Article

Nurses Improve Their Communities' Health Where They Live, Learn, Work, and Play

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Abstract

Nurses are often recognized for their volunteer efforts following disasters and international humanitarian crises. However, little attention is paid to the activities of nurses who promote a culture of health in their communities through local volunteer work. In this article, we describe nurses' perceptions of how they promote health in their communities through formal and informal volunteer work. Using 315 written responses to an open-ended question included in a 2016 survey of the career patterns of nurses in the U.S., we utilized conventional content analysis methods to code and thematically synthesize responses. Two broad categories of nurse involvement in volunteer activities arose from the participants' responses to the open-ended question, "Please tell us what you have done in the past year to improve the health of your community": 17% identified job-related activities, and 74% identified non-job-related activities. 9% of respondents indicated they do not participate in volunteer work. Job-related activities included patient education, educating colleagues, and "other" job-related activities. Non-job-related activities included health-related community volunteering, volunteering related to a specific population or disease, family-related volunteering, church activities, health fairs, raising or donating money, and travelling abroad for volunteer work. Nurses are committed to promoting a culture of health in their communities both at work and in their daily lives. Leveraging nurses' interest in volunteer work could improve the way nurses engage with their communities, expand the role of nurses as public health professionals, and foster the social desirability of healthful living.

Keywords

community health, health promotion, nursing workforce, public health, nursing

The spirit of volunteerism has persisted in the nursing profession since Nightingale's aid to British soldiers during the Crimean War (Fee & Garofalo, 2010). The 38 volunteer nurses who followed Nightingale to the battlefield began a tradition of nurses volunteering their services during times of need (Fee & Garofalo, 2010). The role of nurses in disaster relief in particular has become highly publicized in the media as nurses are called upon to volunteer during events such as Hurricane Sandy and the 2011 Joplin, MO tornado (Gebbie & Qureshi, 2006; Robert Wood Johnson Foundation [RWJF], 2016; VanDevanter, Kovner, Raveis, McCollum, & Keller, 2014). After a 7.0 magnitude earthquake struck Haiti in 2010, thousands of nurses volunteered to assist individuals and communities recover from the disaster (Sloand, Ho, Klimmek, Pho, & Kub, 2012). More than 20,000 nurses currently serve as volunteers with the American Red Cross (n.d.), supporting victims of natural and man-made disasters. However, as nurses gain increasing visibility as disaster respondents and international aid volunteers, little attention is paid to how nurses promote a culture of health daily in their communities whether as volunteers or for pay as a part of their jobs.

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Background

Although the general volunteer rate in the United States has been steadily declining over the past decade, an increasing number of nurses have sought volunteer positions at home and abroad (Healthcare Volunteer, 2008; Putnam, 2000; U.S. Bureau of Labor Statistics, 2016). Many nurses feel that they have an obligation to their communities beyond their responsibilities at work and engage in public health promotion activities outside of their jobs (Kemppainen, Tossavainen, & Turunen, 2013; Ward & Henderson, 1993).

The contribution of nurses to the promotion of public health has been encouraged by the *IOM Report on the Future of Nursing* in Recommendations 1 and 7, which suggest that nurses should "practice to the full of their education and training" (Institute of Medicine, Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, 2011, p. 85) and be prepared to lead change and advance the health of the population. Diana Mason, past president of the American Academy of Nursing (AAN), discussed the strategic goal of addressing the range of factors that "shape the health of individual, families, and communities" (Mason, 2015, p. 383). The promotion of healthy living and improving health outcomes across populations continues to be a high priority in the United States for federal, state, and local governments (e.g., healthy people 2020) and private entities, such as managed care organizations, community health centers, and foundations with an interest in health (Kottke & Isham, 2010; Parrish, 2010; RWJF, 2015; The Kresge Foundation, 2015). As leaders in these entities, including nurses, understand that health is vitally linked to where people live, work, learn, and play (RWJF, 2016), it is essential that health professionals work with and in communities, promoting what RWJF has coined a "culture of health" (Institute of Alternative Futures, 2012).

When individuals and organizations identify healthful living as a desirable social value, they foster a culture of health in their communities. Individuals will strive to make healthier choices and engage in activities that ultimately prevent the rise of health-care costs, such as exercise, smoking cessation, and making healthy nutritional choices. A culture of health also means that individual and organizational health-care providers will continually improve the equity and quality of care, resulting in improved patient outcomes and a reduction in health disparities. As a culture of health flourishes, health-care professionals, policymakers, and patients hold a shared accountability for health (Lavizzo-Mourey, 2014).

Nurses have an important role in the promotion of a culture of health, both as employees and as members of their communities. Volunteer nurses have the ability to raise awareness of health concerns in their communities and implement health promotion interventions for at-risk populations (Ferdinand, 1997; Mark, Conklin, & Wolfe, 2001). Evidence that nurses promote a culture of health by providing needed health services in community and acute care settings abounds (Grobler et al., 2009; Mark et al., 2001; McGinnis & Zoske, 2008). The 3.85 million nurses (Budden, Moulton, Harper, Brunell, & Smiley, 2016) in the United States are a vital part of our health-care system. Although a majority of nurses work in institutions caring for those who are ill, increasingly, nurses are also promoting healthy behaviors in community-based settings where people live, work, learn, and play. About 25% of nurses work in community settings such as schools, while 56% work in hospitals caring for patients during the 36.5 million annual hospital stays in the United States (Budden et al., 2016; Weiss & Elixhauser, 2014).

In particular, nurses working in public health departments, schools, adult day care centers, assisted living, faith-based entities, and other community-based settings have health promotion as their primary responsibility. In addition to professional roles, we know anecdotally that nurses often serve as a resource or informal adviser for family and friends. For example, some nurses help people with decisions about exercise, breastfeeding, or vaccines. Although there are numerous opportunities for nurses to volunteer their skills and expertise formally (e.g., everyNurse, OneNurseAtAtime, Doctors without Borders), a search of the sociology and nursing literature from the past three decades produced no published articles that document the extent of nurses' formal and informal volunteer efforts.

The purpose of this article is to describe nurses' perceptions of how they help promote a culture of health through formal and informal volunteer work in their communities—where they live, work, learn, and play. Although we did not intend to study how nurses promote a culture of heath at their job, respondents provided information about that aspect of their lives, and we therefore included the data here. The next sections of the article cover methods, findings, and a discussion that includes implications of our work for practice, policy, and research.

Methods

In a larger study of which the study reported here is a part, we obtained electronic and paper lists of nurses' names and contact information for those licensed the first time in a U.S. state or the District of Columbia between August 1, 2004 and July 31, 2005. We asked state officials from state boards of nursing in 34 states (AL, AR, AZ, CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NV, NY, OH,

OK, OR, PA, SC, TN, TX, WV UT, VA, WA, and WI), and the District of Columbia and all sent lists. From those lists, in January, 2006, we sent by U.S. postal mail (USPM) 14,523 surveys to randomly selected nurses from Metropolitan Statistical Areas (MSAs) and rural areas previously identified by the Center for Health Systems (Center for Studying Health System Change, 2003) as representative of the U.S. population.

Institutional review board approval was granted prior to the study's commencement. Using USPM because we did not have e-mail addresses, we followed the Dillman total design approach (Dillman, 2007) in that we used a five-dollar incentive in the first survey mailing and then sent up to three subsequent mailings if there was no response to earlier mailings. In the first mailing, potential respondents were provided with a paper copy of an information sheet that included the purpose of the study, risks of completing the survey, and contact information for the coprincipal investigators; completion of the survey implied consent.

In the first wave of data collection from this panel (2006), we contacted all 14,523 potential survey participants by USPM. At our request in the last question of that survey, many of the respondents provided their e-mail addresses. In the following five waves of the survey (Wave 2 to Wave 6), we contacted those respondents who had provided us with e-mail addresses by letter for the first contact, e-mail for the next three contacts for those who provided e-mail addresses in Wave 1 and if necessary, USPS overnight mail for the last contact. For those who had not provided an e-mail address in Wave 1, we only used USPM for sending subsequent surveys.

The original state lists included nurses who did not meet our inclusion criteria, because many states could not identify who was licensed for the first time by exam, also referred to as "newly licensed." Some of the states were only able to identify whether someone was licensed for the first time in that state and could not identify those nurses who were licensed previously in another U.S. jurisdiction. One state could not provide any information about when and how the nurse was licensed. Thus our sampling frame included many nurses who were not eligible to participate in the study. We only included in our analyses those nurses who answered *yes* to the question asking if they were newly licensed. Details of the methods are available elsewhere (Brewer, Chao, Colder, Kovner, & Chacko, 2015; Kovner et al., 2007). The response rate, the number of eligible sample units that cooperate in a survey, which took into account that the sampling frame included ineligible nurses, (American Association for Public Opinion Research, 2011), was 58% for Wave 1. There were 3,370 respondents to the first survey after data cleaning.

In 2016, as a part of Wave 6 of the larger study of nurses' career patterns, we included an open-ended statement: "Please tell us about what you have done in the past year to improve the health of your community." Responses to that statement are reported here. Fully 1,200 responded to that survey.

The 1,200 nurses who responded to the Wave 6 (2016) survey had been licensed for about 10 years. Of these respondents, 1,108 answered all of the demographic items (e.g., age) for which we wanted to compare those who responded to this open-ended statement and those who did not. Of the 1,108 who responded to the survey and answered the demographic items, 315 (28.4%) wrote a response to the statement.

Staff from the survey firm that managed the data collection transcribed all responses into an excel spreadsheet. Using conventional content analysis methods, open-ended responses were tagged with distinct codes representing recurring ideas and themes (Hsieh, 2005; Mayring, 2000). We (C. T. K. and M. M.) separately read all of the responses and identified preliminary categories of "job-related" and "non-job-related." We then met and agreed on the following descriptive themes within these categories: patient education, education of self and coworkers, other job-related, general health-related-community volunteering, specific disease or population-focused volunteering, raised or donated money, church-related volunteering (there was no one who mentioned another type of faith entity), health fair, family-related volunteering, and international travel. Then we each (C. T. K. and M. M.) categorized the responses into one of the descriptive themes. We met and discussed all differences in our individual categorizations, resolved any disagreements, and reached consensus on the coding of responses into descriptive themes.

Findings

Sample

As shown in Table 1, the analytic sample respondents and nonrespondents had similar demographic characteristics.

However, respondents to the open-ended statement were significantly less likely to work in hospitals, more likely to be managers, and have no children or no children living at home compared with those who did not answer the question.

Two broad categories of involvement in "improving health of the community" arose from the participants' responses to the open-ended questions. These categories were job-related activities ($n = 54$; 17%) and non-job-related activities ($n = 232$; 74%). In addition, 29 respondents (9%) indicated *none* or something similar. We grouped descriptive themes under these two categories and describe them in detail later.

Table 1. Comparison of Nurses Who Answered About Their Contribution to Community's Health and Those Not Answering.

Variables	Responded to community health questions *N* (%)	Did not respond to community health questions *N* (%)	Significance
Setting			
All else	123 (39.0)	254 (32.0)	0.03*
Hospital	192 (61.0)	539 (68.0)	
Unit spent most of working time			
Special	107 (34.0)	289 (36.5)	0.55
General	44 (14.0)	137 (17.3)	
Home	26 (8.3)	52 (6.6)	
ABM care	37 (11.7)	87 (11.0)	
Home health-care hospice	16 (5.1)	39 (4.9)	
Nursing home	16 (5.1)	45 (5.7)	
Other	69 (21.9)	142 (18.0)	
Position-job title			
Manager	77 (24.4)	152 (19.1)	0.01*
Consultant	7 (2.2)	10 (1.3)	
Instructor	5 (1.6)	6 (0.8)	
Direct care	160 (50.8)	431 (54.3)	
Advanced Practice Nurse	18 (5.7)	94 (11.8)	
Other	48 (15.2)	101 (12.7)	
Position-Job title			
Direct care	160 (50.8)	431 (54.3)	0.29
Non-direct care	155 (49.2)	363 (45.7)	
Current marital status			
Married	265 (76.4)	620 (77.4)	0.85
Widowed, divorced, separated	44 (12.7)	92 (11.5)	
Never married	38 (11.0)	89 (11.1)	
Children living at home			
No children or no children living at home	136 (39.1)	265 (33.1)	0.01*
All less than 6 years old	51 (14.7)	178 (22.2)	
All 6 years or older	112 (32.6)	232 (29.0)	
Some less than 6 and some 6 or over	49 (32.2)	126 (15.7)	
Overall health			
Poor	2 (0.6)	5 (0.6)	0.63
Fair	21 (6.0)	53 (6.6)	
Good	115 (33.0)	249 (31.0)	
Very good	155 (44.5)	340 (42.3)	
Excellent	55 (15.8)	157 (19.5)	
Ethnic background			
White, non-Hispanic	274 (80.4)	714 (84.9)	0.34
White, Hispanic	8 (2.3)	10 (1.2)	
Black, non-Hispanic	22 (6.5)	37 (4.4)	
Black, Hispanic	0 (0)	1 (0.1)	
Asian	12 (3.5)	26 (3.1)	
Other	25 (7.3)	53 (6.3)	

(continued)

Table 1. Continued.

Variables	Responded to community health questions *N* (%)	Did not respond to community health questions *N* (%)	Significance
Sex			
Female	309 (88.8)	786 (92.3)	0.054
Male	39 (11.2)	66 (7.7)	
First (basic) nursing degree leading to registered nurse licensure			
Diploma	19 (5.5)	24 (2.9)	0.17
Associate	190 (55.4)	478 (57.0)	
Baccalaureate	132 (38.5)	333 (39.7)	
Master's or doctoral	2 (0.6)	4 (0.5)	
Variables	Responded to community health questions Mean (*SD*)	Did not respond to community health questions Mean (*SD*)	Significance
Age at the time of survey	44.06 (9.50)	41.65 (8.99)	0.06
Total yearly income from your principal job (including overtime)	$63,885.72 (28,618.2)	$66,848.95 (31,778.2)	0.37

Note. *Statistical significance $p < .05$.

Job-Related (54 Responses)

All the 54 respondents reported job-related community work. Job-related responses were about patient education, education of coworkers, and other types of job-related.

Patient education (23/54) 43%. Many of the 54 newly licensed nurses who wrote about job-related activities explained how they were promoting health within their communities through their actions at the bedside. For example, one respondent noted that he or she was "engage[d] in patient teaching at every opportunity." Nurses explained how they do not limit their patient education to one aspect of their health but provide well-rounded teaching about staying healthy outside the hospital. Another nurse wrote:

> I educate my patients with a holistic approach. They may come in for a cough, but if they are smokers or have high blood pressure, I always address those issues as well... I try to teach my patients how to avoid follow-up visits for chronic conditions.

Nurses provide care and education that reach beyond the patient's bedside to the community. Specifically, nurses often address concerns of patients and provide teaching to their patients' family members. Several respondents described referring patients' families and members of their communities to health care and social services agencies. As one nurse wrote,

> My job allows me to teach our outpatients risk factor modification to reduce risk of CAD [coronary artery disease]. I take every opportunity to teach and encourage patients and their spouses/partners to increase regular aerobic exercise and healthy eating habits.

Another nurse pointed to "informal education of patients' family members and others in the community, including referral to clinics." One nurse explained "I work in a county jail and am able to provide health education, health care, and community referrals to individuals who may not otherwise seek these out."

Educating colleagues and other nurses (9) 17%. Nine nurses wrote how they improve the health of their communities by enhancing their own knowledge or educating their colleagues. Nurses mentioned activities such as "regional education of staff and providers regarding statewide quality improvement programs." Others indicated that they "participated in national CHF [congestive heart failure] certification" through their hospital or completed a doctor of nursing practice education program or education to practice as a pediatric nurse practitioner.

Nurses felt that pursuing further education benefits their patients' health. As one stated, "We have been taking care of many mental health patients at work, so I have taken classes to better my understanding and help social work to get their patients the resources they need upon discharge from the hospital."

Other job-related (22) 41%. Nurses indicated that they are involved in a variety of other health-promotion activities associated with their work. Involvement with state health and human services agencies, the American Nurses Association, and the American Nurses Credentialing Center enhance individual proficiency in patient care and advocacy and improve public health at a governmental or organizational level.

As one nurse explained, "I am now a Chief Nurse Consultant for the . . . Department of Child Services so I interact with community members on a daily basis to improve the health and safety of our children." "[I] participate with . . . Coalition that joins all area hospitals to address collaborative initiatives, i.e., flu precautions/restrictions, time out standardization, pre-surgical wellness/optimization of patients, etc."

Some nurses reported staffing health fairs and mobile clinics and bringing care from the bedside to the community. For example, one wrote, "I participate/lead my job in outside events- a mobile clinic for first aid/injury treatment at different events in the community." This nurse also wrote about attendance at "health fairs and other community programs as a representative of my employer."

Non-Job-Related (232 Responses)

Health-related community volunteering (79/232) 34%. Of the 232 nurses who wrote about non-job-related volunteering, many described educating their friends, neighbors, and communities about optimizing and maintaining wellness—particularly about the importance of exercise, heart health, and obtaining a yearly influenza vaccination. One nurse noted how she or he did not participate in anything "formally in the community" but was "able to educate individuals around me regarding hand washing, vaccines, breast feeding, and other topics."

Some nurses reported dispensing valuable health education to their communities through free clinics and activity-specific groups and clubs, such as running and walking meet-ups. Group exercise activities, in particular, appeared to catalyze conversations about health: "I participate in a local running club that promotes health through running. We sponsor a large kids and women's running clinic during the summer. I also participate and support many organized runs through the year." Others wrote, "Started a group walk for safety every morning when weather permits (no ice or snow)" and "I myself started biking 20 to 75 miles a week and I advocate and encourage others to exercise."

Nurses also described how they improved the health of their communities through one-on-one and individual activities. For example, some nurses reported checking in on their elderly neighbors or assisting them with light exercise and daily tasks such as grocery shopping. One nurse noted the importance of simple, individual interactions, "We have many elderly living in my area and I check on them and if required do odd jobs. What they enjoy most is a person just to talk with." Nurses improved their community's environmental health by picking up trash, building a playground, planting vegetable gardens, and recycling. One wrote, "I deliver Meals on Wheels, I walk with my 79-year old neighbor 3 to 4 days a week for her safety, I grow veggies and share with neighbors, I play music at Senior Citizen Center on Thursday mornings."

Specific population or disease (41) 18%. Nurses often indicated in their responses that they have aligned themselves with the fight against a specific disease or for the assistance of a certain population. Donating blood, giving or receiving influenza vaccinations, and working to prevent and treat chronic conditions such as diabetes and heart disease were the most frequently mentioned.

Some nurses named specific foundations and initiatives such as "Active in [. . .] Clinic's community efforts for stroke awareness- volunteer at the Stroke Awareness Fair" and "educated people about importance of enrolling in the National Marrow Donor Program to give people a chance at life." Another wrote, "[I] participated in the annual homeless veterans' stand down, offering standard screen and influenza vaccines to homeless veterans."

Family-related volunteering (29) 13%. For those nurses who have infants, toddlers, or school-age children, being a parent presents opportunities for improving the health of their children and youth in the community. As one nurse wrote, "I have volunteered for JDRF [Juvenile Diabetes Research Foundation] and have helped organize a walk at my children's school that will teach them about type 1 diabetes." Many nurses find volunteer opportunities for involvement within their children's schools. As one indicated, "volunteered at my daughter's school for vision and hearing screenings."

Church (21) 9%. Nurses who are members of churches offered explanations about how they found ways of connecting with their communities and promoting health (no other faith-based organizations were included in the responses). One nurse described participating in health teaching with her church's congregation: "I am currently on the Health Ministry team at our church. Help with blood pressure screenings, taught a

6-week health course, assist in healing prayers.'' Others reached out to specific groups within their church organization ''I gave an informational session to parents in my church's adventure club regarding hand hygiene and signs/symptoms of infection.''

Health fairs (11) 5%. Nurses actively involve themselves with local health fairs and events offering free health screenings: ''I work in free community events for blood pressure, diabetes, and stroke screenings. I also make quilts for cancer patients for free.'' Nurses who are members of community organizations mentioned participating in health-related initiatives within those groups. For example, one nurse wrote: ''Helped to organize and participated in a health fair. As part of Lions Club, we have collected eyeglasses and assisted some community members in getting eye exams and eye glasses.''

Raised or donated money (10) 4%. Nurses also mentioned making financial contributions to charitable health organizations and participating in fundraising campaigns like races and walks. For some respondents, aid was given in the form of both monetary and material donations:

> Volunteered for a sports physical clinic. Made a monetary donation to a domestic abuse group. Donated a stethoscope kit to the local fire department... Have a horse at a therapeutic horseback riding facility. Have made several donations to Goodwill.

Another wrote, ''I've donated to the American Heart Association.''

Travel abroad (4) 2%. A few nurses reported traveling abroad to volunteer as team members to improve global health. One nurse noted, ''[I go on] medical humanitarian trips'' and another wrote, ''Did a volunteer medical trip to Jamaica.''

Discussion

Our findings show that although some nurses directly promote the health of their communities as part of their jobs (e.g., those who work for health departments), most promote the health of their communities through formal and informal volunteer work as members of communities across the country. Nurses' (e.g., Red Cross volunteers) contribution in disasters is well documented (American Red Cross, 2015; Ranse, Hutton, Wilson, & Usher, 2015), but for many, their day-to-day activities to promote the health of their communities often go unrecognized and unnoticed.

Recognition of risk factors is the first step in changing modifiable risky behavior (Romero, Morris, & Pikula, 2008). Nurses who provide education about hand washing, obtaining vaccines, or encouraging others to exercise are working on the first step to decreasing high-risk behavior. Efforts to decrease potentially modifiable risk factors are likely to lead to better health (Romero et al., 2008; Yusuf, Hawken, & Ounpuu, 2004). There is substantial evidence that physical activity improves cardiac risk factors (Centers for Disease Control and Prevention, 2015; Pollard et al., 2014; Wei, Liu, & Rosenzweig, 2015). Thus, activities by nurses such as walking with an elderly neighbor or starting a group walk are likely to lead to improved community health.

Similarly, there is some evidence that screening at health fairs that identify abnormal findings and referrals to health providers can reduce the burden of disease (Sazlina, 2015; Siddaiah et al., 2014). Nurses who volunteer at health fairs that conduct screening for diabetes or hypertension are part of case findings that can lead to early intervention to decrease health risks. There is clear evidence that vaccines prevent infectious diseases (Anonymous, 2015; Swamy & Beigi, 2015). Thus, those nurses who provide free vaccines to homeless veterans in their communities are improving their community's health.

With over 3 million nurses in the United States, an investment in nursing education and training is investment in the health of communities. As the profession that Americans rate as the most trusted and with the highest ethical standards, nurses are important but often underutilized stakeholders in policy and higher management sectors (Gallup, 2014). Their connections to their communities can serve to better promote health and wellness.

When government funding for programs to educate nurses, such Title VIII of the health, resources, and services administration (Congress, 2015), are evaluated, among the measures used are the number of new primary care providers. This evaluative measure does not note that in addition to educating primary care providers, these programs are producing a cadre of nurses who also promote healthy communities.

From those who completed the open-ended statement in the survey, we know that about 80% (252 out of 315) indicated that they did something to promote a culture of health. We could assume that 80% of those who did not answer the question also did something to improve their community's health. If that is the case and we generalize that to all of the nation's working nurses, we can speculate that 80% or more than 2.5 million nurses are helping to improve their community's health. Even if we assume that all of the nurses who did not respond to the open-ended statement did nothing to improve their community's health, more than 631,800 ($.81 \times .25 \times 3{,}120{,}000$ working nurses) nurses are using their health expertise in their communities.

Study Limitations

Although the original Wave 1 sample was nationally representative, by Wave 6 we had attrition. Those nurses who responded to Wave 6 were more likely to write that they were non-Hispanic and White (83.6% compared with 78.6%) and slightly more likely to have a bachelor's as their first professional degree (39.3% compared with 37.6%). Using content analysis subjects the data to the authors' biases. We had two authors analyze the data to decrease bias. Because we used a self-administered survey, we cannot be sure of who actually completed the survey.

The somewhat low-response rate to this question is a limitation. Survey respondents do not answer questions for a variety of reasons, most often response fatigue (Ben-Nun, 2008; Egleston, Miller, & Meropol, 2011). The statement, ''Please tell us about what you have done in the past year to improve the health of your community'' was the final statement on a long survey, so it is likely that many people did not respond because the respondents were fatigued. Another reason for not responding to questions is that respondents did not think that the questions applied to them and ''not applicable'' was not an option on the survey (Dillman, 2007).

Implications for Nursing Practice and Policy

The responses to the open-ended question used in this study demonstrate that nurses have an interest in the health of their communities and have committed their time and resources to improving the health of their family, friends, and neighbors. The challenge for policymakers and health-care administrators is to leverage nurses' experiences and interests so that they can be leaders in expanding the role of nurses in promoting a culture of health. Nurses also need to be given the means to document their contributions to promoting a culture of health and be rewarded or recognized for their efforts. Systematically connecting local nursing organizations, nurse employers, and nursing educational institutions to health-care volunteer opportunities might improve participation even more. Increasing the visibility of community health promotion activities by nurses could foster the social desirability of healthful living in their communities and encourage patients to make healthy choices in their daily lives. Nurses in this study were involved in their communities both through their employment and in their personal lives, so it would be beneficial to nurses and patients if nurses were provided better education and training about how to work across settings and follow patients where they live, learn, work, and play.

Implications for Research

This study provides a starting point for further research into the day-to-day volunteer activities of nurses and fills the knowledge gap regarding the non-disaster-related volunteer efforts and interests of nurses. Additional research is necessary to understand what prevents nurses from participating in community volunteer activities, what motivates those who do, and how we can better support nurse volunteerism in the community.

Conclusion

Our evidence shows that nurses contribute to promoting a culture of health within and beyond their job descriptions. The spirit of volunteerism in the nursing profession extends beyond disaster relief and aid work abroad and is present in day-to-day activities that often go unrecognized. Whether volunteering in health-related activities at schools, health fairs, or churches, or raising and donating money, nurses are invested in promoting the health of their communities. It's time to draw the nation's attention to the key role that nurses have in promoting a culture of health.

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