ORIGINAL RESEARCH

Generic competencies for community health nurses: A qualitative study in Austria

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Received: March 31, 2025 **Accepted:** May 15, 2025 **Online Published:** May 22, 2025

DOI: 10.63564/jnep.v15n6p43 **URL:** https://doi.org/10.63564/jnep.v15n6p43

ABSTRACT

Objective: Austria's healthcare system is highly fragmented and decentralized, with primary care typically delivered by independent physicians and limited integration of other health professions. To address this, the federal government is piloting a community health nursing system across several regions from 2022 to 2024. This study explores the essential generic competencies required for community health nurses (CHN) within the Austrian healthcare and social systems, aiming to inform future training guidelines.

Methods: Fifteen experts in community health nursing and public health participated in qualitative interviews. The transcripts were analyzed using Qualitative Content Analysis, following established research standards.

Results: Findings highlight the importance of generic competencies – grouped into six professional, sixteen personal, and sixteen social skills – as key enablers of CHN effectiveness. Social competencies enhance patient relationships, personal competencies support autonomous and responsible practice, and professional competencies enable comprehensive care for complex cases. Communication emerged as the most frequently cited competency across all categories, along with information delivery, education, and social interaction skills.

Conclusions: Expanding the scope of community health nurses through a structured set of competencies could strengthen primary care and promote more integrated service delivery in Austria's healthcare system.

Key Words: Austrian healthcare system, Community health nursing, Generic competencies, Qualitative research

1. INTRODUCTION

In Austria, community health nursing could or in some actors' plans should play an essential role in the national health care system, serving as the frontline in delivering preventive, promotive, and rehabilitative health services across diverse settings. As the Austrian health care landscape evolves, marked by demographic shifts, increased prevalence of chronic conditions, and heightened health awareness, the competencies of community health nurses must adapt to meet these changing demands. This paper aims to delineate the generic competencies essential for community health nurses in Austria, providing a foundation for enhancing training programs and improving patient care.

Primary care, essential not just for health systems but also for the social and economic growth of communities, is a key focus for the World Health Organization (WHO).[1] Around the world, different models and concepts of primary care are adopted. Austria predominantly uses general practitioners for this purpose,[2] whereas countries like Norway, Finland,

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and Ireland integrate nursing professionals into their primary care frameworks.[3] Furthermore, community health nursing significantly shapes the primary care landscape.

Community health nursing, as defined by the WHO, merges nursing expertise, public health awareness, and certain aspects of social care into a cohesive public health effort to promote health, improve social and physical environments, and assist in the rehabilitation from illness and disability.[4] Community health nurses (CHN) are seen to be crucial in preventing disease, promoting health, and meeting healthcare needs, utilizing diverse social skills to effectively engage with individuals, families, and broader communities. The Canadian Nurses Association defines these necessary skills and knowledge as the competencies required for nurses to operate safely and ethically within specific roles and settings.[5] These competencies aid in creating job descriptions, which outline roles, contributions, and expectations within organizations and help in evaluating job performance.[6, 7]

This article explores the essential generic competencies of community health nurses in Austria. Competencies in this case are meant in the broadest sense of social sciences, the skills and it aims to enhance competency profiles in research and aid in developing training curricula for Austrian community health nurses. Lidauer et al.[8] conducted a scoping review focusing on these competencies and identified a wide spectrum of required skills, categorized into four main groups: generic competencies, planning and collaboration, public health, and advanced clinical and care management skills. Notably, specific studies focus on global and public health competencies for nursing education,[9] and interdisciplinary competencies in medicine and nursing[10] highlighting a lack of direct focus on Community health nursing.

Our research uncovered a gap in studies specifically addressing the generic competencies of community health nurses within Austria, despite extensive international research, particularly from the United States and the United Kingdom.[11–16]

This leads us to the following research question: What are the essential generic competencies for a community health nurse in Austria? This article contributes to the ongoing discourse on healthcare professional development in Austria and offers practical insights for policymakers, educational institutions, and healthcare providers. By focusing on generic competencies, this study supports a holistic approach to community health nursing, ensuring that nurses possess the necessary generic skills to adapt to a dynamic healthcare environment and meet the needs of the Austrian health care system.

2. METHOD

To address the research question, a qualitative research design was employed, using expert interviews conducted in person (qualitative interview study). We used problem-centered interviews, which allow to either build theories or collect and analyze data both, inductively and deductively.[17] Throughout the research process, particular attention was paid to the quality criteria of qualitative research, drawing on the work of Mayring[18, 19] as well as other scholars.[20–22]

2.1 Sampling

Access to the appropriate study population involved identifying initial interview participants through websites, press releases, publications, ResearchGate, and social media profiles of relevant institutions, authorities, or companies.

To ensure maximum heterogeneity, interview participants were selected based on diverse combinations of characteristics. Specific inclusion criteria defined the study population; an overview is provided in Table 1. The goal was content relevance,[23] but not statistical representativeness.

In addition to the central questions relevant to the research, comprehension and ad-hoc questions were also used.[24] After the fifteenth participant, theoretical saturation was reached, which, according to Glaser and Strauss,[25] means that no new data were generated and the responses began to repeat.

2.2 Data collection

To access the perspectives of the interview participants, semi-structured expert interviews were conducted. These expert interviews focus on the knowledge advantage that results from the position of the experts. The focus was less on the feelings, characteristics, and sensations of the individuals, but more on the observations, actions, and knowledge they possess in their role as experts.[26]

Initial contact via email with potential interviewees provided general information about the study. The interviews were conducted and recorded via video conferencing.

For the research question at hand, this method represents a good compromise between addressing relevant topics and the comparability of the interviews on one hand, and the openness of the interviews, which allows delving into details on the other hand. The guided open interview form allowed for a flexible conduct of the interviews and gave the interviewed persons the opportunity to talk about their professional experiences within a certain topic area.

Table 1. Inclusion criteria for the study

1. Selected Experts	
Government and Public Institutions	- Employees at the Austrian Federal Ministry of Social Affairs, Health, Care and Consumer Protection - Employees at Gesundheit Österreich GmbH (GÖG)
Labor and Consumer Advocacy	- Representatives from the Austrian Chamber of Labour involved in healthcare and nursing policy
Academic and Educational Institutions	- Program directors and lecturers of CHN academic programs at universities and universities of applied sciences - Directors and lecturers of CHN-related education and training programs at other Austrian institutions
Professional Nursing Organizations and Leadership	- Individuals in leadership roles within nursing organizations Leaders of primary healthcare units in Austria
Field Practitioners and Project Participants	- Professionals actively involved in local CHN or Community Health projects in Austria
Primary Healthcare Advocacy and Interest Groups	- Members of the Austrian Forum Primary Health Care (ÖFOP) - Members of the Austrian Primary Care Platform
Advisors and Policy Contributors	- Individuals serving in advisory capacities within the Austrian nursing and healthcare sector
2. Experience	
Professional Experience	- Minimum of 3 years of experience in their respective professional field
3. Knowledge	
Healthcare System Knowledge	- Demonstrated knowledge of the Austrian healthcare system

A total of 15 qualitative interviews were conducted between May and June 2022. The interviews lasted between 41 and 105 minutes and were conducted in German.

2.3 Data collection instrument

For empirical work a guideline was developed based on the literature and the research question established at the beginning. The interview guideline was structured according to thematic areas.

In the development of the interview guide, the SPSS approach as outlined by Helfferich[24] was employed. The guide underwent initial testing and refinement through a series of pilot interviews. As part of this process, a pre-test was conducted with two individuals who were not members of the expert group; accordingly, the data obtained from these interviews were excluded from the final analysis. Additionally, the first three interview participants were deliberately selected to ensure the possibility of recontact in the event of issues arising with the interview guide or specific questions (e.g., for supplementary interviews or clarification). In the course of the actual research project, however, no follow-up contact with these participants was required.

Ultimately, the pilot interviews did not lead to any changes in the sequence of questions, nor were any items in the interview guide substantially revised. Only minor linguistic adjustments and clarifications were made to the phrasing of individual questions.

Questions were asked according to the guideline, but the method of explication (focus on specific situations) was also employed. This involves understanding the spoken content through follow-up questions.[24]

2.4 Data analysis

Using Qualitative Content Analysis according to Mayring,[27] the transcripts were analyzed. According to Bortz and Döring,[28] the goal of Qualitative Content Analysis is "to interpret the manifest and latent contents of the material within their social context and meaning, highlighting primarily the perspective of the actors." The results of the analysis are interpreted against the background of theory, and the analysis steps are guided by theoretical considerations.[29]

Qualitative Content Analysis does not consider the text in isolation but in relation to the material being analyzed. A key feature of this analysis is working with categories or category systems on the textual material. The analytical procedure in Qualitative Content Analysis follows strict rules. During this process, analysis units are defined, which determine the text segments to be analyzed. These segments are processed using categories. The category system, developed based on the text material, is continually reviewed and revised if

necessary.[29]

For the present study, a combination of the techniques of summarization[19] and structuring[19] was chosen. In a first step the text material was divided into paraphrases and reduced while maintaining a recognizable form at a higher level of abstraction. Once this coding was completed, categories were formed, each connecting multiple codes.

The determination and definition of the categories were both deductive and inductive. Deductive category definition determines the evaluation instrument based on theoretical considerations, while inductive category definition derives the categories directly from the text material.[19]

For this work, the following main category including subcategories was identified and competencies were ranked according to the number of text passages in the interview transcripts: professional competencies, personal competencies and social competencies.

After forming the categories, the material was reviewed again using the category system. It was checked whether the established categories adequately represented the central contents of the material and thus could answer the research question.

2.5 Quality criteria

This study embedded quality assurance throughout all research phases, drawing on frameworks by Mayring[18,19] and supporting literature.[20,21] Aligned with the interpretive paradigm, quality criteria were applied contextually and the research process was thoroughly documented (procedural transparency). A foundational literature review enabled a theoretically informed entry into the empirical field.[20]

The study followed principles of rule-guided research, applying Mayring's Qualitative Content Analysis. This included defining coding units, iterative categorization, and adaptive procedures. Interpretations were validated through argumentative reasoning and intersubjective consensus within a research team (doctoral researcher, peer, supervisor), enhancing credibility and dependability.

Given the limits of objectivity in qualitative research, intersubjectivity was the key criterion for methodological rigor. This was ensured through comprehensive documentation, consensus-driven analysis, and transparent decision-making.

Reliability was supported by clear category definitions, ongoing refinement (formative checks), and final validation of the coding framework across the full dataset (summative reliability).[30]

To enhance the validity of the study, several methodological strategies were employed. First, theoretical sampling was used to ensure both external validity and empirical saturation. Second, interviews took place in the participants' natural environments via videoconferencing, following Hermanns'[31] recommendations to reduce potential bias. Third, all empirical material was included in the analysis to avoid selective interpretation. Furthermore, categories were developed inductively, allowing central meanings to emerge from the data itself.[30] Interpretations were repeatedly revisited and refined in light of relevant theoretical frameworks, as suggested by Kühn and Witzel.[32] Finally, the results were validated through comparison with existing literature.

2.6 Ethical considerations

To protect participants' rights and privacy, research data is generally collected anonymously. Where this is not feasible (e.g., face-to-face interviews with audio or video recordings), personalized raw data must be treated confidentially and accessed only by authorized personnel.[33] In this study, expert interview recordings were anonymized (each assigned a numerical code) and stored on the doctoral candidate's private, password-protected computer, with a backup on a secure external drive. Transcripts were pseudonymized to ensure anonymity of the textual material. Access to personal data was limited to the candidate, his supervisor, and staff of the professional transcription service. The latter, granted access for professional purposes, are bound by data confidentiality under § 6 (1) of the Data Protection Act (BGBl I 1999/165).

Ethical approval for this study (application number 3069) was granted by the Research Committee for Scientific Ethical Questions (RCSEQ) at UMIT TIROL.

3. Results

To ensure transparent data interpretation, the presented themes are supported by exemplary original quotes from interview participants. The final subsection elaborates on the evaluation of generic competencies drawn from international literature by the interview participants.

Before going into the generic competencies in detail, it is important to present an overview of these (see Table 2). They were categorized into three areas: (a) professional competencies, (b) personal competencies, and (c) social competencies.

Within these subcategories, a ranking of competencies was made based on the number of excerpts from interview transcripts assigned to each competency during the interview analysis (such as situational decision-making with the number 10).

Table 2. Generic competencies of community health nurses

Professional Competencies	Situational decision-making (10) Problem-solving (6) Competency in social issues (4) Holism (3) Application of evaluation methods (2) Integrated thinking (1)
Personal Competencies	Independent work (10) Personal competency (8) Proactive attitude (7) Adaptability (6) Leadership/Role modeling (5) Self-accountability (5) Client commitment (5) Responsibility (5) Accountability (5) Ethics (4) Self-reflection (4) Perseverance (3) Resilience (3) Time management (2) Articulation of professional values and beliefs (2) Willingness to learn (1)
Social Competencies	Communication (42) Information dissemination and education (32) Social competency (26) Cultural competency (18) Pedagogical skills (15) Leadership skills (14) Relationship building (13) Assertiveness (5) Respect for individuals (5) Self-management (5) Moderation and presentation (5) Understanding family systems (5) Trust in the practices of other healthcare professions (4) Negotiation skills (2) Social justice (1) Handling gender diversity (1)

3.1 Professional competencies

The interviews reveal that situation-appropriate decision-making (10) is a key competency for Community health nurses. It involves the ability to "truly grasp situations and – based on health determinants – think critically about whom to involve and what needs to be organized" (Int. 4, ll. 692-694). As one participant succinctly puts it: "Decision Making" (Int. 5, l. 208) is essential. Nurses must be able "to make decisions independently," particularly in urgent cases such as when "someone is already neglected" (Int. 6, ll. 145-148), and know "whether this or that laboratory test is necessary, or perhaps whether an X-ray should be ordered" (Int. 7, ll. 298-299).

Yet effective decision-making also includes recognizing one's own limitations. As one interviewee states, "Okay, this is a point where medical expertise is necessary, and therefore I will refer [the patient]" (Int. 12, ll. 414-415), drawing a parallel to "a midwife during childbirth, who supports independently but eventually says: now we need a doctor" (Int. 9, ll. 437-439).

Closely tied to decision-making is problem-solving (6), described by several participants as "daily troubleshooting" (Int. 3, ll. 277-278), with one emphasizing that "Community [Health] Nursing is actually biopsychosocial troubleshooting" rather than solely medical (Int. 3, ll. 283-285). Thus, a proactive, problem-oriented approach is required: "actively approaching the population, identifying problem areas or care deficits together with those affected and their families, and taking joint steps to meet the needs" (Int. 7, ll. 266-271).

Further competencies include dealing with social issues (4), which encompasses an "ethical dimension and ethical reflection" (Int. 14, ll. 248-249). As one participant notes, it requires sensitivity: "Where do I need to engage more, where less, and which questions must I ask?" (Int. 6, ll. 472-474). Moreover, the ability to "properly meet people where they are" – beginning from the first encounter at the door – is critical (Int. 6, ll. 485-488). This competence also extends to working with children and addressing their specific needs (Int. 7, ll. 321-322).

Holistic competence (3) is equally important: perceiving "the person as a whole with their needs – professionally and on a human level" (Int. 6, ll. 88-90), ensuring a comprehensive understanding of patients' living conditions, physical, and mental states (Int. 6, ll. 543-545).

Finally, a few participants highlight the importance of applying evaluation methods (2) to "collect data that can be used for further research, promoting public health and enabling project evaluations" (Int. 12, ll. 426-428). Networked thinking (1) is also noted as a key skill, fostering interdisciplinary collaboration.

3.2 Personal competencies

When discussing personal competencies, interviewees consistently emphasize the importance of working independently (10). As one puts it, the Community Health Nurse must "decide in the moment what must be done" (Int. 6, l. 149), demonstrating "decision-making ability, joy in taking responsibility and initiative" (Int. 6, ll. 152-155), coupled with "self-organization, efficiency, and organizational discipline" (Int. 6, ll. 122-129; Int. 8, l. 92).

Closely linked to this is the broader concept of personality competence (8), encompassing leadership, resilience, assertiveness, relationship-building, respect for individuals, and self-reflection.

A proactive attitude (7) is considered foundational. Com-

munity Health Nurses are expected to "actively seek out problems and care deficits" (Int. 7, ll. 266-267), supporting individuals beyond clinical needs by assisting with grants, forms, or social services (Int. 8, ll. 119-121). As one participant vividly states: "I don't need a desk-bound person; I need someone who knocks on doors and says, 'Hello, I'm here now. How are you doing?'" (Int. 6, ll. 460-462).

Adaptability (6) is equally crucial – "speaking the language of the people" (Int. 8, l. 99) and building trust through "translation work" (Int. 8, ll. 102-103), starting "from the very first greeting" (Int. 6, ll. 488-503).

Leadership (5) is framed not as traditional authority but as role modeling, "accompanying and coaching others to bring the topic of health into the community" (Int. 12, ll. 78-81). Moreover, strong self-responsibility (5) is essential: "organizing oneself independently," daring to "initiate and implement" interventions (Int. 6, ll. 142-153), and working autonomously without a permanent institutional framework (Int. 4, ll. 271-275).

Responsibility and accountability (5) are closely intertwined, particularly in regulatory matters such as prescribing aids for insurance reimbursement (Int. 7, ll. 292-295).

Ethics (4) and self-reflection (4) are considered vital: "Ethical decision-making" and a "continuous process of self-assessment and development" are viewed as fundamental to professional practice (Int. 12, ll. 126-127; Int. 4, ll. 221-224).

Persistence (3) and resilience (3) are seen as crucial traits for coping with the emotional demands of community-based, one-to-one care (Int. 9, ll. 77-79). Effective time management (2) is emphasized as necessary to balance flexibility with clear time boundaries (Int. 6, ll. 122-130; Int. 8, ll. 93-96). Additionally, articulating professional values and convictions (2) is seen as important, requiring the nurse "to speak confidently and eloquently in public settings such as health fairs or municipal councils" (Int. 3, ll. 466-467).

Lastly, participants note the necessity for ongoing professional development (1), highlighting the need for "flexibility and willingness to travel" (Int. 6, ll. 172-176).

3.3 Social competencies

The most unanimously emphasized competency is communication (42). As one participant states, "communication is such a basic competence that is needed" (Int. 12, l. 397). Effective communication involves "speaking the language of the people" (Int. 8, ll. 99-100) and adapting to their communication styles without appearing "too theoretical or distant" (Int. 15, ll. 266-268).

Beyond patient interactions, communication must extend to cooperation with other health professionals, community representatives, and authorities (Int. 14, ll. 241-243), including the ability to document precisely and accurately (Int. 8, ll. 337-338).

Closely tied to communication is the competence of information delivery and education (32). Community health nurses are tasked with promoting health literacy, empowering patients, educating caregivers, and strengthening self-management skills among the population (Int. 13, ll. 530-542; Int. 11, ll. 238-239).

Social competence (26) is considered foundational. As one expert notes, "you must be someone who actively approaches others" (Int. 6, ll. 463-464), showing empathy and building trust in advisory and care situations (Int. 13, ll. 421-423). Cultural competence (18) also emerges as critical, particularly in urban areas, to support diverse communities and facilitate equitable healthcare access (Int. 9, ll. 451-456; Int. 1, ll. 371-374).

Pedagogical skills (15) are recognized as essential for effective education – "explaining complex content clearly, even to laypersons" (Int. 6, ll. 352–353; Int. 11, ll. 93-94). Leadership (14) is perceived variably, but its importance in coordinating interdisciplinary efforts is broadly acknowledged (Int. 14, ll. 245-247). Relationship-building (13) is repeatedly identified as critical: "only when a relationship exists can interventions be truly effective" (Int. 13, ll. 426-448).

Further competencies mentioned include assertiveness (5), respect for individuals (5), self-management (5), moderation and presentation skills (5), systemic family understanding (5), trust in other health professions (4), negotiation skills (2), commitment to social justice (1), and competence in dealing with gender diversity (1).

4. Discussion and Limitation

The findings of the study underscore the essential role of generic competencies for community health nurses in Austria, which are integral to their competency framework. The absence of these generic competencies significantly hinders their professional effectiveness, a gap that cannot be offset by proficiency in other areas. Thus, the subcategories of personal and social competencies emerge as critical components for community health nurses.

Interviews revealed a diverse array of skills within the generic domain, reflecting the wide scope of the sector. Interview participants named six professional competencies, 16 personal competencies, and 16 social competencies, not merely listing them but elaborating on their significance in enhanc-

ing performance. The interviews affirmed that robust generic competencies, both comprehensive and nuanced, are vital for implementing and applying other necessary skills in practice. High social competencies foster closeness to clients, while strong personal competencies allow community health nurses to work professionally, independently, and responsibly. Professional competencies, on the other hand, provide a holistic view and thorough consideration of complex cases.

Within the breadth of competencies discussed, certain competencies were mentioned frequently, notably communication (42), information dissemination and education (32), and social competency (26). These figures highlight the importance of social competencies within the community health context. Unlike the other subcategories, professional and personal competencies did not reach similar high mention counts, although they consistently appeared in the interviews.

The interviews brought to light ten additional competencies not found in the literature review by Lidauer et al.,[8] with relationship building (13) being frequently noted, alongside leadership/role modeling (5), responsibility (5), family systemic understanding (5), perseverance (3), resilience (3), negotiation skills (2), integrated thinking (1), willingness for further education (1), and dealing with gender diversity (1).

Communication and leadership skills were the most frequently discussed topics in the literature, followed by cultural competence, and ethics.[9, 12, 13, 15, 16, 34–36] Then, with the same number of mentions, there were holism, situation-appropriate decision-making, application of evaluation methods, independent work, self-responsibility, self-reflection, social competence, self-management, social justice, as well as moderation and presentation. In the interviews, the most frequently mentioned competencies were also communication, information dissemination and education, social competence, cultural competence, and pedagogical skills.

Methodological limitations stem primarily from the selection of interview participants. These limitations could be minimized by applying the principle of theoretical saturation and by dividing the population into several groups, ensuring that – regardless of whether theoretical saturation was fully achieved – at least two experts from each group were interviewed. To further strengthen the validity of the results, future studies could incorporate methodological triangulation, such as focus groups or field observations, to complement and cross-verify interview data. Using additional methods could help to better understand context-specific practices and bring to light views that one-on-one interviews might miss.

As this is a relatively new area within the Austrian healthcare system, the pool of potential interview participants with expertise in this field was limited. It is possible that, over the course of the ongoing implementation of the CHN system, certain skills and competencies may evolve or be assessed differently in the coming years. Additionally, as expertise in this field grows, more detailed information and requirements may emerge. Nevertheless, the generic competencies identified in this study should provide a solid foundation for efficiently and purposefully structuring the training of this professional group.

The applicability of our findings to other nations may be limited due to variations in healthcare and social systems, as well as differing legal frameworks.

Practical implications

The findings offer clear recommendations for health policy and workforce development in the healthcare system. Education and training programs for CHN should focus on building generic competencies such as communication, interdisciplinary collaboration, crisis management, and cultural sensitivity.

Given the shortage of physicians in Austria, it is crucial to expand the scope of practice for CHN. Granting them greater autonomy in areas like prevention, health promotion, chronic disease management, and emergency care can ease the burden on general practitioners, and help strengthen primary care services.

This expansion will require legal and structural reforms. The extended responsibilities of CHN must be clearly defined and aligned with international models such as Advanced Practice Nursing.

CHN should be actively integrated into interprofessional teams and healthcare networks to ensure coordinated, community-based care – particularly in underserved regions. Moreover, CHN are well positioned to address social determinants of health through community engagement and targeted support for vulnerable populations.

5. Conclusion

The generic competencies of community health nurses are broad, reflecting the different roles in health promotion, disease prevention and community engagement.

The discussion above has underscored the importance of generic competencies for community health nurses involving professional, personal, and social competencies. Therefore, it is crucial to promote education and development in these areas to ensure that CHN can effectively fulfill their crucial role in healthcare delivery.

In summary, generic competencies of community health

nurses are essential for addressing the broad spectrum of health-related issues in various community settings. These generic competencies include personal, professional and social skills, tailored to public health, along with an in-depth understanding of social determinants of health that have an effect of community well-being. Their knowledge in health promotion, emergency preparedness, and disease prevention makes it possible for community health nurses to manage individual and population health needs.

To sum up, generic competencies of community health nurses are crucial for maintaining resilient communities that prioritize health, and wellness. Their comprehensive and proactive approach to healthcare guarantees that every community member gets the necessary support to strengthen and sustain his or her health outcomes.

In Austria, healthcare services are primarily delivered by independent physicians, with other healthcare professionals having considerably less autonomy than their international peers. There is a growing recognition of the need to reevaluate and broaden the role of non-medical professionals, such as community health nurses, to address the physician shortage and modernize the system based on global practices.

Future studies should investigate the criteria that the training of community health nurses in Austria needs to meet to adequately reflect the competencies identified in this study, along with the requisites for an associated curriculum. Furthermore, it is crucial to assess how the structural and organizational aspects of implementing a CHN concept in Austria can be evaluated, considering organizational, professional legal, labor, and social legal perspectives.

ACKNOWLEDGEMENTS
We thank everyone who helped with the organization of the study and supported us during the data collection procedure.

AUTHORS CONTRIBUTIONS
Mag. Dr. Stephanie Kainrath, MSc. was responsible for drafting the manuscript as well as for writing, review, and editing. Mag. DDr. Harald Lidauer, LL.M., LL.B. contributed to methodology, investigation, and conceptualization. Univ.-Prof. Dr. Gerhard Müller was responsible for supervision and project administration. Univ.-Prof. Dr. Harald Stummer contributed to project administration, supervision, and resource provision. All authors read and approved the final manuscript.

FUNDING
Not applicable.

CONFLICTS OF INTEREST DISCLOSURE
We have no conflict of interest to disclose.

INFORMED CONSENT
Obtained.

ETHICS APPROVAL
The Publication Ethics Committee of the Association for Health Sciences and Education. The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

PROVENANCE AND PEER REVIEW
Not commissioned; externally double-blind peer reviewed.

DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

DATA SHARING STATEMENT
No additional data are available.

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