REVIEWS

Social competencies: A qualitative study of community health nurses in Austria

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Received: April 17, 2025 **Accepted:** July 11, 2025 **Online Published:** July 24, 2025
DOI: 10.63564/jnep.v15n8p32 **URL:** https://doi.org/10.63564/jnep.v15n8p32

ABSTRACT

Background and objective: The Austrian healthcare system is characterized by a high degree of fragmentation, with primary healthcare mainly delivered by independent physicians. However, there are limited integrations of other healthcare professions into primary care. The Austrian federal government plans to introduce a community health nursing system in the future. Currently (period from the beginning of 2022 to the end of 2024), corresponding pilot projects are running in numerous communities in Austria. The present study addresses the question of what social competencies a community health nurse in Austria needs to have. This study investigates the importance of social competencies in community health nursing within the context of the Austrian healthcare and social care system. From this, recommendations for the education of community health nurses in Austria can be derived.
Methods: Fifteen qualitative, problem-centered interviews were conducted with experts in community health nursing and public health. Qualitative content analysis, following the approach of Mayring (2015), was employed.
Results: The study identified several key social competencies, including communication, information dissemination and education, cultural and social competencies, pedagogical skills, leadership skills, relationship-building, assertiveness, respect for individuality, self-management, moderation and presentation, understanding of family systems, trust in other healthcare professions, negotiation skills, social justice, and dealing with gender diversity.
Conclusions: Social competencies are vital for community health nurses, enabling them to establish trust, address health disparities, and meet the needs of vulnerable groups. Continuous professional development and training can enhance these competencies, thereby improving community health outcomes. Expanding the professional scope of non-physician groups, such as community health nurses, could be beneficial within the Austrian healthcare system. Future education programs for community health nurses in Austria should emphasize the development of social competencies.

Key Words: Community health nursing, Social competencies, Austrian healthcare system, Nursing education

1. INTRODUCTION

Primary care, a pivotal topic for the World Health Organization (WHO), is vital not only for healthcare systems but also for the social and economic development of communities.[1] Various primary care concepts and models are implemented globally. While Austria relies heavily on general practitioners for primary care,[2] countries such as Norway, Finland, and Ireland incorporate nursing professionals into primary

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care settings.[3] Additionally, the model of community health nursing plays a significant role in primary care concepts.

The terms “Community Nursing” and “Community Health Nursing” carry distinct meanings. In an international context, “Community Nurses” provide professional care within home settings, while in Austria, this service, termed “Hauskrankenpflege”, is part of “mobile Pflege und Betreuung”.[4,5] In contrast, international “Community Health Nursing” extends beyond traditional home care, encompassing comprehensive counseling, family support, and community-wide prevention efforts.[6]

The WHO interchangeably uses the terms “Community Health Nursing” and “Public Health Nursing ”.[7] The WHO defines community health nursing as: “a special field of nursing that combines the skills of nursing, public health, and some phases of social assistance and functions as part of the total public health program for the promotion of health, the improvement of the conditions in the social and physical environment, rehabilitation of illness and disability”.[7] This definition, serve as the basis for our work. While the term “Public Health Nursing” generally refers to the contribution that nursing professions make to the management of public health-related tasks.[8]

Community health nurses play a pivotal role in disease prevention, health promotion, and addressing healthcare needs within communities, leveraging a diverse set of social competencies to engage with individuals, families, and communities effectively.

The Canadian Nurses Association defines these competencies as “the specific knowledge, skills, and personal attributes required for a nurse practitioner to practice safely and ethically in a designated role and setting”.[9] The definition of competencies contributes to the formulation of job descriptions. Job descriptions, in turn, provide a general overview of the person’s activities and their specific contribution to the employing organization’s field of activity. They also define the organization’s expectations by describing the level of knowledge and skills and provide a tool for measuring work performance.[10,11]

Social competencies play a crucial role in the practice of community health nursing, encompassing a diverse array of interpersonal skills, communication abilities, and cultural sensitivities necessary for navigating the complex social dynamics within communities. These social competencies empower community health nurses to establish trust, build rapport, and effectively engage with diverse populations.

In this article, we will explore the significance of social competencies of community health nurses and further analyze their required social competencies in Austria. What is more, the present study aims to contribute to the refinement and consolidation of competency profiles in the field of research, and also to the development of curriculum criteria for training community health nurses in Austria.

Lidauer et al.[12] focus in their study on the competencies of community health nurses. The researchers conduct a scoping review in databases such as CINAHL, Medline, APA PsycInfo and Scopus. They identify two large groups of publications: on the one hand, those that address a whole range of necessary competencies of community health nurses (competency bundles), and on the other hand those with a single competency. They divide the results into four central categories: a) generic competencies, b) planning and collaboration, c) public health, and d) health and care management, support management, advanced clinical skills. The authors identify scientific articles such as the study of Clark et al.,[13] which deals with the core competencies in the area of global and public health for nursing education, concentrating primarily on the increasing globalization and global networking and the resulting qualifications required in the field of nursing. Another study identified in the scoping review of Lidauer et al.[12] is the one of Ladhani et al.[14] Ladhani et al.[14] conduct an interdisciplinary study focusing on competencies in the areas of medicine and nursing. The absence of a systematic framework for social competencies in community health nursing necessitates the application of the model developed by Chrzan-Rodak et al.[15] in the context of primary care. The study systematizes social competencies in medical professions and patient care in eight subdimensions: (1) communication, (2) patient-centered care, (3) quality of care, (4) interpersonal contacts, (5) teamwork, (6) professional work aspects, (7) stress and burnout, as well as (8) area of emotion. This reflects a very broad view of social competencies (e.g. stress and burnout).

Our literature search on the competencies of community health nurses revealed that there is no published analysis with relation to the competencies of community health nurses in the Austrian healthcare system. The required competencies of community health nurses have been extensively researched for the United States,[16–18] as well as for the United Kingdom.[19–21] Few studies exist for Canada[22,23] and one refers to Latin America and the Caribbean.[24] However, an explicit reference to Austria is missing.

Building on this research gap, the following research question arises from the problem setting covered above: What are the key social competencies expected of community health nurses in the Austrian healthcare system?

2. METHODS

A qualitative research approach was selected to address the research question, with expert interviews serving as the primary data collection method. This type of research emphasizes the acquisition of non-standardized data, which is interpreted using specialized, non-statistical analytical techniques.[25,26]

Experts, in this context, are individuals who possess specific practical or experiential knowledge of a clearly defined issue and who, through their interpretations, can meaningfully structure the field of practice for others.[27] The expert interview, which follows a semi-structured format organized around predefined themes, is not defined by its content or technique but by its focus on a particular respondent group, namely, experts.[28] This method is suitable for addressing a range of research objectives.[29]

Throughout the research process, particular attention was given to maintaining high standards of qualitative research quality. The study adhered to the evaluation criteria outlined by Mayring,[30,31] and was further informed by the work of Strübing et al., Haas-Unmüßig and Schmidt, as well as Lamnek and Krell.[32–34]

2.1 Sampling

Within this qualitative framework, the term "population" refers to all potential study participants relevant to the research question.[35] The specific inclusion criteria used for selecting interviewees are summarized in Table 1.

Table 1. Expert profile details for community health nurses in Austria

Category	Subcategory	Details
Experts	Government and Public Sector	Individuals working at the Austrian Federal Ministry for Social Affairs, Health, Care and Consumer Protection Professionals at Gesundheit Österreich GmbH (Austrian National Public Health Institute) Employees at the Austrian Chamber of Labour involved in nursing and healthcare issues
Experts	Academia	Program directors and lecturers of community health nursing-related degree programs at Austrian universities and universities of applied sciences Heads and instructors of other community health nursing-related training or continuing education programs at Austrian educational institutions
Experts	Healthcare Practice	Individuals in leadership positions within nursing organizations or primary care units (e.g., primary care centers, health centers) Professionals actively involved in local, community (health) nursing projects across Austria
Experts	Interest Groups and Advisory Roles	Members of Austrian primary care interest groups (e.g., Austrian Forum for Primary Care in Health Care – OEFOP, Austrian Primary Care Platform) Individuals holding advisory roles in the field of nursing in Austria, offering policy or strategic guidance
Experience	Professional Experience	At least 3 years of experience in their respective field (e.g., practice, academia, policy, administration) relevant to community health nursing or the Austrian healthcare sector
Knowledge	System Familiarity	Demonstrated familiarity with the Austrian healthcare system, including its structure, primary care models, nursing education pathways, and current community health nursing initiatives

To guide participant selection, the study employed theoretical sampling,[36,37] a core principle of Grounded Theory. This purposive, theory-driven approach allowed for the selection of participants in parallel with data collection and analysis, enabling a dynamic and iterative process. Each step informed the next, continuing until theoretical saturation was reached, when no new insights emerged from additional interviews.[25]

Initial recruitment followed a broad orientation within the thematic field. As interviews progressed, the sampling strategy evolved to become more targeted and precise, reflecting the process-oriented nature of the methodology.[25,28]

2.2 Data collection

Gaining access to the field involved identifying potential participants via institutional websites, online platforms, publications, and media presence, as well as through social networks like ResearchGate. In some cases, interviewees were contacted through gatekeepers, and additional participants were recruited using snowball sampling. All initial contact was conducted via email.

The study relied on semi-structured expert interviews for data collection due to their balance of structure and openness.[38] Specifically, the problem-centered interview method was used,[39,40] aligned with Grounded Theory principles.[37,41,42] This approach facilitated an exploration of individual meaning-making processes concerning socially relevant issues through open-ended, narrative-based dialogue.[28]

Problem-centered interviews are notably dialogical and interactive.[43] The use of pre-interpretation techniques – probing and reflecting during the interview - enhanced the depth of subsequent analysis.[43]

Between May and June 2022, a total of 15 expert interviews

were conducted. Each interview was held individually via video conferencing and conducted in German. The interviews had an average duration of 66 minutes, with lengths ranging from 41 to 105 minutes.

Participants received detailed information and signed informed consent forms in advance, which covered data protection, withdrawal rights, and audio recording permissions. The interview process followed established guidelines by Hermanns[44] and Przyborski and Wohlrab-Sahr.[45]

2.3 Data collection instrument

A semi-structured interview guideline served as the central data collection instrument, developed using the SPSS method[40,46] and grounded in existing literature. Rather than a fixed questionnaire, it functioned as a flexible thematic framework, allowing the interviewer to guide the conversation while maintaining openness.[43,45]

The guideline was pilot tested with two non-expert individuals, whose interviews were excluded from analysis. The first three expert interviews were treated as potential pilot interviews, but since no methodological issues emerged, the guideline remained unchanged.

Thematically, the guideline centered on the skills and competencies of community health nurses in Austria, drawing from the Public Health Intervention Wheel[47] and incorporating current academic debates in the context of the Austrian health and social care system.

Each interview began with a broad, narrative-eliciting question: "In your opinion, what are the social skills and competencies a community health nurse in Austria should have?" Supplementary questions were posed as needed, and interviews ended with reflective prompts, such as: "If you could design a community health nurse system for Austria, what core tasks would a community health nurse take on, and what skills and competencies would they need?"

All interviews were recorded and supplemented with field notes and diary entries. Only one interview was conducted per day to ensure reflective depth.[48] Table 2 provides an overview of the characteristics of the interview participants.

Table 2. Overview of the characteristics of the interview participants

Number of the interviews	Gender	Age Group
1	Female	Over 50
2	Male	Over 50
3	Male	Over 50
4	Female	Over 50
5	Female	Over 50
6	Male	Under 50
7	Male	Over 50
8	Male	Over 50
9	Female	Under 50
10	Female	Under 50
11	Female	Under 50
12	Female	Under 50
13	Female	Under 50
14	Female	Over 50
15	Male	Over 50

2.4 Data analysis

The recorded interviews were transcribed verbatim following the standards of Dresing and Pehl,[49] then reviewed, corrected, and pseudonymized. Ambiguities were resolved by cross-checking audio files. Transcripts were analyzed using MAXQDA Plus.[50–52]

The analysis followed Mayring's qualitative content analysis method,[31] which applies a systematic, category-based approach to interpreting textual data. In this study, both summarization (as outlined by Mayring[31]) and structuring techniques (described by Mayring[31]) were employed to analyse the material.

After an initial familiarization phase, key content was paraphrased and reduced to essential elements. The category system was developed iteratively, combining deductive categories from a previous scoping review[12] with inductive categories derived from the interview data.[31]

The system was piloted during early coding and refined iteratively. Final categories were applied to all interviews, including a re-coding of the first five. Reliability was ensured through strict rules and regular consistency checks.[31]

To enhance abstraction, redundant or overlapping content was generalized and merged. In the final phase, thematic fields were identified based on Green et al.[53] and interpreted with reference to the research question. Strategies from Meuser and Nagel[54] also informed the analysis.

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. For a better overview see Table 3.

2.5 Quality criteria

To ensure scientific rigor, the study followed quality frameworks established by Mayring,[30,31] Haas-Unmüßig,[33] and Strübing et al.[32]

Procedures were documented in detail, from subjective assumptions to data interpretation, ensuring transparency and traceability. Interpretative validity was supported through theoretical grounding and peer consultation.

Table 3. Social competencies and frequency

Social Competency	Frequency
Communication	42
Information dissemination and education	32
Social competency	26
Cultural competency	18
Pedagogical competency	15
Leadership competency	14
Building relationships	13
Assertiveness	5
Respect for the individual	5
Self-management	5
Moderation and presentation	5
Understanding of family systems	5
Trust in the practices of other health professions	4
Negotiation skills	2
Social justice	1
Dealing with gender diversity	1

Recognizing the interpretive nature of qualitative research, the study emphasized intersubjectivity. Coding and interpretation were based on consensus among researchers, supported by a structured and systematic procedure.[31]

To establish reliability, category definitions were carefully formulated and refined. A final validation step involved rechecking the entire dataset with the finalized coding structure.

Validity was ensured through several strategies. These included theoretical sampling and reaching data saturation, maintaining reflexivity to minimize bias, and ensuring the inclusion of all relevant material. Empirically and inductively developed categories were used, with data and coding processes undergoing iterative validation. Additionally, findings were continually compared with existing literature to strengthen credibility.

2.6 Ethical considerations

The research adhered to established ethical guidelines, prioritizing participant protection and responsible data handling.[55] Three core principles guided the study:[55,56] voluntary participation with full information, informed consent (including for audio recording and pseudonymization), and the right to withdraw at any point without consequences.

Given the focus on professional, non-sensitive content, risks were minimal. All data were anonymized and securely stored on password-protected devices, accessible only to the authors.

The study received ethical approval from the Research Committee for Scientific Ethical Questions (RCSEQ) at UMIT TIROL (Application #3069).

3. Results

This chapter includes the social competencies of the community health nurse as identified in the research question. 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 key social competencies drawn from international literature by the interview participants.

The social competencies were categorized into subgroups, and their ranking was determined by the number of text passages in the interview transcripts allocated to each competency during the analysis.

All interview participants agree that communication is a truly central and particularly significant competency of the community health nurse. It is the skill that was most frequently mentioned, addressed, and discussed during the interviews. Communication is “such a basic competency that is needed” (Int. 12, line 397). “Working in seclusion is likely to be rather difficult in this field of work” (Int. 9, lines 216–217). The community health nurse must “speak the language of the people. The worst thing is always when experts from the health sector do not speak the language of the people” (Int. 8, lines 99–100). It is important that “I can immerse myself in people’s language worlds, in their communication worlds, and not come across as too theoretical or aloof, because otherwise, probably not much will be achieved” (Int. 15, lines 266–268). This requires “an intensive or a very good education in social-communicative competence (. . .). It’s no use if they speak very intelligently but are not understood” (Int. 13, lines 82–84). A community health nurse should be able to “communicatively build trust (. . .) because, of course, it is a role where one becomes quite involved in people’s intimate spheres” (Int. 7, lines 58–60). Listening is also always important – “if I don’t listen to the people and their needs, then I cannot fulfill the role of a community health nurse” (Int. 12, lines 445–446).

However, the ability to communicate also includes “communication with other professional groups, with municipal representatives, with the district administration office – so communication has a broader context” (Int. 14, lines 241–243). Regarding their field of work, “this nurse never works alone” (Int. 4, line 672). In this context, a commu-

nity health nurse should "be able to express themselves well (. . .) especially what is needed, what is wanted, and what is noticed. (. . .) This refers to needs existing in the region, for example, or if there are problems with someone who is a health service provider in this region, to be able to address these problems or in meetings (. . .). And if necessary, also communicate with stakeholders who perhaps have nothing to do with health or social issues. For example, the mayor" (Int. 11, lines 67–75). Finally, one expert emphasizes that in the context of documentation, a community health nurse must also be "linguistically precise": "What they deliver in words and images must be presentable" (Int. 8, lines 337–338).

Almost all experts also highlight the competency of conveying information and providing education. Community health nurses take on "a significant role (. . .) when it comes to information, training, education" (Int. 14, lines 78–79). In doing so, they naturally "don't have to provide everything themselves but also see what already exists" (Int. 14, lines 79–80) and refer to the available services accordingly. The goal is to "build up knowledge and know-how in the population" (Int. 13, line 96). "Advising is (. . .) a very central topic (. . .), how do I effectively convey something to my patients or my clients. Training, workshops, instructions (. . .) how can I present this in a way that benefits the patients" (Int. 10, lines 64–67). In the context of this health teaching, the aim is "to improve the health literacy of the population, to ensure that the sick have more and better knowledge about their illness – that is essentially patient education" (Int. 7, lines 180–182). "My term for these people is coach (. . .) they accompany and guide me, (. . .) they advise me." The patient "should decide. But the patient does not have the knowledge to make decisions (. . .). That means I must succeed in educating a patient so that they can decide by themselves." The aim is "to inform the patient well enough that they can give informed consent" (Int. 13, lines 530–542). Furthermore, the patient should be "empowered to be able to care for and manage themselves" (Int. 11, lines 238–239). A key point is also the ability to "instruct family caregivers" (Int. 7, line 73): "A very important aspect would be that they also take on a kind of quality management for family caregivers. So, where family caregivers reach their limits or need support" (Int. 8, lines 304–306). The community health nurse should therefore be able to "appropriately encourage, guide, and make lay caregivers available to the people" (Int. 6, lines 354–355).

Some interviewees mention another aspect of the competency of information dissemination and education, namely that the knowledge acquired as a community health nurse should also be passed on in the sense of a sustainable system "to young community [health] nurses or young nursing professionals" (Int. 11, lines 302–303), but also sometimes to "other professional groups," such as "employees of (. . .) mobile services" (Int. 8, lines 313–315).

Almost all interviewees refer to social competence as a general and overarching skill. One expert notes: "I believe you need to bring a lot of social competence with you" (Int. 3, lines 306–307). The community health nurse "really needs to be someone who can actively approach others – that is what's needed" (Int. 6, lines 463–464). It is clear "that the ability to empathize simply must be present – in other words, high social competence, of course. (. . .) This is not an office situation, but in the context of counseling, I must be able to engage with the person I'm dealing with" (Int. 6, lines 55–58). "The real quality is that I can enter into a relationship with a person to identify their needs and thus become effective" (Int. 13, lines 421–423). Community health nurses "will not be effective if the key doesn't fit the lock, so to speak" (Int. 13, lines 446–447). In this regard, the community health nurse must "to some extent be a trusted person" (Int. 9, lines 456–457) and also know "how to purposefully approach, for example, a vulnerable group in the community to empower them" (Int. 12, lines 142–143). Especially in the initial phase of implementing a community health nurse system for the first time, "gaining the acceptance of the population (. . .) will be a huge challenge, where the required skills (. . .) lie in high communication and social competence" (Int. 4, lines 367–369). Finally, social competence is also required in dealing with other healthcare providers and various decision-makers: It may be "that I need to use binding words and actions to include all the players. So, social competence is also very important here" (Int. 6, lines 67–68).

Cultural competence (18) is also emphasized by almost all interview participants. The assessment of the importance of this competence ranges from average to high: "Cultural competencies (. . .) [are] certainly not unimportant in view of sociocultural backgrounds, migration status, certain life preferences, certain behavioral patterns" (Int. 15, lines 243–245). "I find cultural competence extremely important" (Int. 1, lines 370–371). One expert notes a different level of importance of cultural competence depending on whether the area is urban or rural: „I believe that it is a bigger issue in urban areas than in rural ones" (Int. 11, lines 219–220). "Different communities" have "partially different understandings of the healthcare system," and the community health nurse could "buffer a lot in advance. Because then someone doesn't show up at the emergency room at midnight with stomach pain that they've actually had for three weeks already. That means a lot could be alleviated, which wouldn't have to be done by the physicians" (Int. 9, lines 451–456). In addition, it is

important to prevent "people with a migration background (...) from falling through the cracks of healthcare provision because they have no access, etc." (Int. 1, lines 371–374). In terms of content, cultural competence means: "I have to meet people where they are (...) and I just need to know who is going to answer the door when I ring the bell" (Int. 6, lines 485–487). Additionally, one needs "the ability to perceive where I should go? Where should I go more? Where should I go less? Where should I ask which questions?" (Int. 6, lines 472–474).

Pedagogical skills (15) are closely related to the competence of information delivery and education, as pedagogical skills are very beneficial—if not, to some extent, even necessary—for this area. One respondent stated: "I believe that (...) educational competence is needed" (Int. 11, lines 299–300). "I also must be able to convey it. I must be able to communicate the content (...) ideally to a layperson" (Int. 6, lines 352–353). For example, it's necessary to explain issues in simple terms "to people (...) when something is said in press conferences that may cause uncertainty, so that they can be clarified, for example, about incidence rates" (Int. 11, lines 93–94). It is important that the community health nurse "first learns to understand (...) what people already bring with them, what their expertise is, so that support can then truly be derived only from where they definitely need help" (Int. 4, lines 375–377). Pedagogical skills should also especially include dealing with young people (children, adolescents): "A community health nurse, school nurse – to broaden the field – would then be needed to connect people with the topic of health at an early stage" (Int. 12, lines 151–153).

Leadership competence (14) is mentioned by many interviewees, although there are differences in how it is prioritized. Some respondents consider leadership competence to be quite important: "This leadership, having that lead—yes, a community health nurse needs that. She needs an overview; she needs to have the lead" (Int. 13, lines 319–321). Others are more reserved: "Leadership competence (...) is not quite the top priority" (Int. 2, lines 193–194), and some experts even consider it of little relevance: "To what extent (...) leadership competence is required, I don't really know, because this will be a very lean organization, and in my opinion, the community health nurse won't have many subordinate (...) people" (Int. 15, lines 238–241). Notably, some interviewees prefer to speak of "leadership" rather than "leadership competence": "Leadership is, of course, a topic – not just leadership within the nursing professions, but also leadership within a community, leadership within the system in which she operates, in coordination" (Int. 14, lines 245–247), where the community health nurse functions as a "connecting point between different professions, but also between different organizational units, intra- and extramural" (Int. 13, lines 128–129). One interviewee summarizes it as follows: "For me, she would be the primary nurse out in the community. The go-to person who coordinates, through whom the threads run, and who has the whole thing under control" (Int. 8, lines 319–321).

Relationship-building competence (13) is highlighted by most interview participants: "One of the most important competencies" will be "this relationship work. I think they really need to be miracle workers; they must be able to build relationships to be effective" (Int. 13, lines 102–104). "If I can't convey it through my appreciative, empathetic attitude, my ability to engage with others, then all my professional competencies will certainly not help me" (Int. 13, lines 448–450). A community health nurse must know "how to gain access, how to approach people, how to make sure I reach them" (Int. 12, lines 153–154). She should be able to "build a good personal relationship with the people she works with and cares for" (Int. 11, lines 64–65). She must also "be able to build trust through communication" (Int. 7, line 58). Ultimately, relationship-building is not only important in relation to the clients of the community health nurse but also in relation to all stakeholders in the region with whom the community health nurse collaborates. In this latter area, the community health nurse also needs "a corresponding understanding of networking" (Int. 7, line 62) and should effectively "invest in building these relationships (...) to truly cooperate and coordinate well" (Int. 4, lines 251–252).

Some interview participants bring up the competence of assertiveness (5). The community health nurse should represent the standpoint: "I am not someone who can be brushed aside" (Int. 3, lines 206–207). She needs to have "presence" and "self-confidence" (Int. 3, line 216); she must also be able to sit down with someone and "speak plainly" (Int. 3, line 258). And she "has to endure when the blusterers bluster (...) she has to withstand the headwind without running away grumpily or crying" (Int. 3, lines 467–469). Especially in the pioneering phase, she must "fight for her place" (Int. 9, line 80).

The competence respect for the individual (5) is occasionally mentioned in the interview transcripts. "First, I have to perceive the person as a whole with their needs (...), professionally, but also on a human level" (Int. 6, lines 88–90). The community health nurse also needs the ability to "bridge the gap between evidence-based care (...) and what the patient needs (...). Because even if it turns out a hundred times that something is evidence-based, if it does not meet the patient's needs, (...) then I must bridge that gap" (Int.

13, lines 431–434). She must also be capable of adopting a particular attitude: "Not to go in and say: this and that has to be changed, but (...) to really accompany [the clients] in this process-oriented approach, starting from their own strengths and abilities" (Int. 4, lines 210–212). The goal is "first to learn to understand what people already bring with them, what their expertise is, in order to derive support only from the areas where they definitely need help" (Int. 4, lines 375–377).

From the statements of some experts, it becomes clear that the competence of self-management (5) has a certain importance. The community health nurse will "probably already be working very independently (...), so being able to manage oneself well is probably a good competence" (Int. 11, lines 216–217). She will "need the ability to organize herself very, very responsibly. (...) That requires a lot of discipline, especially when one initially comes from an employee relationship (...) and then suddenly transitions into self-employment" (Int. 8, lines 88–91).

The competence of moderation and presentation (5) is also occasionally highlighted. The aspect of moderation is mainly mentioned in the context of conducting meetings or fixed jour fixes: If there are "nursing jour fixes, for example, in a region, she should be able to moderate them as well" (Int. 11, lines 72–73). The aspect of presentation is primarily discussed in the context of trainings, workshops, etc.: "How can I present it in a way that benefits the patients?" (Int. 10, lines 66–67). Some experts focus on the competence of understanding family systems (5): "In terms of the competence area, they need a family-systemic understanding (...). They must learn to understand families as systems" (Int. 4, lines 207–209). The community health nurse must "have strong systemic know-how. Like how families function" (Int. 5, lines 59–60).

In the context of the competence trust in the practice of other health professions (4), the community health nurse must be "able to set boundaries for herself and also be capable (...) of recognizing where my competencies and possibilities end and where I need other professional groups or other qualifications" (Int. 8, lines 71–73). It is about "alternating case leadership" (Int. 14, line 332), a "multi-professional collaboration" (Int. 14, lines 329–330). "We have to move away from this silo thinking among professions" (Int. 14, line 330). For example, if "social work finds that nursing is needed, it is good if they refer, and vice versa" (Int. 14, lines 335–336). The aim is to "break down some walls so that there is more cooperation and less of 'this is mine, that is yours'" (Int. 14, lines 339–340).

In individual passages, further competencies are addressed, such as negotiation skills (2) ("e.g., also with insurance providers (...) to get certain services or service packages reimbursed" (Int. 1, lines 237–239)), social justice (1) ("I believe that ethical reflection, specifically the question of fair distribution, of economic-ethical considerations, is centrally important for nursing professionals" (Int. 14, lines 248–250)), as well as dealing with gender diversity (1) ("The big issue (...) we still face is gender in nursing. That it may not just be the classic male-female role patterns, but (...) fortunately the world is much more colorful" (Int. 9, lines 730–734)).

4. Discussion

Social competencies such as intercultural sensitivity and communication skills are vital for community health nurses, who work directly with individuals, families, and communities. These competencies enable them to establish trust, communicate effectively, and navigate complex social dynamics within communities.

During the interviews, participants discussed a wide range of social competencies in detail, underscoring their significant importance. They not only mentioned these competencies but also provided detailed explanations within the context of the Austrian health and social systems practice.

The identified social competencies required for community health nurses in Austria in descending order of importance were: communication, information dissemination and education, social competency, cultural competency, pedagogical skills, leadership skills, relationship building, assertiveness, respect for individuals, self-management, moderation and presentation, understanding of family systems, trust in other health professions' practices, negotiation skills, social justice, and dealing with gender diversity.

Communication emerged as the most frequently discussed social competency during the interviews. Effective communication skills are essential for promoting health, preventing diseases, and interacting with diverse groups of people. These competencies empower community health nurses to convey health information, build trust, and collaborate with communities, families, and individuals. Effective communication involves active listening, cultural competency, empathy, clarity and the need to tailor messages to the needs of the patients and their preferences. Strong communication competencies empower community health nurse to deal with health disparities, overcome barriers to care and promote positive health results within the communities they serve. This is very much in line with studies on competencies for nurses in general or specially in primary care[15,57] and is mentioned in various studies about nursing and nursing education.[58,59]

Information dissemination and education was also frequently mentioned by interview participants. This competency is crucial for providing resources, conducting workshops, and educating communities about various health-related topics. Additionally, it involves supporting the relatives of patients and passing on knowledge to younger nursing staff and other professionals. Here our study has some novelty as this category is hardly mentioned in primary care. It is clearly seen as a task for community health nurses,[12] but the competencies behind are not integrated in frameworks.

Social competency, as a subcategory of social competencies, was emphasized for its importance in engaging with individuals, families, and communities and understanding their needs. Trustworthiness, empathy, and the ability to connect with vulnerable groups are essential attributes for community health nurses.

Another social competency addressed in the interviews is cultural competency. Cultural competency is crucial for understanding and respecting the beliefs, values, and practices of different cultures, thereby providing effective and culturally sensitive care. It also plays a role in preventing individuals with migration backgrounds from slipping through the healthcare system. This refers to patient-centered care in most frameworks, adjusting to the situation of patients, "also in terms of culture".[15]

Additionally, pedagogical competencies are a subcategory of social competencies. They are closely related to information dissemination and education and include effective communication, adaptability to diverse learning styles, creating educational materials, and assessing and evaluating teaching interventions.

Leadership competency, while varying in perceived importance among interviewees, was also discussed. However, there are differences in the importance of the distinctive competencies. While some interviewees regard leadership competency as important, others do not consider it as essential for a community health nurse in Austria. Leadership competencies are widely mentioned in literature,[60] here our results are absolutely in line with the literature.

Building relationships was considered important for establishing trust and collaboration with stakeholders in the community. A community health nurse must be able to build good personal relationships and trust with the people she or he works with.

The other social competencies received less attention in the interviews, such as assertiveness (5), respect for individuals (5), self-management (5), moderation and presentation (5), understanding of family systems (5), trust in other health professions' practices (4), negotiation skills (2), social justice (1), and dealing with gender diversity (1).

Overall, our research findings confirm the essential role of social competencies for community health nurses in the Austrian healthcare system. They further constitute an essential part of the required competencies of a community health nurse in Austria.

In their scoping review, Lidauer et al.[12] emphasized the significance of communication, leadership, and cultural skills for community health nurses in countries such as the USA, Canada and the United Kingdom. Our research findings demonstrate the importance of communication competency for community health nurses within the Austrian healthcare system. Additionally, our study reveals that pedagogical skills, information dissemination, and educational proficiency are crucial for community health nurses in Austria, although they appear to be less emphasized in the study by Lidauer et al.[12] However, our results suggest that leadership competency and cultural proficiency might have slightly less significance for community health nurses in Austria. Patient education, information dissemination and educational proficiency show higher importance in our exploratory study than in international literature which can be possibly explained by a highly fragmented health system and a very low health literacy in Austria.[61]

Certain limitations stem from the selection of interview participants. To address this, we applied the principle of theoretical saturation by interviewing at least two experts from each identified subgroup. Nonetheless, it must be acknowledged that individual competencies may continue to develop as the implementation of the community health nurse system progresses. This ongoing evolution may lead to the identification of additional requirements or more nuanced skill profiles in the future.

Despite these limitations, the social competencies identified in our study should serve as a robust foundation for the targeted and effective design of training programs for community health nurses in Austria.

Finally, regarding the transferability of our findings to other countries, structural differences in healthcare and social systems—as well as divergent legal frameworks—may limit their broader applicability.

5. Conclusion

Social competencies play a vital role in the work of community health nurses and significantly contribute to enhancing health and well-being in communities. This discussion has underscored the importance of these competencies for com-

munity health nurses' work and shed light on their varied impacts on healthcare. Therefore, it is crucial to promote education and development in these areas to ensure that community health nurses can effectively fulfill their crucial role in healthcare delivery. The core competencies of community health nurses in Austria must encompass a broad spectrum of activities, ranging from acute care to health promotion, education, planning, collaboration, management, and supporting chronic diseases. It is crucial to maintain an overarching perspective while prioritizing client care.

Currently, both primary and specialized healthcare in Austria are predominantly provided by independently practicing physicians. The autonomy of professional groups within the healthcare system, excluding physicians, is relatively limited compared to international standards. There is a need to reassess this focus on the medical profession, especially considering the shortage of physicians, and initiate a process of change and evaluation. This should involve revising professional rights to expand the rights of other non-medical professional groups within the healthcare system, such as community health nurses, following international models.

For the education of future community health nurses in Austria, research suggests a focus on comprehensive education rather than specialized qualifications in a few areas. A tailored and diverse education should be developed, promoted, and supported for this new professional group. Instead of predefined subject bundles, emphasis should be placed on individual core competency areas and sub-competencies to effectively implement them within the legal framework of studies.

Building on a broad and general education at the bachelor's level, integrating the mentioned social competencies into a master's program seems reasonable. Thereby taking the framework conditions and needs of the Austrian health and social systems into account. Emphasizing salutogenesis over an individual-centric and pathogenetic-oriented approach is important.

Moreover, research highlights the necessity of a strong theoretical foundation complemented by practical knowledge. Thus, focusing on practical elements within the master's education through internships, teaching staff from practice, or cooperation models based on the buddy principle is advisable. Additionally, offering an optional part-time education program aligns with this approach.

Building on this, future research should investigate which specific criteria the training of a community health nurse in Austria must fulfill to adequately reflect the skills and competencies identified in this study. This includes determining the requirements that an associated curriculum must meet.

Furthermore, it is crucial to examine how the structural and organizational implementation of a community health nurse concept in Austria can be evaluated from various perspectives, including organizational and professional law, labor regulations, and social legislation.

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

The authors declare that there is no conflict of interest.

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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