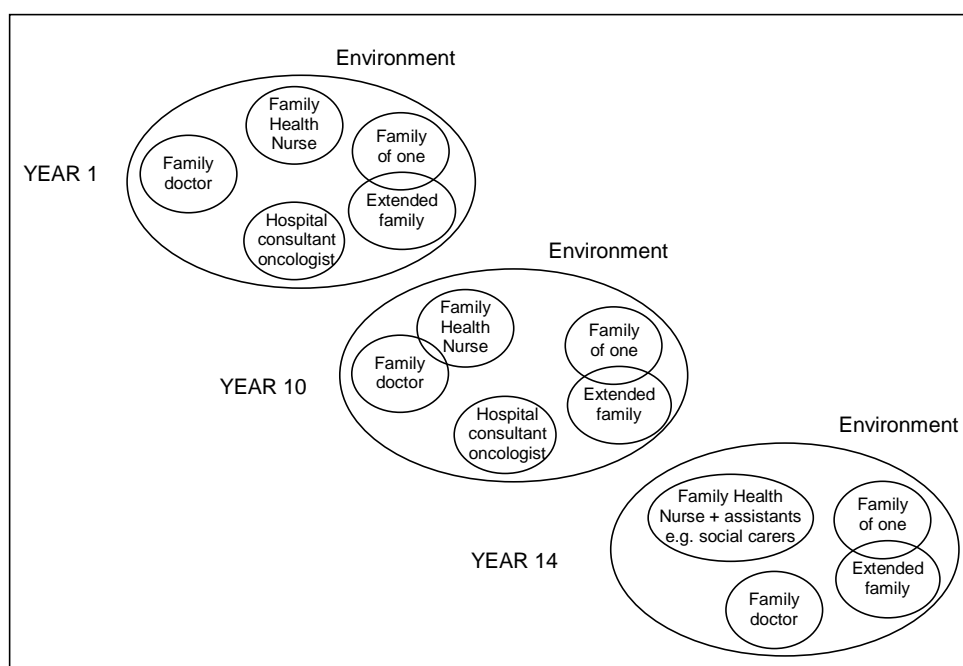


The relationship between these theoretical concepts and actual practice is shown in the next section.

3.5 Care scenarios

To aid understanding of the new concept of Family Health Nurses, of the breadth, depth and scope of their role, and of the advanced knowledge, skills and attitudes they will need to master, a portfolio of sample care scenarios is given in Annex 2. These scenarios, each concluding with a brief commentary, simulate what might be part of a typical caseload for a Family Health Nurse. They illustrate how and to what extent Family Health Nurses may be involved in events at different times in the life course of families or individuals, the related nursing activities which they might be expected to carry out, and the varying time scale of their involvement (see Fig. 4 and refer to the care scenario about the single person suffering from metastatic breast cancer). They also illustrate how the Family Health Nurse may be involved with communities and may work and liaise with a large number of agencies (refer to the care scenarios about chronic disease prevention and management and about accident prevention/inequalities in health). Analysis of the care scenarios will indicate the Family Health Nurse's broad contribution to the targets of HEALTH21. A selection of the targets prioritized in the individual scenarios is also given at the close of each commentary.

Fig. 4. Example of the varying extent of involvement of the Family Health Nurse in the care scenario of a single person suffering from metastatic breast cancer



The scenarios are purely examples, drawn from a number of countries in WHO's European Region. The majority were written by members of the Curriculum Planning Group, based on their experience and their shared discussions in preparing this curriculum. Others were drawn up by experienced colleagues. However, these scenarios, together with those derived by students from their experience of family health nursing, will form the basis for some of the teaching/learning activities in the Family Health Nurse curriculum, using the problem-solving approach.

The care scenarios given in Annex 2 illustrate the role of the Family Health Nurse in the following situations:

- chronic disease prevention and management;
- care of a family where the mother has cancer of the breast;
- care of a single person suffering from metastatic breast cancer (see Fig. 4);
- care of a family with mental health and alcohol-related problems;
- care of a family with a new baby;
- care of an elderly couple, both of whom are in poor health;
- care of an elderly widower with multiple disease pathology;
- care of a family where the father is a heavy smoker who wants to stop smoking;
- care of a diabetic lady who has gradually lost her independence and has to be admitted to residential care;
- care of a family preparing for the birth of their first child;
- care of a single parent who is pregnant and who is a drug abuser;
- care of a teenager who is pregnant;
- care of an ethnic minority refugee family;
- accident prevention/inequalities in health.

3.6 Competencies or learning outcomes

The key components of the role of the Family Health Nurse are similar to those of the “Five-Star Doctor” or “Five-Star Nurse”, cited in *Doctors for health. A WHO global strategy for changing medical education and medical practice for health for all* (8) and *Nurses and midwives for health. A WHO European strategy for nursing and midwifery education* (5). These components, key to the role, are also the fundamental or core competencies of the nurse who has successfully completed the Family Health Nurse curriculum. The Family Health Nurse therefore is expected to be, and required to be competent as, a:

- care provider
- decision-maker
- communicator
- community leader
- manager.

These core competencies will be achieved through a process of developing the underpinning competencies, i.e. those which will enable Family Health Nurses effectively and efficiently to:

1. identify and assess the health status and health needs of individuals and families within the context of their cultures and communities;
2. make decisions based on ethical principles;
3. plan, initiate and provide care for families within their defined caseload;

4. promote health in individuals, families and communities;
5. apply knowledge of a variety of teaching and learning strategies with individuals, families and communities;
6. use and evaluate different methods of communication;
7. participate in disease prevention;
8. coordinate and manage care, including that which they have delegated to other people and personnel;
9. systematically document their practice;
10. generate, manage and use clinical, research-based and statistical information (data) for planning care and prioritizing health- and illness-related activities;
11. support and empower individuals and families to influence and participate in decisions concerning their health;
12. set standards and evaluate the effectiveness of family health nursing activities;
13. work independently and as members of a team;
14. participate in the prioritization of health- and illness-related activities;
15. manage change and act as agents for change;
16. maintain professional relationships and a supportive collegiate role with colleagues; and
17. display evidence of a commitment to lifelong learning and continuing professional development.

3.7 Content of the curriculum

The curriculum will be delivered in a series of seven modules, detailed in section 7. Apart from the Introductory module, which sets the scene in relation to the concepts and the teaching/learning and assessment strategies underlying the curriculum, all the other modules will have a practice-based component. Two modules will run concurrently, for example the Introductory module might be delivered on one day a week, followed by the Decision-making module, also delivered on one day a week, and during these weeks, the first Provision of Care module would also be running. This type of structuring of the content should ensure that students are kept in touch with care provision while also being encouraged to see how the theoretical concepts are translated into the reality of practice from the very beginning of the course.

3.8 Teaching/learning and assessment strategies

These strategies will stimulate learning at all six levels of cognitive skills, as described by Bloom (9). The teaching/learning and assessment strategies employed in the course should be congruent

with andragogic principles, the rationale for which is that teachers and students will bring to the course existing competencies – relevant knowledge, skills and attitudes – to contribute to a mutually educative process. Active student participation, facilitated by nurse teachers (who will have a role both in a university setting and in practice), and by mentors (in practice), will be the norm. Care scenarios will be the focus of much of the teaching, which will use a problem-solving approach as well as a diverse range of other methods. Overall, emphasis will be placed on interactive approaches such as student-led seminars and team work, and on practical demonstrations, for example of physical health assessment, the use of technical equipment, and the skills of effective verbal and non-verbal communication. The latest technology available to the university in the particular Member State, for example interactive video, should be used to promote such approaches. There will continue to be a place for the didactic lecture, but it will constitute a relatively minor proportion of the curriculum. Assessment methods should be supportive of the adult learning approach, should be research-based and could include, for example, project work, literature searching, case study presentation, health assessment, community profiling and independent learning contract work.

The success of these teaching/learning and assessment strategies will depend critically on the availability and deployment of appropriately qualified and prepared nurse educators who are committed to the philosophy of adult learning approaches. In addition, such interactive and problem-solving andragogic approaches must be supported by adequate space, library and other technological resources, and this should be borne in mind at the planning stage.

3.9 Supervision of practice

In time, the practice components of the family health nursing course will be supervised by qualified Family Health Nurses, although this will not be possible in the early years of the course. In order to build up a critical mass of Family Health Nurses, it will be necessary for Member States to launch courses in family health nursing, and to release selected practising community nurses and community nurse teachers to attend these courses. In the interim years, nurse teachers and community nurses who have been introduced to the concept of family health nursing should act as teachers and supervisors.

3.10 Optimum student intake and teacher/student ratio

As interactive adult teaching/learning and assessment strategies will be used throughout the course, which will include the requirement for clinical supervision, the optimum intake per course is likely to be 30 students and, based on the same rationale, the ideal teacher–student ratio should not exceed 1 : 10, i.e. 1 teacher per 10 students.

3.11 Quality control and evaluation

External audit will be essential to evaluate the quality and standards of the course, as evidenced by the curriculum design, the teaching/learning strategies, the marking of student assessments and the results in both academic work and in practice competencies. Curriculum evaluation should be carried out by teachers, students and also by those providing the service, i.e. nurse managers and, in due course, practising Family Health Nurses.

4. Teachers and mentors

The types of teaching/learning and assessment strategies considered essential for this curriculum are challenging for teachers, mentors and students. It is therefore important, if they are to be effectively delivered, that only qualified nurse teachers and mentors are involved (see also section 3.8 above). The setting up of structures to ensure peer group support and close liaison between teachers and mentors will be particularly important in the early years, as there will be no role models either in education or in practice.

5. Location of the course

The theoretical components of the course should be delivered in a university or equivalent higher education institution. Practice elements will take place in family homes and other non-institutional community settings.

6. Qualification on successful completion of the course

On successful completion of the curriculum, the nurse will receive the specialist qualification and postgraduate academic award of “Family Health Nurse”.

7. Course content – Modules 1 to 7

Descriptions of all these modules, which comprise the curriculum, are given in the following pages. It should be noted that a number of concepts and subjects introduced in one module are revisited and further developed in another. As knowledge and experience are gained, students will be able to view these concepts and subjects from different aspects and build upon earlier work. To give just two examples, the concepts of “family health nursing” *per se* and of “teamwork” will be developed and enriched as the student works through the curriculum, in both its theory and its practice elements.

WHO Regional Office for Europe Family Health Nurse Curriculum

Module 1

Title: The Family Health Nurse Course
Introductory Module
Concepts, Practice and Theory

Duration: 2 weeks

Module Content Summary

This module introduces students to the key concepts which have shaped the curriculum and the course. The approach will encourage students to build on, integrate and expand their existing knowledge, skills and experience, using the new knowledge and experiences which they will gain. The close relationship between the practice of nursing and the theoretical and research knowledge related to nursing will be explored using the students' pre-course work experience placement with a family.

The teaching/learning strategies will encourage the nurses to get to know their fellow students and to share professional knowledge and experiences. The value of debate about the relevance of the theoretical content to nursing practice will be explored.

This module will take place in a university setting.

Syllabus

The Family Health Nurse

Care scenarios

A life course approach, including critical life events

The competency-based and research-based curriculum

The concept of competency

Andragogy – appropriate teaching and learning strategies for students and for adult clients

Facilitation of learning

Transferable skills

Problem-solving

Teamwork

Debating as a form of constructive challenge

Analytical and critical thinking and its relationship to the practice of family health nursing

Continuing professional development/lifelong learning

Reading list

WHO publications
National and international literature covering the syllabus

Teaching/learning strategies

Lecture (key concepts)
Case studies
Brainstorming
Seminars
Teamwork (working in groups)
Debate and discussion
Role play

Assessment methods

Date assignment due: two weeks after end of module

Format of assignments:

Course work: (50% of whole) Mark awarded%

Students will choose two concepts from those listed in the syllabus and write a short essay (maximum 600 words) discussing the relevance of the chosen concepts to their personal understanding, at this early stage of the course, of what will be expected of them as a qualified Family Health Nurse.

Module final examination: (50% of whole) Mark awarded%

Total assessment: Aggregate mark (out of 100%)%

WHO Regional Office for Europe Family Health Nurse Curriculum

Module 2

Title: Provision of care 1: working with families

Duration: 10 weeks

Module Content Summary

This module will enable nurses to identify various concepts which influence family nursing practice. The focus will include professional issues in the family nursing role, and the nursing interventions of promotive, preventive, curative, rehabilitative, palliative and supportive care services. Nurses will develop the principles and methods of planning, initiating and evaluating family care within the context of a resource-conscious and dynamic community health care environment. The learning strategies of reflective dialogue and self-directed learning will provide opportunities to explore family nursing practices and interventions in a supported environment.

40% of this module will be practice-based.

Syllabus

The family – definitions, relationships, dynamics, roles
The concept of the family as a client
The concept of the family as a context – impact of the family on health and health management of individuals
Theories of the family
Conceptual frameworks for family health nursing – the concept of health as an equilibrium and of nursing as enabling people to cope
The Family Health Nurse – role, responsibilities, functions, professional, legal and ethical perspectives
The home as the location of care
Family health nursing using a life course approach
Development of the child, adult and older person – the life course approach
Family assessment
The “dysfunctional” family
Family therapy
Counselling approaches and application
Conceptual frameworks in family nursing
Health assessment – types, tools

Approaches to health promotion and health education
The application of primary, secondary and tertiary prevention interventions
Risk assessment
Health surveillance
Infection control
Management of emergencies
Therapeutic interventions in relation to life crises
Managed programmes of curative and rehabilitative care for patients with acute and chronic diseases
Using a palliative care approach in family nursing
Substance abuse
Learning disability
Mental health
Supporting families
Balancing/prioritizing the needs of individuals with those of the family and community
Empowering families
The rights of families
Working in partnership with families
Advocacy
Evaluation – strategies, outcomes

Reading list

WHO publications
National and international literature covering the syllabus

Teaching/learning strategies

Lecture (key concepts)
Interviews
Demonstrations
Case studies
Brainstorming
Discussion
Role play
Field trip

Assessment methods

Date assignments due:

Format of assignments:

Course work: (30% of whole)	Mark awarded %
Practical assessment: (40% of whole)	Mark awarded %
Module final examination: (30% of whole)	Mark awarded %
Total assessment:	Aggregate mark (out of 100%) %

WHO Regional Office for Europe Family Health Nurse Curriculum

Module 3

Title: Decision-making

Duration: 4 weeks

Module Content Summary

This module will enable nurses to extend their knowledge of decision-making processes, typology and skills in preparation for their future family nursing role.

The learning strategies will encourage nurses to draw on their own personal and clinical experiences, encouraging them to develop skills in reflective thinking.

10% of this module will be practice-based.

Syllabus

Decision-making – theories, processes, skills
Diagnostic reasoning, therapeutic, clinical
Concepts of accountability and autonomy in decision-making
Critical thinking in practice
Strategic decision-making
Negotiating skills
Prioritizing care
Rationing of care
Legal aspects
Accountability, autonomy, ethics
Decision-making in the home

Reading list

WHO publications
National and international literature covering the syllabus

Teaching/learning strategies

Lecture (key concepts)
Demonstration (audiovisual methods)

Case study
Teamwork (working in groups)
Discussion
Role play
Field trip

Assessment methods

Date assignments due:

Format of assignments:

Course work: (30% of whole)	Mark awarded%
Practical assessment: (40% of whole)	Mark awarded%
Module final examination: (30% of whole)	Mark awarded%
Total assessment:	Aggregate mark (out of 100%)%

WHO Regional Office for Europe Family Health Nurse Curriculum

Module 4

Title: Information management and research

Duration: 6 weeks

Module Content Summary

This module is designed to help nurses to develop their knowledge and skills in relation to applied aspects of information management and research. It will develop their understanding of approaches to information management, research, learning, motivation, communication and teaching methods. The research component will have a particular focus on studies and evidence which contribute to knowledge within the area of family health nursing.

The learning strategies will combine traditional methods of teaching with experiential learning to facilitate the development of interaction and research skills.

10% of this module will be practice-based.

Syllabus

Sources/types of information, knowledge, evidence
Critical thinking, critical appraisal and questioning of practice
The research process, research design and methods
Basic statistics – interpreting demographic and statistical data, summarizing data and drawing conclusions
Identifying and measuring outcomes
Information management and information technology
Documentation – structure and standardization
National and local information systems
Report writing
Core/minimum data sets
Ethical issues, confidentiality and security
Theories and principles of learning and motivation
Teaching methods and their application to family health nursing
Objective-setting
Preparation and evaluation of teaching methods

Reading list

WHO publications
National and international literature covering the syllabus

Teaching/learning strategies

Lecture (key concepts)
Discussion
Tutorial
Student-led seminars
Role play
Case study
Workshop
Field trip

Assessment methods

Date assignments due:

Format of assignments:

Course work: (30% of whole)	Mark awarded%
Practical assessment: (40% of whole)	Mark awarded%
Module final examination: (30% of whole)	Mark awarded%
Total assessment:	Aggregate mark (out of 100%)%

WHO Regional Office for Europe Family Health Nurse Curriculum

Module 5

Title: Provision of care 2
(The Family Health Nurse – working with communities)

Duration: 10 weeks

Module Content Summary

This module will explore aspects of “the community” in relation to the role of the Family Health Nurse. Within the module, an exploration of the social determinants of health will enhance nurses’ knowledge and understanding of identifying and meeting the needs of the community in which they practise.

The learning strategies in this module will encourage nurses to synthesize and use policies and statistical data to understand the community.

40% of this module will be practice-based.

Syllabus

The concept of the community as a client
Concepts and approaches of public health
Determinants of community health
Health and social welfare
Systems of health care (national and local policies)
Primary, secondary, tertiary health care systems
Community and public health
The family health care service
Definitions of health, disease, illness and disability
Inequalities and health
Epidemiology
Communicable diseases
Pharmacology – medicines, storage, administration, immunization programmes, protocols, treatment of anaphylaxis, legal and professional issues
Definition of communities
Disadvantaged groups
Discrimination
Culture, race and religion

Education and employment
Poverty
The concept and definition of need
Community assessment (including profiling)
Community-based interventions, e.g. community development
Accessing statistics (national and local)
Working with communities
Empowering communities
The role of the Family Health Nurse with communities

Reading list

WHO publications
National and international literature covering the syllabus

Teaching/learning strategies

Lecture (key concepts)
Interviews
Demonstrations
Case studies
Brainstorming
Discussion
Field trip

Assessment methods

Date assignments due:

Format of assignments:

Course work: (30% of whole)	Mark awarded%
Practical assessment: (40% of whole)	Mark awarded%
Module final examination: (30% of whole)	Mark awarded%
Total assessment:	Aggregate mark (out of 100%)%

WHO Regional Office for Europe Family Health Nurse Curriculum

Module 6

Title: Managing resources

Duration: 4 weeks

Module Content Summary

This module will explore aspects of management which have an impact on the care given, and the role of the Family Health Nurse in practice.

The teaching/learning strategies used will enable nurses to examine and apply knowledge of concepts of management to their field of specialist family health nursing.

10% of this module will be practice-based.

Syllabus

Management – theories and processes
Managing human resources
Budgetary control
Time management
The family as a resource
Statutory, voluntary and private agencies
Organization and management of family nursing services
The coordinating role of the Family Health Nurse
Care management
Quality assurance systems

Reading list

WHO publications
National and international literature covering the syllabus

Teaching/learning strategies

Lecture (key concepts)
Case study
Team work
Discussion
Role play

Assessment methods

Date assignments due:

Format of assignments:

Course work: (30% of whole)	Mark awarded%
Practical assessment: (40% of whole)	Mark awarded%
Module final examination: (30% of whole)	Mark awarded%

Total assessment:	Aggregate mark (out of 100%)%
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WHO Regional Office for Europe Family Health Nurse Curriculum

Module 7

Title: Leadership and multidisciplinary working

Duration: 4 weeks

Module Content Summary

Within this module nurses will explore and reflect upon aspects of leadership. They will be helped to recognize the importance of teamwork and to appreciate the complex nature of organizational change.

The learning strategies will provide opportunities to work in teams. This requires respect, trust, cooperation and delegation. The development of these skills is essential to enable nurses to explore team interaction and to transfer this knowledge to family health nursing practice.

10% of this module will be practice-based.

Syllabus

Leadership – theories, typology, processes and skills
Management of change
Principles of teamwork, roles, responsibilities, functions
Team dynamics
Delegation
Clinical supervision and monitoring
Legal/professional issues
The Family Health Nurse as an agent of change
The family as a team member
Working with other agencies

Reading list

WHO publications
National and international literature covering the syllabus

Teaching/learning strategies

Lecture (key concepts)
Teamwork
Discussion
Case study
Role play
Field trip

Assessment methods

Date assignments due:

Format of assignments:

Course work: (30% of whole)	Mark awarded%
Practical assessment: (40% of whole)	Mark awarded%
Module final examination: (30% of whole)	Mark awarded%
Total assessment:	Aggregate mark (out of 100%)%

References

1. *HEALTH21: the health for all policy framework for the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 1999 (European Health for All Series, No. 6).
2. FAWCETT-HENESEY, A. *The family health nurse – a new nurse on the horizon*. Copenhagen, WHO Regional Office for Europe, 1999 (unpublished document DLVR020106/6).
3. WHYTE, L.A. & ALEXANDER, M.F. *Community nursing: transition curriculum. A foundation course to prepare experienced hospital nurses to work in the community*. Copenhagen, WHO Regional Office for Europe, 1999 (unpublished document DLVR020402).
4. ASVALL, J. The Alma-Ata Declaration – 20 years of impact on the European Region of WHO. In: *WHO Primary health care 21: “Everybody’s business”*. Geneva, World Health Organization (in print).
5. *Nurses and midwives for health. A WHO European strategy for nursing and midwifery education*. Copenhagen, WHO Regional Office for Europe, 2000 (unpublished document EUR/00/5019309/15 for the Second WHO Ministerial Conference on Nursing and Midwifery in Europe, Munich, June 2000).
6. CLARK, J. A model for health visiting. In: Kershaw, B. & Salvage, J.J. *Models for nursing*. London, Wiley and Sons, 1986.
7. ANTONOVSKY, A. *Stress, health and coping*. New York, Jossey Bass, 1999.
8. *Doctors for health. A WHO global strategy for changing medical education and medical practice for health for all*. Geneva, World Health Organization, 1996 (unpublished document WHO/HRH/96.1).
9. BLOOM, B. *Taxonomy of educational objectives, handbook 1*. New York, David McKay Co., 1996.

Annex 1

HEALTH21 TARGETS

- Target 1 – Solidarity for health in the European Region
- Target 2 – Equity in health
- Target 3 – Healthy start in life
- Target 4 – Health of young people
- Target 5 – Healthy aging
- Target 6 – Improving mental health
- Target 7 – Reducing communicable diseases
- Target 8 – Reducing noncommunicable diseases
- Target 9 – Reducing injury from violence and accidents
- Target 10 – A healthy and safe physical environment
- Target 11 – Healthier living
- Target 12 – Reducing harm from alcohol, drugs and tobacco
- Target 13 – Settings for health
- Target 14 – Multisectoral responsibility for health
- Target 15 – An integrated health sector
- Target 16 – Managing for quality of care
- Target 17 – Funding health services and allocating resources
- Target 18 – Developing human resources for health
- Target 19 – Research and knowledge for health
- Target 20 – Mobilizing partners for health
- Target 21 – Policies and strategies for health for all

Annex 2

PORTFOLIO OF CARE SCENARIOS¹

¹ In these scenarios, references to the Family Health Nurse and the family physician should be taken as applying equally to either sex.

Chronic disease prevention and management

Initial stage

During their weekly meeting, the Family Health Nurse and family physician discuss a recent clinical trial report which identifies the risk of cardiac and renal disease for people with type 2 diabetes (non-insulin-dependent).

1st month

The Family Health Nurse searches the medical and nursing records of families, and uses this database to identify people with diabetes. She also reviews clinical practice guidelines for evidence of effective interventions in the care of people with type 2 diabetes.

2nd month

In partnership with the family health physician she plans a care strategy focusing on health promotion, disease prevention and diabetes management.

3rd month

With the local community she plans a health promotion display about diabetes, obtaining posters and leaflets from the public health department. Displays are located within the family care centre, community centre and local churches.

6th month

The Family Health Nurse visits families who have diabetes and screens relatives of existing patients for the disease, conducting urinalysis and blood pressure checks. During these visits she teaches existing patients about more effective blood glucose monitoring, diet and lifestyles, and counsels them on complications of the disease. At subsequent visits she discusses patients' medication regimes, assesses their concordance with the prescribed treatment and monitors their blood pressure, blood glucose and renal function. She discusses the outcomes of these visits with the family physician, who alters some medication regimes to encourage more effective control of the diabetes.

12th month

An evaluation of the strategy by the Family Health Nurse 12 months after the initial stage demonstrates that 70% of patients with existing disease are maintaining their blood glucose levels within an acceptable range. In addition, early symptoms of cardiac and renal disease have been identified in 20% of patients. The health promotion strategy has prompted several people in the community to contact the Family Health Nurse about concerns they have about their health. To date, four patients have been diagnosed with type 2 diabetes from the routine screening of people aged 65 years and over.

Ongoing

From the family physician's records and register she obtains the names of everyone over 65 years and invites them to the family care centre for a urinalysis and blood pressure check to screen for type 2 diabetes.

Commentary

This scenario of a Family Health Nurse demonstrates the many facets of her role, including health promotion, disease prevention and chronic disease management. She must have a knowledge of diseases, their management and possible complications and have skills in selecting and evaluating interventions in primary, secondary and tertiary prevention. In addition, detailed knowledge about the community in which she practises enables the Family Health Nurse to involve local groups in health promotion and disease prevention activities. She is seen by members of the community as someone they are welcome to contact and she encourages an open access policy for people concerned about their health.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to target 8 (see Annex 1).

Care of a family where the mother has breast cancer

The family consists of the father (aged 45), an engineer, the mother (aged 45), a teacher, and two boys of 13 and 9 years of age.

Eighteen months ago, the mother discovered a lump in her breast, which was diagnosed as cancer. At this point, the Family Health Nurse visited the family, to help them prepare for their mother's admission to hospital and surgery. The mother had a mastectomy and a course of chemotherapy.

After the mother was discharged from hospital, the Family Health Nurse continued to visit the family for approximately a year because her wound would not heal. The mother returned to work, but recently she lost her job because of her frequent absences through illness. She does not expect to recover from her cancer, and now she is obviously dying. The family is quite open about the situation and both parents have prepared the boys for their mother's death. The 13-year-old boy has just started secondary school and the father finds him unnecessarily aggressive and violent against his younger brother. The father would like to spend more time with his sons, but is busy with his work and is afraid that if the home situation affects his work he may be dismissed. He asks the Family Health Nurse how to handle the boys.

By working closely with the family, the Family Health Nurse is able to assess their needs and encourage them to share in the care of the mother while also assuring them that she will provide continuity of care. She encourages the family members to ask questions about anything that is worrying them. She cares for the mother (pain management, wound dressing, personal hygiene, counselling about the next stages in the disease) and discusses with her the possible reactions to expect from her husband and sons. The Family Health Nurse, in her coordinating role, organizes the staffing to secure round-the-clock care for the mother, as she wishes to die at home, and also organizes the provision of equipment. She confers with the family physician, social worker and others about specific problems, advises friends and family members about making visits short and positive, counsels the father about the stress factors involved in children changing schools and suggests that he should discuss the situation with the older son's main teachers. She informs him about grief and loss support groups. She supervises and teaches staff members who have not had experience of caring for a patient dying at home.

Commentary

The principal role of the Family Health Nurse in this scenario is one of support and liaison, while at the same time enabling the family to make their own decisions and be involved in the care of the mother. The complex needs of this family, changing over the period of time in which she is in contact with them, require the Family Health Nurse to identify problems and intervene before they reach crisis point. The Family Health Nurse provides a single point of contact for the family, while also coordinating the other support services and agencies.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to target 15 (see Annex 1).

Care of a single person suffering from metastatic breast cancer

The “family” in this scenario is a single lady, living alone in her own home. She is very independent and articulate, holds a full-time professional post, has a large close family of brothers and sisters, and is a much-loved aunt for many in the next generation.

Year 1

She finds a lump in one breast, visits her family physician and is referred to the local hospital for diagnostic tests. Cancer of the breast is diagnosed and the patient has a mastectomy and commences a regime of chemotherapy, radiotherapy and long-term medication thought to diminish the likelihood of recurrence of the tumour. Recovery is good, and she continues with her work and normal activities. The Family Health Nurse knows of the patient, visits once but does not need to visit again for some time.

Year 5

The lady begins to experience pain in her lumbar spine, radiating to the right leg. The family physician prescribes pain medication and refers the patient to the hospital, where, following investigations, an outpatient course of radiotherapy to metastases in the spine is commenced. The Family Health Nurse makes contact with the patient, leaving her telephone number and encouraging the patient to make contact at any time.

Years 6–11

During this period the patient has retired at the normal age for retirement, and she remains active. However, gradually the pain increases, and she returns to hospital for further radiotherapy. The Family Health Nurse keeps track of the patient’s progress by: regularly examining her case notes in the shared records held in the family physician’s practice; maintaining regular contact by monthly, then weekly visits to the patient; checking on how the patient is coping generally; and checking whether the prescribed pain medication is controlling the pain. This she monitors by providing the patient with a pain assessment chart, the use of which she explains. The pain assessment chart is then kept by the patient who enters the times at which she takes her pain medication and the amount taken, and assesses her pain on a scale of 0 (no pain) to 10 (unbearably severe pain). This exercise indicates that pain control is not satisfactory and the Family Health Nurse, in discussion with the family physician, arranges a visit to the oncologist who has been caring for the patient. The pain medication is increased but is still taken orally. The patient values her independence and the Family Health Nurse respects this, continuing to visit weekly but encouraging the patient, as before, to contact her if she feels the pain is not under control.

Throughout all these years the extended family is very supportive, but as the patient’s pain increases the Family Health Nurse becomes concerned for those family members, young and old, who are close to the patient and who visit her frequently, often meeting the Family Health Nurse when she is with the patient. With the knowledge and support of the patient, the Family Health Nurse maintains regular contact by telephone with the key person in the extended family, talking through her concerns with her and answering questions as they arise.

Years 12–14

The patient’s physical condition slowly deteriorates and, although she can walk with the aid of a wheeled walking frame, she spends more time in bed. Because she is very thin, she is vulnerable to pressure sore formation. The Family Health Nurse gradually spends more time on direct care, turning her when she is in bed, assisting with hygiene and organizing, in discussion with the family physician, increased pain medication, now being given by injection. The Family Health Nurse acts as the lynchpin by managing the whole complex set of health care needs of the patient, but always in partnership with her, taking her views into account. The Family Health Nurse organizes the provision of equipment including a special bed and mattress, and a rotation of 24-hour cover by herself, other qualified Family Health Nurses, nursing assistants and a home help who attends to the laundry and cleaning in the home. The Family Health Nurse also organizes meals on wheels for the main meal of the day. She is aware, from talking with the patient,

that she fully understands the progress of the cancer and the poor prognosis, and is also aware of the patient's strong faith and that she is spiritually prepared for the fact that death is now not far off. The Family Health Nurse keeps in close touch with the main family member on whom the patient relies for daily company, support and shopping needs, and in close liaison with the family physician, advising him when she feels the patient may need to be considered for transfer to inpatient hospital care.

Year 15

The patient herself decides that the time has come for her to be admitted to hospital for what she expects will be the last time, i.e. for terminal care. The Family Health Nurse communicates the patient's wish to the oncologist in the hospital, and arranges her admission in liaison with the hospital nursing staff. She also arranges for cessation of the visits by the home care team and returns all unused medication and equipment to the health centre. She completes the documentation which she has maintained throughout the patient's care. She visits the patient from time to time over the three weeks of hospitalization, prior to her peaceful death there, in the presence of several of her family members.

The Family Health Nurse visits the closest member of the patient's family on three occasions following the bereavement to provide a listening ear, and to assess how this branch of the patient's extended family is coping (see Fig. 4).

Commentary

The Family Health Nurse has recognized this patient's need to be independent and to have control over her illness. She assesses the situation, then monitors the patient's progress at regular intervals, ensuring that the patient has sufficient information to enable her to make contact with the Family Health Nurse when she feels that she needs her assistance. The Family Health Nurse gradually provides more support and research-based nursing care. She introduces other agencies as and when the patient has communicated this need. Her knowledge of this patient enables her to provide holistic care; for example, the Family Health Nurse knows about, understands and respects the therapeutic value of the patient's deeply held religious beliefs in preparing her for death. The Family Health Nurse's knowledge and understanding of grief and bereavement enable her to continue to support the patient's extended family after the death of the patient. She also recognizes her own need to grieve over a patient she has known and cared for over a long period of time.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to targets 6 and 15 (see Annex 1).

Care of a family with mental health and alcohol-related problems

A 21-year-old man, following treatment for schizophrenic symptoms, was discharged home to his family one week ago. The mother has symptoms of depression. The father has begun to drink more and more alcohol since their son discontinued his studies at the university. After just one week at home, the son has stopped taking his medication. He has become increasingly preoccupied with hallucinations, especially during the night. His parents are anxious about being alone in the home with him. Observing that the situation for the family is very difficult, a friend contacts the health centre.

The Family Health Nurse gathers information from the man's records and plans to visit the family after a discussion with the family physician. The Family Health Nurse meets the mother and son in their home and obtains a good overview of the situation, but recognizes that she needs to obtain information from all members of the family, in order to make a full assessment and prioritize what has to be done. It is clear that family relationships have broken down, and that mother and son have "lost contact" with each other. She therefore decides to visit the family daily for a week. Following further discussions with the family physician, priority is given to trying to persuade the son to comply with his treatment programme by taking his prescribed medication.

The Family Health Nurse returns to the family home in the afternoon, in order to try to establish a relationship with the son and administer an injection. He agrees to take the injection, but does not talk. The mother cries.

The Family Health Nurse prepares a priority care plan for her interventions, based on her assessment and each nursing diagnosis, with related short-term and long-term goals.

During the following days, she strives to establish relationships with all members of the family, but it is difficult to arrange a visit when the father is at home.

The first priority is to improve the son's mental state, so she continues the injections throughout the following days. The mother is so depressed that the Family Health Nurse, with the mother's consent, arranges for her to visit to the outpatient clinic where she is examined by a specialist doctor who prescribes some medication. The father too is in need of treatment for his alcohol problem, so the Family Health Nurse decides, after discussion with the family physician, to contact a professional therapist who could spend time working with the family, in an effort to get to the root of the alcohol and other problems and help the family members to establish improved relationships with each other. During this period, the Family Health Nurse visits the family once a week.

About a month later, the situation within the family has improved. The son is now more interested in establishing better relationships and the mother is less depressed; for example, one day when the Family Health Nurse visits, she finds that the mother has cleaned the house (previously it was rather dirty and neglected) and baked bread. The father is still drinking an excessive amount of alcohol, but he is staying at home more, and the couple are talking to each other more.

The Family Health Nurse evaluates the various interventions at the end of the next month, and records in her notes that the son has decided to participate in day-care rehabilitation. She arranges a session with the family physician to discuss the family's progress.

The Family Health Nurse's long-term goal is to work in partnership with the family in order to increase their ability to support each other and cope with stress, to help the son qualify for a job and to assist them all to establish at least some contacts in the community in which they live.

Commentary

In her care of this family, the Family Health Nurse displays specialist skills related to mental health, but combines these with her knowledge of family dynamics and relationships. She recognizes the need to involve the family physician and the more specialist skills of a family therapist. One very important consideration is the need for the Family Health Nurse to be trusted by all the family members. She needs quickly to build up a rapport and relationship with a family in crisis. She recognizes the need for close monitoring and long-term evaluation of the strategies she has decided upon and implemented.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to targets 6 and 12 (see Annex 1).

Care of a family with a new baby

The Ruzats are a young family with an 18-month-old daughter and a 6-month-old son. They arrived from Sarajevo during the political conflict. They have found it difficult to settle in the host country. Mr Ruzat was employed as a taxi driver until recently. Mrs Ruzat is on maternity leave from her job as a domestic assistant in the local hospital. The family live on the sixth floor in an apartment block. There is no elevator. The apartment is damp and difficult to heat.

The baby is bottle-fed. He has had difficulties with feeding since discharge from hospital at five days. He has had persistent upper respiratory tract infections, treated by antibiotics, over the past three months and has generally been unsettled. The 18-month-old has exhibited difficult behaviour since the birth of the new baby and has a disrupted sleep pattern. The father is a heavy smoker. The mother is finding it difficult to lose the excess weight gained during her pregnancy. She will soon return to work. Mr Ruzat's mother will visit the family for a short stay in the coming weeks. The relationship between Mrs Ruzat and her mother-in-law is not good. Mrs Ruzat senior believes that her daughter-in-law is not a good wife or mother, which puts further pressure on the family relationships.

Commentary

The role of the Family Health Nurse, in the first instance, is to work with the family to identify how best they feel their needs can be met, and in doing so she is careful to explore with them their own cultural practices related to child care. She offers support during their times of stress and is particularly vigilant regarding the symptoms of postnatal depression in the mother, or indeed depression in the husband. She is a teacher and health counsellor, helping both the mother and father with lifestyle changes with regard to diet, exercise and smoking cessation. She works alongside the family, providing information about other services and, when necessary, helping them to gain access to them – for example, to obtain assistance in regard to their damp housing and financial assistance if needed. She also raises their awareness of the existence of support groups, for example for refugees, the unemployed, and mother and baby groups.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to target 3 (see Annex 1).

Care of an elderly couple, both of whom are in poor health

In this scenario, the elderly man cares for his wife, who has type 1 diabetes and who is also suffering from Alzheimer's disease. He has found her relatively easy to care for, but admits to the Family Health Nurse that she occasionally has aggressive outbursts which, he says, he can cope with. He has cancer of the prostate which is currently well under control.

The couple's daughter has approached the Family Health Nurse because she suspects her father is abusing her mother physically. She alleges that she has witnessed bruising on her mother's inner thighs. The Family Health Nurse is a regular visitor to the family in relation to helping them manage the mother's diabetes and the effects of her Alzheimer's disease. She offers the husband support and advice on how to cope with his wife's aggressive periods and puts him in touch with support groups, as well as facilities which offer respite care. The Family Health Nurse examines the wife, in the light of the daughter's concerns but cannot find any evidence of bruising. She consults the care assistant who regularly supervises the elderly lady's bathing, and she is unable to substantiate the daughter's complaint, either.

The Family Health Nurse decides to maintain a programme of regular visits to this vulnerable family and to offer ongoing support to the couple, all the while being vigilant for any signs of potential abuse. During these visits she will use her knowledge of family relationships to try to help the daughter and her parents to reconcile their differences, and will encourage them to seek specialist help from a counselling agency. She ensures that the family physician is informed of her actions and records in the multidisciplinary records her decisions about the care of this family.

Commentary

The accessibility of the Family Health Nurse to individuals in the community in which she practises is demonstrated by the fact that the daughter of this family made initial contact with the Family Health Nurse over a particularly sensitive matter. The principal role for the Family Health Nurse with this family is that of: monitoring, to ensure early detection of a potentially dangerous deterioration of family relationships, or deterioration in the physical health of the husband or wife; teaching the care assistant how to recognize any evidence of physical abuse and how and where to report this; and ensuring that the family physician is aware of the family's situation. She employs her decision-making skills in relation to the level of actions to be taken at this point, including which members of the health care team to involve, and in the delegation of tasks to the care assistant. The Family Health Nurse is fully aware that she remains accountable for the care which this family receives, and that she is accountable for her decisions.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to targets 5 and 9 (see Annex 1).

Care of an elderly widower with multiple disease pathology

This man has lived alone for eight years. He is retired and was formerly a carpenter. His only interest now is stamp-collecting. He takes very little exercise or outdoor activity. He had a prostatectomy for cancer of the prostate some time ago, and for two years now he has had an in-dwelling catheter, which occasionally blocks, causing acute pain from retention of urine. His catheter has been changed by the Family Health Nurse on a number of occasions, due to the blocking. The Family Health Nurse tests his urine regularly to check for infection, which does occur from time to time. She encourages him to drink at least two litres of fluid daily, which he is reluctant to do. She also tests his urine regularly for glucose, in case he should develop diabetes mellitus. In addition to his main presenting problem related to his urinary system, he has other health problems. He has a leg ulcer which the Family Health Nurse has dressed weekly over a period of seven years, always keeping a check on the latest research into treatments for such ulceration and maintaining a regular dialogue with the family physician. The patient is also very overweight, has arteriosclerosis, congestive heart failure and related dyspnoea.

The Family Health Nurse tries to motivate the man to participate in some activities in the day care centre near his home. She arranges the meals on wheels service and regularly attempts to assess his nutritional intake.

At her latest visit, the Family Health Nurse assesses the patient as slightly depressed, which, in discussion with him, he confirms is a correct assessment. With his consent, she contacts his family physician to suggest that he is referred to the specialist psychiatric nursing team.

The Family Health Nurse regularly explains to the patient the importance to his health of taking regular exercise, such as a walk every day, perhaps before lunch when the traffic is low in the area in which he lives. She does her best to motivate him. However, it is clear to her that the patient has lost interest and does not care about undertaking these activities, or about attending the day care centre.

The Family Health Nurse continues to discuss this man with the health care team of which she is a member, seeking other ideas as to what may motivate him to take action to improve his health and quality of life. She will continue to visit at regular intervals, so that she can assess any potential further threats to his health and wellbeing and intervene proactively, always doing so in agreement and if possible in partnership with the patient.

Commentary

The Family Health Nurse, in addition to providing direct care for this man, also recognizes that motivation and illness behaviour are important aspects in attempting to prevent complications in well established disease processes. The patient has complex pathology and, in spite of the Family Health Nurse's efforts to involve him in his own care, expresses no interest in self-care or in becoming more independent. The Family Health Nurse feels that his lack of motivation may in part be linked to his social isolation and that he may fear, if he becomes more able to care for himself, that he will lose contact with his one regular visitor – the Family Health Nurse. She understands that the aim of care is not always curative; it can be to maintain the maximum possible potential for health. She decides to continue to visit, to involve other members of the health care team in an attempt to improve some of the identified health problems, and to continue to encourage the patient to attend local day care facilities. She recognizes that this may become an attainable goal if she can arrange for his depression to be treated.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to target 5 (see Annex 1).

Care of a family where the father is a heavy smoker who wants to stop smoking

Mr Virtanen is a 39-year-old father of two daughters. He began smoking when he was 14 years of age, because his best friends were smoking. Very gradually, he became aware that he was unable to stop. Mr Virtanen's wife has recently developed asthma, and he is aware that she is nervous that his heavy smoking will exacerbate her condition. Also, he does not want to be a poor role model for his daughters. "My wife and my daughters are asking me to stop smoking", he says to his Family Health Nurse. "I really do want to quit smoking, but I am afraid I will have withdrawal symptoms. I have been smoking 20 cigarettes a day now for about 25 years. I have no experience of even trying to quit. I am so keen on smoking that I feel I am not even awake until I have my first cigarette in the morning. Anyway, now I am really motivated to try quitting."

The Family Health Nurse supports and strengthens Mr Virtanen's resolve to stop smoking. Together, they work out a "stop smoking" plan, which Mr Virtanen decides to follow for the next six months. The plan includes such activities as negotiating the date on which he will stop smoking, taking measurements of carbon monoxide levels in his blood, doing a nicotine dependence test, and assembling practical advice on how to avoid or to handle difficult situations where there is a risk of relapse, for example when he is relaxing in the company of friends who are smoking. Together they draw up a schedule of follow-up meetings, and the Family Health Nurse gives Mr Virtanen and his family information about withdrawal symptoms and how to overcome them. She also explains to them the effectiveness of nicotine replacement therapy as a smoking cessation strategy, especially for someone who is nicotine-dependent but at the same time is motivated to stop smoking. She provides him with written information, in the form of a leaflet on smoking cessation, which she suggests he share with his family, and she refers him, with his consent, to a local self-help group which meets in the community hall.

After Mr Virtanen's "quitting date", he and the Family Health Nurse meet twice during the first week, then once a week for the next two months. Thereafter they meet monthly for six months and establish telephone contact, for any future occasions when Mr Virtanen might want to talk over anything to do with his efforts to stop smoking. Now, almost a year after he has stopped smoking, his wife's asthma has improved, as they now live in a smoke-free environment, and his daughters are happy and proud of their non-smoker father. Mr Virtanen continues to attend the self-help group and takes an active part in their activities.

Commentary

In this health-focused scenario the Family Health Nurse demonstrates the appropriate non-judgmental attitude and also her skills in counselling and appropriate intervention. Her knowledge of the diverse and serious impacts of smoking on health motivates her to ensure continuing support for this man and his family. She also understands that there are often complex reasons why people smoke and that these reasons can make it difficult for them to stop. Her knowledge of national and local support facilities for those who wish to stop smoking enables her to target these and introduce the family to them. Smoking prevention and smoking cessation are among the most crucial issues in the Family Health Nurse's work in all health care facilities. She, together with others in the health and social care teams, is in a key position to arrange individual smoking cessation services, and to coordinate and participate in anti-smoking interventions at community level.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to target 12 (see Annex 1).

Care of a diabetic lady who has gradually lost her independence and has to be admitted to residential care

Over a number of years, the Family Health Nurse has visited an elderly lady who lives alone, with just her dog for company. She is a diabetic, and the reason for the regular visiting, conducted twice a year, is to monitor her general health and wellbeing and the state of her diabetes, and assess her continuing ability to live independently, which she is determined to do. She is a widow, but has a daughter and two grand-daughters. Her relationship with her daughter has not been good for a number of years, so there is little contact between them and, as a result, she sees little of her grand-daughters.

Although this lady lives a rather isolated life, from her own choice, she is active and well. Efforts by the Family Health Nurse to discuss with her whether she might like to rebuild her relationship with her daughter and family are all rejected. However, her general health remains good and she seems to be coping with her diabetes until, at one of the regular monitoring visits, the Family Health Nurse detects several problems when she checks the lady's blood pressure, blood sugar and general health. The lady's blood sugar is found to be well above the normal level, and further questioning reveals that she is not feeling well, she feels tired most of the time, and she has been neglecting to prepare and eat her normally well balanced diet.

The Family Health Nurse arranges for the lady to be seen by the diabetes specialist at the Health Centre, visits her daily for some time to ensure that she understands and is complying with her new regime for insulin, arranges for a volunteer service to bring a main meal daily, including at the weekends, and arranges for regular help with keeping the house clean. All of this is done with some opposition from the old lady at first, because she sees these services as a threat to her independence, but as she insists that she wants to remain at home, and she so much enjoys the company of her dog, she grudgingly accepts the help. The Family Health Nurse takes the decision to arrange these support services, rather than admit the old lady to institutional care, because she knows how important it is to this old lady to remain in her own home.

Over the next two years, the old lady's health very gradually deteriorates, her peripheral circulation becomes compromised, due to her diabetic state, and the Family Health Nurse, in partnership with the old lady, comes to the decision that admission to residential care is now the only appropriate option. She arranges this admission, and in discussion with her colleagues at their team meeting, they find a good home in the country for the lady's dog.

The Family Health Nurse now visits the lady weekly in the home for the elderly. Relationships with her daughter have been renewed and the daughter and grandchildren visit her in the home. Although the old lady is now unable to walk unaided and is very forgetful – from time to time she does not recognize her daughter – she is relatively well and has adjusted to living a communal life in the home. Although she still remembers and misses her dog greatly, she is relieved to know that he has gone to a good home.

Commentary

This scenario highlights the role of the Family Health Nurse in recognizing the right of this elderly lady to lead an independent life for as long as possible. The Family Health Nurse's knowledge of gerontology enables her to provide therapeutic interventions and social support until such time as the lady's physical problems become exacerbated and both recognize that she can no longer cope alone at home with her dog. The Family Health Nurse is the advocate for the patient, in the absence of the family, and she encourages the patient to be involved in decision-making about her future care. She recognizes the psychological needs of the patient and the bond that she has with her long-time dog companion. The intervention of the Family Health Nurse has enabled this lady to maximize her independence and to be reunited with her family.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to targets 5 and 14 (see Annex 1).

Care of a family preparing for the birth of their first child

The Family Health Nurse and the midwife often work in very close collaboration and are partners in the care of the same family. The Family Health Nurse has received a referral from the midwife about a young couple who are expecting their first child. The Family Health Nurse routinely visits all such families about three to four weeks before the expected date of delivery. The reason for this visit is to prepare the parents for the new family situation they will enter when their baby is born. There are many practical issues to discuss, for example how to prepare the home for a child and how to take care of a newborn child. One major issue is breastfeeding and preparing the couple for this. Breastfeeding will of course have been discussed with them by the midwife earlier in the pregnancy, but the Family Health Nurse is the person who will visit the family most often after delivery, and it is important that she continues the discussion and preparation of the couple in relation to breastfeeding. It is known that the more prepared both parents are, the longer the mother will breastfeed their child. There is also evidence that “breast is best” and that a breastfed infant is healthier and at less risk of infection than a bottle-fed infant. Thus, the most important purposes of the Family Health Nurse’s first visit to the family are for them to get to know each other, to discuss the couple’s expectations of having a baby, including preparing for the birth, and to discuss breastfeeding. The Family Health Nurse and the midwife recognize that there is an overlap between their roles with the child-bearing family, and both are aware of their responsibility to maintain shared records and to involve the family physician as and when necessary.

Commentary

This scenario illustrates the need for the Family Health Nurse to work in close collaboration with the midwife in relation to this major life course event for a family – the birth of their first child. In order for the Family Health Nurse to carry out her role with this family, she must have a knowledge and understanding of the midwife’s role and responsibilities, of interdisciplinary working, of family dynamics and of spousal relationships, particularly when a first child enters the family, and of the process of normal and abnormal pregnancy. It is also important that she practises evidence-based nursing care and is an effective communicator.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to target 3 (see Annex 1).

Care of a single parent who is pregnant and who is a drug abuser

A young, single woman who is addicted to heroin is pregnant with her second child. Her first child, who is two years old, has been removed from her care because of the continuing drug abuse. The young woman does not know who the father of the first child is. She does know who is the father of the second child but has not informed this man, for fear of breaking off this new relationship which she seems to value. She has lost all contact with her family, lives alone in a small flat in a large housing scheme and depends for her income on social benefits. She finances her drug addiction by prostitution. At an early stage of her second pregnancy, the woman has visited her family physician, who has referred her to the care of the Family Health Nurse and to the hospital.

The Family Health Nurse, recognizing the complexity of the young woman's situation, and knowing that previous attempts to help her come off drugs have failed, decides to bring the woman's case to a multidisciplinary group which she has formed to help her work more effectively with young people in such very difficult life circumstances. This group consists of a social worker who specializes in the care of drug addicts, a clinical psychologist, the nurse counsellor who works in the family physician's practice, the obstetrician and midwife who will care for the young woman in the maternity hospital, and a representative from the local drug addiction prevention support group. The young woman is invited to attend the group's meetings, but initially declines to do so. The Family Health Nurse, who is the coordinator of the group, agrees to keep the woman in touch with the group's discussions, which will consider the whole situation of the woman and how to support her in the antenatal period, and make a plan for the birth and for the postnatal months. Longer-term plans for the young woman's future health will also be discussed by the group, who will rely on the Family Health Nurse to act as the lynchpin between the various agencies who will be involved in her care.

The Family Health Nurse visits the young woman regularly, together with the midwife. They persuade her to rejoin a nationally funded initiative which provides treatment as well as support for those trying to come off drugs, help her begin to reorganize what she herself has described as a chaotic lifestyle, and assist her to prepare for the birth of her baby. Both provide non-judgmental care during the pregnancy, endeavouring to rebuild the young woman's self-esteem and monitoring the progress of the pregnancy, answering any questions she has and discussing whether she wishes to keep this baby or offer it for adoption.

After the successful delivery of the child in the maternity hospital, the Family Health Nurse continues to visit this woman and to support her in caring for her child. The woman appears to be off drugs, but the Family Health Nurse is all too aware of the risk of relapse. The multidisciplinary group, which meets on a regular basis either face-to-face or by e-mail to consider progress with particularly vulnerable families or individuals in the community, continues to support the Family Health Nurse in her decisions concerning the care of this woman.

The long-term outcome for this young woman is successful rehabilitation, and some two years later, her marriage to the father of the second child. The first child continues to live with the foster family with whom she has been placed, as the relationships are very settled and the child is well cared for in a loving and stable family environment.

Commentary

In this scenario, the lynchpin role of the Family Health Nurse is pivotal to the successful outcome of this young woman's second pregnancy and her eventual return to much improved life circumstances and a supportive relationship with her new husband and their baby. The Family Health Nurse, in her multifaceted role, demonstrates all five of the core competencies of the qualified Family Health Nurse (see section 3.6). She is a care provider, decision-maker, communicator, community leader and manager, and fulfils all these competencies by acting as a knowledgeable professional who has the authority and

responsibility to bring together those she judges best able to assist her in improving the health of the family/individual for whom she cares.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to targets 3 and 12 (see Annex 1).

Care of a teenager who is pregnant

Emma is a 16-year-old unmarried teenager who is the mother of a 10-week-old child. Emma lives at home with her parents and two younger brothers, Stephen aged 12 and George aged 7. Her father is a night shift worker in a local factory, but he is worried about his future employment as a number of the workers have been made redundant. Emma's mother works as a part-time domestic help.

Emma had a difficult pregnancy and a long labour. The baby was born at term, but weighed only 2.45 kg, i.e. a low birth weight, possibly due to the fact that Emma smoked cigarettes throughout her pregnancy. The baby is now successfully bottle-feeding and gaining weight. Emma's parents are supportive of their daughter and also of the baby, but there is tension in the family because they do not approve of Darren, Emma's boyfriend and the baby's father. He is currently without a job and is considered by Emma's parents to be a bad influence on her. Her youngest brother's behaviour has become disruptive since his sister came home from hospital with the baby.

The Family Health Nurse first visits this family because Emma did not attend the clinic for her postnatal appointment. She talks with Emma alone, and the teenager confides in the Family Health Nurse that she is very tired and finds it difficult to adapt to being a mother. She is afraid to let the baby cry during the day, in case her father's sleep is disturbed, and she is worried about her little brother George's behaviour with the baby. She says he "is a bit rough with her".

The Family Health Nurse listens carefully to Emma and encourages her to express her fears and worries. She reassures Emma that the baby is thriving, and that it is not surprising that she is finding it difficult to adapt to the baby's arrival. Many young mothers do. She explains about parenting classes and says that there are other very young mothers there, some unmarried teenagers like Emma, and suggests that she ask her mother to take care of the baby sometimes, so she can go along to these classes. She also explains that George may be feeling jealous of the new baby, who has replaced him as "the baby of the family". He may resent the attention his mother pays to the new baby and be trying to gain attention by his disruptive behaviour. She suggests that Emma should spend time alone with George to reassure him that she still loves him, even though she now has the baby, but also that she should be careful not to leave the baby alone with her little brother. She also suggests that when she next comes to see Emma, they plan it for a time when her mother is at home so that they can talk about how to help George accept the new baby. The Family Health Nurse then talks with Emma about the importance of going to have her postnatal examination, discusses the possibility of contraception, and then raises the issue of immunization of the baby, explaining what is involved and encouraging her to make an appointment with the family doctor's "well-baby clinic". The Family Health Nurse asks her what she has noticed about how her baby is developing and she examines the baby. She praises Emma for her care of the baby, who is progressing very well, and explains the next stages of child development, ensuring that Emma knows she should take precautions when her baby begins to roll over and reach for things. Before leaving, she gives Emma a note of how to contact her and reassures her that she should do so if she is at all anxious. She encourages her to discuss the visit with her parents, and to make an appointment with the Family Health Nurse when her mother is able to be there too.

Commentary

Teenage pregnancy is a major health issue in many countries, and very often these young mothers do not have the support of the baby's father. The Family Health Nurse in this scenario realizes that the girl's parents are supportive, but she also recognizes the tensions which exist. She skilfully blends health education and advice-giving with praise for the efforts the young mother is making, knowing that it is important to rebuild the teenager's confidence in herself. She raises the issue of smoking and discovers that Emma's father also smokes. She realizes that this is possibly not the best time to ask Emma to stop smoking, but explains that passive smoking can be harmful and suggests that Emma and her father do not smoke in the baby's bedroom and try to avoid doing so when they are near her. The Family Health Nurse

knows the research evidence which links smoking with an increased risk of sudden infant death, and with a higher risk of respiratory disease in babies and young children, but makes the decision that this is not the time to alarm the young mother with this information. She makes a mental note to monitor Emma's smoking behaviour.

The Family Health Nurse's knowledge of community groups enables her to encourage the teenager to extend her social support network by attending the parenting classes, at the same time reassuring her that she will not be unique in that group as a teenage mother.

This scenario illustrates the Family Health Nurse's role in encouraging a healthy start in life for this young baby, in supporting the young mother in this life course crisis for her, and in supporting the family, who are also facing and attempting to cope with what is becoming a more frequent event in the lives of families – an unplanned pregnancy for their teenage daughter. In addition, the Family Health Nurse is herself a member of a "Community action for health" group, which meets in the housing scheme where young Emma lives. She also works with the local schools, assisting in matters related to health and sexual health in particular. This district has a higher teenage pregnancy rate than any other part of the conurbation, and the local council has given funding to a project to tackle this problem. The project group includes lay members from the community, and professionals work in partnership with them in seeking positive solutions to the problem. The Family Health Nurse, with her in-depth understanding of human development and family relationships, is a valuable member of the group.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to targets 4 and 11 (see Annex 1).

Care of an ethnic minority refugee family

The family of seven arrived in the host country from neighbouring Kosovo. They are Albanian. The grandfather is 40 years of age, the grandmother is 38 years, their son is 19 years and his wife is 17 years. They have three children – twin boys of 2 years and a baby girl of 10 months.

The family has never been in the host country before, and they have no relatives or friends there. They have lost their home and have no money, no work and no health insurance. They are very distressed, but thankful to be alive and to be together as a family group. They have temporary tented accommodation in the refugee centre.

The Family Health Nurse is part of a health and social care team which has been brought together to work in the refugee centre. The Family Health Nurse speaks the refugee family's language and she meets with them and carries out a comprehensive assessment of their needs. She records this in the multidisciplinary care record, which was started by the reception team who documented each family's arrival.

Her initial assessment reveals that the family members are physically healthy, although emotionally very distressed. The four adults often argue among themselves. She diagnoses the baby daughter as suffering from the chromosomal abnormality of Down's syndrome.

Over the first two months of weekly visits to this family, the Family Health Nurse gradually gains an understanding of their culture and way of life, which is different in many respects from that which predominates in the host country. While she respects the family's right and need to retain their culture and beliefs, she realizes that, in some respects, this poses health challenges. For example, they do not select a healthy balanced diet from the meals available in the refugee centre; the parents wish the young boys to be circumcised but initially they refuse to see a doctor so that this can be done using aseptic techniques in the hospital; and the adults show no interest in gaining employment.

The Family Health Nurse prioritizes the following actions, in the full knowledge that it will take time to gain the family's trust, and recognizes that regular re-assessment will be needed before they can achieve their full health potential in their changed circumstances. She first arranges an appointment for the whole family with the qualified counselling team who are part of the refugee support system set up by the host country. This is so that they can begin the process of emotional healing. She then explains to the family the nature of the baby daughter's chronic disability and arranges for them to have an appointment with the paediatrician. She accompanies them to that appointment.

Over the next four months, together with a Family Health Nurse colleague, she ensures that they are visited weekly, providing continuity of care and advice. She finds work for the young father in a private car-wash company and persuades him to take the job. She also arranges for the grandfather to work as a helper on a farm, as he was a farmer in his home village, and he seems interested in doing this. The family has decided that they wish to remain in the host country, so the Family Health Nurse makes arrangements for health insurance for all family members and for them to commence negotiations with the team responsible for finding permanent homes for those wishing to stay. She begins a systematic programme of health education, initially focusing on the grandmother and young mother. Working very much in dialogue and partnership with them, and taking into account their views, she concentrates on discussing healthy nutrition for all members of the family and on child growth and development, so helping the mother and grandmother to give the children a healthy start in life in their new circumstances. She raises the sensitive issue of contraception for both the grandmother and the young mother. She understands the cultural and religious issues that are important for this ethnic group; for example, in relation to contraception, she arranges for a male Family Health Nurse to talk with the two men in the family. She also successfully encourages the whole family to attend a community action group where those not intending to return to their own country can attend classes and discussion groups to help them

make informed choices about the options for their lives, after the crisis which they have endured. This group has a crèche for young children and also provides leaflets in the languages of the refugees, which they can take home and discuss in the privacy of their own family group.

Commentary

In her key lynchpin role, the Family Health Nurse demonstrates, in her professional care of this refugee family, her extensive professional knowledge of the determinants of health, of the disabling condition called Down's syndrome and its implications for the family and the child, of the wider health and social care systems which her own country provides, and of the recent crisis intervention policies which have been put in place to deal with the influx of refugees. She shows sensitivity to the refugee family's cultural and religious beliefs and blends this knowledge into proactive health education. She seeks to empower the adults by introducing them to the community group, and to raise their self-esteem by persuading the two men to take on employment, thus earning money and beginning to support their families again. She systematically documents her work with this family and regularly monitors their successes and difficulties, so that others in the multidisciplinary support team can contribute their expertise within the holistic context of the care of this family.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to target 2 (see Annex 1).

Accident prevention/inequalities in health

The Family Health Nurse and the family physician have been informed that their government has given high priority to reducing accidents to children. The Family Health Nurse has been monitoring the rate of accidents to children occurring in her community and is aware that the rate is higher than in other, more affluent, communities. She works in an area where all the housing is rented from the government, and where there are a number of busy roads and very few safe play areas for children.

She discusses the issue with colleagues in public health, who provide her with epidemiological information about attendance by children in her area at the hospital accident and emergency department, and these data support her concerns. She reviews the evidence on effective interventions in accident prevention and decides to concentrate on accidents in the home and on the roads.

In discussion with the family physician, they decide that this should be the priority for prevention for the year. The Family Health Nurse uses her existing local networks with community workers, schools, child care centres, housing and transport authorities to set up an accident prevention coordinating group. With the community worker she arranges a meeting of local parents, to provide them with information about the number of accidents and to hear their views on what they think the problems are. The parents' group raises a number of issues that they want to be addressed. These include:

- the speed at which traffic drives through the area
- the lack of safe play areas for the children
- first aid training for parents
- the lack of safety catches on the windows of their apartments, and
- the problem of being able to afford safety equipment in the home.

The Family Health Nurse arranges a joint meeting of the coordinating group and the parents' group, and an action plan is agreed.

The Family Health Nurse sets up a four-week course on first aid for local parents, which includes information on how to prevent accidents in the home. She teaches the first three of these courses herself and then decides to train local parents to run the course. She develops an information pack for them to use. With the community worker, she supports the parents in applying for a grant to set up a safety equipment loan scheme. They are successful and eventually take charge of the scheme themselves, with one of the parents taking on the role of paid coordinator. The housing department agrees to look at the safety locks on the windows, and new locks are fitted in all apartments where there are young children.

The Family Health Nurse provides the parents with information on the impact that traffic calming measures have on reducing accidents and, through her contacts with her nursing colleagues, puts the parents' group in touch with an area where these traffic calming measures have been put in place. Following considerable lobbying and campaigning by parents, the transport department agrees to put down traffic calming humps on the roads and to reduce the speed limit throughout the housing estate.

The coordinating group has not yet been successful in getting safe play areas for children but the parents' group is continuing to put pressure on local agencies and has begun raising funds to buy equipment.

The Family Health Nurse keeps in close contact with public health colleagues who are monitoring local accident rates and, as part of her contacts with individual families, she asks all parents to identify the dangers in their homes and to think of ways of protecting their children. She continues to record accidents that happen and regularly feeds this information back to the coordinating group. She is planning a display and information stand to raise awareness of accidents to children; this stand will be set up in the local shopping centre and run by members of the parents' group.

Commentary

In this scenario the Family Health Nurse demonstrates a community development approach to addressing an important health issue in a deprived community. Her community development role focuses on facilitating the setting up and running of a parents' group and acting as an advocate in their campaign for traffic calming. She does not do all the work herself; rather she draws on the knowledge and skills of local people to know and find solutions to local problems. She is also concerned to strengthen the community by providing opportunities for learning, improving local skills and providing employment. She sees all these aspects as vitally important for improving health in the long term.

She demonstrates her understanding of the need to collect and use health data and to liaise with public health specialists. Planning on the basis of need is the key to her approach. She works as part of a multidisciplinary and multi-agency accident prevention team, recognizing that achieving real and sustainable change requires action by other services, such as housing and transport, rather than solely by the health care service. She uses her skills in group work and health promotion and her knowledge of first aid to give parents the knowledge and confidence in their ability to provide first aid both at home and in the community. Her non-judgmental attitude and her skills in working in partnership with local families mean that they do not perceive her as a threat, seeing her instead as a useful resource for the community.

The majority of the HEALTH21 targets are addressed by the Family Health Nurse's work in this care scenario. More specifically, priority is given to target 20 (see Annex 1).

Annex 3

CURRICULUM PLANNING GROUP

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