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RESEARCH ARTICLE **OPEN ACCESS**

Transformation of Nursing Practice Following Health Service Decentralisation in Thai Subdistrict Health Promoting Hospitals: A Qualitative Study

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Abstract:

Background: Health service decentralisation has transformed the delivery of primary healthcare in Thailand. Since transferring health promoting hospitals to local government, the role of nurses and day-to-day practices have altered; however, limited research has explored the ways in which nurses are navigating these changes. To investigate registered nurses' experiences of practice transformation following health service decentralisation in Thailand.

Methods: This was a qualitative descriptive study undertaken with 14 registered nurses in Subdistrict Health Promoting Hospitals (SHPH). Data were generated from semi-structured interviews and analyzed using thematic analysis.

Results: Fourteen community nurses from six Subdistrict Health Promoting Hospitals participated in the study. Participants had varying levels of experience in community nursing and had worked within both pre- and post-decentralisation contexts. Five themes were derived from the data. (1) expanded scope of nursing practice, (2) complexity of navigating decentralised healthcare systems, (3) ongoing professional development and learning, (4) resilience and compassionate care, and (5) enhanced relationships and community engagement. Nurses expressed an expanding array of work, including health care planning, administration and community work, along with increasing administrative workload and pressures. Nevertheless, nurses described sustained commitment and efforts to deliver high-quality care.

Discussion: The findings indicate that health service decentralisation has reshaped community nursing practice by expanding professional roles and increasing organisational complexity. The study highlights the need for workforce support, continuing professional development, and organisational strategies that enable nurses to respond effectively to evolving responsibilities while sustaining person-centred community care.

Conclusion: Health service decentralisation has contributed to an expansion of nursing work and an increase in the complexity of nursing practice within the Thai context. A focus on appropriate training, professional support and organisational support are likely to assist in ensuring quality primary healthcare services by supporting nurses through this ongoing process.

Keywords: Health service decentralisation, Nursing practice, Primary healthcare, Qualitative research, Thailand, Workforce development, Health system reform.

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1. INTRODUCTION

Nurses play a key role in the provision of primary health care services and are normally the first point of contact with individuals, families, and communities. In Thailand, the role of nurses in HPPSs is crucial because they provide comprehensive health promotion, disease prevention, chronic disease management, rehabilitation, and long-term care services [1]. They are often called on to collaborate with village health volunteers, local leaders, and multidisciplinary teams to address broader community health needs beyond patient care. In the last 10 years, primary healthcare services have encountered rising population demands due to ageing and increasing incidences of chronic diseases, coupled with public expectations attendant upon equitable availability and sustained continuity of care. As a result, nurses have had to take on expanded roles and additional competencies including care coordination, community engagement, health information management and interprofessional collaboration [1, 2]. Thus, nursing practice in primary healthcare remains dynamic and relevant to the realities of changing health systems and practice models.

Primary healthcare is considered the bedrock of a well-functioning health system with its emphasis on equitable access to services and promotion of better population health [2]. In turn, nurses are a critical component of continuity of care and wide-ranging health needs responded to at community levels. In modern nursing practice, nurses are expected to merge clinical expertise with leadership skills, communication acumen, decision-making abilities and population health management capabilities [3]. This means that changes in organisational structures within health care systems may directly affect the performance of nurses' professional roles and responsibilities. Background: Health service decentralisation is one of the reforms in Thailand affecting primary healthcare services. Many SHPHs have been decentralised from the Ministry of Public Health to Provincial Administrative Organisations (PAOs) under this policy. The change is an important organisational shift as SHPHs are the first-level points of access to basic healthcare services in local communities [4]. The transfer of management functions has changed the reporting structures, administrative processes, resource allocation mechanisms and coordination with local government agencies. These changes establish a new practice environment for nurses, which may impact both service delivery and professional duties.

Studies in various countries have argued that decentralisation opens up potential for higher local responsiveness and community engagement. But it can also bring heightened administrative burdens, alter workforce roles and require that health professionals engage with new organisational expectations [5, 6]. Organisational change in nursing is often linked with workforce re-design, changes in scope of role and the challenge to manage competing clinical and non-clinical workloads [7]. Nurses employed in decentralised settings may consequently encounter challenges pertaining to service coordination, resource allocation, workforce shortages and evolving accountability mechanisms. Decentralisation is an important topic in health policy and health systems literature; most of the available empirical evidence focuses on areas such as governance, financing and service performance [8]. In contrast, the experiences of frontline nurses implementing community-level health services have been relatively neglected. Evidence of how nurses experience changes in practice following the transition of SHPHs in Thailand are still needed. Since nurses are the largest professional group in primary healthcare, their experiences are important to understand because they influence service quality, continuity of care and community trust.

This study therefore explored nurses' practice transformation experiences after health service decentralisation in Thailand. This study aims to generate understanding of workforce adaptation across decentralised primary healthcare services and guide future workforce development and organisational supports by investigating how nurses describe change with respect to the nature of their role, responsibilities and everyday practice. Accordingly, the study addressed the following research questions: (1) How do nurses describe changes in their roles, responsibilities, and everyday practice following health service decentralisation? And (2) What challenges and opportunities do nurses experience in adapting to decentralised primary healthcare services?

2. MATERIALS AND METHODS

2.1. Study Design

In Thailand, health service decentralisation happened in 1995–2006, but no study had focused on nurses' lived experience of changes to their professional practice. Participants' descriptions of everyday practice and workplace experiences were best elicited using a qualitative descriptive approach since the design is not theory-driven but instead seeks to understand participants' experiences. Nurses were asked to capture in their own words how the changes organisationally impacted their role, responsibilities, and engagement with the communities they served [9]. The study was reported following the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [10].

2.2. Study Setting

The study took place in eastern Thai Prachinburi Province. Data were obtained from Subdistrict Health Promoting Hospitals (SHPHs) that act as the frontline primary healthcare facilities providing health promotion, disease prevention, treatment and care, including rehabilitation and long-term care services within local communities.

Up to October 2023, the participating SHPHs were operating under the decentralised administrative setup that came into force with their transfer from health departments to Provincial Administrative Organisations (PAOs). Such a shift in organisation had implications for reporting, governance and service management. It means

nurses in these settings were able to offer direct testimonies about the impact of decentralisation on their daily work. Participants were recruited from large, medium and small SHPHs, which would capture a variety of experiences in serving diverse community populations.

2.3. Participants and Sampling

Purposive sampling was used to recruit participants who had direct experience of working in decentralised primary healthcare services. Eligible participants were required to

1. Work in SHPHs: Community-based healthcare. Be working as community health nurses at the level of SHPHs operating in community situations under decentralised administration.

2. A minimum of 1 year of experience in community healthcare practice.

3. Have been in the workforce during the decentralisation period.

4. Be prepared to give a comprehensive interview.

Purposive sampling was used to recruit 14 registered nurses from six SHPHs across five districts who had direct experience of working during decentralisation. Sample adequacy was guided by Malterud *et al*.'s concept of information power [11], considering the focused study aim, participants' relevant experience, and the depth of the interview data. Sampling and analysis were conducted concurrently. By the 12th interview, coding largely repeated previously identified issues without adding new themes. Two additional interviews were conducted to confirm the developing analysis and contributed further examples but no new themes. The 14 interviews were therefore considered sufficient to address the study aim.

2.4. Data Collection

Semi-structured interviews were carried out in Oct–Dec, 2025 to collect data. All interview questions were based on the selections made from community nursing literature and the study objectives following previous studies. The guide explored participants' experiences of

1. Changes in community nursing practice.

2. Clinical and non-clinical responsibilities.

3. Management of complex community care.

4. Workload and organisational challenges.

5. Professional adaptation and learning.

6. Patient, Family and Community Relationships.

Interviews lasted between 45–60 minutes, were audio-recorded in Thai inside a venue of the participant's choosing. With permission, all interviews were audio-recorded and supplemented with field notes recording contextual observations and reflections of the researcher.

2.5. Data Analysis

Audio-recorded interviews were transcribed verbatim and analysed using thematic analysis following the six-phase approach by Braun and Clarke (2006) [9]:

1. Familiarisation with the data.

2. Generation of initial codes.

3. Searching for themes.

4. Reviewing themes.

5. Defining and naming themes.

6. Producing the final report.

We used an inductive approach where themes are driven directly by participants' narratives. Team members independently assigned codings to each unit of data, which were then discussed until consensus was reached. As analysis unfolded, new concepts were constantly compared with the interview data to maintain consistency. Based on the output of this method, five interlinked themes were constructed that describe participants' experiences of adapting to a changing professional role and practice requirements in the context of health service decentralisation.

2.6. Trustworthiness

To ascertain the credibility, dependability, confirmability, and transferability of this study [12], an assessment was conducted based on criteria proposed by Lincoln and Guba (1985).

2.6.1. Credibility

Member checking and ongoing discussions with the research team during the data analysis phase increased its credibility.

2.6.2. Dependability

Methodological choices and the analytic process were documented in an audit trail.

2.6.3. Confirmability

Throughout the study, reflective notes were used to avoid researcher biases in interpreting the data.

2.6.4. Transferability

Studies that were included provided a detailed description of the study setting, participants, and findings to enable an assessment as to whether the previous research is relevant in similar contexts.

2.7. Reflexivity

Because of their backgrounds in community health nursing, the researchers wrote reflective notes and held regular team discussions to reflect on how prior experiences might affect data collection and interpretation.

2.8. Ethical Considerations

Ethical approval: Ethical approval was received from the Institutional Review Board, Faculty of Medicine, Chulalongkorn University (COA No. 0349/2025; IRB No. 0010/68) before data collection. Written information about the study was provided to all participants, who also completed written informed consent for participation following a verbal explanation.

Table 1. Characteristics of participants (N = 14).

Participant ID	Sex	Age (Years)	Education Level	Position	Years of Nursing Experience	Years Working in SHPH	SHPH Size*
N01	Female	51	Bachelor's Degree	Registered Nurse	28	20	Large
N02	Female	47	Bachelor's Degree	Registered Nurse	24	15	Medium
N03	Male	43	Bachelor's Degree	Registered Nurse	20	12	Small
N04	Female	52	Master's Degree	Head Nurse	29	22	Large
N05	Female	41	Bachelor's Degree	Registered Nurse	18	10	Medium
N06	Female	45	Bachelor's Degree	Registered Nurse	21	14	Small
N07	Female	39	Bachelor's Degree	Registered Nurse	15	8	Medium
N08	Female	50	Master's Degree	Head Nurse	27	19	Large
N09	Female	42	Bachelor's Degree	Registered Nurse	19	11	Small
N10	Female	48	Bachelor's Degree	Registered Nurse	25	17	Medium
N11	Female	44	Bachelor's Degree	Registered Nurse	20	13	Small
N12	Female	53	Master's Degree	Head Nurse	30	23	Large
N13	Female	46	Bachelor's Degree	Registered Nurse	22	16	Medium
N14	Female	49	Master's Degree	Head Nurse	26	18	Large

Note: *Large = >8,000 population coverage; Medium = 3,000–8,000 population coverage; Small = <3,000 population coverage.

Enrollment: All procedures were voluntary, and participants were able to withdraw from the study at any time without penalty. Participant confidentiality was ensured by generation of identification codes (N01–N14). The recordings and transcripts of the interviews were stored securely, accessible only to staff working on this research.

3. RESULTS

3.1. Participant Characteristics

In this study, 14 registered nurses participated. Participants were experienced in community healthcare, worked with SHPHs of different sizes, and had a rich history. Their nursing experience varied in length between 15 and 30 years, with almost all of them having firsthand experience of working around the transition to decentralised health services. Additional information is presented in Table **1**.

Nurses' experiences were described through five themes: (1) broadening the scope of community nursing practice, (2) operating in more complex health systems, (3) needing to constantly learn because of changing demands on practice, (4) maintaining compassion and professional resilience, and (5) cultivating therapeutic relationships with communities.

3.2. Theme 1: Expanded Footprint of Nursing In Community Practice

Nurses spoke of how they had gradually moved beyond the clinical aspect of care. Along with offering curative and health promotion services, they were also more involved in care coordination rather than just passive referral or follow-up, community health activities, or using HIT to guide service planning.

3.2.1. Delivering Holistic and Person-centred Care

Caring for people in the community meant not just looking at their medical conditions, but understanding a lot about what happens in daily life, many nurses explained. Knowledge of family connections, living situations, and support services was considered vital to providing care-oriented interventions. As one participant noted:

“We do not only think of a patient as their illness when we evaluate them. It is necessary to be clear on who provides for them, how they eat, sleep and fare or suffer in life.” (N02)

Home visits were often highlighted as an important way of better understanding patients' circumstances. The home context helps nurses assess whether factors present are related to health outcomes; the home context is an adjusting process between nursing care and lifestyle.

3.2.2. Managing Complex Patient Needs

Based on data up to October 2023, participants reported increased caring for older adults and people living with complex chronic conditions. Such situations would typically necessitate effective communication and collaboration with family members, caregivers, and other health professionals. One nurse explained:

“Most patients have multiple health issues. Because many possess the so-called co-morbidities—diabetes, hypertension and renal problems all at once—we need to organize their theatre of operations in unison and watch them continuously” (N01)

Many respondents observed that in addition to clinical knowledge, the effectiveness of care was dependent on the practitioner working in partnership with existing community resources and support networks.

3.2.3. How to Use Health Information in Daily Practice

Nurses were also increasingly aware of the role that health information systems played in their work. Community health data were frequently used to identify vulnerable populations, track health trends and inform local health programmes. As described by one participant:

"Community health data will help identify those who are at risk and design activities that target the issue close to the community level," he added. (N03)

Participants reported being able to use access to local health data to act more responsively in regard to needs and treatment of the community, and they also followed this up with appropriate planning of preventive activities depending on the profile of health around where they served.

3.3. Theme 2: Managing Complexity within Decentralised Systems of Healthcare Delivery

Adjustment of coping during reforming health care context after decentralisation: Nurses' comments. Besides their clinical jobs, they had to face additional administrative tasks, limitations with staffing, and incentives from the organisation.

3.3.1. Balancing Clinical and Administrative Responsibilities

Widespread concern among participants was around the increasing amount of administrative burden. Besides treating patients, nurses prepared reports, did documentation and monitored indicators while communicating with local agencies. One participant explained:

"We have to deal with reports, paperwork and coordinating between agencies in addition to treating patients." (N02)

A number of nurses stated that administrative requirements diverted time away from direct patient care, including community visits and health promotion activities.

3.3.2. Workforce Constraints and Workload Pressures

Many participants indicated that they were doing work with fewer staff while the demand for services continued to increase. It was common for them to juggle multiple roles in a single workday. As one nurse noted:

"We are still doing more work, with the same number of staff. There is much more documentation, which cuts away time sometimes spent in a room with patients." (N06)

Holding competing tasks had become a practical fact of their work, participants explained. The ongoing challenge of balancing service quality with high levels of workload pressure was identified as continuing (higher levels of work-related stress, for example).

3.3.3. Adapting to Organisational Change

With decentralisation came changes that required nurses to adapt to new procedures, reporting mechanisms, and expectations of the organisation. Adaptation for most participants was a gradual process of discovery and troubleshooting. One participant reflected:

"The fact that this system has changed considerably quickly and especially after decentralisation. We have had to learn new systems and new ways of working as we continue to provide a service to the community." (N14)

While the transition in relevant roles was not always well defined, nurses often expressed a commitment to adjusting their practice to advance community health care needs.

3.4. Theme 3: The Never-ending Journey of Learning and Professional Development

Profiles regularly raised the point about keeping up with change. Continuing updating of Knowledge and skills: Nurses recognized that they had to frequently update their knowledge and skills to respond better to changing health needs, new technologies, and necessary service expectations from patients.

3.4.1. Self-directed Learning

A lot of participants stepped up to the plate with a desire to learn independently. This involved attending training programmes, using online searches and clinical guidelines in support of their work. One participant stated:

"Healthcare changes all the time. We have to continually educate ourselves so that we can offer the best care." (N03)

Ongoing learning was viewed by participants as a key component to sustaining professional practice in community contexts.

3.4.2. Learning through Experience

Nurses also frequently cited everyday practice, in addition to formal training, as a source of learning. Working in varying patient situations, along with family and community involvement, prepared them for practical skill development with confidence.

"Most skills are practised through working with patients in the community." (N04)

Many nurses found that experience served them well in dealing with difficult situations that could not be learnt from textbooks.

3.4.3. Developing Digital Competence

We learnt more about how digital technologies were being used increasingly. Participants described the general work activities they performed using electronic health records, communication platforms, and online resources. One nurse commented:

"Part of your daily job now is technology; whether to document, communicate or find clinical data." (N01)

The participants acknowledged the growing relevance of digital skills for managing information, coordinating care and supporting clinical decision-making.

3.5. Theme 4: Resilience and Compassionate Nursing Care

Both the personal and emotional demands of community nursing were talked about by participants. Their workloads were growing, but they remained committed to supporting their patients and communities with quality care.

3.5.1. Maintaining Professional Commitment

All the interviews revealed a strong sense of responsibility towards patients. Most nurses expressed putting the needs of their patients at the forefront of their work, despite scarcity and time-boundedness. One participant stated:

"Our decisions impact people's lives, and therefore patients always come first, regardless of how much work there is before you." (N04)

Another theme that emerged was the importance of professional commitment, which for many participants also involved their role as trusted providers within a larger community.

3.5.2. Emotional Resilience

Participants highlighted the emotional demands of working in community nursing. The previous workloads often posed stress due to caring for patients with long-term illnesses, and handling rapid responses on family concerns. As one nurse explained:

"A huge number of you have also been telling me how being in community is quite literally an emotional job. It can be stressful at times, but we learn to manage and go on treating our patients." (N12)

While some participants characterized strategies they developed as personal coping mechanisms, many also described relying on the support of colleagues in managing some of these challenges.

3.5.3. Compassionate Care

Knowledge of Patients' Experience and the Emotional Component of Care: Participants often or frequently talked about the importance of understanding patients in physical, psychological, and social domains. One participant reflected:

"Whenever patients need not just medicine but a person that understands them." (N01)

The majority of nurses believed that empathy built trust and led to greater patient engagement in their care. Hence, compassion was seen then to be a key component of what in the community we called `everyday nursing practice.

3.6. Theme 5: Building Therapeutic Alliance and Community Involvement

Most of the participants had learnt that relationships with patients, families and community members were an integral part of their work. Nurses provided insights about how ongoing contact with people in the local area initiated an understanding of community needs, assisting nurses in providing more responsive patient care.

3.6.1. A Trust Issue with Patients and Families

Trust was cited by many participants as important to community nursing. They said trust was built in the long run *via* constant communication, availability and continuing assistance. One participant commented:

"That trust leads to patients being more willing to talk about problems and follow care recommendations." (N09)

Many nurses stated that building strong relationships most often led to patients and family members reporting concerns which would otherwise be left unreported.

3.6.2. Supporting Community Participation

Working together with community members and local stakeholders was a key theme. As one nurse explained:

"Community participation rather than solely healthcare professionals, is crucial to achieve success in health programmes." (N05)

Collaborating with community groups was described by participants as an enabler for entraining local buy-in for health initiatives and augmenting access to services.

3.6.3. Enhancing Continuity of Care

The continuing support through multiple phases of care was attributed to strong therapeutic relationships established between nurses and patients. One participant stated:

"Because we know our patients so intimately, we can follow them longitudinally and intervene sooner when things go wrong." (N07)

Nurses often believed their familiarity with patients and families provided continuity of care and enabled delivery of care better aligned to individual and community needs.

3.7. Summary of Findings

Interviews revealed that with decentralisation of the health service, nursing practice had changed both in scope and complexity. Participants reported more extensive responsibilities, increased workload and emerging demands from their organisations. Meanwhile, they stressed the need for embracing learning, adaptation and compassion. And these are all clinical care experiences that exemplify the shifting nature and responsibilities of nurses in primary health care (PHC) and community health services.

4. DISCUSSION

Objective: To gain an understanding of how nurses experienced changes in their work after the decentralisation of health services in Thailand. As described in the results section and illustrated in the supplementary file, interviews indicated that nursing practice in SHPHs now

extends beyond direct patient care. Reporting showed improved participation in care coordination, community health work, health information management, and working together with local organisations. At the same time, they commented on rising demands for administration, pressures of limited staffing, and needed adjustments to new organisational arrangements. These experiences imply that decentralisation has not only affected the management of services but also how nurses perform their everyday work. The expansion of nursing responsibilities identified in this study is consistent with previous research showing that decentralisation and changes in primary healthcare delivery can broaden frontline nurses' roles beyond direct clinical care [3, 13]. However, participants in the present study also described increased responsibilities for administration, coordination, health information management, and cross-sector collaboration. This pattern may reflect the specific governance transition of SHPHs from the Ministry of Public Health to Provincial Administrative Organizations, which requires nurses to work across both clinical and local administrative systems. These findings suggest that decentralisation changes not only the scope of nursing practice but also how professional roles are organised and negotiated within local health systems.

A major consequence of role expansion was the challenge of balancing clinical care with growing administrative responsibilities. Participants described documentation, reporting requirements, and communication with multiple agencies as increasingly routine components of their work. Although similar administrative pressures have been reported among nurses in other primary healthcare settings [14, 15], participants in this study linked these demands specifically to organisational changes following decentralisation. One possible explanation is that the transfer of SHPHs to local administrative authorities introduced new reporting relationships and coordination requirements while nurses continued to fulfil their existing clinical and community-based responsibilities. Consequently, administrative work could compete with time available for direct patient care, home visits, and health promotion activities. This finding highlights a potential tension within decentralised primary healthcare: greater local administrative responsiveness may be accompanied by additional organisational demands on frontline nurses.

Another important dimension of changing practice involved health information management and digital technologies. Participants described using community health data to identify local health needs, monitor patient outcomes, and support service planning. This finding reflects broader developments in nursing practice, in which digital technologies and data increasingly support care delivery and clinical and organisational decision-making [7]. In the context of decentralisation, however, these competencies may have particular importance because nurses must respond to both community health needs and the information requirements of local administrative systems. Participants also described the need to continually update their knowledge and skills as technologies and reporting systems changed. This finding reinforces the importance of strengthening digital literacy and providing accessible continuing professional development for nurses working in primary healthcare settings [16].

Continuous learning was closely linked to changing practice demands and nurses' efforts to adapt. Some participants described learning independently, whereas others emphasised learning through everyday experience and interaction within the community. Professional development was therefore not viewed simply as an occasional formal activity but as an ongoing component of practice. This finding is consistent with previous evidence emphasising lifelong learning in contemporary nursing practice [3]. In the context of decentralisation, continuing education may need to extend beyond clinical competencies to include leadership, local health-system management, interprofessional coordination, digital literacy, and the use of health information for planning. Nursing schools and healthcare organisations may therefore have an important role in preparing nurses for these broader responsibilities and in providing continuing professional development for nurses already working within decentralised primary healthcare systems.

Resilience also emerged as an important aspect of adaptation to changing practice demands. Previous studies have linked nurses' resilience with well-being, turnover intention, and quality-of-care outcomes [17, 18]. The present findings similarly suggest that nurses drew on professional values, experience, and collegial support when responding to increased workloads and organisational pressures. However, participants also described situations in which limited resources and workplace demands constrained their capacity to provide the level of support they wished to offer patients and communities. This suggests that resilience should not be viewed solely as an individual attribute, but also in relation to the organisational conditions that enable nurses to sustain high-quality care.

The importance of relationships with patients and communities remained more central to participants' picture of nursing practice. Trust, communication and long-term relationships with patients and families were themes shared by nurses often. Such relationships were considered to be especially critical in community settings where nursing care often spans numerous years and cross-generationally. This finding is in line with relationship-centred models of care, which suggest that meaningful interaction to foster health and self-management support has value [19, 20]. Participants still believed that relationship-centred care underpinned their professional identity despite increasing administrative and organisational burdens. This study identifies that the interpersonal aspects of nursing practice remain valued elements of primary healthcare delivery systems in contemporary settings.

Conclusion: Health service decentralisation has reshaped community nursing practice in Thai SHPHs,

requiring nurses to work across clinical, administrative, coordination, and community-facing responsibilities. Supporting this evolving role requires organisational arrangements that recognise these interconnected responsibilities rather than adding new administrative demands without corresponding workforce support. Continuing professional development in leadership, coordination, digital and information-management competencies, together with adequate organisational resources, may help nurses adapt to decentralised primary healthcare systems while maintaining the relational and community-based dimensions of nursing practice.

4.1. Implications for Community Nursing Practice and Education

In-depth qualitative data show the challenges faced, which highlight implications for support that are aligned with the evolution of nursing practice into primary healthcare settings. Adequate staffing and organisational support may help reduce workload pressures associated with expanded clinical, administrative, and coordination responsibilities, thereby allowing nurses to maintain sufficient time for direct patient and community care. Continuing professional development should extend beyond clinical competence to include leadership, care coordination, interprofessional collaboration, digital health, health information management, and local health-system planning. Nursing schools may also need to strengthen undergraduate and postgraduate preparation in these areas to better equip future community nurses for increasingly complex roles within decentralised health systems. In addition, accessible continuing education programmes should be provided for nurses already working in SHPHs to support ongoing adaptation to organisational and technological change. Strategies that promote nurse well-being, professional support, and workforce retention may further contribute to the sustainability and quality of community-based healthcare services.

4.2. Strengths and Limitations

A strength of this study was the inclusion of nurses from six SHPHs across five districts and facilities of different sizes, providing perspectives from varied primary healthcare contexts. Participants also had direct experience of nursing practice during decentralisation, allowing them to reflect on changes in their work over time. Several limitations should be considered. First, the study was conducted in one province, and experiences may differ in other regions of Thailand. Second, interviews were the sole data source; workplace observations or document analysis were not used to compare participants' accounts with practice or organisational records. Future studies using multiple data sources may provide a more comprehensive understanding of practice change.

The sample included 13 women and one man, and all participants had 15–30 years of professional experience. The findings may therefore reflect the perspectives of experienced female nurses more strongly than those of male or less experienced nurses, particularly those entering practice after decentralisation, which may limit transferability across career stages. Purposive recruitment may have introduced self-selection bias, as participants may have had greater interest in organisational change. Social desirability may also have influenced responses concerning professional commitment and patient care. To minimise this risk, interviews were conducted privately, confidentiality was emphasised, and open-ended, non-judgmental questions were used. Finally, the researchers' backgrounds in community health nursing may have influenced questioning and interpretation. Reflexive notes and team discussions were used to examine these assumptions and keep interpretations grounded in participants' accounts. However, researcher influence cannot be completely excluded in qualitative research.

CONCLUSION

This research indicates that the decentralisation of health services has affected the breadth and depth of community nursing practice in Thailand. On the other hand, participants reported increased responsibilities and new demands/ organisational context to adapt to new working surroundings. Despite these challenges, nurses continued to be focused on person-centred care and the health needs of their communities. Investment in workforce development, professional learning and organisational support could further enhance community nursing services in decentralised primary healthcare systems.

AUTHORS' CONTRIBUTIONS

The authors confirms their contributions to the paper as follows: S.S. and J.S.: Conceptualisation and study design; S.S.: Data collection; S.S. and J.S.: Data analysis and interpretation; S.S.: Manuscript drafting; S.S. and J.S.: Critical revision of the manuscript; Final approval of the manuscript: All authors read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

LIST OF ABBREVIATIONS

COREQ	=	Consolidated Criteria for Reporting Qualitative Research
IRB	=	Institutional Review Board
PAO	=	Provincial Administrative Organisation
PHC	=	Primary Health Care
SHPH	=	Subdistrict Health Promoting Hospital

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval was received from the Institutional Review Board, Faculty of Medicine, Chulalongkorn University (COA No. 0349/2025; IRB No. 0010/68) before data collection.

HUMAN AND ANIMAL RIGHTS

All procedures involving human participants were

conducted in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

CONSENT FOR PUBLICATION

Written informed consent was obtained from the participants.

STANDARDS OF REPORTING

COREQ guidelines were followed.

AVAILABILITY OF DATA AND MATERIALS

All the data and supporting material is available within the article.

FUNDING

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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SUPPLEMENTARY MATERIAL

Supplementary material is available on the publisher's website along with the published article.

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