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To be sure or not to be sure: concepts of uncertainty and risk in the construction of community nursing practice

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This paper focuses on one aspect of a research study exploring qualified and student nurses' constructed meaning of nursing in a community context. Uncertainty and risk were particularly important factors in the practice constructions reported by qualified nurses. However, this aspect of practice did not constitute a significant element of the clinical curriculum, and students displayed a limited appreciation of these concepts. The visibility and articulation of these aspects of practice may therefore need to be enhanced to develop a more accurate appreciation of practice in the community context, as well as refining the education agenda for this aspect of health care. Four types of uncertainty were identified in this research, namely uncertainty as a consequence of an unpredictable practice context, uncertainty created by the nurse–patient power balance, uncertainty created by exposure to diverse needs and finally, facing risk and dealing with uncertainty when alone. By drawing on a range of literature, the particular dimensions of risk and uncertainty experienced in community practice are differentiated. It is argued that as a core tenet of the practice experience it is timely and appropriate to review perceptions of risk and uncertainty. Acknowledging these as an accepted part of practice may not only facilitate the practitioner's ability to manage the experience but also allow learners to develop their appreciation and understanding of risk and uncertainty.

Key words: clinical curriculum; community; constructed meaning; risk; uncertainty

Introduction

There is an international movement in health and social care away from institutional settings and into the community. This is evident in the policy agenda of the UK – for example, the NHS and Community Care Act (Department of Health, 1990), *Primary Care: Delivering the Future* (Department of Health, 1996) and *The New NHS: Modern, Dependable* (Department of Health, 1997). This philosophical shift was addressed by the World Health Organization (1985), which recommended a reorientation in the nurse education curriculum towards an increased emphasis on primary health care and community health. However, there has been limited exploration and exposure of those dimensions of practice which are specific to this particular health care context.

This paper arises from research which aimed to access and describe the constructed meaning of community nursing practice in an attempt to enhance the way in which practising nursing in the community is understood (Carr, 1999). The phenomenon of nursing in this context was explored by comparing the reality construction of specialist practitioners (community nurses; CNs) with Diploma in Higher Education/Registered Nurses (Dip HE/RN) in the final year of their 3-year adult branch programme.

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This discussion focuses on one of the concepts, namely *risk and uncertainty*, which emerged as a consequence of juxtaposing the CN and student accounts of practice experience. The concept is acknowledged by both CNs and students, but more predominantly by CNs. Plurality in the construction of meaning by these two groups is to be expected. However, the distinctions found in this research serve to highlight this as a facet of practice where further articulation may be valuable. This paper does not set out to explore the problem of the existence of risk and uncertainty, but rather it seeks to acknowledge them as important dimensions of practice which have received limited attention in the learning agenda, and which can be experienced in a distinct way by virtue of the context of practice.

A brief description of the research methodology is provided in order to contextualize the results within the research process. A range of literature relating to risk and uncertainty is then explored. This is followed by the presentation and integration of the research results in order to differentiate the experience of these concepts within the specific practice context. A continuum of nursing practice in relation to risk and uncertainty is described, and key messages from the research are then highlighted.

Methodology

As this paper is principally a discussion of the findings from the study rather than an exposition of the study itself, research methodology is only briefly addressed. A detailed report of the research process is available elsewhere (Carr, 1999).

The study is based on an interpretive approach, aiming to elucidate how community as a *context* for *practice* is perceived and experienced by both CNs and students. This is consistent with the aim of addressing weaknesses in the understanding of nursing in the community. For example, McIntosh (1996: 316) claims that 'an exclusive focus on activity fails to capture the range and depth of nursing care in the home'.

This research focuses on making meaning more transparent, and is therefore approached from a phenomenological perspective. This is supported by a constructivist perspective which builds an educational picture derived from the meanings of experience voiced by the participants.

The research sample was recruited from within two NHS community trusts in the north of England. The research was conducted over a period of approximately 2 years. The design consisted of multiple phases of data collection. Six focus group interviews with CNs and students constituted the first exploratory phase of the research. As the data accessed by means of this strategy were primarily retrospective, the second phase was designed to access a more concurrent level of practice by conducting five episodes of nonparticipant observation of CN practice with concurrent interviewing. The rationale for this strategy was to give the researcher the ability to discuss the meaning of practice as near as possible in time to when it actually occurred.

In order to capture the student voice, the third phase of the research took the form of practice narratives recorded by CNs and students. Seven CN and student pairs recorded their individual 'story' of the same practice episode, producing a total of 18 narratives. As the ethos of the research was to 'mine meaning' in partnership with the participants, the final phase of the research consisted of tape-recorded practice narrative discussion groups with CNs, in which transcripts of the practice narratives were shared and discussed.

In keeping with the guiding philosophy of hermeneutic phenomenology, this provided a means of capturing 'the story behind the story'. Analysis was guided by the interpretive paradigm – a dynamic and iterative process throughout the course of the study and the interpretations reported in this paper developed over the process of the research. Issues relating to risk and uncertainty were raised in each phase of the research which increased the confidence level (Fielding and Fielding, 1986). Direct quotes from the data are drawn on to support the discussion and make the process of concept development more visible to the reader (Lincoln and Guba, 1985; Koch, 1994).

The literature: definitions of risk and uncertainty

The term risk is used in health care in a variety of ways, (e.g., child-protection 'at-risk' registers, pressure-sore risk calculators, risky lifestyle behaviours, risk assessment, risk management, etc.). Indeed, Roberts and Holly (1997) suggest that risk

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is part of 'every clinical and organizational action'. However, Macmillan (1994) has identified difficulties in exploring the issue of risk because in the demotic literature it is often used loosely. Similarly, in relation to social work, Brearly (1982) reports that risk is a well-perceived but poorly understood concept. In their recent research exploring perceptions of risk held by district nurses, social workers and learning disability nurses, Alaszewski and Alaszewski (1998) found that although risk was an important aspect of practice for all of these professionals, it was not something to which they had given a great deal of reflection.

It is apparent, therefore, that risk and uncertainty are not in any way unique to community practice. However, it is argued in this paper that the distinctive presentation of the concepts in the community environment warrants articulation and clarification.

Hayes (1992) traces risk from a neutral concept in the seventeenth century to the present day, where risk has acquired a negative outcome association. The 'negative' quality to current constructions may be significant where risk and uncertainty are relatively hidden and unarticulated aspects of practice. There is a potential suggestion of loss of control and inadequacy in coping.

The perpetuation of this type of perception may be a source of conflict for a number of health and social care practitioners, especially in view of the experiences which may be encountered when practising in the community context. Acknowledging risk and uncertainty as accepted aspects of practice, rather than perceiving them as something which must be avoided or reduced, may provide a more appropriate model for current practice. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1986) endorsed the existence of uncertainty in practice in their recommendations for education reforms:

> In considering the potential changes in the NHS as a result of government policy, the UKCC concentrated essentially on the issue of the necessity to develop practitioners who will have confidence to cope with uncertainty.
>
> (quoted in Ramprogus, 1995: 11)

It is therefore very timely to acknowledge how risk and uncertainty are experienced in practice generally, and also within specific contexts.

Alaszewski (1998) notes that the term 'risk' is used in different ways by different professional groups, such as epidemiologists, engineers and social scientists. For example, at one end of the continuum is objective risk as encountered in engineering. In contrast, Alaszewski (1998) identifies risk in the social science discipline as being a constructed concept with higher levels of subjectivity. Moreover, there is a considerable medical literature relating to risk. This often focuses on accident avoidance, reduction in the probability of litigation, risk control, and protocol development (Vincent, 1995).

Although related literature has some relevance, it is important that studies specific to both professions and contexts of practice are also developed. This paper therefore aims to make a specific contribution with regard to nursing, and more precisely nursing in the community context. Indeed, it is the context which is the driving issue in this paper and its relevance may therefore be to a range of community workers rather than to nursing alone.

Two specific issues have been identified in the literature which are of particular relevance to community practitioners. These issues are introduced briefly here and will be developed further in the paper.

First, there is the question of uncertainty and risk in relation to problem definition. Williams identifies uncertainty as an aspect of medical practice in a community context. He defines general medical practice as follows:

> a branch of medicine characterized by high levels of uncertainty . . . grey areas exist where it is impossible to formulate an exact definition of the problem which might include not only physical, but social, psychological and environmental components.
>
> (Williams, 1995: 294)

Littlewood's description of health-visiting practice identifies similar problems:

> dealing with clients who are not classified in any dominant way, but may have problems that require the health visitor to disambiguate in order to extract meaning, see focus, negotiate care within the home or in a restatement of care in the public sphere.
>
> (Littlewood, 2000b: 650)

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Although Littlewood (2000a) draws distinctions between the roles of district nurses and health visitors in relation to experiencing ambiguity in practice (suggesting that it is experienced to a greater degree by the latter group), it may be that ambiguity and subsequent risk and uncertainty are a commonality shared by all community practitioners as a consequence of the context in which they practise, irrespective of particular specialisms.

The second issue which contributes to the development of the experience of uncertainty and risk arises when beneficence has to be balanced with autonomy. This dilemma is encountered in a variety of health care situations. For example, Heyman *et al*. (1998) have discussed it in relation to the care of learning disability clients and their families, and it has also been explored by Cook and Procter (1998) in relation to rehabilitation nursing. However, although there may be similarities between many branches of health and social care in this respect, it will only be by comparing and contrasting community nurses with other professionals that the experiential phenomenon of this dilemma in the community setting may be further clarified and differentiated.

Research findings

This discussion of research findings draws on examples from the different phases of the research both to illuminate aspects of practice and to further an understanding of the constructed meaning of risk and uncertainty in community nursing.

When discussing their practice, CNs report that they experience four types of uncertainty which include elements of risk. These are listed in Box 1.

Box 1 Types of uncertainty encountered in community nursing practice

Uncertainty as a consequence of an unpredictable practice context
Uncertainty created by the nurse–patient power balance
Uncertainty created by exposure to diverse needs
Facing risk and dealing with uncertainty when alone

Uncertainty as a consequence of an unpredictable practice context

One concept which arose from the focus groups was that of 'routineness'. Students categorized some practice as 'routine', with connotations of being undemanding, not critical, and predictable. They sometimes indicated that a less senior practitioner might be more appropriate for some aspects of practice: 'in hospital a D grade would do some of this' (Student focus group).

When this type of comment was relayed to the CNs at subsequent focus groups they often conceded that the *content* of some of their practice may not warrant a specialist practitioner grading, but practising in a community *context* did. They identified that one of their key skills lay in being able to deal with nonroutine visits. Several others repeated the essence of this quote from one CN: 'A routine visit may turn out not to be routine – students couldn't cope with that' (Community nurses focus group).

Another commented: 'Community is about the unexpected – things you can't plan for' (Community nurses focus group).

These comments appear to endorse McIntosh's (1996) concern that focusing principally on nursing activities carries the potential for missing aspects of practice. It would also appear that the dimension which may be missed is complex if it is seen to be an aspect of practice with which a student or novice could not cope. Although it may therefore not be a competence which preregistration nurses would be expected to achieve, it is a dimension of practice of which they need to be aware, to allow them to appreciate the totality of practising in context and therefore identify potential future learning needs. Student participants in this research did appear to neglect the context in which practice was taking place, and instead prioritized the content of practice. Although preregistration students may rarely practise alone in the community environment, contextual development of their conceptualization of risk and uncertainty may also have relevance for other areas of their practice through insights into the decision-making dilemmas faced by colleagues operating in the community context.

CNs referred to situations that 'just bubble

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along' – apparently stable situations which had the potential to be destabilized: '. . . all of a sudden there's a big wave and a crisis' (CN).

Monitoring is therefore an aspect of practice which involves engaging in nonspecific assessments: 'watching everything' (Community nurses focus group) and 'taking everything in' (Community nurses focus group).

It may be that the nonspecific nature of this assessment makes this a difficult issue to share and teach. However, it was an aspect of practice which was generally recognized by the CN research participants.

Another important dimension of problem definition which needs to be noted is that the 'routineness' or otherwise of a visit can in general only be categorized retrospectively rather than prospectively. CNs referred to not knowing what type of situation they are about to face. This is well illustrated in the words of one community nurse with 18 years of experience:

> you knock on a door and you don't know what's behind – in a sense that's what gets the adrenaline going – I always take a deep breath when I knock on a door for the first time.
>
> (CN)

Again, highlighting this as a commonality between different community workers, Cowley (1995) defines a routine health-visiting encounter as one that has passed. This is a stage prior to being faced with making a decision which may have an uncertain outcome. It is about a state of expectedness about what may happen next. Accident and Emergency is another health care environment where similar scenarios exist. For example, Kelly and May note that:

> with its more-or-less off-the-streets access for patients, doctors surrender a great deal of control over their workloads and consequently stand in constant danger of being overwhelmed.
>
> (Kelly and May, 1982: 147)

However, what distinguishes the experience for CNs is that 'You get out of the car, you knock on the door and go in – *alone*, you have an idea what to expect, but you can never be sure' (CN).

The issue of facing risk and uncertainty alone is explored further later in this paper.

Uncertainty created by the nurse–patient power balance

The patient's potential influence on the care situation is clearly stated by Kelly and May:

> Patients are not passive recipients of nursing labels, although much of the literature tends to depict them in just this way. As parties to the interaction they retain power to influence, shape, and ultimately to reject nurses' attempts to impose their definition of the situation.
>
> (Kelly and May, 1982: 154)

When the context of practice is the patient's home, it appears that the opportunity to exercise this power is both increased and endorsed by the holistic philosophy of practice. Therein lies the dilemma of balancing patient safety and utilization of professional knowledge with patient choice and autonomy. For example, it was commented that 'you sometimes have to wait for things to happen' (CN).

This CN was talking about an elderly client who was living in a potentially unsafe environment. The CN felt in a state of uncertainty, having identified a potential risk to the client, which the client refused to take measures to avoid. The CN was then waiting to see 'if things [an accident] happened.' The nurse reported not being in full control of the decisions because she was not in control of the context. The level of control that was managed by the patient, largely as a consequence of care taking place in their home, was seen to be distinct from the level of control possessed by the hospital-based patient. Joseph (1993) has presented a number of case studies of patient risk taking and asserts that 'most of us can identify clients who take risks and get into trouble.' However, it could be argued that what distinguishes this common health care scenario for community practitioners is the degree to which this risk taking is shared with them and is on display to them, by virtue of the fact that they see the patient in their home environment. Practitioners in other contexts may therefore experience a more dilute experience of this phenomenon and may thus face a different dimension of the autonomy/beneficence dilemma.

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Uncertainty created by exposure to diverse needs

CNs reported dilemmas primarily created by being exposed to details of patients' lives and working according to a holistic philosophy. Although it is focused on the different issue of anxiety and nursing, Menzies' (1960) work helps to identify how these dilemmas may be generated. Menzies noted that task allocation was a social defence developed in order to reduce nurse anxiety. This was achieved by preventing the nurse from: 'coming effectively into contact with the totality of any one patient and his illness and offers some protection from the anxiety this arouses' (Menzies, 1960: 101).

All branches of nursing have since evolved towards a more holistic approach to care. This may or may not have had the consequence of increasing anxiety levels in nursing – that issue is not open for debate here. However, this change in practice has had the potential to expose the nurse to a more intense patient contact. Add to this the community or home environment of practice, together with a generalist role, and the impact for community practitioners becomes evident.

The potential for becoming more deeply involved is obviously an important issue that can create uncertainty for practitioners: 'Sometimes it's frightening to what degree people will disclose to you' (CN).

Several CNs raised the impact of context:

> Things you would never touch on in hospital – you see family life as it happens, warts and all – you might have to deal with it or acknowledge it or try not to see it.
>
> (CN)

Interestingly, this issue was also raised by a number of students:

> The intensity of the relationship struck me, how much they [patients] divulge and open up to you. It seems like you're in their home so you're part of them.
>
> (Student focus group)

An important source of uncertainty for CNs therefore appears to relate to the questions 'Should I deepen my involvement here?' and 'Is this my business?'. Practising holistically creates dilemmas as to where the boundaries of practice should lie, as demonstrated by the following data examples:

> I call them support visits, I go in looking for x, y and z, but just say 'how are you today?', there's something in with how they respond – you have to decide whether to pry or not.
>
> (CN)

> You need to be a bit of a detective in this job – chipping away at something to see if there is anything there.
>
> (CN)

Another CN's comments gave a slightly different perspective on this type of uncertainty:

> You go in and you know there is something, but there is nothing. . .you continue to probe…you might be on the wrong lines, you're not 100% sure that you are right – you could be hanging yourself. . .it's about putting yourself on the line.
>
> (CN)

Facing risk and dealing with uncertainty when alone

Practising alone adds another dimension to facing risk and dealing with uncertainty. Many decisions have to be made without the opportunity to collaborate with a colleague. This has two consequences: first, not being able to confer with a colleague until after the event, and secondly, being very aware that if you miss something you do not have the safety-net of the patient being in the protected environment of the hospital where the assessment may be revisited by a colleague:

> in hospital you check so many things, not just drugs, without really knowing it – you don't realize until you come out here and there's no one to check with how much you actually rely on checking.
>
> (CN)

This is a dimension of practice which is shared with a number of other professionals (e.g., general practitioners and social workers). Making decisions alone was the dominant facet of risk and uncertainty identified by students. They were generally fearful of the responsibility of working alone, and desired situations where there was a more diffuse level of responsibility:

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> What got me was that there was no one there to double check.
>
> (Student focus group)

> They have to be sure of themselves, you can't just turn round and ask someone if you're stuck – you're on your tod – that would frighten me, being the only person there and having the whole thing on my shoulders.
>
> (Student focus group)

We would suggest that it is inappropriate to allow students' appreciation to be regarded as a fear-provoking experience, and that a currently neglected educational issue is that of nurturing their understanding and management of decision making in these circumstances.

Discussion

Macmillan (1994) suggests that the traditional view of nursing has been one of caring for and undertaking tasks for vulnerable, sick people and therefore inherently removing or diminishing risk as much as possible. However, this present research demonstrates that practising within a framework of risk and uncertainty is also a dimension of nursing practice. Current policy developments, such as the NHS and Community Care Act 1990, and The NHS Plan 2000 (Department of Health, 2000: 4), which advocate the shaping of services 'around the needs and preferences of individual patients, their families and their carers', may also increase the potential for risk and uncertainty in practice. It is therefore very timely to address the presence, assessment and management of risk and uncertainty in nursing practice in the community context.

One factor which significantly influences the level of uncertainty and risk in the community is the power balance between client and nurse and control over the care agenda. In relation to medical uncertainty, Holden suggests that it is:

> inextricably linked to an ill-defined sense of responsibility which in turn generates guilt and anxiety. Katz argues that one of the major defences standardly employed by physicians (and *ipso facto* – nurses) against anxiety of uncertainty is to establish authoritarian relationships with patients and colleagues.
>
> (Holden, 1990: 231)

The source of uncertainty described by Holden is evident in the community nursing situation, but the coping strategy is contradictory to the nurse–patient power base described by CNs. Indeed, CNs reported several examples of negotiating their practice with their patients, despite the resulting situation containing elements of risk and uncertainty for them. The issue of the control of risk and where the power to achieve this is located is further developed with reference to Sines (1995). He describes community nursing as providing care within a negotiated client-directed care plan. This may include a calculation of risk and endorsement of a course of action chosen primarily by the client. This level of power in risk management was a repeated area of conflict between CN and student in the focus group interviews conducted during the first phase of this research. Students often found it difficult to accept the level or amount of power that the CNs allowed the client to hold, with a tendency to want to attain as risk free a resolution as possible. CNs repeatedly rationalized their practice decisions by saying that 'you have to do what the patient wants, you can't force them. Students want to take control, you can't do that in the community' (CN).

However, it is important to note that CNs work to this agenda but struggle with the risky situations that result. They do talk about difficulty in switching off:

> I'm often not 100% happy when I leave a patient. I know no one else is there for them for the next 24 or 48 hours and I often don't feel comfortable with that.
>
> (CN)

An important factor that may contribute to the feelings of uncertainty is that although the CNs refer to sharing decisions with the patient, they have only a limited opportunity to share the professional responsibility. Therefore at one level the decision is shared, but at another the CN carries it alone. This is perhaps an argument for the adequate availability of clinical supervision for community practitioners.

By comparing CN practice construction with that of students and previous published research, it is possible to identify what appears to be a continuum of practice in relation to risk and uncertainty which is distinctive to the community context:

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- being receptive to the possibility of risk;
- recognizing a risk situation when it occurs;
- managing the risk or uncertainty.

Being receptive to the possibility of risk

While they were listening to the tapes and reading the transcripts of the CN focus groups, the researchers built up a picture of the CNs walking along the edge of a cliff, aware of the potential for falling over the side, and therefore constantly striving to keep their balance. In contrast, the CNs' discussion of student nurses conjured up an image of students walking along the same cliff edge, but being unaware of the potential drop and not accommodating to it. Indeed, the lack of reporting of student comments in this paper reflects the limited reference made by them to risk and uncertainty. In view of the significance it holds for CNs, this is a learning deficit which needs to be acknowledged and addressed.

It is possible to identify several factors which may contribute to the current situation, and consequently to suggest some solutions. Students rarely work alone, and so are not exposed to the same decisions as the CNs. The short time scale of students' placements may mean that they only experience the 'bubbling-along' phase rather than any 'big waves', and therefore they may be unaware of what types of situation may occur. Reference to the literature on uncertainty in the very different profession of property development may further clarify this discrepancy in the experience of student and qualified nurses. Byrne (1996) defines two types of decisions, namely single-stage or 'terminal' decisions and multi-stage or 'sequential' decisions. The latter are interpreted as revisiting of situations to gradually clarify the issue concerned and reassess the interpretation after the presentation of each new set of information. Relating this to the nursing context, students may only be exposed to single episodes or a limited number of stages in the multi-stage process, and may therefore be unaware of the interpretation process at the time when the uncertainty is experienced.

Another explanatory factor may be that CNs do not articulate or share their experience of risk and uncertainty with the student. This would concur with Brearly (1982) and Alaszewski and Alaszewski (1998), who identified that although practitioners experience uncertainty and risk, this has received only limited consideration or articulation.

Recognizing the potential for risk and uncertainty

Aspects of the discussion on risk presented by Reason (1995) allow development of the issue of risk recognition. Reason refers to the signal-to-noise ratio. In order for someone to recognize it, a signal has to be very loud and clear, or at least it must be possible to differentiate it from other background noises. The wide and varied parameters of practice in the community, exacerbated by the intertwining of health and social care, may have the effect of creating a high level of 'background noise' that potentially interferes with signal recognition. CNs described performing nursing activities while being involved in a state of 'watchful alertness'. Sharing the details of a task with the learner is the easiest aspect of practice to articulate. The consequence, of course, is that the student may primarily be aware of, and concerned with, the task that is undertaken by the CN. The construction which individuals (i.e., students, other nurses, purchasers) make of community nursing is largely determined by the building blocks of information that are presented to them by CNs. By favouring the task-oriented and espoused knowledge paths to sharing clinical knowledge, some facets of practice may be hidden, and this would appear to be true of risk and uncertainty.

Managing risk or uncertainty

Dickson (1995) notes that central facets of risk management involve reducing exposure to risk by controlling the environment. The community as a context for practice poses challenges to this mechanism which may not be met in other care environments. When the context of practice is patients' homes, there are high levels of diversity and limits on how much control or influence is available to the nurse. For example, the support or informal care framework required by the patient may be crucial to the overall care package, but largely outwith the nurse's control, especially when it is provided on a voluntary basis.

Diversity is also met in relation to potential patient needs. By its very nature, community nursing provides a generalist service and must therefore be responsive to the varied situations that are encountered during practice. The 'balancing act' described by CNs of whether to become more involved in a patient situation appears to have

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something in common with Culham's (1982) comments on helping:

> to offer help is to become involved in another's life and may be seen, however altruistic the motive, as gross intrusion physically and psychologically.
>
> (Brearly, 1982: vii)

Working in the home setting may in fact exacerbate the complexity and dilemmas that are involved in helping or caring. In their discussion of risk management in health care, Roberts and Holly (1997) refer to different types of error. One type, namely acts of commission (i.e., doing something inappropriate), appears to be particularly relevant. CNs report being faced with uncertain signals (i.e., 'Is this a legitimate nursing issue or an aspect of the client's life I am aware of but should not become involved in?'). Of course, this dilemma is exacerbated by the risk of acts of omission (i.e., not doing something that is required) occurring. The risk may also be heightened when the practitioner is alone and the judgement or opinion of another practitioner is not readily available. Exposure and sharing of decision making between one practitioner and another, and between practitioner and student, would appear to be an important development for nurturing this aspect of practice and acknowledging it as a complex skill rather than a fearful risk.

Conclusion

Comparison of students' and CNs' construction of the meaning of practice has highlighted important themes relating to perceived routine practice, problem definition and the dilemmas of facilitating patient power and autonomy balanced with professional responsibility. Construction of the process of recognizing and dealing with uncertainty is a complex and central concept in community nursing. Context impacts on practice in at least three ways which make the experiences of risk and uncertainty in the community distinct from those in other health care settings.

1) Working alone without the opportunity in the first instance to collaborate with others on identification or response to risk. The private nature of practice is often such that only one nurse may have the opportunity to assess the situation. This is very different from a hospital ward environment, where there is the potential for more than one nurse to participate in the assessment process. This adds another dimension to the risk of acts of omission.
2) Encountering facets of patients' lives which are often not revealed to hospital nurses, and which perhaps could only be revealed in the patient's home. CNs refer to being exposed to details of life that are 'put on hold in hospital'. This may make the signals difficult to interpret. CNs particularly report the dilemma of risk as acts of inappropriate commission.
3) The control and power base shifts towards the patient in the community context. The care agenda is perceived to be very much more negotiated with the patient. This adds an additional dimension to risk management in terms of the potential for conflict between the CN and the patient with regard to the acceptable level of risk to be allowed.

This research has shown that CNs and students nearing completion of their initial nurse education programme appear to have different paradigms of practice. This is of course to be expected from different levels of practitioner. The areas of risk awareness and dealing with the dilemma of uncertainty do not appear to be highly visible to students. This raises a number of education issues. It reinforces the assertion that preparation to practise must focus beyond the technical skills and tasks of practice. Neglect of the other context-specific aspects of practice jeopardizes the likelihood of students achieving the full learning potential of their practice experiences. However, the challenge in relation to learning about risk and uncertainty in the community context is considerable. The facilitation of learner confidence in practising under conditions of uncertainty is a difficult concept for learners to accommodate to, and is at odds with other driving forces in education, such as evidence-based practice.

An important message from the research is that learning from a practitioner whose practice is usually carried out alone is an aspect of education which deserves special consideration. Although sharing practice constructions between mentor and student appears to be a difficult process, it is one which warrants greater attention as one way to

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expose these issues. It must also be acknowledged that the aspects of practice which need to be shared can be difficult to capture and articulate (e.g., 'being alert', 'multi-stage' decisions). The ethical and moral dilemmas faced by practitioners are important aspects of practice and therefore worthy of exposure and debate as part of the academic and clinical curriculum. The students in this study were drawn to favour beneficence over autonomy. It is difficult to say if that was a deliberate moral choice or a more manageable option for learners. Assuming the latter, it does raise awareness of the demands that this type of role places on practitioners – a demand which is often not articulated and acknowledged. Progress with acknowledgement is often hindered by practitioners' reluctance to expose their experience of uncertainty. This is an issue which can be facilitated by practitioner – practitioner sharing of practice experiences and decision processes in an environment where risk and uncertainty are recognized as an accepted part of practice.

Risk is an integral element of many clinical situations. The changing contexts of care provision and partnerships with patients increase the potential for exposure to risk and uncertainty. This study has made some contribution to developing our understanding of risk and uncertainty as manifested in a community context, and it identifies the value of addressing as both a professional and an educational issue the facilitation of the experience of risk and uncertainty. Closer scrutiny of different practice environments may show that practitioners focus on different dimensions of the concepts of risk and uncertainty, yet use the terms across practice boundaries. This scenario could have implications for multidisciplinary and multispecialism communication.

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