Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Gap Analysis

by

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Abstract

It is widely believed that in Canada, nursing practice and health care are moving from acute care into the community. What has yet to be established, however, is the degree to which undergraduate nursing students are being prepared for community health nursing practice through their community health clinical rotations. In particular, how well non-traditional or innovative community placements prepare students for registered nursing practice in the community has never been quantified. The purposes of this province-wide multi-stakeholder mixed method research study were to: delineate the competencies required of nursing students from stakeholder (industry, faculty, and student) perspectives; understand the nature of the gap between desired and observed competency level; and establish strategies for moving forward in the preparation of new nurses for community health practice in Alberta.

Findings suggest that undergraduate pre-registration nursing students are not being adequately prepared for registered nursing practice roles in community health. In all competency performance items on the survey tool, observed scores were significantly lower than desired scores. Faculty and students rated observed and desired scores higher than did community health nurses, for whom the observed-desired gap was also wider. Focus group findings reveal that perspectives differ by stakeholder group regarding what it means to be prepared for community health nursing practice and how this readiness is best accomplished. As well, faculty and student perspectives often differ significantly from perspectives of practicing nurses about what new graduates need in order to be ready for community health practice.

Preface

This dissertation is an original work by Em M. Pijl-Zieber. The research project, of which this thesis and manuscripts are a part, received ethics approval from the University of Alberta Research Ethics Board, Project Name "Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Gap Analysis," No. Pro000454649, March 22, 2014-March 31, 2015. Furthermore, ethics approvals were obtained from all Schools of Nursing in Alberta and all community health areas in Alberta Health Services Zones. The four manuscripts contained herein were prepared by Em M. Pijl-Zieber and at this time are in various stages of peer review for publication, with the supervisory committee as co-authors.

This dissertation is dedicated
to my community health nursing students.

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List of Abbreviations

BN, BSN, BScN	Bachelor of Nursing, Bachelor of Science in Nursing
CARNA	College and Association of Registered Nurses of Alberta
CASN	Canadian Association of Schools of Nursing
CHN	Community Health Nurse
CHNC	Community Health Nurses of Canada
CNA	Canadian Nurses' Association
CRNE	Canadian Registered Nurse Exam
EPA	Entrustable Professional Activities
ETPC	Entry-to-Practice Competencies
HCN, HHN	Home Care Nurse, Home Health Nurse
NCLEX, NCLEX-RN	National Council Licensure Examination (for Registered Nurses)
OSCE	Objective Structured Clinical Examination
PHN	Public Health Nurse
RN	Registered Nurse
WNRCASN	Western Northwestern Region of the Canadian Association of Schools of Nursing

Glossary of Terms

Registered Nursing in Alberta:

Competence:	The ability of a registered nurse to integrate and apply the knowledge, skills, judgment and interpersonal attributes required to practice safely and ethically in a designated role and setting (College and Association of Registered Nurses of Alberta, 2006, p. 17).
Competency/Competencies:	The integrated knowledge, skills, abilities, and judgment required to practice nursing safely and ethically (College and Association of Registered Nurses of Alberta, 2013a, p. 19).
Competent:	The application of knowledge, skills, abilities, and judgment required to practice nursing safely and ethically (College and Association of Registered Nurses of Alberta, 2013a, p. 19).
Individual Competence:	The ability of a registered nurse to integrate and apply the knowledge, skills, judgments, and personal attributes to practice safely and ethically in a designated role or setting. Personal attributes include, but are not limited to: attitudes, values, and beliefs (College and Association of Registered Nurses of Alberta, 2013a, p. 21).
Entry-to-Practice Competencies for the Registered Nurses Profession (Alberta):	The competencies expected of the new graduate from an approved nursing education program for initial entry-to-practice as a registered nurse. The competencies serve as a guide for curriculum development and also for public and employer awareness of the practice expectations of entry-level registered nurses (College and Association of Registered Nurses of Alberta, 2013a, p. 1).
Entry-Level Registered Nurse:	The registered nurse at the point of initial entry to the profession is prepared to practice safely, competently, compassionately, and ethically, and in situations of health and illness, with people of all genders, across the lifespan, in a variety of settings, with individuals, families, groups, communities, and populations; and a graduate from an approved nursing education program (College

	and Association of Registered Nurses of Alberta, 2013a, p. 20).
Practice Standards for Regulated Members [of the Registered Nurses Profession] (Alberta):	An authoritative statement that describes the required behaviour of every nurse and is used to evaluate individual performance (College and Association of Registered Nurses of Alberta, 2013b, p. 5).
Restricted Activities:	High risk activities performed as part of providing a health service that requires specific competencies and skills to be carried out safely. Restricted activities are not linked to any particular health profession and a number of regulated health practitioners may perform a particular restricted activity. Restricted activities authorized for registered nurses are listed in the *Registered Nurses Profession Regulation* (College and Association of Registered Nurses of Alberta, 2013b, p. 5).
Requisite Skills and Abilities:	The basic skills and abilities required to attain the entry-to-practice competencies for registered nurses in Alberta. The basic skills and abilities are required for progression through a nursing education program and for initial entry to practice as a registered nurse (College and Association of Registered Nurses of Alberta, 2013a, p. 23).
Scope of Practice:	The knowledge of registered nurses and the comprehensive application of that knowledge to assist clients in meeting their health needs in whatever setting, complexity and situation they occur throughout the lifespan. Scope of practice includes all the interventions that registered nurses are authorized, educated and competent to perform (College and Association of Registered Nurses of Alberta, 2013a, p. 23).

Community Health Nursing in Canada:

Canadian Community Health Nursing Standards of Practice:	Expectations that apply to community health nurses working in practice, education, administration or research. They set a benchmark for new community health nurses and become basic practice expectations after two years of experience (Community Health Nurses of Canada, 2011b, p. 3). For a visual

depiction of the relationship between standards and competencies, see Figure 1.

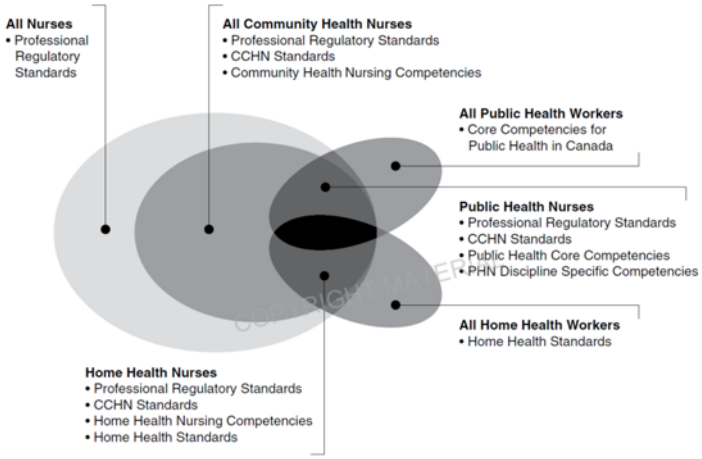

Figure 1. Diagram of the relationship between standards and competencies *(Community Health Nurses of Canada, 2011a, p. 31).* In this diagram the black intersection represents competencies that overlap for home health nurses and public health nurses.

Community Health Nursing Practice in Canada:

Community health nursing practice describes the work of nurses who work in the community. Community health nurses partner with people where they live, work, learn, meet and play to promote health (Community Health Nurses of Canada, 2009b, p. 4). Community health nurses work in diverse positions such as Clinical Nurse Specialist, Clinical Resource Nurse, Clinical Educator, Consultants, Counselor, Coordinator/ Case Managers, Home Health Nurse, Manager/ Supervisor/Administrators/ Directors, Nurse Practitioners, Occupational Health Nurse, Parish Nurse, Outpost Nurse, Public Health Nurse, Primary Care Nurses, Mental Health Nurse/Registered Psychiatric Nurse, Researcher, Policy or Informatics Analyst, Street Health Nurse, Community Development Nurse, and Physician Office Nurse (Community Health Nurses of Canada, 2009b, 2011a).

Public Health:

An organized activity of society to promote, protect, improve, and when necessary, restore the health of people, specific groups, or the entire population. It is a mix of sciences, skills, and values that function

	through programs, services, and institutions aimed at protecting and improving the health of all people. The term "public health" is a way of thinking, a set of disciplines, an institution within society, and a type of practice. It has more and more specialized domains and requires its practitioners to have a larger set of skills and expertise (Community Health Nurses of Canada, 2011b).
Public Health Nursing Discipline Specific Competencies:	The integrated knowledge, skills, judgement and attributes required of a public health nurse to practice safely, ethically, and effectively with minimal supervision. Attributes include, but are not limited to, attitudes, values, and beliefs (Community Health Nurses of Canada, 2011b, p. 13).
Home Health Nursing Competencies:	The integrated knowledge, skills, judgement and attributes required of a nurse working in home health to practice safely and ethically. Attributes include, but are not limited to, attitudes, values and beliefs (Community Health Nurses of Canada, 2011b, p. 7).

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Chapter 1: Introduction

In this research study, the competence of senior nursing students and new graduate nurses working in community health practice areas was assessed from multiple perspectives to determine the degree to which undergraduate nursing students are being prepared for these practice areas in their educational experiences. The research project began as a quantitative survey-based study but later in the data collection process, focus group interviews with respondent groups (faculty, nurses and students) were added to triangulate the data in a mixed method study.

Background

Over the past decade or longer, many baccalaureate schools of nursing have used non-traditional placements for undergraduate practice rotations in community health. These placements, which often lack a registered nurse (RN) on site and lack opportunities for students to learn traditional nursing skills, include schools, homeless shelters, workplaces, correctional centers, shopping malls, police stations or even places of worship. These non-traditional experiences are eclipsing traditional preceptored placements in public health and home care—sectors that make up the largest portions of community health nurses, employing 34% and 19% of community health nurses, respectively (Underwood et al., 2009). Non-traditional experiences typically occur at agencies not organizationally affiliated with the health care system and typically do not employ RNs.

Strong empirical evidence, indicating the degree to which non-traditional community health nursing clinical rotations are preparing students for practice in

community health, is lacking. What is unclear is to what degree, "within a competency-based framework, students are able to prepare for community and/or public health nursing practice without ever practicing as, or viewing the actual work of, a [community health nurse]" (Pijl-Zieber & Grant Kalischuk, 2011, p. 5). Furthermore, it has not been established whether a disconnect exists for students who graduate from a program that was focused on community health nursing at the population level, and enter a system of community-based nursing that is focused on individuals and curative care (Cohen & Gregory, 2009).

A determination of the degree to which students are being prepared for community health practice is dependent upon establishing the nature of foundational and core knowledge, skills and attitudes in this area of nursing. This is difficult, given that community health nursing is a broad area of nursing that comprises diverse practice areas and role descriptions, including public health, home care, clinic, occupational health, and primary care nursing as the dominant practice areas.

Significance of the Issue

It has been predicted by the Canadian Nurses Association (CNA) that by the year 2020, 60% of nurses will be working in the community (Villeneuve, 2006). The CNA (2009b) suggests that in the years to come there will be an increased focus on health promotion and addressing the determinants of health. The CNA also predicts greater collaboration across sectors and health disciplines to enable health for all Canadians, although these foci will not be delivered as a replacement for illness care and supportive care, which will remain a priority. What remains to be seen, and this has direct relevance

for nursing educators, is whether by 'community care' what is really meant is non-hospital tertiary care as a cost-saving measure, or whether governments will finally overcome their preoccupation with acute, downstream care in favor of population health promotion that acts on the determinants of health. Either way, the fact that schools of nursing have not evaluated how well they are preparing baccalaureate nursing students for real-world practice in the community, despite significant educational program changes over the past decade or two, means that an evaluation could not be more timely.

Purpose of the Study

The purposes of this research project, therefore, were to: (1) establish the level at which community health nurses, senior baccalaureate nursing students and community health faculty *desire* to see specific competencies demonstrated in nursing students; (2) establish the level at which nurses, students and faculty are *observing* these specific competencies in nursing students; and, (3) determine the nature of the gap between what nurses, students and faculty desire to see demonstrated and what they are actually seeing demonstrated by nursing students in community health practice.

Research Questions

The research questions guiding this project were:

1. Which Entry-to-Practice Competencies (ETPCs) (College and Association of Registered Nurses of Alberta, 2013a) for new registered nurses in Alberta are most strongly represented by and aligned with established community health competencies, as delineated by the Community Health Nurses of Canada (Community Health Nurses of Canada, 2009a, 2010)?
2. What is the *desired* level of competence in nursing students, according to stakeholders[1]?

[1] Stakeholders include: Practicing nurses and managers in community health; faculty who teach in community health; senior nursing students; and, new nursing graduates working in community health.

3. What is the *observed* level of competence in nursing students, according to stakeholders?
4. In quantitative terms, what is the nature of the gap between what the stakeholders desire to see demonstrated and what they are actually observing in nursing students? Which competencies are being observed at the desired level and which are not? Which variables are associated with high or low performance?
5. How do perspectives on competence differ by stakeholder group?
6. What is the impact of the type of undergraduate community health clinical experience (traditional versus non-traditional) on developing competence for registered nurse practice in community health practice?

Context of the Study

This study was conducted in the Canadian province of Alberta. Community health faculty and senior nursing students at all baccalaureate schools of nursing in the province were invited to participate, as were community health nurses in all health regions of the provincial health authority.

Assumptions Underpinning the Study

This study was premised on the following assumptions:

1. That undergraduate nursing education programs leading to initial entry to practice as a registered nurse have a *required number of clinical hours* to be completed involving individuals, families, groups, communities, and populations (Canadian Association of Schools of Nursing, 2004, 2013a, 2013b; Canadian Association of Schools of Nursing Task Force on Clinical/Practice Education, 2003; College and Association of Registered Nurses of Alberta, 2005; P. M. Smith et al., 2007).
2. That the majority of undergraduate nursing education programs in Canada provide a *range of clinical experiences*, usually including: acute medical and surgical nursing, perinatal nursing, mental health nursing, pediatric nursing, geriatric

nursing, and community health nursing (Canadian Association of Schools of Nursing, 2004; P. M. Smith et al., 2007).

3. That while clinical experiences are required in undergraduate nursing education programs (Canadian Association of Schools of Nursing, 2011), the *exact number, type and location of clinical experiences is determined by the school of nursing* and approved by provincial approval processes (Black et al., 2008; Canadian Association of Schools of Nursing, 2004; Canadian Association of Schools of Nursing Task Force on Clinical/Practice Education, 2003; College and Association of Registered Nurses of Alberta, 2005).
4. That because the number of clinical hours and types of experiences are determined by individual schools of nursing in conjunction with local health regions, there is *considerable variation in these experiences*—especially in terms of community health nursing clinical experiences—occurring in Canada (Canadian Association of Schools of Nursing Task Force on Clinical/Practice Education, 2003; Cohen & Gregory, 2009).
5. That Canadian undergraduate nursing education programs and Canadian registered nursing practice are based on *competency frameworks*, representing a shift from content-based curricula (Black et al., 2008; Canadian Association of Schools of Nursing, 2011, 2013b; International Council of Nurses, 2003).

Clinical Practice Rotations in Undergraduate Nursing Curricula

A graphical depiction of the placement of clinical rotations in nursing education and practice is shown in Figure 1.1 below. Clinical rotations represent opportunities for

nursing students to access the world of professional nursing in a limited but supported way. They provide a bridge between theoretical education and clinical education, and between the academic experience and practice roles. A mix of theoretical and practical opportunities forms the foundation of nursing education programs. At the completion of the nursing education program, students must have achieved competence at an entry-to-practice level, at which point they enter into professional nursing practice.

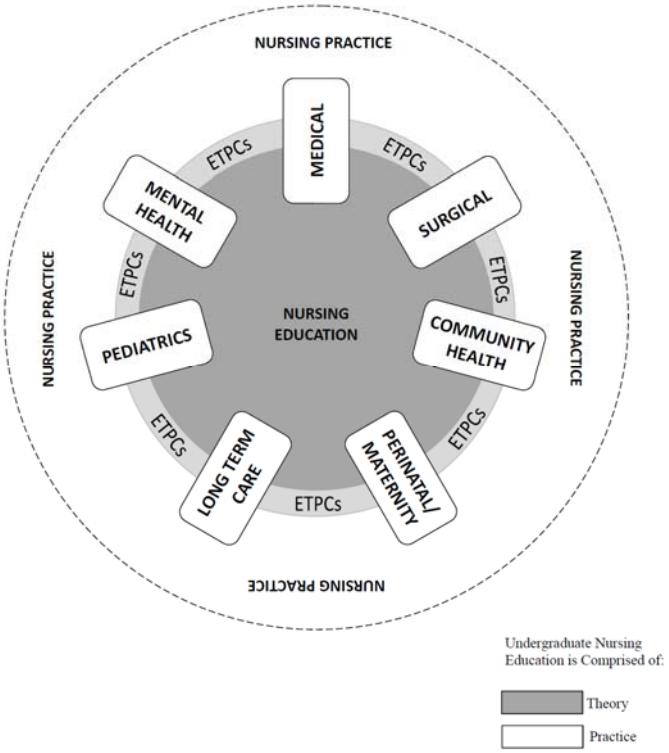

Figure 1.1. Placement of clinical rotations in nursing education within the context of nursing practice

Community Health Clinical Delivery

In Canada, many baccalaureate schools of nursing are using "non-traditional" or "innovative" placements for undergraduate practice rotations in community health (Cohen & Gregory, 2009; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005b).

These clinical placements, which often lack an RN on site, are not organizationally affiliated with the health care system and include a wide range of sites. Students in these clinical experiences typically lack opportunities to develop areas of unique nursing knowledge and skills, such as restricted nursing acts. These non-traditional experiences are eclipsing traditional preceptored placements in public health and home care (Cohen & Gregory, 2009; Hoe Harwood, Reimer-Kirkham, Sawatzky, Terblanche, & Van Hofwegen, 2009), sectors that make up the largest portions of community health nurses, employing 34% and 19% of community health nurses, respectively (Underwood et al., 2009).

Numerous factors have caused this shift in the way community health clinical rotations are delivered in Canadian undergraduate pre-registration nursing programs. First, there is a shortage of community health preceptors such as home care and public health nurses (Canadian Association of Schools of Nursing, 2004; Cohen & Gregory, 2009; Ravella & Thompson, 2001; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005a; Reimer Kirkham et al., 2005b; Valaitis, 2008). This shortage, which is part of a global shortage, is the result of the natural ebb and flow of demand for RNs as dictated by government, health care restructuring, cuts to community health programs, and increased nursing program enrollments (Canadian Association of Schools of Nursing (CASN) Task Force on Public Health Education, 2006; Valaitis, 2008).

A second reason for the use of non-traditional placements for undergraduate community clinical rotations is that many Canadian nursing programs are heavily oriented towards community *health* nursing, as opposed to community-*based* nursing.

Whereas community-*based* nursing focuses on acute, rehabilitative and chronic care at the individual level, community *health* nursing focuses on health promotion and illness/injury prevention at the population level (Cohen & Gregory, 2009). Non-traditional placements allow nursing students to work at the population level, incorporate the principles of primary health care, enact social justice and equity, increase access to services, and address the determinants of health (Reimer Kirkham et al., 2005b; Wade & Hayes, 2010).

A third reason for the use of non-traditional experiences is that Canadian nursing curricula are based on competency frameworks. In Canada, a competence approach to professional practice is legislated and health professions are required to adopt a competency-based approach to licensure (Black et al., 2008). The former Canadian RN licensure exam, in use up until 2014, was also competency-based. It should be noted that the Canadian registered nurse licensure exam is changing to one that is more aligned with the American National Council Licensure Examination for Registered Nurses (NCLEX-RN). The NCLEX-RN is not competency-based, but instead, is based on job-analysis of new RN graduates with six months of experience. Changes are made to NCLEX-RN content every three years by analyzing the current nursing practice of approximately 12,000 recently licensed RNs, most of whom work in acute care settings. Thus, in 2015, there will be a considerable disconnect between Canadian nursing education and our licensure exam, with the former based on a competency framework, and the latter which tests the learner's familiarity with unique nursing knowledge in the workplace, usually medical, pharmacological or surgical. Questions abound regarding the impact of the

NCLEX-RN on Canadian nursing education. For example, it is unclear whether nursing programs will have to reduce their community theory and clinical content to make room for more medical/surgical content, since medical/surgical sites are where new nurses generally work and the NCLEX-RN draws on this reality. It is also unclear whether Canadian nursing programs should continue to educate students based on a competency framework, expecting that they will perform well on the content-driven NCLEX-RN and at the same time excel in achieving a full range of competencies.

At present, there are a wide variety of community health clinical rotations occurring at Canadian schools of nursing, ranging from preceptored experiences with public health or home care nurses, to population health experiences in non-traditional settings (Cohen & Gregory, 2009). Some programs contain both elements—preceptored experiences *and* non-traditional placements. Whereas a preceptorship arrangement for the community health clinical rotation is reminiscent of the apprenticeship model which has been prevalent throughout nursing's history, the educational model that is commonly employed in non-traditional experiences is often called 'service learning.' Service learning is "a structured learning experience that combines community service with explicit learning objectives, preparation, and reflection" (Seifer & Connors, 2007, p. 9). With the guidance of nursing faculty, students involved in these experiences "provide a service to the community while learning about the context in which the service is provided and make conceptual links to their academic coursework" (Pijl-Zieber & Grant Kalischuk, 2011, p. 2).

In service learning for community health clinical, students (guided by the clinical instructor) are engaged in a variety of activities. Common themes in these experiences in Canada include: critical reflection, healthy public policy, community partnerships, leadership development, advocacy, health education, and social justice, within a population health and/or community development framework. Common clinical sites include: anti-poverty organizations, environmental groups, churches and religious communities, correctional facilities, wellness or resource centres, schools, seniors' organizations, seniors' residential facilities, homeless shelters, shopping malls, police stations, and workplaces (Cohen & Gregory, 2009; Diem & Moyer, 2005; Falk-Rafael, 2005; Reimer Kirkham et al., 2005a, 2005b).

The extant literature describes both benefits and drawbacks of service learning for community health nursing clinical rotations. The benefits of non-traditional placements, which are primarily process-oriented, and the drawbacks of non-traditional placements are listed in Table 1.1. Strong empirical evidence indicating the degree to which non-traditional community health nursing clinical rotations are preparing students for practice in community health is lacking.

While some nursing education programs utilize both traditional and non-traditional sites for community health clinical experiences, many do not, and oftentimes students are only exposed to non-traditional experiences in placements lacking an RN and that do not offer opportunities for students to develop knowledge and skills that is uniquely nursing or uniquely community health. Thus, it seems that there is considerable

disjuncture between what nursing students accomplish in their community health clinical

Benefits	Drawbacks
• Students carry out the community health nursing process • Students engage in population health promotion • Students engage in program planning • Students participate in intersectoral collaboration • Students address the determinants of health • Students enact the principles of primary health care • Students develop leadership skills and cultural competence • Students develop teamwork skills • Students foster critical thinking skills	• Students might not see the value of the placement • Students often prefer sites in which a registered nurse is present • Students might struggle with the abstract and unbounded nature of the experience • Students might not get the hands-on psychomotor skills that traditional placements offer • Students might not be exposed to the role of the community health nurse • Students engage in activities that differ significantly from what community nurses actually do in the practice setting • Students might struggle in the shift from individual as patient, to community as patient • Students might not see the relevance of their activities to 'real nursing' • Students might not have opportunities to develop basic entry-level core competencies and specialized nursing knowledge and skills • Students may lack opportunities to interact with health care professionals and practicing RNs • The time constraints of the semester artificially compress the community development process
(Cohen & Gregory, 2009; Francis-Baldesari & Williamson, 2008; Reimer Kirkham et al., 2005a, 2005b)	*(Cohen & Gregory, 2009; Laplante, 2007; Reimer Kirkham et al., 2005a, 2005b; Valaitis, 2008; Wade & Hayes, 2010)*

Table 1.1. Benefits and drawbacks associated with non-traditional community health rotations

experience and what they will be doing following graduation. It is unclear whether nursing students and new graduates can be prepared for the role of and equipped with the competencies for community health nursing practice without ever learning in a place where community health nurses work, and without ever doing or observing the work that community health nurses do.

What is also murky is the future of health care. While many groups presuppose that health care is moving to the community, the fact is that governments are preoccupied with the funding of acute and curative care at the individual level, at the expense of broader population health promotion measures. Given that the percentage of nurses working in the community (home care, public health, and community health centre) remained fairly steady at 17% between 1998 and 2007 (Underwood et al., 2009), it is unclear exactly when the big migration (60% of nurses) to community practice will occur. Thus, the future role of the community health nurse is largely unknown at this time.

Competencies and Competence

As a noun, *competence* refers to a quality or state of being. *Competence* is a holistic term that refers to a person's overall capacity or *ability* to do something successfully (Carraccio, Wolfsthal, Englander, Ferentz, & Martin, 2002; Eraut, 1994; ten Cate & Scheele, 2007). A view of competence as the "command of pertinent knowledge and/or skills," considers that the competent person "not only possesses the requisite competencies but is also able to use them" (Eraut, 1994, p. 179) and able to make appropriate decisions and judgements according to the situation and context. Epstein and Hundert (2002) put forward this definition:

> The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served. Competence builds on a foundation of basic clinical skills, scientific knowledge, and moral development. It includes a cognitive function…; an integrative function…; a relational function…; and an affective/moral function. Competence depends on habits of mind, including attentiveness,

> critical curiosity, self-awareness, and presence. Professional competence is developmental, impermanent, and context-dependent (pp. 226-227).

A *competency* is a specific capability demonstrated by the doer. A competency represents the integration of knowledge, skills, values and attitudes (Carraccio et al., 2002; Eraut, 1994; Frank et al., 2010). *Competencies* are ingredients of *competence* (Frank et al., 2010). Generic competencies are valid across different clinical contexts, whereas specific competencies indicate what a competent nurse can do within a specific clinical area of practice (Eraut, 1994).

Competence as a construct derives from a variety of educational theories, including behaviorism and progressivism, and human performance (Hodges, 2012). These theories also informed the design of this study. The original intention of competency based education was to develop graduates who were able to 'put it all together' instead of merely being in possession of decontextualized knowledge (Hodges, 2012).

In Canada, a competence approach to professional practice is legislated as a way to ensure accountability in the health professions (Black et al., 2008). Competence began as a way for the professions to establish qualifying examinations and demarcate the boundaries of the profession, but it has also become a concept used by legislative bodies to justify control over licensing and limit professional autonomy to protect the public (Eraut, 1994). In Canada, registered nurses have both a required set of competencies and a set of practice standards, with competencies referring to behaviour, and standards referring to a level of service, intervention or outcome (Underwood, 2007).

In Canada, governments consult with nursing regulatory bodies to create and amend nursing legislation at the federal, provincial and territorial levels. Part of this legislation involves provincial and territorial colleges and associations of nursing self-regulating and delineating competencies for new nurses in consultation with employers, educators, government, and others (Black et al., 2008; Canadian Nurses Association, 2007, 2008). Provincial regulatory bodies (colleges and associations of registered nurses) implement and enforce federal, provincial and territorial legislation that governs nursing practice, and set standards for nursing education programs within their jurisdictions (Black et al., 2008). Nursing education programs that prepare entry-level registered nurses, then, can use entry-to-practice competencies to measure student progress towards entry-level nursing practice. It is important to note that while the use of competence frameworks is a global phenomenon (International Council of Nurses, 2003), it is not the only way of describing nursing practice; however, it is currently the framework used in Canada for professional nursing.

In Alberta, the competency profile for new RNs is captured by the document "Entry-to-Practice Competencies for the Registered Nurses Profession," (College and Association of Registered Nurses of Alberta, 2013a). Responsibilities of the College and Association of Registered Nurses of Alberta (CARNA), the regulatory and professional body for registered nurses in Alberta, are dictated by the Health Professions Act (HPA) (Government of Alberta, 2013) and the Registered Nurses Profession Regulation (Government of Alberta, 2005). CARNA implements these responsibilities through "regulatory processes such as registration and licensure, setting standards governing

nursing practice and education, defining the scope of nursing practice, and identifying competencies required for entry-level registered nurse practice" (College and Association of Registered Nurses of Alberta, 2013a, p. 1).

The Entry-to-Practice Competencies for the Registered Nurses Profession (Appendix A) delineate the competencies expected of the new graduate of an approved baccalaureate nursing education program in Alberta. These competencies are also used in nursing education program approval, a legislated mandate of a self-regulated profession (College and Association of Registered Nurses of Alberta, 2013a). The entry-to-practice competencies "serve as a guide for curriculum development and also for public and employer awareness of the practice expectations of entry-level registered nurses" (College and Association of Registered Nurses of Alberta, 2013a, p. 1).

While the entry-to-practice competencies represent broad competencies applicable to basic, generalist practice, some nursing specialty groups in Canada have developed competency frameworks unique to certain areas of practice. These specialty competency documents identify the knowledge, skills and abilities required for practice in these specific practice areas. For example, the Community Health Nurses of Canada have developed a set of competencies for home health nursing (Community Health Nurses of Canada, 2010) and public health nursing (Community Health Nurses of Canada, 2009a). For the purpose of this study, the Home Health Nursing (Appendix B) and Public Health Nursing (Appendix C) competencies were mapped to the Entry-to-Practice Competencies in Appendix D. A visual depiction of the relationship between the three sets of competencies is in Figure 1.2.

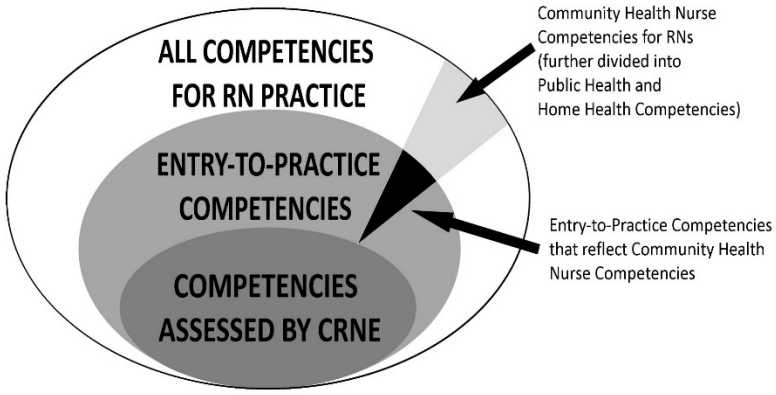

Figure 1.2. The nesting of competencies within all levels of professional nursing practice. CRNE (Canadian Registered Nurse Exam) is the national licensure exam for all nurses in Canada (until 2015, when the American exam [NCLEX] will complete its 'Canadianization' and be administered instead). This diagram has been modified from its original (Canadian Nurses Association, 2009a, p. 5)

Measuring Competence

At first blush, it may appear that a competency framework, such as entry-to-practice competencies or community health specific competencies, is an ideal framework to assess the performance of nursing students and new graduates. However, there are some problematic areas in the operationalization of competence. For starters, competence is difficult, if not impossible, to measure. Reliability and validity issues plague clinical evaluation tools, as do competing tensions of sensitivity and specificity and the need to balance a tool's manageability with its exactness (Watson, Stimpson, Topping, & Porock, 2002; Windsor, Douglas, & Harvey, 2012; Yanhua & Watson, 2011). It is also theoretically and practically problematic to determine at what level of performance a student should be deemed competent or incompetent (Watson, 2002; Watson et al., 2002). Extending this uncertainty further, any determination of a threshold of competence can be seen to inherently imply that a degree of incompetence is acceptable, a notion that is problematic particularly in the clinical practice realm.

Another problem with evaluating competence is that *performance* stands in as the observable proxy for *competence*, and therefore assessment depends upon the perception and judgement of evidence about performance (Epstein & Hundert, 2002; Khan & Ramachandran, 2012; Watson et al., 2002). The determination of competence is often clouded by the distractors of a student's level of comfort, confidence, and self-efficacy. Competency-based assessments are especially complicated because they require a holistic, not reductionist, approach and are invariably subjective because they rely on observation and reflection (Epstein & Hundert, 2002; Khan & Ramachandran, 2012; McMullan et al., 2003; S. A. Smith, 2012). As well, on a conceptual level, competencies represent ideas, not measurable phenomena; therefore, in and of themselves, competencies do not function well as indicators of actual performance (Lurie, 2012).

Another issue with competency frameworks—and one that has great relevance to nursing programs that seek to prepare generalist nurse graduates—is that a set of general competencies can be so vague that it fails to demarcate nursing from other professions while also failing to define actual nursing practice (Cowan, Norman, & Coopamah, 2007). While general competencies are often used to assess students, it may be of greater benefit (and a greater challenge) for students to attain specific nursing competencies. The prevailing belief that nursing programs cannot teach students 'everything' may result in an over-reliance on general competencies such as critical thinking and problem solving, at the expense of the knowledge and skills training that was so iconic of the previously esteemed behaviourist model. If students lack exposure to basic nursing skills, perhaps in favor of the many other aspects of nursing practice, they may gain insufficient experience

for even minimal competence. While such students may have sailed through their clinical education on *general* competencies and are ultimately deemed competent, this designation may be inappropriate. Thus, an important distinction must be made in nursing education between being in possession of certain general qualities and mastering specific nursing acts and being able to effectively use nursing knowledge and skills in clinical practice. Educators may also be doing a disservice to nursing students by treating all competencies equally or by attributing disproportionate weighting to non-critical competencies (Bork, 2003; Eraut, 1994; Tilley, 2008; Watson et al., 2002).

A further issue with the competence framework of nursing education is that there is often a lack of shared assumptions about what to expect from new nursing graduates (Bradshaw et al., 2012; Eraut, 1994; Tilley, 2008). Patients, for example, understand the foundation of competent nursing practice to be technical skill—and that following technical competence, which they assume to be present by virtue of the nurse's employment and registration, interpersonal attributes were the most significant indicator of quality nursing care (Calman, 2006). Conversely, in my observation, many nursing faculty disparage students' enamorment with technical skills, leading to confusion and value conflicts with students, who in general hold medically elite skills in high regard and who require confidence in the discharge of these skills in order to feel comfortable entering the clinical setting. Indeed, nurses and preceptors may be concerned that "students can pass their competencies and not be competent in fundamental nursing skills (Butler et al., 2011, p. 301);" since there are often no specific skills associated with the

competencies, it is theoretically possible for a student to "never be assessed on essential nursing skills" prior to employment as a registered nurse (Butler et al., 2011, p. 301).

As a nurse educator, I often hear students lament that in their community health rotation they lack exposure to traditional nursing skills. As an experiment, I gave to each of my students the competencies for both public health and home health (Community Health Nurses of Canada, 2009a, 2010), and had them read them and put an asterisk beside the ones that were obviously connected with a traditional nursing skill. The result of the exercise surprised me, too: only 3 or 4 of the scores of competencies on each list were related to a traditional nursing skill. Somewhere in the pursuit of the competence framework, the role of skill mastery has become unclear. While the goal of hospital-based schools of nursing was to produce a "competent" bedside nurse (Watson et al., 2002), the vision has changed for baccalaureate nursing graduates.

In one way, competency-based education and how it plays out in non-traditional community health clinical experiences might be considered as akin to the 1984 movie *Karate Kid* in which Mr. Miyagi teaches the young Daniel basic karate moves by having Daniel wax his car for days or weeks on end. The infamous line is, "Wax on, wax off." Daniel eventually gets frustrated that all he is doing is waxing Mr. Miyagi's car and not learning karate at all. At this point in the movie, Mr. Miyagi uses that phrase ("wax on, wax off") as he teaches Daniel in rapid fire basic blocking techniques. The thinking here is that it may be possible to learn one thing by doing another seemingly unrelated task. Perhaps this is the hope of non-traditional community experiences—that even though

students are doing ‘non-nursing’ functions, that they will through this process learn how to be a nurse who works in the community.

Despite the flaws in the competency framework, it formed the basis of this research project because of its wide acceptance and usage in the Canadian health professions. As well, it is probably more advantageous to use an existing framework than to create a new framework that has little bearing in current practice. Additionally, RN education in Canada is competency-based, in which “assessments ensure that graduates…have the essential knowledge, skills, and attitudes to enter the workforce and begin functioning in entry-level positions” (Anema, 2009, p. 3).

Approaches to Assessment of Competence

Competence is difficult (perhaps even impossible) to measure with any accuracy. Several approaches to assess competence are prominent in nursing education today. First, a performance or behaviourist approach relies on task analysis based on structured observation, and the process of delineating competence is a technical matter and often very narrowly defined (Eraut, 1994). Performance approaches to assessing competence focus on students’ practicing and demonstrating skills and ultimately, achieving mastery through repetition. Behaviorist methods are criticized because they atomize processes that are in reality integrated and contextual, and because they often lack a valid theoretical construct for combining and prioritizing assessment evidence (Eraut, 1994; Hodges, 2012).

Second, a psychometric approach to measuring competence in nursing education entails the use of standardized scales, rating scales and checklists in a wide range of

tasks, including performance assessments (such as objective structured clinical examinations [OSCEs], simulations, and scoring rubrics). A psychometric approach links psychology, evaluation, statistics, and measurement, and reduces competence to a reliable test score. The role of the teacher is to shape student characteristics and behaviors toward a norm; the student's role is to adapt the self to the norm to maximize statistical alignment with standardized measures. This view is criticized primarily for its focus on standardization and subsequent loss of authenticity, resulting in individuals with nonstandard, creative, or intuitive approaches scoring low even though they are highly competent and even experienced (Hodges, 2012).

Reflection is another approach commonly used in the assessment of competence, based on the work of Donald Schön in the mid-1990s (Hodges, 2012). In reflection discourse, the role of the teacher is to guide introspection, to mentor, and to act as 'confessor'; the role of the student is to reflect and demonstrate self-assessment and self-regulation (Hodges, 2012). A competent individual is "one who engages in a trinity of self-reflection, self-assessment, and self-regulation" (Hodges, 2012, p. 30). Competence is assessed through portfolios and reflective exercises; whereas the learner was once viewed as a repository or a processor of information, the learner is now viewed as a self-motivated, self-directed problem-solver (Hodges, 2012). This discourse has extended to professional licensure organizations that require clinicians to submit a learning portfolio as evidence of continuing competence (Hodges, 2012). Critics of the reflection approach cite two significant issues. First, those individuals who lack the insight to recognize their own ignorance are at a dangerous disadvantage, since 'you don't know what you don't

know' (Kruger & Dunning, 1999). Second, "an overemphasis on reflection discourse runs the risk of rewarding individuals who *appear* to be reflective, but who may have deficiencies in knowledge, skills, or attitudes that are not directly measured" (Hodges, 2012, p. 30).

Assessing and measuring competence is complex and imperfect. No system of competence assessment, regardless of definition or underpinning discourses, is foolproof for determining the degree to which students are ready to practice, because as a construct it is virtually impossible to measure with accuracy, especially given resource constraints of higher education. However, we should not be deterred in assessment; rather, we should be increasingly cautious in its execution and contemplative in the consideration of findings. While a self-report from students and graduates is highly problematic (Barnsley et al., 2004; Baxter & Norman, 2011; Dunning, Johnson, Ehrlinger, & Kruger, 2003; Kruger & Dunning, 1999; Lai & Teng, 2011), comparing and combining self-report with the observations of others may yield more holistic and representative data about competence (Mahar & Strobert, 2010; Overeem et al., 2009; Palmer, Rayner, & Wall, 2007). Additionally, some medical education leaders are suggesting the operationalization of competencies through "entrustable professional activities"—activities of the health professional in which competencies are activated and demonstrated (ten Cate, 2005, 2014; ten Cate & Scheele, 2007); thus making them more observable and measurable. This idea has not yet taken hold in nursing education.

Previous Research on Student Competence in Community Health

Most of the literature assessing undergraduate nursing students' achievement of community health competencies is qualitative or merely descriptive (Bouchaud, 2011; Bramadat, Chalmer, & Andrusyszyn, 1996; Brosnan et al., 2005; Ciesielka, 2008; Francis-Baldesari & Williamson, 2008; Hjälmhult, Haaland, & Litland, 2012; Kirkham, Harwood, & van Hofwegen, 2005; Laplante, 2007; Lasater, Luce, Volpin, Terwilliger, & Wild, 2007; Ravella & Thompson, 2001; Van Doren & Vander Werf, 2012). Few empirical studies have been completed that seek to determine, quantitatively, the degree to which nursing students are prepared for community health practice in their undergraduate community health clinical experiences. There are two exceptions: a study by Diem and Moyer (2010) (University of Ottawa), and a study sponsored by the Canadian Association of Schools of Nursing (Canadian Association of Schools of Nursing, 2010b).

Diem and Moyer (2010) set out to evaluate: (1) the confidence of students in using public health nursing skills; and (2) the satisfaction of students with team projects. The students were exposed to non-traditional placements (sometimes referred to as 'community projects' in the literature) and later evaluated using the developed tools. The confidence tool was developed using the American (Quad Council) and Canadian (Community Health Nurses of Canada) policy documents on public health and community health nursing and also based on the themes and skills identified as important or satisfying by nursing students during their clinical experience. The tool was tested for reliability and validity. The satisfaction tool was developed from student responses to

short-answer questions on satisfaction, and included aspects of the design and delivery of the non-traditional clinical experiences. The tool was developed to enhance the design and evaluation of appropriate clinical experiences.

While the Diem and Moyer (2010) study does contribute to our understanding of what is learned in non-traditional community health clinical experiences, the selected items, particularly the 'confidence' tool, are reflective of general competencies, not specific competencies for public health. The tool's items include teamwork, collaboration and leadership skills, which are by no means specific to community health clinical, public health nursing, or nursing in general. In addition, the findings may be of limited value because *confidence* is not the same thing as *competence*, and self-report is inherently problematic (Barnsley et al., 2004; Baxter & Norman, 2011; Dunning et al., 2003; Kruger & Dunning, 1999; Lai & Teng, 2011). Combining self-report with the observations of others might have contributed to more representative data about the students' actual competence (Mahar & Strobert, 2010; Palmer et al., 2007). The 'satisfaction' tool was interesting but relied upon the students' experience in working with teams and was not specific to either public health nursing or nursing in general.

The second study of interest is an unpublished study by the Canadian Association of Schools of Nursing [CASN] (2010a), the national voice for nursing education, research, and scholarship. The purposes of this study were to: "(1) understand the competencies required in the graduates from a client perspective; and (2) understand the level of satisfaction of the clients as it relates to graduate competencies" (Canadian Association of Schools of Nursing, 2010a, p. 6). This Canada-wide study involved a

needs analysis in which practicing community health nurses and managers and community health faculty prioritized the competency areas and specific competencies for public health. Respondents were asked to indicate the degree to which they desired to see competencies demonstrated. The study drilled down into individual competencies within the competency areas, and a number of variances were noted. Data was segmented by geographical region and role in the workplace (i.e. community health nurse, manager in community health, community health faculty, etc.). The study then established the gap between what the stakeholders wanted to see demonstrated and what they were actually observing. Many significant gaps were isolated. The gaps naturally prioritized the actions that needed to be taken to align the expectation with the delivery.

Unfortunately, this study was not published, despite having a considerable sample size (n=252) and quantitatively revealing numerous gaps in how student nurses are prepared for community health practice. In speaking with a CASN representative, there were some sampling errors in the study (Dr. Ruta Valaitis, personal communication, March 30, 2012). Another issue of note is that nursing students and new graduates working in community health were not sampled. Such additional data would reveal interesting observations about how students and new graduates perceive their own competence compared with how others perceive their competence.

Study Design

The present study began as a quantitative study that utilized gap analysis as its primary design. However, we later decided to triangulate the data using a mixed method sequential explanatory design (Creswell & Plano Clark, 2011) in which the quantitative

phase had dominance and the qualitative phase was used to elucidate the quantitative findings further (Leech & Onwuegbuzie, 2009) (see Figure 1.3).Thus, the research began as deductive, confirmatory and theory-driven and ended with an exploratory phase that was inductive and open-ended (Taber, 2012). The underpinning worldview for such an approach begins with a postpositivist perspective in the initial quantitative project that is bound by empirics; then, a constructivist worldview or stance was adopted for the focus group (qualitative) portion to elicit meanings from participants (Creswell & Plano Clark, 2011). In part, this decision was made in response to a high attrition rate within the survey, and a low response rate to the survey overall. In the following section, the two components comprising this mixed method study is described: a quantitative gap analysis, and qualitative focus groups. It should be noted that mixed method designs continue to develop and at present face criticism concerning: the degree to which it is possible to mix its underpinning paradigms; how methodological rigour is best established; and, whether mixed methods should be lodged within a larger methodological framework (e.g. ethnography) (Creswell & Plano Clark, 2011).

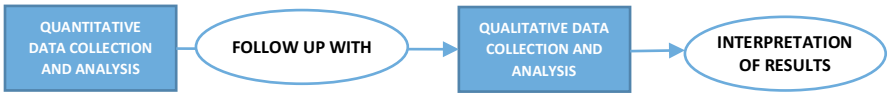

Figure 1.3. Mixed method explanatory sequential design

Gap Analysis

Gap analysis is one way to quantify the nature of the gap between desired and observed levels of competency achievement of nursing students and new graduates; one that provides important information for curricular enhancement. Using existing competency frameworks established by regulatory bodies, an analysis was conducted to

determine the gap between the degree of mastery of selected competencies desired by stakeholders, and the observed level of mastery of these competencies.

Gap analysis arises out of performance analysis, the purpose of which is to identify discrepancies between current and desired or expected performance levels (Matzler, Bailom, Hinterhuber, Renzl, & Pichler, 2004; Rothwell, Hohne, & King, 2007). In essence, the performance gap for each identified item is calculated by subtracting the observed or actual performance level from the desired or expected level of the item in question (Rothwell et al., 2007). If perceived performance exceeds expectations, satisfaction or positive confirmation results; if perceived performance is lower than expectations, dissatisfaction or negative disconfirmation results; and if performance meets expectations, moderate satisfaction or indifference results (Matzler et al., 2004).

There are several significant differences in the use of gap analysis in nursing education as opposed to in customer satisfaction studies. In nursing education, there are more stakeholders, with a greater diversity of perspectives on 'readiness to practice;' there is a greater necessity to collaborate with all stakeholders in the pursuit of excellence; and cost and competitiveness are not the primary concerns, but rather, patient safety is. For these reasons, gap analysis is best carried out in consultation with all stakeholders associated with nursing education. Operationalizing gap analysis is somewhat complicated in health care services, due in part to the diverse interests of the stakeholders, who may have a wide range of agendas and performance expectations (Gomes & Yasin, 2013). This diversity, the need for patient safety, and the fact that

nursing programs work so closely with clinical sites, amplifies the need for close collaboration with stakeholders.

Clark and Estes (2008) describe a gap analysis model consisting of seven steps. The first step in conducting a gap analysis is to define a performance goal. In the case of nursing education, this goal may be a set of competencies that accurately describes and reflects the construct of competence at a particular level such as a new graduate. Developing a valid and reliable instrument can be facilitated through the use of existing competence frameworks and assessment tools, such as those developed by nursing regulatory bodies for credentialing. Using established competencies for a gap analysis promotes uniformity between educational preparation and workplace expectations, and provides a common language between stakeholders.

Gap analysis, while being advantageous for finding areas of strength and weakness in programs, does have some areas that require attention and transparency. First, human perceptions are subjective and often appear vague; as such, there may be considerable variations in respondents' perceptions, resulting in the same words having different perceived meanings (Anitha, 2011; Deng, 2008). This issue has particular relevance for the current study, in which respondents are asked to report both observed and desired performance levels; both of these items rely upon subjective processes.

A second area of awareness is that the competencies upon which the instrument is based must be meaningful, valid and reliable for describing nursing practice, while not being so long that they are daunting to respondents (Abalo, Varela, & Manzano, 2007; Siniscalchi, Beale, & Fortuna, 2008). This particular challenge bears importance to the

present study, in that the 119 ETPCs (College and Association of Registered Nurses of Alberta, 2013a) tend to be fairly subjective, wordy, and not weighted as to *relative* or *proportional* importance to the work of a new graduate. For example, ETPC #10 states that the new graduate "Organizes own workload and develops time-management skills for meeting responsibilities" (College and Association of Registered Nurses of Alberta, 2013a, p. 9), and ETPC #16 states that the graduate "Seeks out and critiques nursing and health-related research reports" (College and Association of Registered Nurses of Alberta, 2013a, p. 9). While the document does not state that a graduate should perhaps pursue one over the other, it would seem counterintuitive for a graduate to pursue #16 instead of #10. As well, chances are the graduate will be focusing most of her or his time and attention developing #10, which does take considerable practice. It is unlikely that a graduate would have workplace or clinical performance issues based on their failure to seek out and critique research, whereas it is quite likely a graduate would face some type of remedial performance requirements if they were not able to manage an RN caseload. The present study addresses this issue by mapping the ETPCs to the content area, using public health and home health competencies as put forth by the Community Health Nurses of Canada (2009a, 2010).

To help overcome the dual problems of subjectivity of assessment and representativeness of the competencies, results should be interpreted and validated in collaboration with key stakeholders. Once the data has been collected and patterns identified, causes and solutions need to be identified. Clark and Estes (2008) categorize causes into three categories: knowledge and skills, motivation, and organizational barriers

(including materials, policies and procedures). Interpreting the findings and developing solutions in consultation with stakeholders is important for nursing education because schools of nursing, regulatory bodies, students, patients, and health care agencies often value different attributes and competencies, while patient safety remains the primary concern. The data from a competence gap analysis can then lead to strategic adjustments in current practices of the school of nursing and the health institution or authority in its student and new graduate preparation to foster smoother transitions from student to graduate nurse. Openly sharing feedback results with all stakeholders to collaboratively arrive at workable solutions can help maximize student and new graduate opportunities to develop competence for professional RN practice.

A unique feature of the present study is the addition of focus groups to further explain, beyond mere measurement, the nature of the competence gap. Focus groups were used to triangulate the data to further understand the views of each respondent group, adding a richness to the data and its meaning for stakeholder groups.

Instruments

In developing the instrument for the present study, existing competence frameworks were utilized. Because the home health and public health competencies (Community Health Nurses of Canada, 2009a, 2010) are not necessarily required for entry-to-practice competence, these were not immediately seen as useful for assessing the achievement of senior nursing students or new graduate nurses. Therefore, the Alberta Entry-to-Practice Competencies (ETPCs) (College and Association of Registered Nurses of Alberta, 2013a) are used as the basis for this study. To ensure that community health

content is captured adequately for the purpose of this study, using the Alberta ETPCs, the Canadian public health and home health competencies (Community Health Nurses of Canada, 2009a, 2010) were mapped conceptually to the ETPCs to ensure a set of attributes were delineated that accurately described and reflected the construct of competence for community health practice at the entry-to-practice level. This mapping document can be found in Appendix D. ETPCs were included in the instrument if:

- 3 or more home care competencies AND 3 or more public health competencies aligned with the ETPC (this process resulted in 35 items), AND
- 2 home care competencies AND 5 or more public health competencies aligned with the ETPC
  OR 2 public health competencies AND 5 or more home care competencies aligned with the ETPC (this process resulted in an additional 8 items).

The selection process was carried out to maximize equal representation of the competencies from both home care and public health. The strongest representation that was equally weighted to home care and public health yielded a total of 35 ETPCs. Ideally, 40 or more items would be a stronger instrument without being cumbersome. Therefore, the next sets of competencies selected had only two (instead of three) competencies in either home care or public health that align with an ETPC, but had five or more aligning in the other. This process yielded a total of 43 ETPCs which strongly cross-reference with the public health and home care competencies. The inclusion process is demonstrated in Appendix D, following the mapping chart.

An online survey was developed, consisting of the 43 top-loading competencies that overlap most heavily between the Alberta Entry-to-Practice Competencies (College and Association of Registered Nurses of Alberta, 2013a), the Home Health Competencies, and the Public Health Competencies (Community Health Nurses of

Canada, 2009a, 2010). The majority of items on the instrument required respondents to indicate the *desired* and *observed* levels of demonstrated student/new graduate competence on a 5-item Likert scale. Likert scale items provided ordinal data regarding the achievement of competencies for an entry-to-practice level registered nurse. The instrument is in Appendix E. Pilot testing with a small sub-sample was conducted to ensure the tool was sensitive regarding the separation levels of the measurement scales (Arbore & Busacca, 2011).

To enhance *inter-rater reliability* (the consistency of two or more raters classifying the same behaviour in the same way) (Clark-Carter, 2010) we asked respondents to make judgemental measures of competence, based on their observations of whether the student/graduate has attained a level of performance (Pangaro & Holmboe, 2008). To enhance inter-rater reliability we ensured that the language of the instrument was clear; ensured that goals and objectives are clearly defined and operationalized for respondents; and pilot tested the tool with a small test sample.

Validity refers to the degree to which what is being measured is what the researchers intended (Clark-Carter, 2010). *Face validity* refers to "the perception which the people being measured, or the people administering the measures, have of the measure" (Clark-Carter, 2010, p. 29). If survey respondents misperceive the nature of the measure, or if respondents do not understand what is being measured or do not believe that the item is an effective measure, the results may be negatively impacted. While clarity in the items being evaluated was important, as was giving respondents enough information to motivate participation, it was also important to not be so transparent about

the hypotheses or hunches that the data was biased (Clark-Carter, 2010). The instrument had good face validity in that it was formed using existing sets of competencies. The Entry-to-Practice Competencies for the Registered Nurses Profession (College and Association of Registered Nurses of Alberta, 2013a) formed the basis for the instrument, and Public Health Nursing Discipline Specific Competencies and Home Health Nursing Competencies (Community Health Nurses of Canada, 2009a, 2010) drew out the areas most heavily weighted for community health nursing practice. This representativeness of traits contributed to the instrument's face validity. Additionally, respondents were asked to rate the instrument in terms of the degree to which respondents thought that the 43 identified competencies reflected the work of a community health nurse in Alberta. A Kruskal-Wallis test found no significant differences in the mean rank between groups and all groups had a mean of 4 on a 5-point Likert agreement scale. This finding suggests that the instrument has good face validity as respondents believed that the identified competencies reflected the work of a community health nurse in Alberta.

Construct validity refers to the ability of a test to assess a theoretical construct. A test with high construct validity will assess the construct well. For example, the proposed study assessed behaviours to measure the more abstract construct of competence, using a convergence of three established sets of competencies that demarcate what an RN should be able to do. *Content validity* refers to the "degree to which a measure covers the full range of behaviour of the ability being measured" (Clark-Carter, 2010, p. 31). The basis of this study was three sets of competencies that have been mapped based on their

overlap in content, to create a reduced list of competencies that are most important in community health practice (Appendix D):

1. **Entry-to-Practice Competencies for the Registered Nurses Profession** (College and Association of Registered Nurses of Alberta, 2013a). The Jurisdictional Collaborative Process "used the results of environmental scanning, literature reviews, and simultaneous stakeholder consultation within each jurisdiction" to renew the Entry-to-Practice Competencies document.
2. **Home Health Nursing Competencies** (Community Health Nurses of Canada, 2010). These were developed by an expert committee involved in national certification and a large advisory group, based initially upon a review of the literature, and organized by the framework of the Canadian Community Health Nursing Standards of Practice (Community Health Nurses of Canada, 2008). (The Standards were developed through an extended process of literature review, environmental scan, cross-Canada focus groups, a Delphi process, and an expert group.)
3. **Public Health Nursing Discipline-Specific Competencies** (Community Health Nurses of Canada, 2009a). These were developed by an expert committee involved in national certification and a large advisory group, based initially upon a review of the literature as a foundation and a Delphi process with public health nursing experts.

The reductive process in this proposed study was accomplished by transcribing the Entry-to-Practice Competencies for the Registered Nurses Profession (College and Association of Registered Nurses of Alberta, 2013a) into the far left column of a three-column table. Each competency was analyzed for its themes, and then competencies from Public Health Nursing and Home Health Nursing (Community Health Nurses of Canada, 2009a, 2010) were analyzed for their themes, and one by one, matched thematically to the ETPCs. Home Health Competencies were coded by unique identifiers so that they correlated back to the original document, and then entered into the table's middle column, according to the ETPCs with which they had the most conceptual overlap. Likewise, Public Health Competencies were also coded so that they correlated back to the original document, and then they were individually analyzed and entered into the table's

far right column. The 43 top loading ETPCs—those with the heaviest weighting of community health competencies from both Home Health and Public Health—were extracted for use in the data collection tool, which can be found in Appendix E.

Convergent validity refers to the instrument's ability to measure the same concept as a different measurement method, with similar results. Unfortunately, there was no equivalent testing method available, as objective structured clinical examinations (OSCEs) are both resource intensive and costly and would suffer from the same threats to validity as the proposed instrument. Licensure exam (at the time of the study, the CRNE) results are not available from the Canadian testing service, and the only other mechanism for comparison of concept measurement would be having respondents also complete a series of CRNE-style questions, which is cumbersome and not without its own validity issues.

Discriminant validity refers to the ability of an instrument to differentiate concepts and levels of performance, such as whether the instrument can distinguish between expert and student groups and between experts at different stages of their progression. Because the instrument can divide groups of respondents by type (i.e. student, new graduate, public health nurse, home care nurse, faculty), statistical analyses could compare multiple dependent variables and post-hoc comparisons between groups, establishing discriminant validity.

External validity refers to "the extent to which the inferences that are drawn can be generalized to other conditions or populations" (Myers, Well, & Lorch, 2010, p. 16). The study is generalizable to most Canadian provinces (with the exception of Quebec,

which structures professional nursing and regulatory processes differently than the rest of Canada). In reviewing the literature concerning the state of community health clinical education in Canada, it is clear that the shortage of placements and dramatic rise in the use of non-traditional placements is not unique to Alberta (Cohen & Gregory, 2009; Pijl-Zieber & Grant Kalischuk, 2011; Reimer Kirkham et al., 2005b; Valaitis, 2008). Additionally, using national community health competencies means that the study findings will likely have value outside of Alberta.

Qualtrics Research Suite®, an online research survey tool, was used to collect and store data. The online survey was posted and activated, reviewed by the investigative committee, and then pilot-tested by a small test sample from the projected sample. Modifications were made to ensure complete understanding by potential respondents. Throughout the duration of the survey, which was left open for 8 months of active recruitment, both responses and attrition were monitored and points of attrition scrutinized and mitigated. The data collection instrument is in Appendix E. Amendments made to the instrument during data collection are listed in Appendix F.

Participants and Recruitment

Potential respondents were in Alberta *and* were:

- Practicing community health nurses (over 2 years of experience and exposure to new graduates and/or students in community health): public health nurses, home care nurses, and community health centre nurses, as these roles make up the largest group of community health nurses (Underwood et al., 2009).
- Managers of practicing community health nurses.
- Faculty teaching community health nursing.
- Senior baccalaureate nursing students who have had a community health clinical rotation *or* are preceptoring in community health.
- New graduates (0-6 months practice) working in community health.

Potential respondents were determined by phone consultation, mail-out letters, and posters to: (1) Deans of university schools of nursing in Alberta: to recruit faculty that teach community health nursing content, and to recruit senior or preceptor students; and, (2) Alberta Health Services research office to gain access to managers of community health offices: to recruit community health nurses and managers who have a role in relation to new nursing graduates or students in community health. An invitation to participate was sent to recruit participants (Appendix G), with the research information sheet (Appendix H) and a website was developed with study information. Potential respondents were reached through emails, forwarded through appropriate channels after ethical, administrative and operational approvals. A lottery style incentive was offered. Follow up emails were sent to ascertain comprehension and interest. The study remained open for 8 months and 3 email reminders were sent to those eligible to participate.

An adequate sample size was pursued to ensure statistical power so that accurate estimates could be made regarding the impact of negative competency performance on dissatisfied respondents, as well as the impact of exceptional competency performance on satisfied respondents (Arbore & Busacca, 2011). A sample size of 719 respondents was sought ($\alpha = .05$, $\beta = .15$), representing around 10% of registered nurses working in community health areas in the province of Alberta and 10% of senior nursing students and new nurse graduates in community health areas in Alberta. However, of a paltry 249 respondents, only 75% completed the survey, resulting in only 187 valid cases despite multiple attempts to resend the survey through the appropriate channels.

The online survey had a low response rate, despite multiple attempts to increase it, and a high attrition rate (25%). Therefore, two actions were taken. First, paper-based surveys were generated and completed in person at two schools of nursing (students and community health faculty) to which I had access. Surveys were distributed to the target population via the course leads of senior nursing courses once ethical, administrative and operational approvals were obtained. Respondents were given a $10 gift card to either Starbucks Coffee or Tim Horton's in exchange for their completed survey. Receipt of the completed survey implied consent.

Secondly, focus groups were conducted to triangulate the data, based on a parallel sample of: two student groups (each at a different school of nursing in Alberta, within a different health authority zone); two faculty groups (each at a different school of nursing in Alberta, within a different health authority zone); one home care nurse group and one public health nurse group, within one health authority zone. The same channels were used as for the quantitative process, using deans, managers and key informants to find respondents who could respond to the questions. Focus groups were audiorecorded and transcribed and then analyzed using NVivo 10 to manage the data. Data was subjected to a thematic analysis (Clark & Braun, 2013) and coded into categories and organized into themes. Inferences were drawn after the quantitative and qualitative phases of data analysis, allowing the interpretation of the connected results and draw meta-inferences related to how the qualitative data helped describe the gap identified in the quantitative phase.

It was immensely beneficial for stakeholder participants to reflect on their values with regards to graduate nurse competence and to consider that the values of other stakeholder groups may differ. There were differing opinions regarding many points, resulting in robust and fascinating findings that are reflected in the results papers (see Chapter 4: Paper 3, and Chapter 5: Paper 4). A full ethics amendment was obtained from the University of Alberta, the University of Lethbridge, and Alberta Health Services South Zone prior to the addition of focus groups. The Letter of Invitation for the focus group is in Appendix I; the Research Information Sheet for the focus group is in Appendix J; the Consent Form for the focus group is in Appendix K; and a recruitment poster for the focus group is in Appendix L. Prompting questions for the focus groups are in Appendix M.

Data Analysis and Management

Once the survey period was complete, the survey was closed and the data downloaded for analysis using Statistical Package for the Social Sciences (SPSS) v. 21 for analysis. Additional paper survey data was entered manually into SPSS. Text data from "other" text entry options was examined for their suitability for categorization within existing category definitions (Groves et al., 2009).

Focus group data was audio-recorded and transcribed. NVivo v. 10 was used for analysis. Textual data from the final unstructured and open-ended comments and focus group data was also subjected to a thematic analysis and coded into categories during analysis, seeking the minimum grouping threshold to avoid an overwhelming number of small categories. To ensure that conflation of text did not occur, a table or log file was

created to track changes between original text and the conflated version, to ensure the original text and its intent was retained (Schmidt, 2010). Poignant textual data and explanatory accounts were also retained in support of findings. Thematic analysis arises from a realist/essentialist philosophical perspective (Vaismoradi et al., 2013) and is useful for identifying, analysing and reporting themes within qualitative data (Braun & Clarke, 2006; Clarke & Braun, 2013, 2014). The thematic analysis process involves description and interpretation, an emphasis on context, mapping the concepts and codes, and a non-linear approach (Vaismoradi et al., 2013).

While inferences were drawn after the quantitative and qualitative phases of data analysis, interpreting the connected results involved drawing meta-inferences relating to how the qualitative data helped elucidate the problem identified in the quantitative data (Creswell & Plano Clark, 2011). In other words, the qualitative data elucidated the nature of the performance gap identified in the quantitative portion of the study. The samples had a high level of integration between the quantitative and qualitative samples, permitting the drawing of appropriate meta-inferences and enabling good transferability (Collins & Onwuegbuzie, 2013). A variable-oriented analysis consisted of identifying relationships and themes that cut across cases and among entities and yielded rich findings that supported both the qualitative and quantitative findings (Onwuegbuzie, Slate, Leech, & Collins, 2009). Furthermore, statistical tests run on the quantitative data collected from focus group participants (questions that were experience and process oriented) supported the quantitative findings of the survey. Such triangulation of data

produced a rich dimensional understanding of the topic (McLafferty, Slate, & Onwuegbuzie, 2010).

Ethics

This study received ethical approval from the following Ethics Review Boards, and administrative and operational approvals from the relevant departments, as indicated below. Sites with an asterisk (*) indicate that an ethics amendment and additional approvals were acquired for the qualitative phase of the study.

- University of Alberta*
- University of Lethbridge*
- University of Calgary
- Mount Royal University
- Medicine Hat College
- Red Deer College
- MacEwan University
- Alberta Health Services—North Zone
- Alberta Health Services—Edmonton Zone
- Alberta Health Services—Central Zone
- Alberta Health Services—Calgary Zone
- Alberta Health Services—South Zone*

Informed consent was obtained prior to any data collection, providing information about the study, describing the nature of the participant's involvement, and outlining what the participant's time commitment would be. Participant consent was obtained by checking an informed consent checkbox prior to proceeding to the survey. Selecting this checkbox indicated willingness to participate and that they were informed, prior to proceeding, that they had the right to withdraw at any time and to choose not to answer any questions.

There were no obvious dangers for participants. Confidentiality of the data was maintained through password-protected data collection software. Any identifying information was stripped from the data prior to analysis. Participants were informed that only aggregate data and qualitative data (severed from revealing personal identity) would be shared in the dissemination of the study results. Individual participants' anonymity was maintained to the fullest extent possible, and data was stored separately from any personal identifiers within Qualtrics Research Suite, SPSS and NVivo. All data was secure within Qualtrics, as this program requires a password; data within SPSS and NVivo was secure because the host computer requires a password for entry. Captcha verification was used at the end of each survey to ensure real people were completing the survey, not bots.

Challenges Encountered in Conducting a Cross-Province Multi-Site Study

Several challenges were encountered in the course of conducting this multi-site, cross-province study. First, obtaining ethical, administrative, and operational approval from multiple sites was a challenge. One school of nursing—despite having a reciprocal agreement in place—actually required me to have their own principal investigator take on the study, effectively removing me and the supervisory committee from the study. The process was arduous and involved multiple forms and processes. Some health zones were not digitized in their ethics approval process and had lengthy non-formatted Word documents for me to complete (and format as I went along). Considering the reciprocal agreement has been on the table for some years now and the provincial process is supposedly harmonized, I was disappointed in how disjointed the process was. That said,

I am very thankful for those faculty and staff who were helpful to me in the process of securing all approvals.

Dissemination of Findings

The findings of this study have been shared at the Western Northwestern Region of the Canadian Association of Schools of Nursing's (WNRCASN) annual conference, on February 19, 2015. The findings will also be shared at the Community Health Nurses of Canada Annual Conference in June, 2015, although the focus of this presentation will be on the gap between the reality and the ideals of community nursing practice. Four papers have been written (Chapters 2, 3, 4 and 5) and are in various stages of review and publication. This dissertation will also be posted to my professional web site.

I have created a document, *Tips for Teaching and Organizing Community Health Practice/Clinical Courses: Practical Tips for Instructors, Administrators, and Organizers of Innovative/Non-Traditional Community Health Experiences*. This document builds on the Canadian Association of Schools of Nursing Sub-Committee on Public Health (2010) document *Guidelines for Quality Community Health Nursing Clinical Placements for Baccalaureate Nursing Students* and is also readily available on my professional website (http://scholar.ulethbridge.ca/em_pijlzieber/) and is located in Appendix N. I created this document as a living document so that I can update it as contexts and information change and as new opportunities arise.

Organization of Dissertation Papers

Four manuscripts and one other document have been prepared. In the first paper, *Enhancing the Development of Community Health Competencies in Undergraduate*

Nursing Education, I explore the role of clinical practice rotations in nursing education in general, and then discuss the role and pedagogy of community health practice rotations in specific. I question the degree to which the goals of community health practice education are being met in undergraduate schools of nursing. I suggest that by re-framing the issues in terms of general and specific competencies, educators can find ways to improve students' readiness for practice in community health practice areas. This manuscript has been submitted for peer review.

The second paper is entitled,*Assessment of Student Competence in Community Health Nursing Practice Courses.* The purpose of this discussion paper is to examine the intersection of these two issues: the non-traditional rotation and the assessment of competence. In this paper I articulate the unique challenges for community health nursing educators, and suggest potential solutions to enhance the assessment of student competence in community health rotations. This manuscript has been submitted for peer review.

The third paper represents the findings of this mixed method study and is entitled *Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Mixed Method Gap Analysis.* It has been submitted for peer review.

The fourth paper highlights additional qualitative findings from the study and is entitled *Undergraduate Community Health Nursing Clinical Experiences: Disconnects in Pedagogy and Practice.* It has been submitted for peer review.

Conclusion of the Dissertation

The concluding section of this dissertation consists of a brief discussion of the findings, what this study brings to our understanding of the topic, and the limitations of the study. As well, I suggest recommendations for enhancing student competence in community health practice experiences. This conclusion represents a more theoretical recommendation overall with questions to prompt further reflection on ways to enhance undergraduate nursing education.

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Chapter 2: Paper 1: Enhancing the Development of Community Health Competencies in Undergraduate Nursing Education

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Abstract

It is believed widely that in Canada and in the West in general, nursing practice and health care are moving from acute care into the community. Concomitant with these predictions has been a shift in how undergraduate nursing students learn about and experience community health clinical practice. Many nursing programs are using non-traditional or innovative placements to teach the principles of community health practice. In this paper, we explore the role of clinical practice rotations in nursing education, generally, and then discuss the role and pedagogy of community health practice rotations, specifically. Clinical practice is a fundamental aspect of nursing education as it prepares students for entry level competence within professional practice roles, a prerequisite for safe, effective, and ethical care. We question the degree to which the competencies of community health practice are being developed in undergraduate nursing students. We suggest that by re-framing the issues in terms of general and specific competencies, educators can find ways to improve students' readiness for practice in community health practice areas.

It is believed widely that in Canada and in the West in general, nursing practice and health care are moving from acute care into the community. It has been predicted that in the years to come there will be an increased focus on addressing the determinants of health and on health promotion, although not as a replacement for illness care and supportive care, which will remain a priority (Canadian Nurses Association, 2009). Villeneuve (2006) predicted that by the year 2020, 60% of nurses will be working in the community. Concomitant with these predictions has been a change in how undergraduate, pre-registration nursing students learn about and experience community health clinical practice. With the shortage of community placements and fewer community nurses able to take students, many Canadian nursing programs are using non-traditional or innovative placements and engaging students in non-nursing activities to teach the principles of community health practice. But do educators know if undergraduate community health practice experiences are achieving the intended goal of entry-to-practice competence? In this paper, we explore the role of clinical practice rotations in nursing education, generally, and then discuss the role and pedagogy of community health practice rotations, specifically. We question the degree to which the goals of community health practice education are being met in undergraduate schools of nursing. We suggest that, by re-framing the issues in terms of general and specific competencies, educators can find ways to improve students' readiness for practice in community health practice areas.

Clinical Practice Rotations: The Heart of Nursing Education?

A mix of theoretical and practice opportunities form the foundation of nursing education programs (Hoe Harwood, Reimer-Kirkham, Sawatzky, Terblanche, & Van

Hofwegen, 2009). Clinical practice rotations are an established tradition and pedagogy in nursing education; in Canada, clinical rotations are generally categorized into acute care, long term care, and community care (Smith, Spadoni, & Proper, 2013). Undergraduate nursing education programs leading to initial entry to practice as a registered nurse in Canada have a required number of clinical hours and experiences to be completed involving individuals, families, groups, communities, and populations (Canadian Association of Schools of Nursing, 2011; Canadian Association of Schools of Nursing Task Force on Clinical/Practice Education, 2004b; College and Association of Registered Nurses of Alberta, 2005; Smith, Spadoni, et al., 2007). Usually these experiences include: acute medical and surgical nursing, perinatal nursing, mental health nursing, pediatric nursing, geriatric nursing, and community health nursing (Canadian Association of Schools of Nursing Task Force on Clinical/Practice Education, 2004b; Smith, Spadoni, et al., 2007). The exact number, type and location of clinical experiences is determined by the school of nursing and approved by provincial approval processes (Black et al., 2008; Canadian Association of Schools of Nursing Task Force on Clinical/Practice Education, 2004b; College and Association of Registered Nurses of Alberta, 2005, 2013).

Clinical practice is a fundamental aspect of nursing education as it prepares students for entry level competence within professional practice roles, a prerequisite for safe, effective, and ethical care (Smith, Seeley, et al., 2007). Practice experiences provide opportunities for nursing students to access the world of professional nursing in a limited but supported way; as such, clinical rotations are places in which education and practice meet (Hodges & Kline, 2005). They provide a bridge between theoretical education and

clinical education, and between the academic experience and practice roles. A graphic of the location of clinical rotations in nursing education is depicted by the first author in Figure 2.1 below.

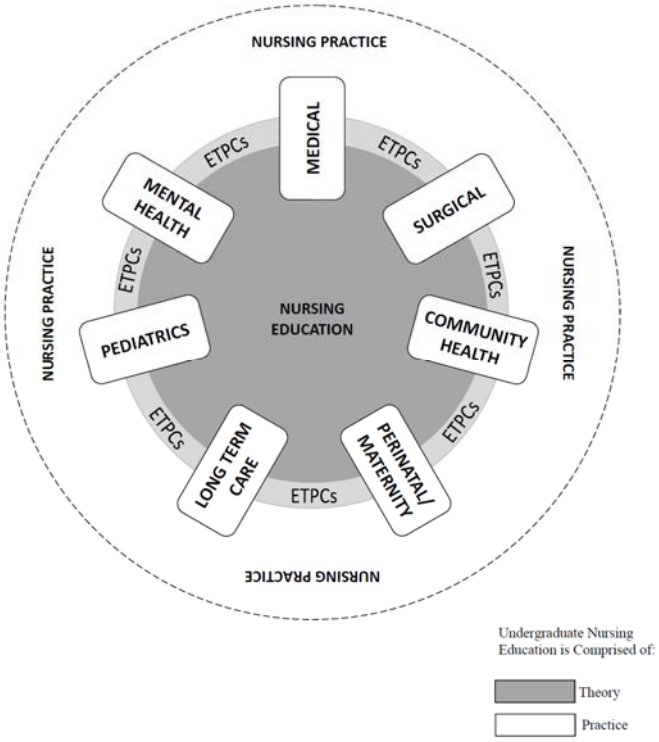

Figure 2.1: Location of clinical rotations in baccalaureate nursing education, positioned to bridge education and practice by exposing students to the professional role of the registered nurse in various practice areas.

Community Health Clinical Practice Education in Canada

Community health practice experiences are a standard part of most nursing education programs (Cohen & Gregory, 2009a), along with the already well-established acute care practice rotations. Furthermore, the Canadian Association of Schools of Nursing Sub-Committee on Public Health (2010) supports a strong community health clinical practice component in schools of nursing, so that students can acquire the requisite knowledge and skills for community health nursing practice. Traditionally,

student practice placements in community health settings have employed a one-to-one preceptorship model within the sectors of public health and home care, the two areas that comprise the largest portions of community health nurses, employing 34% and 19% of community health nurses, respectively (J. Underwood et al., 2009). At present, there are a wide variety of community health clinical rotations occurring at Canadian schools of nursing, ranging from preceptored experiences with public health or home care nurses, to population health experiences in non-traditional settings (Cohen & Gregory, 2009a).

Community health practice courses are diverse across Canadian schools of nursing (Cohen & Gregory, 2009a). Some undergraduate nursing programs have distinct demarcations between clinical rotations, whereby community health remains separate from the other rotations. Other programs institute community health experiences as part of, or at the end of, acute care experiences. A pediatric rotation, for example, may include both acute care and public health or home care components. Due to the number of clinical hours and types of experiences that are determined by individual schools of nursing, in conjunction with local health regions and provincial regulatory bodies, considerable variety exists within and between these experiences across Canada (Canadian Association of Schools of Nursing [CASN] Task Force on Public Health Education, 2007; Canadian Association of Schools of Nursing Task Force on Clinical/Practice Education, 2004a; Cohen & Gregory, 2009a).

Over the past decade or more, many baccalaureate schools of nursing have used non-traditional placements for undergraduate community health practice rotations (Cohen & Gregory, 2009a; Hoe Harwood et al., 2009). These placements, which often are

without a registered nurse on site and lack opportunities for students to learn traditional nursing skills, include schools, homeless shelters, workplaces, correctional centers, shopping malls, police stations or even places of worship (Cohen & Gregory, 2009a; Diem & Moyer, 2005; Falk-Rafael, 2005; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005a, 2005b). In Canada, these non-traditional experiences are more common than traditional preceptored placements in public health and home care (Cohen & Gregory, 2009a; Hoe Harwood et al., 2009). In these non-traditional placements, nursing students are engaged in a variety of activities that highlight one or more common themes: critical reflection, healthy public policy, community partnerships, leadership development, advocacy, health education, and social justice; all within a population health and/or community development framework (Cohen & Gregory, 2009a, 2009b; Reimer Kirkham et al., 2005a, 2005b).

Numerous factors have caused a shift in the way community health clinical rotations have historically been delivered in Canadian undergraduate pre-registration nursing programs. First, the number of available community health preceptors in home care and public health placements is outstripped by the number of students requiring these placements (Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010; Canadian Association of Schools of Nursing Task Force on Clinical/Practice Education, 2004b; Cohen & Gregory, 2009a; Ravella & Thompson, 2001; Reimer Kirkham et al., 2005a, 2005b; Schofield et al., 2011; Valaitis et al., 2008).

Second, many Canadian schools of nursing are oriented towards community *health* nursing, as opposed to community-*based* nursing. While community-*based*

nursing focuses on acute, rehabilitative and chronic care at the individual level, community *health* nursing focuses on health promotion and illness/injury prevention at the population level (Cohen & Gregory, 2009a). Non-traditional placements provide nursing students the opportunity to work at the population level, incorporate the principles of primary health care, enact social justice and equity, increase access to services, and address the determinants of health (Hoe Harwood et al., 2009; Reimer Kirkham et al., 2005b; Wade & Hayes, 2010).

A third factor supporting the use of non-traditional experiences in community health is that Canadian nursing curricula are based on competency frameworks, not task lists or content-driven clinical courses. In their report, the Canadian Association of Schools of Nursing [CASN] Task Force on Public Health Education (2007) found that there was general agreement among key stakeholders in public health nursing education for key areas to comprise undergraduate curricula: primary health care, epidemiology, determinants of health, population health promotion, community development, program planning and evaluation, and partnership/collaboration expertise in building relationships. In this way, non-traditional clinical rotations in community health seem to be a promising arena in which to learn community health competencies.

Are Students Developing Competence for Community Health Nursing Practice?

In Canada, a competency approach to professional practice is legislated as a way to ensure accountability (Black et al., 2008), to justify control over licensing, and limit professional autonomy to protect the public. Canadian undergraduate nursing education programs and Canadian registered nursing practice are based on *competency frameworks*,

representing a shift away from content-based, task-focused curricula (Black et al., 2008; Canadian Association of Schools of Nursing, 2011; International Council of Nurses, 2003). Entry-to-practice competencies for registered nurses delineate the competencies that are expected of the new graduate from an approved nursing education program; these are generated at the provincial level. These competencies are also used in nursing education curricula development, in program approval, and to inform the public and employer of the practice expectations of entry-level registered nurses (College and Association of Registered Nurses of Alberta, 2013). These entry-to-practice competencies represent broad competencies applicable to basic, generalist practice at the new graduate level.

As a result of the role of nurses in community settings that tends to be less clear than their acute care counterparts (Ladhani, Stevens, & Scherpbier, 2014), some nursing specialty groups in Canada and the United States have developed competencies unique to certain areas of practice, including home health (Community Health Nurses of Canada, 2010) and public health nursing (Community Health Nurses of Canada, 2009; Quad Council of Public Health Nursing Organizations, 2011). These specialty competency documents identify the knowledge, skills and abilities required for practice in these specific areas of nursing. Recently, a set of entry-to-practice public health competencies was also released (Canadian Association of Schools of Nursing, 2014), applicable to new graduates working in public health in Canada. These competency frameworks can be used to guide practice and inform education related to community health nursing education.

Given the overall challenges of securing appropriate undergraduate practice opportunities, the Canadian Association of Schools of Nursing Sub-Committee on Public Health (2010) has delineated important guidelines to foster quality clinical experiences for students. These guidelines help educators select and shape clinical experiences to foster students' developing competence in community health; however, they do not indicate exactly how competence is to be developed, nurtured or assessed. So, what does it mean to be developing entry-to-practice competence for community health nursing practice? Well, that depends.

Generalist versus Specialist Preparation for Practice

There is an ongoing debate within nursing education concerning the nature of "generalist" competence and whether graduates should be in possession of speciality competencies, since many full time professional nursing roles occur in speciality areas (Eggertson, 2013). Community health settings such as public health are one of these speciality areas. To what degree should new baccalaureate nursing graduates be prepared to enter the role of a community health nurse? A generalist nursing education, by definition, is one that does not seek to have students develop any specific competencies. Despite the fact that the very purpose of a competency approach is to enhance health professions student performance and to meet workforce expectations (Ladhani, Scherpbier, & Stevens, 2012), the theory-practice gap according to Benner et al. (2010) is wider than ever in all areas of nursing practice, including community health practice areas (Schofield et al., 2011). While the role demands of community health nursing are growing, the literature indicates that nursing education has not kept pace with the

requisite preparation of nursing students for these encompassing and autonomous roles (Schofield et al., 2011).

To better appreciate the complexity of new graduate competence, perhaps it is prudent to explore the two domains of competence: general and specific. *General* competencies are required of all nursing practice roles and include essential skills, knowledge and abilities necessary for nursing practice (Eraut, 1994; Underwood, 2007, p. 1). A *specific* competency indicates what a competent nurse can do within a specific clinical area of practice (Eraut, 1994). A specific competency exists in relation to a domain or role; for example, in the case of public health it could be the act of discussing childhood immunization with a hesitant parent. Specific competencies may also refer to clinical procedures commonly carried out by public health, home care, and other community health nurses.

In the preparation of new graduates there is likely disagreement concerning the degree to which undergraduate clinical experiences help students gain *general* versus *specific* competencies. In the Canadian Association of Schools of Nursing [CASN] Task Force on Public Health Education (2007) survey, the two areas that were most highly contested among key stakeholders were related to the acquisition of specific community health competencies by nursing students—in particular, specific nursing knowledge and skills for practice (such as immunizations and physical assessment). The fact that the need to teach specific competencies is a contentious issue among nursing leaders, educators, and practitioners indicates a schism in values and beliefs about the role of undergraduate nursing education.

All community health clinical experiences do not provide the same opportunities for students to develop competence. Which specific community health competencies students need to develop is largely dependent upon the type of community practice experience in which they are engaged; these experiences widely vary between and within programs in Canada (Cohen & Gregory, 2009a). Different demonstrations of competence are to be expected from students in different contexts, and some locations only provide opportunity for the development of general, not specific, competencies. Non-traditional community health experiences create a competency conundrum, since students are trying to prepare for community health nursing roles without ever practicing as, participating in, or viewing the actual work of, a community health nurse. Oftentimes, students are only exposed to non-traditional experiences that do not offer opportunities for students to develop knowledge and skills that are uniquely nursing, for example, competencies specific to the professional roles of public health nursing or home care nursing (Cohen & Gregory, 2009a). To what degree the development of general competence fosters or enables later development of specific competence has not been established. In other words, being in possession of general competence at graduation, and needing to develop competence in speciality areas, might not be adequate preparation for a smooth transition to professional practice.

Overall, strong empirical evidence indicating the degree to which community health clinical rotations are providing students with opportunities to develop specific community health competencies is lacking. Most of the literature assessing undergraduate nursing students' achievement of community health competencies is qualitative or merely

descriptive, or refers to the development of general competencies which may not even be specific to nursing roles (Brosnan et al., 2005; Francis-Baldesari & Williamson, 2008; Hjälmhult, Haaland, & Litland, 2012; Kirkham, Harwood, & van Hofwegen, 2005; Laplante, 2007; Lasater, Luce, Volpin, Terwilliger, & Wild, 2007; Ravella & Thompson, 2001; Van Doren & Vander Werf, 2012). The one published Canadian study that evaluates students' competence explores the attainment of general competencies, not specific competencies for public health (Diem & Moyer, 2010).

Ideal versus Real World Practice

Another issue regarding nursing students' development of competence for community practice is that the degree of uptake of competency frameworks in Canadian community health areas is unknown. There are many reasons why uptake of competency frameworks might lag behind in the practice area. One reason is that organizational change takes time. Another reason might be that organizational constraints do not permit nurses working to their full scope of practice. Polivka, Valedes Chaudry, and Jones (2014), in an American study exploring the congruence of public health nursing job descriptions with national competency frameworks, found that overall, competencies were poorly and inconsistently reflected in position descriptions. They found that less than half of established public health competencies were addressed in position descriptions, and three-quarters of the position descriptions in public health were not reflective of competencies. This disconnect suggests that expectations of public health nurses do not address the skills that reflect the competencies, and that job descriptions in public health do not fully reflect the competencies expected of baccalaureate nursing

graduates. This disconnect can widen the theory-practice gap and make transition to community health nursing practice awkward for new graduates.

While the first public health nurses in Canada and the United States viewed their mandate as acting on the determinants of health (Abrams, 2008; Kulbok & Glick, 2014; MacKay, 2005), today's public health nurse is often forced by workload to focus exclusively on measurable and clearly demarcated tasks that occur at the level of the individual (Hemingway, Aarts, Koskinen, Campbell, & Chassé, 2013). Loftier ideals, as indicated in competency frameworks for community practice, may guide nurses in their intentions but can only be accomplished off the sides of their desks. Position descriptions and daily job requirements simply do not seem to permit the time or resources to act on the broader determinants of health in a systematic manner (Ladhani et al., 2014; Schofield et al., 2011). Resource allocation demands a heavy emphasis on a biomedical approach and on attending strictly to measurable task requirements as put forth by the employer (Hemingway et al., 2013; Ladhani et al., 2014).

While a similar study has not yet been conducted in Canada, Polivka et al. (2014) may shed light on the academic-practice disconnect as it pertains to graduates entering public health nursing. The Canadian Association of Schools of Nursing [CASN] Task Force on Public Health Education (2007), in their pan-Canadian survey, found that in general, 95-100% of baccalaureate nursing programs covered the majority of public health competencies in their curricula. If schools of nursing employ these competency frameworks in preparing students but practice areas are unfamiliar with them, there is likely to be a greater perceived theory-practice gap than actually exists. The link between

students' inculcation in upstream ideals and nursing practice in downstream realities is unclear; perhaps the upstream ideals form a foundation for downstream practice, perhaps they cause disillusionment and a theory-practice disconnect.

The Goal of Nursing Education

A third issue regarding whether nursing students are developing competence for community health roles concerns the goal of nursing education. Indeed, the matters of developing general versus specific competencies, and ideal versus real world practice, are part of a larger question around for what schools of nursing should be preparing students: actual practice, for the licensure exam, or for a future practice that has yet to materialize.

By definition, a competence-based approach is one psychological approach to employability, with the implication being that by mastering competencies, individuals are more employable (Vanhercke, Cuyper, Peeters, & Witte, 2014, p. 598) and more likely to be retained in the workplace (Duclos-Miller, 2011). Thus, competency-based education should technically be preparing students for actual nursing practice. However, current evidence is mixed and contradictory depending on how readiness is measured. The unfortunate overall finding is that the theory-to-practice gap is wider than ever and that significant challenges exist related to the application of knowledge to real world clinical nursing practice (Benner, Sutphen, Leonard, & Day, 2010; Canadian Association of Schools of Nursing [CASN] Task Force on Public Health Education, 2007; Duchscher, 2008; Wiles, Simko, & Schoessler, 2013). This finding may be related to curricula designed to focus on the development of general competencies at the expense of specific competencies for practice. Certainly this is the case in community health; these specific

competencies are not adequately addressed in undergraduate curricula (Schofield et al., 2011), with its focus on generalist preparation. Perhaps a discussion needs to occur between academe and practice areas regarding the degree of undergraduate preparation required versus the amount of orientation provided in the workplace.

On the other hand, if the goal of nursing education is to prepare students for the licensure exam, a different problem presents itself. With Canada's recent adoption of the American NCLEX-RN, a host of challenges may be at hand for educators. While the Canadian Registered Nurse Exam (CRNE) was community health focused and competency based (both characteristics aligning with most Canadian schools of nursing curricula), the NCLEX-RN is based on task-analyses of where most graduates work, which is acute care. At present, there is no community content represented by the NCLEX-RN (National Council of State Boards of Nursing [NCSBN], 2013). Teaching to the test, then, would involve minimizing or deleting community health courses and content from Canadian curricula and instead focusing on acute care nursing roles and acute care-specific competencies. It is doubtful whether many Canadian faculty at schools of nursing would favor a regression to an acute care-only curriculum.

Finally, if the goal of nursing education is to prepare graduates for a more ideal health system that has yet to materialize, one that focuses on the determinants of health and health promotion at the population level, then established competencies might be useful in the preparation of registered nurses. At this time it is unclear whether community health ideals, with their focus on prevention and health promotion, will ever be realized in an ongoing climate of fiscal austerity and government preoccupation with

the funding of acute and curative care. It is also unclear from where community health nurses will come to meet the growing need for community care, which is predicted to increase without a decrease in the acute sector. It is unclear whether a time will come when the ideals we teach in community health will be a better match to practice realities and possibilities.

Bridging the Gap in Community Health Practice Experiences

To address some of the on-the-ground challenges for nursing educators who assess students' developing competence in non-traditional community health settings, we offer two suggestions. First, general and specific competencies must be located and clearly defined in nursing curricula. Links between the two, and opportunities to develop them, should be clearly delineated for community health experiences. A useful exercise might be mapping the general competencies to be developed in the experience to the specific competencies to be developed. Expectations should be clearly outlined for faculty, students, and hosting agencies so that everyone is aware of the focus of the experience. While providing clinical placements to cover the full range of specific competencies for community health nursing is not realistic, by situating student experiences to align with these roles and settings, specific competencies are more likely to be developed.

Second, community health clinical educators need to find ways to determine if, in fact, students are competent, a challenge given the nature of competence and the types of activities students carry out in non-traditional experiences. By articulating observable performances through which students can demonstrate the competencies, assessment

becomes a more objective enterprise. Competencies are ideas, not actions or objective phenomena, in themselves; they need to be demonstrated through actual behaviours to be observed and measured in a reliable way (Lurie, 2012). A solution to the assessment problem suggested by ten Cate and colleagues is through the articulation of 'entrustable professional activities' (EPAs). EPAs are "responsibilities that faculty entrust to a trainee to execute, unsupervised, once he or she has obtained adequate competence" (ten Cate, 2014, p. 691). These activities are observable and measurable and represent units of work. Whereas competencies describe an individual's abilities, EPAs represent how they are demonstrated in practice (ten Cate, 2005; ten Cate & Scheele, 2007; ten Cate & Young, 2012). By clearly articulating what is expected of them, students' professional development and educators' assessment of students' developing competence can be more objective, accurate, and helpful.

Is it time to evaluate how we 'do' practice education in Canadian schools of nursing? Is it time to evaluate the 'products' of nursing education in Canada in terms of the development of core, general and specific competencies? Is nursing practice, with its vast array of practice requirements, outstripping education's ability to deliver sufficiently competent graduates? Is it time we re-evaluate the role of community health nursing practice courses in the development of general and specific competencies for practice? And is it time to re-open a national conversation on the sufficiency of graduates who are in possession of general competencies? We think so. It has been decades since a formal review of nursing education has occurred in Canada. With the theory-to-practice gap widening, increased demands placed on new nurse graduates, and shifting priorities in

Canada's health care system, the time is ripe for asking how students will be prepared for practice in community health areas—given that, apparently, this is where nursing is headed.

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Chapter 3: Paper 2: Assessment of Student Competence in Community Health Nursing Practice Courses

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Abstract

Community health clinical practice experiences present unique opportunities for students to learn the foundations of community nursing practice and also unique challenges for assessment of student competence. The difficulty of accurately assessing student competence in community health rotations seems to arise from two issues: the nature of competency frameworks, and the nature of the community health rotation. The purpose of this discussion paper is to examine the intersection of these two issues and articulate the unique challenges for undergraduate community health nursing educators. Many of the issues with assessing students' developing competence in community health nursing can be mitigated through the use of existing guiding documents in the structuring of the experience and execution of the assessment. Furthermore, by articulating what students actually do in the clinical experience as entrustable professional activities, and then working backward to the competencies, can make the assessment process more concrete and accurate.

Assessment of Student Competence in Community Health Nursing Practice Courses

As a nurse educator in community health practice courses, I often hear students express difficulty understanding how they are evaluated in a clinical rotation such as community health. The evaluation of student competence has some unique features that differentiate it from student evaluation in acute care experiences: settings are widely diverse; nursing activities often lack the concrete, measurable and observable elements seen in acute care practice experiences; and the geographic distribution of students, combined with often remote supervision. Furthermore, clinical evaluation tools often fail to capture the relational, process-oriented and abstract nature of community practice rotations. The difficulty of accurately assessing student competence in community health rotations seems to arise from two issues: the nature of competency frameworks, and the nature of the community health rotation. The purpose of this discussion paper is to examine the intersection of these two issues— the community health clinical rotation and the assessment of competence—and, articulate the unique challenges for community health nursing educators, and suggest potential solutions to enhance the assessment of student competence in community health rotations.

BACKGROUND LITERATURE

Undergraduate Community Health Clinical Practice Rotations

In Canada, undergraduate community health clinical rotations are diverse. Practice exposures range from preceptored experiences in public health, primary care, and home care, to non-traditional experiences. With the shortage of community placements and fewer community nurses able to take students, many Canadian nursing programs are using alternative, non-traditional, or innovative placements and engaging students in activities to

teach the principles of community health practice (Canadian Association of Schools of Nursing [CASN] Task Force on Public Health Education, 2007; Cohen & Gregory, 2009). These non-traditional sites are generally not organizationally affiliated with the health care system and using a service learning approach to enable students to gain an understanding of holistic care, social justice, diversity, poverty, equity, community development, and the impact of the social determinants of health (Hoe Harwood, Reimer-Kirkham, Sawatzky, Terblanche, & Van Hofwegen, 2009; Kirkham, Hoe Harwood, Terblanche, Van Hofwegen, & Sawatzky, 2007; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005b). Helping students make connections to the full scope of nursing practice can be difficult, and assessment of students is difficult due to large clinical groups with students scattered across various sites and due to evaluation tools not capturing the unique features of community practice.

Competencies for Community Health Nursing Practice

Competence is a holistic term that refers to a person's overall capacity or *ability* to do something successfully (Carraccio, Wolfsthal, Englander, Ferentz, & Martin, 2002; Eraut, 1994; ten Cate & Scheele, 2007). A *competency* is a specific capability demonstrated by the doer (Frank et al., 2010). In the context of nursing practice, *general* competencies are valid across different contexts, and *specific* competencies indicate what a competent nurse can do within a specific clinical area of practice (Eraut, 1994). An example of a set of general competencies are the provincially established entry-to-practice competencies for new registered nurses (College and Association of Registered Nurses of Alberta, 2013; College of Nurses of Ontario, 2014). Examples of specific competencies include those required in speciality areas, such as public health nursing competencies (Community Health Nurses of Canada, 2009), home care nursing competencies (Community Health Nurses of

Canada, 2010), and public health leadership competencies (Community Health Nurses of Canada, 2016). Additionally, in Canada there are public health entry-to-practice competencies (Canadian Association of Schools of Nursing, 2014). These competency frameworks are useful in the development of education and practice (Birt & Foldspang, 2011).

Within health professions, including nursing practice and nursing education, there are a range of perspectives on what it means to be competent (Fernandez et al., 2012). While at a minimum, educators believe that competence comprises at least two components—knowledge and skills—other components also factor in, including attitudes, abilities, reflection, judgement, values, personal characteristics and character attributes (Fernandez et al., 2012). Indeed, competence is a holistic concept that is difficult to atomize into measurable components. In my experience as an educator, students in their community health rotation sometimes do not fully appreciate the holistic nature of competence and the multiple avenues that can lead to its acquisition. Additionally, students often desire more psychomotor skills than are readily available in community placements. As a result of a lack of what they perceive to be requisite nursing knowledge and skills being developed in their community rotation, they express fears that they are not developing competence for registered nursing practice (Canadian Association of Schools of Nursing [CASN] Task Force on Public Health Education, 2007).

To help demonstrate to students that community health nursing is more than psychomotor skills, as an experiment I gave to each of my twelve students the competency frameworks for both public health and home health (Community Health Nurses of Canada, 2009, 2010), and had them read them and put an asterisk beside the ones that were obviously connected with what they considered a traditional nursing skill. The result of the exercise

surprised them: only three or four of the dozens of competencies on each list were related to a psychomotor nursing skill. This discovery resulted in a lively debate about the nature of competence—general and specific—and the nature of the relationship between psychomotor skills, specialized knowledge, clinical judgment, and competence.

Unfortunately, there seems to be another disconnect between competencies and actual community nursing practice. In a study comparing national competency frameworks with job descriptions, little overlap was found between the two (Polivka, Valedes Chaudry, & Jones, 2014). While Polivka's (2014) study explored competencies and job descriptions in the United States, a Canadian equivalent has not yet been completed, although it is likely that the results would be similar. This disconnect, between practice ideals and job realities, also contributes to students' confusion around the role and practice scope of community health nurses. It also contributes to their difficulty appreciating that what they accomplish in their community health practice rotation is, in fact, nurses' work. These discrepancies are depicted in Figure 1.

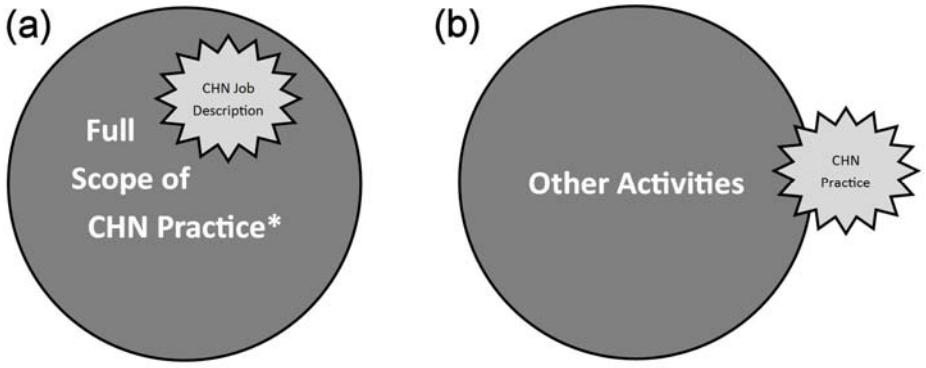

Figure 1: (a) CHNs' job descriptions capture only a small portion of their full scope of practice as put forth by national competency statements. (b) How students often view the discrepancy between CHNs' work and the work accomplished in community health clinical rotations.

Assessment of Competence in Community Health Practice Education

Several approaches to assess competence are prominent in nursing education today. However, clinical evaluation tools are often rendered impotent by their lack of reliability and validity and by lack of balance in the competing tensions of sensitivity and specificity (Andrew et al., 2008; Morris, Gallagher, & Ridgway, 2012; Windsor, Douglas, & Harvey, 2012). Community health clinical rotations are, perhaps, even more threatened by these evaluation issues than acute care rotations, as the clinical experience is difficult to atomize into distinct observable and measurable components amenable to assessment. This mismatch may result in students passing their clinical rotation without actually being competent (Heaslip & Scammell, 2012). While nursing is a practice discipline, in community health practice experiences what is considered 'practice' is often more abstract—and often contains fewer elements students affiliate with the nurse's role—than does nursing practice in an acute care setting.

In nursing practice courses, competence assessment arises from two discourses: a performance discourse, and a reflective discourse. A performance discourse relates to the behavioural aspects of human activity (Hodges, 2012). Cognitive processes are assessed only as they translate to action. Behaviours are used as proxy indicators of personal attributes, abilities and clinical reasoning. Assessments that arise from a performance discourse include rating scales, simulations, and checklists (McCoy & Anema, 2009). Reflection discourse also informs assessment of nursing students in the clinical setting. Based on the work of Donald Schön in the mid-1990s (Hodges, 2012), a competent individual is one who engages in a trifecta of self-reflection, self-assessment, and self-regulation (Hodges, 2012). Competence is assessed through portfolios, written journals and reflective exercises (McCoy & Anema, 2009).

DISCUSSION

Competence Assessment Challenges for Community Health Instructors

Community health clinical practice instructors have unique challenges associated with assessing students' competence. In their national survey, Cohen and Gregory (2009) found that several methods of student competence assessment were in use, including "learning plan/contracts; clinical/professional practice evaluation; community health assessment/planning/promotion project; individual written assignments (e.g., reflective journals, clinical practice portfolios); presentations; teaching assignment; and web-based assignments" (p. 9). It is not known, however, *how* actual competence is assessed through these activities. Cohen and Gregory (2009) also noted that most clinical learning objectives were focused on the assessment phase of the community health nursing process and those that related to collaboration. These objectives numerically far exceeded those action oriented items relating to planning, intervention and evaluation—items which should also be assessed as part of competence.

Another observation in the Cohen and Gregory (2009) report is that there were very few practice course objectives associated with dimensions of the professional community health nurse role that reflected their daily work roles, resulting in a lack of emphasis in "foundational or core learning and practice expectations" (Cohen & Gregory, 2009, p. 14). Perhaps at the root of this lack or gap are conflicting perspectives of the meaning of, or components of, competence; perhaps this gap also represents differing perspectives on what constitutes the foundations of nursing practice. While the Community Health Nurses of Canada have established public health and home care competencies (Community Health Nurses of Canada, 2009, 2010), the uptake of these into the structuring of Canadian curricula, community rotations, and evaluative approaches is unknown. If the work of

Polivka et al. (2014) is any indication, there is little overlap between competency frameworks and job descriptions in community health nursing. Furthermore, no studies have been published that explore the degree to which students are achieving competence in community health practice rotations—data that could come from multiple sources including student evaluations, the national licensure exam, and practice areas.

A third difficulty in student assessment arises from the nature of community clinical experiences themselves. Common themes in these experiences in Canada are diverse and include front line nursing, healthy public policy, community partnerships, leadership development, advocacy, health education, and social justice, within a population health and/or community development framework (Cohen & Gregory, 2009; Diem & Moyer, 2005; Falk-Rafael, 2005; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005a; Reimer Kirkham, Hoe Harwood, et al., 2005b; Reimer Kirkham, van Hofwegen, & Hoe Harwood, 2005). The logistics of not only defining an acceptable level of competence within such diversity but also of assessing competence within that diversity is enormously complex. It is doubtful that clinical practice evaluation tools in use are truly able to capture this complexity, with the shifting goal posts of what individual practice experience can offer, for an accurate assessment of competence.

Additionally, because of the minimal overlap between established competencies and job description for community health, there is considerable disjuncture between what nursing students accomplish in their community health clinical experience and what they will be doing following graduation. While there can be little doubt that these experiences offer foundational perspectives on community health, the links to how these experiences prepare students for existing practice roles is unclear. Since there are no specific skills listed in the competencies, it is theoretically possible for a student to "never be assessed on

essential nursing skills" prior to employment as a registered nurse (Butler et al., 2011, p. 301). The challenge for undergraduate community health clinical educators is to present learning opportunities that capture essential competencies and also to accurately evaluate the competence of students who are involved in diverse activities.

Another problem with evaluating competence is that *performance* stands in as the observable proxy for *competence*, and therefore assessment depends upon the perception and judgement of evidence about performance (Epstein & Hundert, 2002; Khan & Ramachandran, 2012; McMullan et al., 2003). In community practice rotations, the determination of competence is often achieved at a distance, without continuous observation and without the observable psychomotor skill benchmarks of acute care. One commonly used solution to the problem of remote supervision is reflection, which is widely used in community health clinical (Cohen & Gregory, 2009). The opportunities for and types of reflection in community health practice experiences are endless—ranging from journals to structured reflection on a set of competencies. Diem and Moyer (2005) suggest the use of "Weekly Project Summaries" as a reflective and planning tool for community health practice experiences. This Summary assists students to work through the community health nursing process, and to consider both concrete and abstract as well as process-oriented aspects of their practice work. Unfortunately, any type of self-report from students can be highly problematic because few individuals are able to recognize their own ignorance (Barnsley et al., 2004; Baxter & Norman, 2011; Dunning, Johnson, Ehrlinger, & Kruger, 2003; Kruger & Dunning, 1999; Lai & Teng, 2011). This precarious situation is even more pronounced in community experiences than in acute care learning experiences, because the clinical instructor is often remote and cannot correct misconceptions students might have about their own performance.

Because of the difficulties inherent in the notion of competence and the nebulousness of its measurement, subjectivity often prevails alongside multiple interpretations in the assessment of competence (Bradshaw & Merriman, 2008). When it comes to the readiness for practice of new graduates in community health practice areas, strong empirical evidence indicating the degree to which community health clinical rotations are preparing students for practice in community health is lacking. There is also disagreement among stakeholders—students, faculty, practice areas, and patients—about what it means to be competent, and even for what we should be preparing nursing students through their undergraduate experiences (Regan, Thorne, & Mildon, 2009; Wolff, Regan, Pesut, & Black, 2010). Given the breadth of nursing practice roles available to graduates and experienced nurses, it is impossible to expose students to all potential competencies, hence the focus on generalist or foundational competencies.

Potential Solutions for Community Health Nursing Practice Education

To ensure that students get the clinical experience *and* the competence assessment they need to grow as novice practitioners, it is useful to consider several components. First, numerous excellent guiding documents exist, including public health competencies (Community Health Nurses of Canada, 2009), entry-to-practice public health competencies (Canadian Association of Schools of Nursing, 2014), home care competencies (Community Health Nurses of Canada, 2010), and public health leadership competencies (Canadian Association of Schools of Nursing, 2014). These community health nursing competencies can be mapped to either/both provincial entry-to-practice competency frameworks and/or schools of nursing's existing clinical evaluation tools. Doing so can help explicate the application of somewhat abstract competencies to enhance evaluation of students achieving them in community health settings. Because it is unlikely that a single clinical placement can

enable students to meet all of the competencies, further study would be helpful in determining which competencies are deemed foundational and essential by nurses, communities, faculty and students. For example, which of the established competencies represent general competencies and which represent specific competencies, and which of these general and specific competencies should be given priority in community health clinical education? This discussion is one in which it would be beneficial for academe and practice areas to engage so that both entities remain relevant to each other and so that the theory-practice gap can be addressed directly with all stakeholders. Additionally, clinical placement facilitators or administrators may seek to create clinical experiences that are designed to meet as many of the entry-to-practice public health competencies (2014) as possible.

Finding appropriate clinical experiences is also paramount to maximize students exposure to community health competencies. In their position statement on community health nursing education, the Community Health Nurses of Canada (2014) articulate the importance of placing population health at the centre of nursing practice. The Canadian Association of Schools of Nursing Sub-Committee on Public Health (2010) developed guidelines for quality community health nursing clinical placements for baccalaureate nursing students. These two critical documents articulate the necessary components of effective and safe community clinical placements. By providing quality clinical placements, students will have more opportunities to develop competence, while also making the assessment of competence more accurate.

If nationally established competency frameworks are to be utilized in practice, there needs to be greater system support for the expansion of existing roles which are constrained by narrow job descriptions. This is not to say that CHNs are not practicing at levels

consistent with nationally established competency frameworks; it is possible that these competencies are being practiced off the sides of CHNs' desks. Alternately, it is possible that competency frameworks have not "'trickled down' from the academic or theoretical level to the level of practicing PH nurses" (Polivka et al., 2014, p. 233). This disconnect raises the important need for dialogue between undergraduate schools of nursing and practice areas to explore ways to bridge the gap between theory and practice: What are the foundational and essential competencies of which students require a level of mastery by the time they graduate, and how can these competencies best be accomplished? Which competencies are optional, for those who have unique opportunities or special interests?

An approach to assessment gaining momentum in medical education is the development of entrustable professional activities (EPAs) (ten Cate, 2014; ten Cate, Snell, & Carraccio, 2010). In this approach to assessment of competence, the instructor works backward from specific clinical activities to set the objectives of the experience and assessment. In other words, the competencies are 'operationalized' through observable activities, thus attaching competencies to clinical practice activities. By starting with the activities in which students are engaged, and then aligning the associated competencies with each activity, the assessment process is clearer, more concrete, and more likely to be based on what the student has done (as opposed to what they could do given the opportunity). EPAs have eight attributes: they (1) are part of essential professional work in a given context; (2) must require adequate knowledge, skills and attitude, generally acquired through training; (3) must lead to recognised output of professional labour; (4) should usually be confined to qualified personnel; (5) should be independently executable; (6) should be executable within a time frame; (7) should be observable and measurable in their process and their outcomes, leading to a conclusion ('well done' or 'not well done'); and, (8) should

reflect one or more of the competencies to be acquired (ten Cate, 2005, p. 1177). ten Cate (2005) goes so far as to say that educators should "cease to call objectives 'competencies' if we cannot think of EPAs to observe them" (p. 1177). EPAs can be determined by expert panel of stakeholders so that the chosen EPAs for undergraduate community health clinical experiences is defined as essential to CH practice. An example of how EPAs may be developed for a range of community experiences, based on the work of ten Cate (2014) is provided in Figure 2.

EPA	Description and Tasks	Related Competencies[1]		Assessment Methods
		Competency Domain	Specific Competency	
Assist older patients who live at home to manage their chronic conditions and prevent emergencies.[2]	Senior students entering into unsupervised community practice are able to manage stable patients in community settings with a variety of common conditions. • Obtain accurate and complete information to inform the plan of care • Physical and social assessment to determine capacity, norms, and needs • Knowledge of chronic conditions common in older population • Negotiate plan of care with patients, families and caregivers • Knowledge of pathophysiology of common conditions and their management • Adapt care plans to changing information • Knowledge of community resources to help older people with health and wellbeing • Knowledge of aggregates of older people and their health needs	Public Health Sciences in Nursing Practice	1.3 1.4	• Multisource feedback • Direct observation • OSCE or standardized patient • Guided self-reflection
		Population and Community Health Assessment and Analysis	2.1 2.3 2.4 2.5	
		Population Health Planning, Implementation, and Evaluation	3.1 3.2	
		Partnerships, Collaboration and Advocacy	4.1 4.2	
		Communication in Public Health Nursing	5.3	

[1] From Canadian Association of Schools of Nursing (2014) Entry-to-Practice Public Health Nursing Competencies for Undergraduate Nursing Education

[2] Chosen as an example because it allows the development of individual, family and population level competencies

Figure 2: An example of what an EPA could look like for CH clinical experiences

Finally, nursing instructors need to be careful in the execution of student assessment to ensure that the competencies have actually been observed sufficiently. A combination of assessments may provide the strongest evidence of whether students are gaining what they need from their community health clinical rotations, drawing on: direct observation using

established competencies as a guide, objective structured clinical examinations (OSCEs), focused reflection, self- and peer-evaluation based on established frameworks, and stakeholder consultation. Multisource feedback is also gaining popularity in assessment of health professionals (Palmer, Rayner, & Wall, 2007). Individuals who have worked with the student can answer Likert scale questions addressing key competencies or abilities they are expected to have. This type of feedback may have greater use for formative, rather than summative, evaluation.

CONCLUSION

Community health rotations present unique opportunities for students to learn the foundations of community nursing practice and also unique challenges for assessment of student competence. Community health clinical experiences are often relational, process-oriented and abstract in nature which can present difficulties in the accurate assessment of student competence. Many of the issues with assessing students' developing competence in community health nursing can be mitigated through the use of existing guiding documents in the structuring of the experience and execution of the assessment. Additionally, by articulating what students actually do in the clinical experience, and then working backward to the competencies, can make the assessment process more concrete and more accurate.

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Chapter 4: Paper 3: Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Gap Analysis

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Abstract

In Canada, it is widely believed that nursing practice and health care are moving from acute care into the community. What has yet to be established, however, is the degree to which nursing students are actually being prepared for community health nursing practice in their undergraduate education in general, and their non-traditional community health clinical rotations in particular. Through this mixed method study we determined the nature of the gap between what nurses, students and faculty desire to see and actually observe being demonstrated by senior nursing students and new graduates in community health areas. Findings reveal that there is a significant gap between observed and desired competency levels of senior nursing students and new graduates in community health. Faculty and students rated observed and desired student and graduate competence higher than did practice sector registered nurses. Exploration of the gap through focus groups with nursing students, community health faculty, and community health nurses revealed that there are disconnects between theory and practice, particularly in the area of concrete versus abstract. These findings contribute to our understanding of the nature of the gap between desired and observed competence of senior nursing students and new graduates in community health.

In Canada, it is widely believed that nursing practice and health care are moving from acute care into the community. At the same time, increasing numbers of nursing students are engaged in non-traditional clinical experiences for their community health rotation. These clinical experiences occur at agencies not organizationally affiliated with the health care system and typically do not employ registered nurses (RNs). What has yet to be established is the degree to which nursing students are actually being prepared for community health nursing roles through their community health clinical rotations. In this paper we report the findings of a mixed method study that explored the gap between desired and observed levels of competence of senior nursing students and new graduates in community health. The gap was quantified and then the nature of the gap further explored through focus groups with all respondent groups.

Background

In Canada, many baccalaureate schools of nursing are using non-traditional or innovative placements for undergraduate practice rotations in community health (Cohen & Gregory, 2009; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005). These experiences occur at a wide range of sites: schools, homeless shelters, non-profit organizations, industry, workplaces, correctional centers, seniors' centres, shopping malls, police stations or even places of worship. Students in these clinical experiences typically lack opportunities to develop areas of unique nursing knowledge and skills. These non-traditional experiences are eclipsing traditional preceptored placements in public health and home care (Cohen & Gregory, 2009; Hoe Harwood, Reimer-Kirkham, Sawatzky, Terblanche, & Van Hofwegen, 2009), sectors that make up the largest portions

of community health nurses, employing 34% and 19% of community health nurses, respectively (Underwood et al., 2009). Strong, empirical evidence indicating the degree to which non-traditional community health nursing clinical rotations are preparing students for practice is lacking. What is unclear is the degree to which, "within a competency-based framework, students are able to prepare for community and/or public health nursing practice without ever practicing as, or viewing the actual work of, a [community health nurse]" (Pijl-Zieber & Grant Kalischuk, 2011, p. 5).

In Canada, a competence approach to professional practice is legislated as a way to ensure accountability (Black et al., 2008). Part of this legislation involves provincial and territorial colleges and associations of nursing delineating competencies for new nurses, in consultation with employers, educators, government, and other stakeholders (Black et al., 2008; Canadian Nurses Association, 2007, 2008). Provincial regulatory bodies implement and enforce federal, provincial and territorial legislation that governs nursing practice, and set standards for nursing education programs within their jurisdictions (Black et al., 2008). Nursing education programs that prepare entry-level registered nurses use entry-to-practice competencies to measure student progress towards entry-level nursing practice. In Alberta, the competency profile for new registered nurses is captured by the document, *Entry-to-Practice Competencies for the Registered Nurses Profession* (College and Association of Registered Nurses of Alberta, 2013). Additionally, the Community Health Nurses of Canada have developed a set of competencies for home health nursing (Community Health Nurses of Canada, 2010) and public health nursing (Community Health Nurses of Canada, 2009a).

Most of the literature assessing undergraduate nursing students' achievement of community health competencies is qualitative or merely descriptive (Bouchaud, 2011; Bramadat, Chalmer, & Andrusyszyn, 1996; Brosnan et al., 2005; Ciesielka, 2008; Francis-Baldesari & Williamson, 2008; Hjälmhult, Haaland, & Litland, 2012; Kirkham, Harwood, & van Hofwegen, 2005; Laplante, 2007; Lasater, Luce, Volpin, Terwilliger, & Wild, 2007; Ravella & Thompson, 2001; Van Doren & Vander Werf, 2012). No quantitative studies have been published that determine the degree to which nursing students are prepared for community health practice through their undergraduate community health clinical experiences. A study by Diem and Moyer (2010) set out to evaluate students' confidence in using public health nursing skills and satisfaction with team projects. While this study does contribute to our understanding of what is learned in non-traditional community health clinical experiences, the tools are reflective of general competencies, not specific competencies for public health.

Method

The purposes of this research study were to: (1) establish the level at which community health nurses, senior baccalaureate nursing students and community health faculty *desire* to see specific competencies achieved in nursing students; (2) establish the level at which nurses, students and faculty are *observing* these specific competencies in nursing students; and (3) determine the nature of the gap between observed and desired nursing student competence in community practice settings. Gap analysis arises out of performance analysis, the purpose of which is to identify discrepancies between current

and desired or expected performance levels (Rothwell, Hohne, & King, 2007). See Figure 4.1 for a visual depiction of the study.

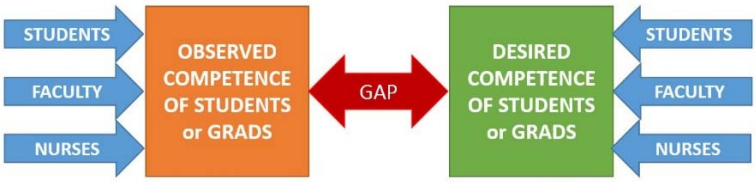

Figure 4.1: Gap analysis study—visual depiction.

This study utilized a mixed method explanatory sequential design, in which quantitative data collection and analysis is followed up with qualitative data collection and analysis to further explain the quantitative results (Creswell & Plano Clark, 2011). The quantitative phase entailed email distribution of an online survey using Qualtrics Research Suite (later during the study period, paper surveys were added at two educational institutions to bolster response rate). The survey consisted of demographic questions, including questions about community health clinical experiences and work role, and the main section consisted of two matrices. The first matrix required respondents to indicate the level of competence they *desired* to see in senior nursing students and new graduates in community health. The second matrix required respondents to indicate the level of competence they actually *observed*. The 5-point Likert scale consisted of five points: unaware, aware, understands, demonstrates with assistance, and demonstrates independently.

The statements being assessed were 43 of the Entry-to-Practice Competencies (ETPCs) (College and Association of Registered Nurses of Alberta, 2013) that most closely aligned conceptually with the Home Health Competencies (Community Health

Nurses of Canada, 2010) and Public Health Nursing Competencies (Community Health Nurses of Canada, 2009b). The 43 competency items were grouped as in the Entry-to-Practice document: professional responsibility; knowledge based practice (with additional subheadings: assessment, planning, provision of nursing care, evaluation), ethical practice, service to the public, and self-regulation. A visual depiction of the conceptual nesting of the three sets of competencies is in Figure 4.2. Respondents were required to make a subjective judgement and rate performance as a proxy for competence. Because the three sets of competencies on which the tool was based are well-researched, established, and widely accepted, the authors believe that the tool had good face and construct validity. Reliability testing was done on the desired competency items, revealing a Cronbach's α of .977 (43 items, n=174), and on the observed competency items, revealing a Cronbach's α of .988 (43 items, n=175). This high score may not necessarily indicate high internal consistency, and instead may indicate that the abstract nature of competency statements make poor items for rating or that the items being rated were too highly intercorrelated.

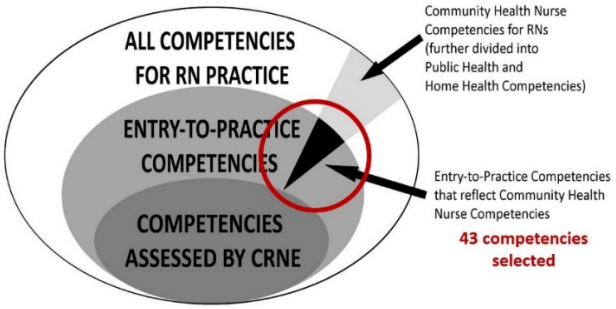

Figure 4.2: Diagram of the relationship between competency frameworks in Canada (modified from Canadian Nurses Association (2010-2015, p. 5). In this diagram the black triangle represents the entry-to-practice competencies that overlap with home health and public health competencies, which are used as the basis for the research instrument. This diagram has been modified from its original (Canadian Nurses Association, 2009, p. 5).

Prior to wide dissemination of the survey, a pilot test was conducted with 30 respondents at the lead author's institution. Minor adjustments were made to enhance readability and flow. The surveys were anonymous and submission of the survey implied consent. Data was managed and analyzed by the lead author using SPSS 21.

Potential respondents were in Alberta *and* were: practicing community health nurses (over 2 years of experience and exposure to new graduates and/or students in community health; managers and educators in community health areas; faculty teaching community health nursing at baccalaureate schools of nursing; senior baccalaureate nursing students who have had a community health clinical rotation *or* are preceptoring in community health; and new graduates (0-6 months practice) working in community health. Potential respondents were determined by emails to deans of university schools of nursing in Alberta; access to practicing nurses and managers was facilitated by the Alberta Health Services research office. Participants self-selected into the study. Ethical, administrative and operational approvals were obtained from all health authority zones and all baccalaureate schools of nursing in the Canadian province of Alberta.

For the qualitative phase, the lead author conducted focus groups with the same respondent groups: senior nursing students at two schools of nursing in two different health authority zones; community health faculty at two schools of nursing in two different health authority zones; home care nurses in one health authority zone; and, public health nurses in one health authority zone. Participants signed a consent form and were free to terminate their involvement at any time. Focus groups were audio-recorded and then transcribed for analysis. Data was managed by the lead author using NVivo 10.

Textual data from the focus groups and survey's open-ended comments was subjected to a thematic analysis (Clarke & Braun, 2013, 2014; Vaismoradi, Turunen, & Bondas, 2013) and coded into categories during analysis, seeking the minimum grouping threshold to avoid an overwhelming number of small categories. To ensure that conflation of text did not occur, a log file was created to track changes between original text and the altered version, to ensure the original text and its intent was retained (Schmidt, 2010). Poignant textual data and explanatory accounts were also retained in support of findings.

While inferences were drawn after the quantitative and qualitative phases of data analysis, interpreting the connected results involved drawing meta-inferences relating to how the qualitative data helped elucidate the problem—i.e., the gap—identified in the quantitative (Creswell & Plano Clark, 2011). The samples had a high level of integration between the quantitative and qualitative samples, permitting the drawing of appropriate meta-inferences and enabling good transferability (Collins & Onwuegbuzie, 2013). A variable-oriented analysis consisted of identifying relationships and themes that cut across cases and among entities and yielded rich findings that supported both the qualitative and quantitative findings (Onwuegbuzie, Slate, Leech, & Collins, 2009). Such triangulation of data produced a rich dimensional understanding of the topic.

Strategies employed to legitimate the truth value of the qualitative findings included several steps as put forth by Onwuegbuzie and Leech (2007b). Persistent observation identified characteristics and attributes that were most relevant to readiness for practice. Data was triangulated using multiple and different methods (quantitative and

qualitative, survey and focus group), theories (various education theories and views on competence) and sources (faculty, students and nurses in two distinct practice areas) to gain corroborating evidence and reduce the possibility of chance associations and systematic biases. The lead author left an audit trail of documents, records, and data, including: the raw data, the raw transcripts, the data reduction process and products, ongoing memos, data reconstruction and synthesis products, process notes, and a running log of amendments to the study. Focus group findings were related back to the survey findings, using the former to elucidate the latter. When findings were unusual or not representative, these instances were noted in the analysis and description of results. In the analysis, data was converged through the use of thematic tables and diagrams that elucidated the nature of the gap that had arisen in the quantitative findings (Creswell & Plano Clark, 2011).

Findings

The survey, which took about 45 minutes to complete, had a high attrition rate of 24.9%, indicating that respondents may have been overwhelmed by the survey itself or its length. Respondents lost to attrition were deleted, resulting in 187 valid cases (students, n=81; nurses, n=87; and faculty, n=19) across 5 zones of the provincial health authority. Nursing students were primarily in their senior year (n=60) or preceptorship (n=19); four respondents indicated they were new graduates working in a community health area. Data was missing for two student respondents. Nurse respondents primarily worked in public health (66.7%, followed by home care (31.0%). Most nurse respondents were involved in direct patient care (60.7%), followed by management and education (23.8%) and case

management (13.1%). The majority of nurse respondents possessed a baccalaureate degree in nursing (92.8%). Faculty respondents had experience in community health theory, clinical or preceptorship, and had practice in community health prior to academe. Unfortunately, the response rate among faculty was particularly low, perhaps as a result of survey fatigue (Porter, 2004; Savage & Waldman, 2008; Umbach, 2004), workload, or other environmental factors.

The majority of students experienced a non-traditional community health clinical experience (85%). That non-traditional sites are commonly used for community clinical was also reported by Hoe Harwood et al. (2009) in their Canadian survey on innovative placements and by Cohen and Gregory (2009) in their pan-Canadian study. Focus group data revealed that a wide range of student experiences and exposures to community health roles is occurring within and between schools of nursing.

The degree to which student respondents felt prepared to work as a registered nurse in community health as a result of their community health clinical rotation was analyzed as a binary: preceptored, or non-traditional. Data was negatively skewed. A Mann-Whitney *U* test was conducted to test whether the average feeling of practice readiness differed between the preceptored (n=19) and non-traditional (n=54) groups. Average feeling of readiness for the preceptored students was 3.21 (SD = .918) whereas the average of the non-traditional students was 2.20 (SD = .979). The mean rank of preceptored students was significantly higher than non-traditional site students, $z = -3.595$, $p < .001$, indicating that students who spent time with a community health nurse for their clinical experience felt more prepared to work in the role of a community health

nurse than students who only had a non-traditional experience (see Figure 4.3). Cohen's effect size value (d = .93) suggested a high practical significance.

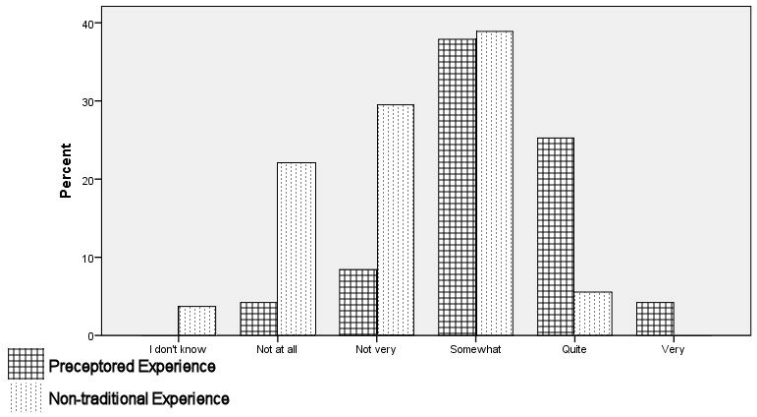

Figure 4.3: Degree to which student respondents feel prepared to work as a RN in community health by type of clinical experience: non-traditional experience (M=2.20, SD = .979) and preceptored experience (M=3.21, SD = .918).

The competency matrix data was analyzed to see if desired competence scores and observed scores differed by respondent type. Descriptive statistics revealed that both the desired and observed scores were negatively skewed and could not be corrected by transformation. As a result, non-parametric tests were used. A Kruskal-Wallis test (with Bonferroni correction) found statistically significant differences in the mean rank between respondent groups in the majority of competency items, $\alpha = .05$. Follow up pairwise comparisons determined that both students and faculty respondents were more likely to rate both desired and observed performance higher than were practicing nurses on all 43 competency items. Overall, desired and observed scores were higher among faculty and students, and lower among practicing nurses. A Wilcoxon test was used to determine the degree and direction of difference between paired *observed* and *desired* scores. All mean observed scores were significantly lower than mean desired scores ($p <$

.05). The size of the perceived gap was also reported as wider (overall) by nurses than by students and faculty (see Figure 4.4). For the largest gap, which was between nurses' and faculty's perspectives, the Cohen's effect size value (d = .496) suggested a moderate practical significance. Similarly, the gap between difference scores provided by students and nurses had a moderate effect size (d = .338) suggesting these differences also have a moderate practical significance.

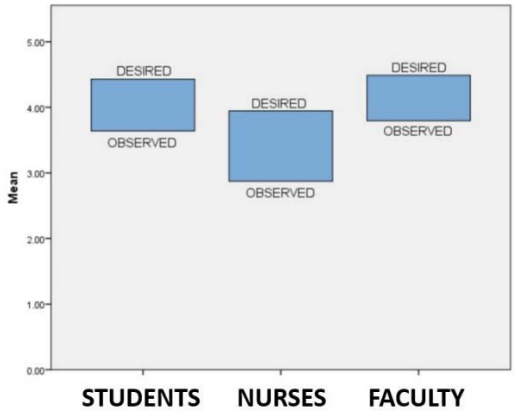

Figure 4.4: Mean scores for each respondent group revealed a statistically significant gap between observed and desired level of performance in community health

Overall, these findings reveal that all respondent groups report a statistically significant gap between observed level of performance and desired level of performance of students in community health competencies. To confirm these findings, competencies were bundled by category onto the Entry-to-Practice competency framework (College and Association of Registered Nurses of Alberta, 2013) and then the means compared between respondent groups. A Wilcoxon test found statistically significant differences between bundles in all groups of competencies except *Planning*, confirming that there is a gap between the observed and desired competence level of senior nursing students.

A survey question about face validity of the 43 selected competencies asked respondents to rate the competencies in terms of the degree to which they thought the competencies reflected the work of a community health nurse in Alberta. All groups had a mean of 4 on a 5-point Likert agreement scale, and a Kruskal-Wallis test found no significant differences between groups. This finding suggests that the instrument has good face validity, as respondents believed that the identified competencies reflected the work of a community health nurse in Alberta.

Finally, observed and desired competency scores were subjected to a factor analysis to determine if there were a small number of core factors underlying the desired and observed competency scores. Some of the variables were skewed, but were not transformed due to the same response options being used for each variable. Principal components extraction was used prior to factor analysis to estimate the number of factors, presence of variable outliers, absence of multicollinearity and singularity, and factorability of the correlation matrix. The presence of several multivariate outliers compromised analysis and results should be interpreted in context and with caution. Four factors were extracted using the Maximum Likelihood procedure and rotated using a Varimax rotation procedure. The factor loadings above .45 were selected, yielding four interpretable factors which are identified in Table 4.1. The identified factors also aligned with the structure of the 43 competencies, supporting the validity of the tool.

Factor	Construct	% Item Variance
DESIRED COMPETENCE		
1	Specific knowledge-based practice	21.39%
2	Ethical practice	18.36%
3	General knowledge-based practice	11.32%
4	Service to the public	10.32%
OBSERVED COMPETENCE		
1	Specific knowledge-based practice	23.64%
2	General knowledge-based practice	18.02%
3	Service to the Public	17.88%
4	Ethical practice	15.69%

Table 4.1: Factor analysis groupings

It is interesting to note that specific knowledge was responsible for most of the variance on both observed and desired scores. That specialized knowledge, and not just general knowledge, is required for new graduate practice is somewhat contested among stakeholders. In their survey on public health education, the Canadian Association of Schools of Nursing [CASN] Task Force on Public Health Education (2007) found that the two areas most highly contested related to the teaching of specific community health knowledge and skills (such as immunizations, physical assessment and more).

The nature of the gap between observed and desired competence level of senior nursing students and new graduates in community health was explored through two focus group interviews with each of the following groups: nursing students (two schools, n=12), community health faculty (two schools, n=11), and community health nurses in public health and home care (n=17), resulting in a total of six focus group interviews across the province. To recruit for the focus groups a parallel sample was drawn, using participants that were different from the quantitative portion of the study but the selection criteria were the same and as such, each sample represented the same respondent groups (Collins & Onwuegbuzie, 2013; Onwuegbuzie & Leech, 2007a). The focus group

participants and survey respondents were similar in demographics and perspectives. The themes that emerged centred on a series of disconnects between theory and practice; these themes contribute to our understanding of the nature of the gap between desired and observed competence. Most prominent was the theme of disconnect between concrete and abstract. The other themes—pragmatism versus idealism, breadth versus depth, and logistics versus pedagogy are discussed elsewhere.

The theme, *concrete versus abstract*, emerged in the areas of *orientation to learning* and *understanding of readiness to practice.* As previously discussed, non-traditional placements exist in a wide variety of formats and typically occur at sites not formally affiliated with the health care system and at which registered nurses do not work. Thus, unlike their other clinical rotations, students do not carry out what they would describe as nurses' work, but instead conduct a variety of other activities through which they are to gain valuable insights regarding health in the community. Unfortunately, a disconnect occurred for students as a result. When students were asked what they did during their community health rotation, they were invariably concrete. For example, one student said, "We put papers in a binder." Others answered in equally concrete terms, such as "taught children", "served tea," or "TB testing." Overall, a climate of discontent centered on the disconnect between what they did and what they perceived they learned that was nursing-related. Students equated quality learning and developing competence with the ability to *do* the work of an RN. Students who had community health experiences in which they were allowed to participate in the work of an RN—such as conducting vascular risk assessments—were much more satisfied with

their clinical learning than students who had to make bigger conceptual links to the visible role of the RN. The more abstractly related to health and nursing, and the further students were removed from doing what they viewed as nurses' work, the greater their dissatisfaction. In clinical experiences that did not resemble the work of a community health nurse, students usually failed to see relevance. Nursing students placed high value on participating in nurses' work, particularly as it relates to nursing tasks.

Students' concreteness was in contrast to the views of faculty, who when asked the same question regarding what students did in the clinical rotation, expounded upon the foundations of community health, standards of practice and the nursing process. Faculty believed that being competent reflected the ability to *learn* and was a way of *being.* Most profoundly, one faculty participant stated, "We can teach them what to do or we can teach them how to be. And that's exactly what we're doing, is we're teaching them how to be." One faculty member, in response to students' dissatisfaction with the lack of concrete skills in clinical, helped students make connections to theory by writing the Standards of Practice for Community Health Nursing on the board and asking the students to call out what they were doing in clinical. Under each Standard, the instructor wrote where the clinical work fit into that framework. This activity resulted in a watershed moment for students, who realized "Oh, we are doing things, this is making a difference, this is what community health nursing is."

Community health nurses were concerned with students' or graduates' ability to be in possession of some basic knowledge and skills related to their specialty area, but also be able to learn. Nurses invariably focused on the integration of skills and

knowledge in the patient encounter. Community health nurses did not mention standards of practice or competency frameworks, but rather, focused on the knowledge and skills needed for direct nursing care.

Concerning readiness for practice and what that entails, again, students were very concrete. Students described the need for basic knowledge and skills for practice, like giving medications and how to landmark. As well, students thought being ready for practice meant that they should to be able to "go out into the field and just need minimal help, just like a guiding hand instead of a person teaching you every single thing." Students reported a feeling of vulnerability regarding their upcoming graduation. This vulnerability was fueled by their feeling of unpreparedness primarily due to a lack of knowledge and skills, which they defined in concrete terms. Students struggled to make the links to their preparation as generalists through the provision of a foundation for lifelong learning. There was a fear of bullying due to not performing at the required level so they felt that "to be ready for practice I need to know my stuff or else I'm gonna get killed out there."

Faculty, when asked about readiness for practice in community health, described being practice ready as having a set of general competencies such as: accountability; fiscal responsibility; good time management skills; using resources; being aware of social justice, access and equity; and applying the community health nursing standards of practice. Other faculty described their role in the preparation of generalists as laying the theoretical foundation for practice. In contrast, faculty who were clinical teachers during the days when students were preceptored in community health spoke less highly of what

is learned in non-traditional settings. These faculty did not believe these experiences helped students get ready for practice, to the extent that they described the non-traditional community experience as a "waste of time." Faculty who had not experienced traditional preceptored community clinical experiences had a rich vision for what the non-traditional experience could deliver in terms of foundations for practice. Faculty overall felt that students in alternative placements were best prepared for population health promotion, and that additional course work specific to the speciality area (home care, public health, etc.) would help the new graduate at an entry-to-practice level.

Community health nurses viewed readiness for practice as the graduate or new hire being able to conduct herself as a community health nurse, particularly by the end of a preceptorship experience. One community health nurse was acutely aware of the theory-practice gap presented by alternative clinical placements, saying students need "real" community health experience or community projects that more closely mirror the work of actual community health nurses:

> You couldn't put a nurse on to an acute care floor and expect them to know anything about the actual work of a nurse in that area if they have only spent 2 months working on wound care protocol in a hospital classroom. You really couldn't even call it acute care experience. Yet that's basically the kind of thing that happens with "community nursing experience" in schools.

Nurses' sense of graduates' readiness for practice was closely tied to real-world nursing practice. Nurses reported that preceptor students and new graduate hires in community health often lacked the foundations for community health practice, which were conceptualized differently depending on their area of practice (home care or public

health). Nurses were, overall, concerned that non-traditional community health experiences were not preparing students for actual practice roles and the situations they would encounter in practice. A public health nurse shed additional light on the role of foundational skills in nursing education, saying that students need to have the basics in place "so you can communicate with intent and not worry about the tasks and checklist." This statement suggests that from a practice perspective, both concrete and abstract aspects are required in the development of competence.

Discussion

Similar to the present study, Wolsky (2014) also found that faculty have significantly higher expectations of graduate practice than did nurses. Similarly, educators had significantly higher perceptions of new graduates' communication and management ability, but the opposite was true of technical skill and assessment ability—of which educators had a significantly lower expectation than nurses. Wolsky's study also reported a performance-expectation gap in several areas between respondent groups; however, that study was not specific to community health but rather all nurses in the Canadian province of Alberta (sampling occurred through the RN professional association in Alberta).

It seems that the different perspectives on readiness for practice in community health areas, as evidenced in the gap between observed and desired competence levels, is multifaceted. Students seem to have little difficulty making links between medical/surgical theory and practice, and the leap from undergraduate preparation and registered nursing practice in a medical/surgical environment seemed smaller than in

community health. This is likely because in medical/surgical education, theory is strongly tied to their clinical work—including pathophysiology, nursing care of the patient, pharmacology, prioritization of care, and other concrete items that directly relate to the clinical experience. During quiet times on the unit, students are able to practice skills and participate in simulation; there was no antidote to downtime in community health clinical. Then, in medical/surgical clinical, the work in which students participate strongly resembles the work of registered nurses, who are also working alongside and act as mentors. Thus, the gap between education and practice requires less of a conceptual and practice leap, as they have already been participating in this work and sometimes for more than one semester or clinical rotation.

In contrast, non-traditional community theory may be fairly abstract in nature and may not be presented in ways that it relates to community health practice roles (Cohen & Gregory, 2009). In non-traditional community health clinical placements, what students do does not resemble community health nurses' work—at least not the bulk or visible part of it. Students neither observe nor participate in the work of a registered nurse (Cohen & Gregory, 2009; Pijl-Zieber & Grant Kalischuk, 2011). Thus, the gaps are wider. The fact that students are working in sites lacking an RN also means that there are few, if any, opportunities for professional identity formation and role modeling. This lack was noted by student participants. In essence, students did not have opportunities to discover the RN role but were instead engaged in a range of activities for which they failed to see direct relevance to nursing. Nurses and preceptors have been concerned that "students can pass their competencies and not be competent in fundamental nursing

skills" (Butler et al., 2011, p. 301). Since there are often no specific skills associated with the competencies, it is theoretically possible for a student to "never be assessed on essential nursing skills" prior to employment as a registered nurse (Butler et al, 2011, p. 301). It is possible that the lack of an RN role model increased students' propensity for the concrete as they sought stability in a nursing identity through recognizable, familiar or traditional nursing tasks. These gaps are depicted in Figure 4.5.

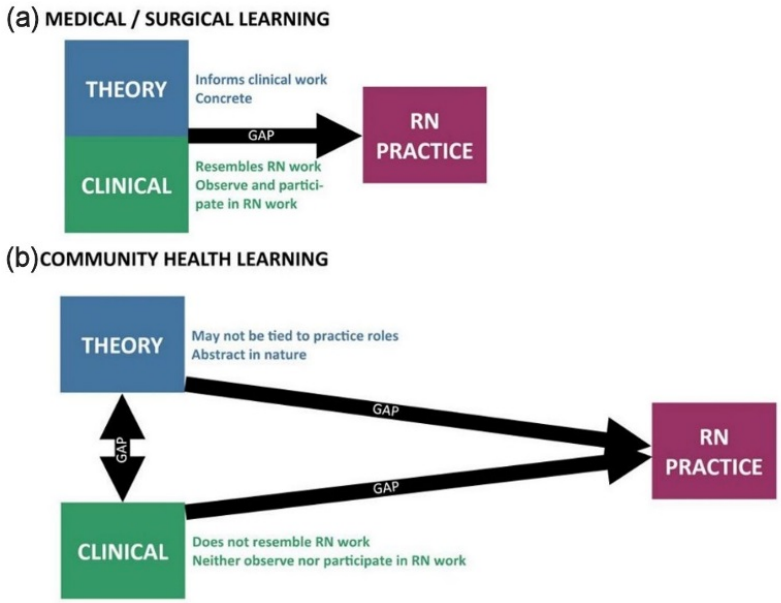

Figure 4.5: Suggested hypothesis of why students have more trouble making links in community health (b) theory and practice than in medical/surgical (a) nursing.

In essence, it seems that non-traditional clinical experiences require students to make much bigger leaps/links between theory and practice, and between education and work roles, than they are able to make. Nursing students are primarily concrete learners (D'Amore, James, & Mitchell, 2012; Hauer, Straub, & Wolf, 2005; Shinnick & Woo, 2015) and work their way from concrete tasks to bigger picture. Non-traditional community health experiences seem to require them to do the reverse. With the focus on

the abstract foundations of community health practice, students may have an increased depth of foundation but also greater difficulty relating what they are doing to actual RN practice, which emphases specialized knowledge and skills. The focus on the abstract is not a result of poor pedagogy or poor experiences necessarily; rather, it is the result of a wide variation in community health experiences and practice, which is much more varied than in acute care. Faculty were able to, as more than one student remarked, "make or break" a clinical experience due to adding extra experiences or incorporating strong pedagogy to help students make links. The passion and resourcefulness of faculty in making a community health rotation valuable for students was profound.

Nursing programs need to ensure that students are exposed to the two biggest areas of community health nursing, home care and public health, so that students can observe and participate in the role of the community health nurse. Ensuring students have foundational nursing knowledge and skills is an important part of professional identity and professional growth. Nursing programs can utilize skills and simulation labs that relate to public health and home care. Students place a high value on hands-on skills, which can act as a springboard to deeper learning while enabling competent, safe patient care. Students with skill mastery are more likely to be competent, which will enhance their confidence, and increase their sense of belonging on the nursing unit due to their enhanced ability to participate meaningfully in the nursing work of the unit (Levett-Jones & Lathlean, 2009). Additionally, in some nursing programs students can earn speciality certificates in addition to a baccalaureate degree, since many nursing jobs are in speciality areas (Eggertson, 2013). Overall, new models of clinical are required to ensure

new graduates are in possession of the skills, knowledge and abilities they require to be competent. A competency-based approach, as opposed to a rotation- or time-based approach to clinical, may allow more students into community health areas. At least one school of nursing is using preprogrammed avatars in multi-user virtual environments to foster learning outcomes (Niederhauser, Schoessler, Gubrud-Howe, Magnussen, & Codier, 2012). Such resources would foster in nursing students a greater understanding of community health nursing roles.

Without a doubt, teaching the principles of community health practice in a non-traditional setting is a challenge for faculty, although many rise to the challenge with passion and ingenuity. Considerations for narrowing the theory-practice gap may include the pursuit of joint appointments to enable faculty practice (Darbyshire, 2010; Rahnavard, Nodeh, & Hosseini, 2013) or a faculty practice model (Aquadro & Bailey, 2014; Barzansky & Kenagy, 2010; Dobalian et al., 2014) so that faculty remain in touch with practice and relationships are re-established with community health practice areas. Collaborations between academe and practice have been shown to ease graduates' transition to practice (Burns & Poster, 2008). Keeping communications open with practice areas is also imperative so academe and practice areas can find new ways to work collaboratively to enhance both practice and education. Community health educators need to foster strong and intentional pedagogy so that students are better able to make links between theory, clinical, and professional practice when these links are not apparent.

While the theory-practice gap continues to be a reality for nursing graduates, it seems to be even more apparent in community health areas due to the lack of exposure students have in their undergraduate experiences. Given that senior students, preceptor students, and new graduates are not achieving to the level they should be, perhaps a conversation with all stakeholders needs to be commenced to find ways to understand each other's values and expectations and what is possible to achieve, given the constraints. Clearly, some different viewpoints among stakeholders may be contributing to the gap.

Limitations

This study was hindered by unequal numbers of respondents in each group, particularly an underrepresentation of faculty, resulting in statistical bias. There was uneven representation across the province; thus, the final sample was not representative. Paper surveys were administered at two sites to enhance response rates; however, paper and online modes each have a different fatigue rate, nonresponse rate, and response error (Porter, 2004; Savage & Waldman, 2008; Umbach, 2004). Participants self-selected into the study.

Conclusion

Preparation for community health roles is an important part of nursing preparation and nurses' service to the public. Nursing education is fractured in its beliefs and values from within and between it and its community partners. A variety of perspectives and logistics fuel the fires of discontent; and local, provincial and national dialogue is critical to ensure that students are actually being prepared for community health nursing. The

theory-to-practice gap is not unique to community health nursing; however, it is accentuated due to the unique features of undergraduate preparation for community health. That there is a significant gap between observed and desired competency level of senior nursing students and new graduates is no surprise; however, the nature of that gap sheds important light on the differences between nursing students, nursing faculty and practicing nurses. By engaging in dialogue with practice partners we can better understand each other so that graduates' level of preparation for practice can be enhanced.

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Chapter 5: Paper 4: Undergraduate Community Health Nursing Clinical Experiences: Disconnects in Pedagogy and Practice

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Abstract

Many baccalaureate schools of nursing are using non-traditional placements for undergraduate community health clinical rotations. These placements occur at agencies not organizationally affiliated with the health care system and typically do not employ registered nurses (RNs). While these types of placements offer unique opportunities for learning through carefully crafted service learning pedagogy, these placements also present challenges for student preparation for practice in community health roles. The theory-practice gap and the gap between the expected and actual performance of new graduates are accentuated through the use of non-traditional community clinical experiences. These gaps are not necessarily due to poor pedagogy, but rather due to the perceptions and values of the stakeholders involved: nursing students, nursing faculty who teach community health clinical, and community health nurses who work with new graduates. In this paper we describe the qualitative findings of a mixed method study that explored these gaps as they relate to pre-registration nursing students' preparation for community health roles.

That there are multiple gaps between nursing education and nursing practice is well documented and widely recognized. One commonly cited gap is the theory-practice gap; another is the gap between the expected and actual performance of new graduates. Both of these gaps have unique significance in the clinical preparation of undergraduate nursing students for community health roles. With many schools of nursing using non-traditional placements for the undergraduate community health clinical experience, these two gaps are accentuated by the lack of exposure to community health nurse roles and responsibilities. In this paper we describe the qualitative findings of a mixed method study that explored these gaps as they relate to pre-registration nursing students' preparation for community health roles through non-traditional experiences.

Background

Many baccalaureate schools of nursing are using non-traditional placements for undergraduate community health clinical rotations (Cohen & Gregory, 2009; Kirkham, Hoe Harwood, Terblanche, Van Hofwegen, & Sawatzky, 2007; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005b). These clinical experiences occur at agencies not organizationally affiliated with the health care system and typically do not employ registered nurses (RNs). They include a wide range of sites. Students in these clinical experiences typically lack opportunities to develop areas of unique nursing knowledge and skills, such as restricted nursing acts or activities that resemble the daily work of community health nurses. These non-traditional experiences are much more common than traditional preceptored placements in public health and home care (Cohen & Gregory, 2009; Hoe Harwood, Reimer-Kirkham, Sawatzky, Terblanche, & Van

Hofwegen, 2009; Kirkham et al., 2007; Reimer Kirkham, Hoe Harwood, et al., 2005b), the two largest areas of community health nursing which employ 34% and 19% of community health nurses, respectively (Meagher-Stewart et al., 2009).

Non-traditional placements allow nursing students to work at the population level, incorporate the principles of primary health care, enact social justice and equity, increase access to services, and address the determinants of health (Hoe Harwood et al., 2009; Kirkham et al., 2007; Reimer Kirkham, Hoe Harwood, et al., 2005b; Reimer Kirkham, van Hofwegen, & Hoe Harwood, 2005; Wade & Hayes, 2010). Common themes in non-traditional clinical experiences in Canada include: critical reflection, healthy public policy, community partnerships, leadership development, advocacy, health education, and social justice, within a population health and/or community development framework. Common clinical sites include: anti-poverty organizations, environmental groups; churches and religious communities, correctional facilities, wellness or resource centres, schools, seniors' organizations, seniors' residential facilities, homeless shelters, shopping malls, police stations, workplaces, and industry (Cohen & Gregory, 2009; Diem & Moyer, 2005; Falk-Rafael, 2005; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005a; Reimer Kirkham, Hoe Harwood, et al., 2005b).

Whereas a preceptorship arrangement for the community health clinical rotation is reminiscent of the apprenticeship model which has been prevalent throughout nursing's history, the educational model that is commonly employed in non-traditional experiences resembles 'service learning.' Service learning is "a structured learning experience that combines community service with explicit learning objectives, preparation, and

reflection" (Seifer & Connors, 2007, p. 9). With the guidance of nursing faculty, students involved in these experiences "provide a service to the community while learning about the context in which the service is provided and [making] conceptual links to their academic coursework" (Pijl-Zieber & Grant Kalischuk, 2011, p. 2). But how valuable are these components in preparing students for community health nursing roles, and how well do they translate into practice-readiness?

The extant literature describes both benefits and drawbacks of service learning for community health nursing clinical rotations. The benefits of non-traditional placements, which are primarily process-oriented, and the drawbacks of non-traditional placements are listed in Table 5.1.

Benefits	**Drawbacks**
• Students carry out the community health nursing process • Students engage in population health promotion • Students engage in program planning • Students participate in intersectoral collaboration • Students address the determinants of health • Students enact the principles of primary health care • Students develop leadership skills and cultural competence • Students develop teamwork skills • Students foster critical thinking skills	• Students may not see the value of the placement • Students often prefer sites in which a registered nurse is present • Students might struggle with the abstract and unbounded nature of the experience • Students may not get the hands-on psychomotor skills that traditional placements offer • Students might not be exposed to the role of the community health nurse • Students engage in activities that differ significantly from what community nurses actually do in the practice setting • Students might struggle in the shift from individual as patient, to community as patient • Students might not see the relevance of their activities to 'real nursing' • Students might not have opportunities to develop basic entry-level core competencies and specialized nursing knowledge and skills • Students may lack opportunities to interact with health care professionals and practicing RNs • The time constraints of the semester artificially compress the community development process
(Cohen & Gregory, 2009; Francis-Baldesari & Williamson, 2008; Reimer Kirkham, Hoe Harwood, et al., 2005a, 2005b)	*(Cohen & Gregory, 2009; Laplante, 2007; Reimer Kirkham, Hoe Harwood, et al., 2005a, 2005b; Valaitis, 2008; Wade & Hayes, 2010)*

Table 5.1: Benefits and drawbacks associated with service learning in non-traditional community health rotations.

Method

The purpose of this research project was to understand the nature of the gap between observed and desired competence of senior nursing students and new graduates in community health. This study, which utilized a mixed method explanatory sequential design (Creswell & Plano Clark, 2011), revealed that students are not being adequately prepared for community health roles through their undergraduate clinical experiences. The goal of the qualitative phase of the study was to develop a deeper understanding of why non-traditional community health clinical experiences are not correcting a theory-practice gap—and perhaps are unwittingly widening it.

The nature of the gap between observed and desired competence level of senior nursing students and new graduates in community health was explored through focus group interviews with the following groups: nursing students (2 groups, n=12), community health faculty (2 groups, n=11), and community health nurses in public health and home care (2 groups, n=17), resulting in a total of six focus group interviews across the province, representing two zones of the provincial health authority and four data collection sites. To recruit for the focus groups, a parallel sample was drawn using the same selection criteria as for the quantitative phase of the study but drawing different participants; thus, each sample represented the same participant groups (Collins & Onwuegbuzie, 2013; Onwuegbuzie & Leech, 2007a). The lead author conducted all focus groups. Participants signed a consent form and were free to terminate their involvement at any time. Focus groups were audio-recorded and then transcribed for analysis.

The lead author conducted a thematic analysis on both textual data from the survey's open-ended comments as well as on the transcribed data from the focus groups. The data was coded into categories during analysis, seeking the minimum grouping threshold (Clarke & Braun, 2013, 2014). A log file was used to track changes between original text and the conflated version, to ensure the original text was retained (Schmidt, 2010). Poignant and explanatory accounts were retained to illustrate the findings. Ethical, administrative and operational approvals were obtained from all health authority zones and all baccalaureate schools of nursing in the Canadian province of Alberta.

To legitimate the truth value of the qualitative findings several steps were followed (Onwuegbuzie & Leech, 2007b). Data was triangulated using different methods (quantitative and qualitative, survey and focus group), various educational theories on competence, and a variety of sources (faculty, students and nurses in two distinct practice areas) to corroborate the evidence. Triangulation reduced the possibility of chance associations and systematic biases thus increasing the quality of interpretations. Through persistent observation of six groups of participants, characteristics and attributes that were most relevant to readiness for practice were identified and focused upon. The primary researcher left an audit trail of documents and records and data, including: the raw data and transcripts, the data reduction process, memos regarding the data, data reconstruction and synthesis products such as diagrams, process notes, and a running log of changes to the method and instrument. Member checking occurred throughout the process. Data that was stronger (i.e. less divisive and more representative) was given more weight than weaker data (i.e. disagreement prevailed or wide range of views

present). Outliers were checked for meaning and examined for explanatory characteristics.

Findings

The themes that emerged revealed several disconnects that widen the theory-practice gap and the gap between the expected and actual performance of new graduates. Distinct and overlapping disconnects were described by all three participant groups (nurses, students and faculty) and these themes contribute to our understanding of the nature of the gap. These themes, and how they were each perceived and experienced by each participant group, are summarized in Table 5.2.

Pragmatism versus idealism

The theme *pragmatism versus idealism* emerged in three ways: foundations for community health practice, the future of nursing practice, and the role of critical thinking. Each respondent group held different beliefs and values about these topics.

THEME	Participant Group		
	STUDENTS	**NURSES**	**FACULTY**
Concrete versus abstract*			
Orientation to learning	Concrete How to *do*	Integration Abstractions meet in the concrete patient encounter	Abstract How to *be*
Readiness for practice	Basic knowledge and skills Skill mastery	Ready to interact with the patient	Strong theoretical foundation Learn on the job
Pragmatism versus idealism			
Foundations of community health practice	Basic knowledge and skills for daily work	Assessment, pathophysiology, pharmacology, epidemiology, interpersonal skills	Standards of practice, competency frameworks, determinants of health, population health, and critical thinking
Future of nursing practice	In community but unable to specify what roles might look like	More existing roles	Novel roles in community in a health care system that has not yet materialized
Role of critical thinking	Subservient to skill and knowledge acquisition	Part of a trinity that includes competent application of skills and knowledge in novel situations	A disembodied skill to help graduates extrapolate new skills and knowledge
Breadth versus depth	Emphasis on maximizing exposure to multiple roles and variety of experiences	Emphasis on an accurate exposure to community health practice	Emphasis on deep learning that can be applied to multiple situations
Logistics versus pedagogy	Desire authentic experience in community health	Advocate for authentic experience in community health	Logistics have become the pedagogy

Table 5.2: Summary of themes by participant group
* Published elsewhere.

Foundations for community health practice. What constituted the foundations for community health practice was a source of disparity between participant groups. Nursing students described the foundations as being "basic knowledge and skills for the daily work of an RN." Faculty, on the other hand, described the community health nursing standards of practice, competency frameworks, determinants of health, the "big

picture", program planning, population health, and critical thinking. Home care nurses described a strong clinical base, pathophysiology, patient assessment, pharmacology, and "basic hands-on skills" as being foundational to community health practice. Public health nurses described epidemiology, interpersonal skills, family centred care, growth and development theory, immunology, and newborn and post-partum assessment as being foundational. Clearly, what was viewed as foundational depended upon participants' context. Discontent is likely when schools of nursing are preparing students one way and practice areas are expecting a different type of readiness in the preceptor student or graduate. Lack of a common understanding of what constitutes the foundation of nursing practice accentuates the theory-practice gap and creates inaccurate expectations of the new graduate.

The future of nursing practice. The future of nursing practice also revealed a tension between pragmatism and idealism. Concerning the future of nursing, all participants believed that health care was heading towards the community, despite the fact that the percentage of nurses working in the community has remained fairly constant at around 16% for a decade or more in Canada (Underwood et al., 2009) and is possibly declining in the United Kingdom (Royal College of Nursing, 2012). However, the ways in which the anticipated exodus (to the tune of 60%, if Villeneuve and MacDonald (2006) are correct) would occur into the community was envisioned differently by each participant group—a finding with direct implications for pedagogy. Students were the least able of study participants to articulate what community health nurse roles might look like in the future; neither were they able to articulate what community health nurse

roles actually entailed in the present. They were, in fact, confused as to why, if health care is increasingly in the community, they were not exposed to community health roles in their education. There seemed to be two disconnects for students: between their clinical experience and actual nurses' roles in the community, and between the rhetoric of the importance of community health nursing roles and the absence of these roles in their education. They were also unable to make the links between what they accomplished in their non-traditional clinical experiences and the role of the nurse in a setting that is not amenable to doing such things.

Faculty, on the whole, envisioned futuristic roles that directly addressed primary health care and the determinants of health. One participant stated that "students need to understand that the role of the RN is changing from front line practitioners in any setting to broader roles within the health care system." Another faculty participant suggested that the "nurse of the future" has to be "independent, accountable, and have skills in program development, community development, and capacity building."

Community health nurses, on the other hand, viewed the community as an ever-increasing destination for health care, but within existing roles. Some nurse participants expressed concern that registered nurses were moving further and further from the proverbial bedside and in effect, "deprofessionalizing" over time to a non-descript general competency skillset that bears little resemblance to existing nursing roles. A fear of "deprofessionalization" was also stated among some faculty in regards to alternative community clinical placements, in that they felt nursing programs were preparing students for a de-professionalized environment and a de-professionalized registered nurse

role. There was little agreement on the role of the registered nurse in sites not affiliated with the health care system; however, there was agreement that as faculty—even as a profession—there needs to be…

> discussion about what we think nursing is and could and should be. Because I think we're all over the page within the faculty. I don't think we have a clear vision…and I mean we'll never agree. But the possibilities need to be out there because I think we have a limited view often of what our position could be within the health care system. And there's a question about are we going to be willing to let other people define it for us or are we going to be part of the definition?

This debate certainly raises the question about the future of nursing, a conversation worthy of great discussion among nurse leaders in all areas of practice, research, education and administration today. This debate also highlights the need to delineate the difference between being in possession of general competence and qualities, and having unique nursing knowledge and skills for community health professional practice; and to articulate the role of nursing education in fostering such competence in nursing students and new graduates. Again, a conversation about the role of the nurse was a source of disparate views, which may make conversations about pedagogy and practice difficult between nurses, students and faculty. As well, disparate views result in a wider gap between what is expected of a new graduate (being able to work at the level of the individual) and the actual skillset of a new graduate (being able to work at the population level).

The role of critical thinking. A third area that demonstrated a tension between pragmatism and idealism is the role of critical thinking. While critical thinking was not being explored specifically in this study, the term *critical thinking* was used often by participants but in different ways by each participant group. For example, students

articulated a murky understanding of critical thinking, suggesting that they hoped possessing the ability to think critically would help them overcome the deficits they perceived in their nursing knowledge and skills. This disembodied perspective of critical thinking was suggested by some faculty as well, although a little differently: that if students can learn how to use metacognitive knowledge, they will be better prepared for practice through the ability to effectively problem-solve. Conversely, when home care nurses unpacked the concept of critical thinking, they came to the conclusion that the ability to think critically comes with practice experience and growing knowledge, skills and expertise; in other words, their view of critical thinking was a highly pragmatic one. They believed that critical thinking was part of a trinity of which knowledge and skills were the foundation, and critical thinking was that which enabled their application to a novel situation. Nurses described situations in which preceptor students lacked knowledge and skills they considered basic and these students had a difficult time making connections and thinking critically. The disparity in perspectives on critical thinking may be an important area for future research, although it may be a simple matter of conflating the terms critical thinking, clinical reasoning and clinical nursing judgement (Victor-Chmil, 2013).

Breadth versus depth

In discussions with nurses, faculty and students, a tension was apparent between the need for breadth versus depth in nurse preparation. Students and nurses valued a wide range of experiences and exposures to prepare them for practice and to expose them to the role of the community health nurse, particularly in the two biggest areas of

community health: public health and home care. Nurses and students alike were concerned that without formal opportunities to observe or participate in these roles, students would graduate without knowing about either role. Nursing students who spent their clinical rotation doing a single type of activity in a single setting—such as teaching in classrooms—felt that a variety of experiences in a variety of settings would have been more beneficial to increase their breadth of understanding of community health. Again, much of their concern was the lack of exposure to nurses' work and the feeling that they were getting a teaching experience, not a nursing experience. While teaching is a part of the role of the nurse, the extent of teaching, which often consumed an entire clinical semester, became monotonous and repetitive and was characterized by "down time" which was invariably used poorly by students, who reported doing homework during clinical or spending time on social media. These students were more likely to describe their community rotation as being "a waste of time" if the experience focused on gaining depth, not breadth of exposure to community health. The depth of the experience was perceived as monotony and irrelevance.

Faculty were divided on the role of non-traditional experiences in nurse preparation. While most faculty described the purpose as being to "promote a foundational learning of concepts to guide future practice," a much smaller contingent described it as "a waste of time." In general, faculty were committed to the conceptual foundations and deep learning associated with immersion in non-traditional sites. Faculty were passionate about helping students make links to theory and to ensure a rich theoretical foundation was developed with depth. For example, "…the practice

experience we facilitate here [is] valuable and foundational. If we change to just hard skill focus, they would go in there with a very surface level vision for health." Most faculty were excited about the possibilities offered by service learning and cited the deep learning and professional "becoming" that occurred in community health clinical experiences. Faculty described moments of epiphany when students finally "get it" and grasp the big picture of community health; in these moments, faculty perceived students were laying a solid foundation for their future professional practice. Even so, a few faculty suggested that community health concepts were often beyond the comprehension of undergraduate students. These instructors desired not a deep, foundational experience, but a breadth of exposure that included exposure to nurses' roles in the community.

Community health nurses, on the other hand, were concerned that by only exposing students to non-traditional sites, students were being given an unrealistic (and perhaps unappealing) view of community health nurses' work. Some nurses questioned the value of non-traditional experiences for community health, saying that "I think that those experiences aren't without value; but they don't prepare you to do a job as a nurse." There was little support among nurses about whether non-traditional or project experiences laid a foundation for public health nursing, and there was no support among nurses that students could learn how to be a public health nurse without ever seeing the work of a public health nurse or without ever participating in the work of a public health nurse. Some community health nurses said there was "value in the projects but it needs to be a little more balanced with hands-on" and broader exposure to nurses' work in the community. Nurses also voiced concern that without exposure to the role of the

community health nurse, students would not have a vision of wanting to work in this capacity. Nurses expected students to come with the breadth of a solid background in foundational knowledge and skills that they could then apply in clinical practice; experience would deepen their practice. All of the community health nurse participants in both home care and public health stated that nursing students (especially preceptor students and new graduates) needed a stronger foundation in basic nursing knowledge and skills.

Logistics versus pedagogy

While the change of community health clinical experiences from a preceptored experience to an alternative/non-traditional experience occurred for logistical reasons (an increase in student numbers), its continuation seems to have become justified for primarily pedagogical reasons. In other words, what began for logistical reasons (lack of placements) grew and became codified as a pedagogical method (in fact, the *best* method to teach community health concepts). On one hand, older and more experienced faculty remember the days when nursing students were welcome to participate in the work of community health nurses; these faculty point out that the historical reasons for the shift have been lost. Newer community health faculty are only familiar with teaching in non-traditional placements, and so they have a different acculturation and appreciation of them and the pedagogy they require. Newer faculty were more likely to see opportunities whereas faculty who had experienced both traditional and non-traditional clinical experiences were more likely to perceive the challenges and deficits in the non-traditional learning in terms of what it offered students. Faculty who had taught in community health

clinical using the previous apprenticeship model were able to recall the historical events that led to the use of service learning experiences; these details and resultant structural barriers were not recounted by the other respondent groups, indicating that the history of these partnerships has likely been lost, leading to a further disconnect in a history that should be shared between nursing education and practice.

Students were largely unaware of the history behind non-traditional community health clinical experiences and service learning. Some students speculated that service learning was used because there were too many nursing students in their program to each have preceptored community health experiences. Other students tried to simply accept the experience for what it was. Overall, students did not understand the purpose of the experience, asking "Why are we doing it if it's not something a nurse would do?" Some students believed that community health nurses were more engaged in school health, teaching young children, and population health, than they actually are within the health authority. All students desired a more authentic experience in community health and questioned the value of the work they completed during the community health clinical experience.

Some students shared stories indicative of the pedagogy their instructor used to make sense of the experience; some instructors were able to make strong links to community health concepts. Many students, however, were unable to make the links between what they were doing, and what they should be learning, either because logistically the placement was inappropriate (e.g. a non-Francophone acting as a teacher's assistant in a French class) or because the instructor was not intentionally

making the links through sound pedagogy. These students were most likely to feel that their time was being wasted in these non-traditional experiences. Students described how the clinical instructor was able to "make or break" the clinical experience by tailoring it to the students' wants and needs, through either logistics or pedagogy. For example, some instructors added on shadow shifts with community health nurses or influenza clinics; these were highly valued by students because these experiences exposed them to authentic nursing roles. Some instructors were able to make strong links to community health theory and in these students, their appreciation of community health grew as a result.

Community health nurses, like nursing students, advocated for authentic experiences for students in community health; however, the nurses were also aware of the limitations, such as high student enrollments and nurse workload. Despite their awareness of the structural barriers to undergraduate nursing student participation in community health roles as a practice experience, nurses were very concerned that students would not get a representative or realistic perspective of community health nursing. Community health nurses doubted the degree to which non-traditional clinical experiences even laid a foundation for community health nursing. Nurses believed that one

> "…purpose of having these practicums is to have valuable exposure so that [students] might have a vision of where they would want to work. And when you're in one project that's not a nursing job, the whole time you have zero vision."

Some nurses believed that nursing programs' failure to adequately prepare students for community health nursing roles was a result of a devaluing of community health roles and that acute care nursing was viewed as more important. Furthermore, when

community health experiences occur early on in the program, nurses also felt this sent the wrong message to students:

> "…students come to the community setting before having solid assessment and nursing decision-making skills. It is often their first rotation, and they are so woefully unprepared to teach, to assess, to communicate with clients or colleagues, that it is a waste of everyone's time for them to be there. Often, no real learning takes place because the basics are not there at all. One wonders whether the first rotation is community based nursing because the schools would like to 'get it out of the way' and get onto the more 'important' hospital-based nursing. It's really unfortunate, because these nurses need to be educated from scratch when they decide to work in this area."

Overall, nurses were interested in schools of nursing returning to basics to ensure that students have a strong grounding in foundational skills and knowledge and exposure to community health roles.

Discussion

It appears that service learning for community health clinical experiences accentuates both the theory-practice gap and the gap between the expected and actual performance of senior nursing students and new graduates, the degree of which depends on one's perspective. The different perspectives on these gaps seems to arise from participants holding often disparate values and beliefs about pedagogy and practice, which relate to their context and experience (Wolff, Pesut, & Regan, 2010; Wolff, Regan, Pesut, & Black, 2010). The lack of registered nurse mentors (other than the clinical instructor) at these sites can be destabilizing and confusing for students as they struggle to find their professional identity. The common themes in non-traditional clinical experiences, including healthy public policy, advocacy, and social justice, within a population health and/or community development framework, have little traction in the

daily roles of community health nurses who function in well-defined roles that focus on care at the level of the individual and with considerable resource constraints. A disconnect is created for students who are expected to develop community health competencies in their education that then cannot be expressed once they are in a traditional community health role. Thus, while non-traditional experiences can be valuable, there is some difficulty in translating these experiences into practice-readiness, particularly as defined by practice areas.

For faculty, it seemed that distance from practice, either in years or in pragmatic appreciation, was associated conceptually with the likelihood of preferring the ideals of community health over practice realities. These faculty were more likely to describe the foundation for practice in highly abstract terms, citing non-tangibles such as standards of practice, competency frameworks and population health concepts. They were more likely to be passionate about the deep learning that can occur in service learning through sound pedagogy.

Conversely, faculty who were in favor of doing away with community health clinical altogether, in light of the perception that it was not meeting students' needs, shared views held by community health nurses; these faculty and nurses tended to be more pragmatic and committed to the idea that foundations were only useful in how they informed the patient encounter. Faculty who were more abstract in their thinking and idealistic about community health, its future, and its possibilities were more committed to non-traditional community placements and had little difficulty helping students make connections to abstract foundations such as standards of practice, practice competencies,

and determinants of health. Even 'critical thinking,' a term used often in multiple health and education settings, took on new meaning depending on the participant group. For faculty who preferred abstractions, the concept of critical thinking was more likely to be viewed as a disembodied meta-cognitive strategy, not an integrated aspect of a trinity that also included foundational knowledge and skills that met in the patient encounter.

Nurses are immersed in the pragmatic world of clinical practice as it exists today; they view the pedagogy and practice through the lens of expertise and practice experience. Nurses did not mention the ideals of community health or competency frameworks and viewed future community health nurse roles as resembling today's roles. While a handful of nurses expected new graduates to "hit the floor running," most believed that new graduates must possess a combination of a generalist foundation and some job-specific capabilities to enable their functioning in the patient encounter, a finding also supported by the research of Wolff, Regan, et al. (2010) and Freeling and Parker (2015). Nurses expected a foundation to consist of tangibles like assessment, pathophysiology, pharmacology, epidemiology, basic psychomotor skills, and interpersonal skills. Nurses viewed the role of critical thinking as part of a more complicated triad that included foundational knowledge and skills.

Nurses and students were both fairly pragmatic about what constituted basic knowledge and skills. Wolff, Regan, et al. (2010) found that practical knowledge was a foundational characteristic expected of new graduates in clinical practice. Being in possession of "an adequate theoretical knowledge base was considered an integral and essential component for providing safe nursing care and an important characteristic of

new graduate readiness" (Wolff, Regan, et al., 2010, p. 8), a finding also supported by the work of Klein and Fowles (2009). While this perspective of what constituted foundations for practice was shared by nurses and students, the latter expressed a desperation for this type of foundation, raising the level of its importance to critical. For students, not feeling in possession of foundations for nursing practice (as defined in pragmatic terms) gives rise to considerable anxiety, which increases as they progress towards graduation. These feelings are not unwarranted; Walker and Campbell (2013) found that new graduates experienced considerable stress and job dissatisfaction if they were not prepared for practice, particularly in the dimensions of organisational acumen, clinical competence, and social intelligence.

Experienced nurses often report that students lack basic foundational nursing knowledge and skills (Freeling & Parker, 2015). Wolsky (2014) also found that significant gaps exist between nurses' performance expectations of new graduates in the areas of technical skills and critical thinking. To prepare for graduation, students prefer placements in which they have opportunities for skill mastery and application of foundational knowledge, as well as socialization into the profession (Murphy, Rosser, Bevan, Warner, & Jordan, 2012). Non-traditional placements that utilize service learning for community health clinical experiences rarely offer the type of learning and socialization that students believe they need for graduation and nursing practice. Overall, there seems to be a breakdown in multiple critical areas between nurses, faculty and students, including the role of foundational knowledge and skills, the role of critical thinking, and the role of the community health clinical experience in undergraduate preparation.

It seems that nurses, faculty and students are each speaking a different language, have different expectations of nursing education and the abilities of the new graduate, and different expectations of the community health clinical experience in terms of what it can and should accomplish. It is possible that some of the different views between faculty and nurses are due to the difference in adoption or uptake of competency frameworks. Indeed, the content of the speech of faculty was replete with the language of established competency frameworks for community health, whereas practicing nurses' speech resembled the actual activities of their daily work. An American study, Polivka, Valedes Chaudry, and Jones (2014) found that public health job descriptions had a very low rate of incorporation of the language of national standards and competencies for public health. While a similar study has not been done elsewhere, their findings align with the present study, in that national community health competency frameworks are not translating into practice on the ground, most likely due to the constraints of a workplace driven by fiscal austerity and a focus on measurable outcomes that results in a tension between role ideals and role realities.

Perhaps the notion of what it means to graduate as a 'generalist' needs to be better understood across participant groups. One way to view the generalist is as an undifferentiated cell, which is one that has not yet expressed signs of its future specific type. Another way to view a generalist is that of one who holds a broad perspective of practice. McWhinney and Freeman (2009) suggest that a mix of generalists and specialists are required in healthcare, and that the role of the generalist, which new nurse graduates are deemed to be, has been demeaned of late, citing the knowledge explosion and the impossibility of knowing everything in an entire field, resulting in the need for more specialties. However, they argue that

this belief is based on the faulty assumption that knowledge is cumulative (the "lump fallacy") (McWhinney & Freeman, 2009, p. 23). Rather, they suggest that generalists function with a breadth of knowledge that deepens with time; thus, the breadth/depth divide may in fact not be a tension at all.

Non-traditional placements for the community health clinical experience tend to accentuate the theory-practice gap and the gap between the expected and actual performance of new graduates in community health. It may be time to re-examine how community health practice rotations are conducted to ensure that students are exposed to a variety of community health competencies, roles and experiences. It is always an appropriate time to examine nursing pedagogy, particularly when the stakes are as high as they are in clinical practice, to find new ways of helping students make links and develop the competence they need for professional practice. With so many disconnects and gaps occurring and even widening, new ways of working with practice partners need to be found to ensure that the needs of the public are met by community health nurses who are prepared for the roles of today and the challenges of tomorrow.

Conclusion

Service learning in non-traditional community health clinical placements poses unique challenges for students, faculty and community health nurses. Without strong pedagogy, the theory-practice gap widens and students are not able to appreciate and learn from the experiences. Furthermore, new graduates are not able to apply what they learned in their non-traditional experience within their role descriptions in community health, contributing to a gap between their expected and actual performance. The theory-

practice gap and the gap between the expected and actual performance of new graduates need to be addressed in the preparation of new nurses for community health roles.

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Chapter 6: Conclusion, Recommendations, and Limitations

Through this mixed method study we illuminated the theory-practice gap in a unique way, blending a quantitative gap analysis with qualitative focus group interviews to shed further light on the gap. We determined the nature of the gap between what nurses, students and faculty desire to see demonstrated by senior nursing students and new graduates in community health areas and what they are actually seeing demonstrated. Findings reveal that there is a significant gap between the observed and desired competency level of senior nursing students and new graduates in community health. Faculty and students rated observed and desired student and graduate competence higher than nurses.

Exploration of the gap through focus groups with nursing students, community health faculty, and community health nurses revealed that there are disconnects between theory and practice and that each participant group views that disconnect differently. Students, nurses and faculty tend to appreciate differently several tensions: concrete and abstract approaches to learning and practice-readiness; and pragmatism and idealism as they are embodied in the foundations of practice, the future of nursing practice, and the role of critical thinking. The theory-practice gap is also widened by different perspectives on the value of breadth versus depth in education and exposure to community health principles and roles. Additionally, a history has been lost between academe and community health practice partners, leading to a lack of understanding about what the other is doing. Finally, the theory-practice gap was accentuated through the tension between logistical realities and pedagogical development.

These findings contribute to our understanding of the nature of the gap between desired and observed competence of senior nursing students and new graduates in community health practice areas. That there are multiple gaps between nursing education and nursing practice is well documented and widely recognized. One commonly cited gap is the theory-practice gap; another is the gap between the expected and actual performance of new graduates. Both of these gaps have unique significance in the clinical preparation of undergraduate nursing students for community health roles. Non-traditional placements for the community health clinical experience tend to accentuate the theory-practice gap and the gap between the expected and actual performance of new graduates in community health.

As for a way forward, many factors and possibilities must be considered. Perhaps the notion of what it means to graduate as a 'generalist' needs to be better understood across participant groups. It may be time to re-examine how community health practice rotations are conducted to ensure that students are exposed to a variety of community health competencies, roles and experiences. It is always an appropriate time to examine nursing pedagogy, particularly when the stakes are as high as they are in clinical practice, to find new ways of helping students make links and develop the competence they need for professional practice. With so many disconnects and gaps occurring and even widening, new ways of working with practice partners need to be found to ensure that the needs of the public are met by community health nurses who are prepared for the roles of today and the challenges of tomorrow.

Additionally, educators may wish explore the construct of *competence*, the degree to which graduates should be deemed competent and in which clinical areas, and whether some level of incompetence is acceptable and what this looks like. These discussions, optimally occurring with the practice sector, would be beneficial and would advance our mutual understanding and expectations of the competence of new graduates.

The Canadian Association of Schools of Nursing (CASN) Sub-Committee on Public Health has published a set of guidelines for undergraduate community health experiences (2010). These guidelines, which are readily available online for schools of nursing to utilize in the development of community health practice experiences, should provide the basis of all baccalaureate nursing education for community health practice. In addition, I have developed a set of detailed, pragmatic recommendations for enhancing student competence in community health practice experiences, expanding upon CASN's (2010) *Guidelines for Quality Community Health Nursing Clinical Placements for Baccalaureate Nursing Students*. These tips are intended to help undergraduate clinical educators and clinical organizers find ways to enhance community health practice education in their own context. This document is entitled *Tips for Teaching and Organizing Community Health Practice/Clinical Courses: Practical Tips for Instructors, Administrators and Organizers of Innovative/Non-Traditional Community Health Clinical Experiences.* It is located in Appendix N. I developed this document as a living document so that I can update it as contexts and information change and as new opportunities arise. The tips in this document expand on CASN's Guidelines and are derived from the literature, my own teaching experience, my research into community

health clinical experiences, and discussions with faculty across Canada who teach community health clinical practice courses. This document is readily available on my professional website (http://scholar.ulethbridge.ca/em_pijlzieber/).

Limitations

This study was hindered by unequal numbers of respondents in each group, particularly an underrepresentation of faculty, resulting in statistical bias. There was uneven representation across the province despite numerous attempts to contact the population and enhance recruitment and completion of the survey; thus, the final sample was not representative. There was a high attrition rate for the online survey and what characteristics distinguish completers from non-completers is not known and may have introduced bias. Paper surveys were administered at two sites to enhance response rates; however, paper and online modes each have a different fatigue rate, nonresponse rate, and response error (Porter, 2004; Savage & Waldman, 2008; Umbach, 2004). Participants self-selected into the study. It is possible the focus group participants were more opinionated than those who chose not to participate in the study.

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Appendix A: Entry-to-Practice Competencies (Alberta)
(College and Association of Registered Nurses of Alberta, 2013a)
MAY 2013
(Transcribed from PDF; Permission to Use Granted in Original CARNA Document)

The following overarching competency statement applies to all categories of competencies:

All registered nurses practice in a manner consistent with:
(a) CARNA *Practice Standards for Regulated members* and all other CARNA standards and guidelines;
(b) CNA *Code of Ethics for Registered Nurses* (2008);
(c) *Health Professions Act* (HPA) (2000), the practice statement in Schedule 24 of the HPA, and the *Registered Nurses Profession Regulation* (2005; and
(d) Federal and provincial legislation and common law that directs practice.

This statement is placed on its own at the outset because of its essential and overriding importance. This competency statement highlights the multiple professional, ethical, and legal sources of knowledge required for safe, competent, compassionate, ethical registered nursing practice.

PROFESSIONAL RESPONSIBILITY

PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY: DEMONSTRATES PROFESSIONAL CONDUCT AND THAT THE PRIMARY DUTY IS TO THE CLIENT TO ENSURE SAFE, COMPETENT, COMPASSIONATE, ETHICAL CARE.

COMPETENCIES: PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY
1. Represents self by first and last name and professional designation (protected title) to clients and the health care team.
2. Is accountable and accepts responsibility for own actions and decisions.
3. Recognizes individual competence within legislated scope of practice and seeks support and assistance as necessary.
4. Articulates the role and responsibilities of a registered nurse as a member of the nursing and health care team.
5. Demonstrates a professional presence and models professional behaviour.
6. Demonstrates leadership in client care by promoting healthy and culturally safe practice environments.
7. Displays initiative, a beginning confidence, self-awareness, and encourages collaborative interactions within the health care team.
8. Demonstrates critical inquiry in relation to new knowledge and technologies that change, enhance, or support nursing practice.
9. Exercises professional judgment when using agency policies and procedures, or when practising in the absence of agency policies and procedures.
10. Organizes own workload and develops time management skills for meeting responsibilities.

11. Demonstrates responsibility in completing assigned work and communicates about work completed and not completed.
12. Uses conflict resolution strategies to achieve healthier interpersonal interactions.
13. Questions unclear orders, decisions, or actions inconsistent with client outcomes, best practices, and health safety standards.
14. Protects clients through recognizing and reporting near misses and errors (the RN's own and others) and takes action to stop and minimize harm arising from adverse events.
15. Takes action on recognized unsafe health care practices and workplace safety risks to clients and staff.
16. Seeks out and critiques nursing and health-related research reports.
17. Integrates quality improvement principles and activities into nursing practice.

KNOWLEDGE-BASED PRACTICE

This category has two sections: Specialized Body of Knowledge and Competent Application of Knowledge.

SPECIALIZED BODY OF KNOWLEDGE: HAS KNOWLEDGE FROM NURSING AND OTHER SCIENCES, HUMANITIES, RESEARCH, ETHICS, SPIRITUALITY, RELATIONAL PRACTICE, AND CRITICAL INQUIRY.

COMPETENCIES: SPECIALIZED BODY OF KNOWLEDGE

18. Has a knowledge base about the contribution of registered nurse practice to the achievement of positive client health outcomes.
19. Has a knowledge base from nursing and other disciplines concerning current and emerging health care issues and trends (e.g., the health care needs of older adults, vulnerable and/or marginalized populations, health promotion, obesity, pain prevention and pain management, end-of-life care, problematic substance use, and mental health).
20. Has a knowledge base about human growth and development, and population health, including the determinants of health.
21. Has a knowledge base in the health sciences, including anatomy, physiology, pathophysiology, psychopathology, pharmacology, microbiology, epidemiology, genetics, immunology, and nutrition.
22. Has a knowledge base in nursing sciences, social sciences, humanities, and health-related research (e.g., culture, power relations, spirituality, philosophical, and ethical reasoning).
23. Has a knowledge base about workplace health and safety, including ergonomics, safe work practices, prevention and management of disruptive behaviour, including horizontal violence, aggressive, or violent behaviour.
24. Has theoretical and practical knowledge of relational practice and understands that relational practice is the foundation for all nursing practice.
25. Has knowledge about emerging community and global health issues, population health issues and research (e.g., pandemic, mass immunizations, emergency/disaster planning, and food and water safety).

26. Knows how to find evidence to support the provision of safe, competent, compassionate, and ethical nursing care, and to ensure the personal safety and safety of other health care workers.
27. Understands the role of primary health care and the determinants of health in health delivery systems and its significance for population health.
28. Understands nursing informatics and other information and communication **technologies** used in health care.

COMPETENT APPLICATION OF KNOWLEDGE: DEMONSTRATES COMPETENCE IN THE PROVISION OF NURSING CARE. THE COMPETENCY STATEMENTS IN THIS SECTION ARE GROUPED INTO FOUR AREAS ABOUT THE PROVISION OF NURSING CARE: ONGOING COMPREHENSIVE ASSESSMENT, HEALTH CARE PLANNING, PROVIDING NURSING CARE, AND EVALUATION. THE PROVISION OF NURSING CARE IS AN ITERATIVE PROCESS OF CRITICAL INQUIRY AND IS NOT LINEAR IN NATURE.

(AREA I) ONGOING COMPREHENSIVE ASSESSMENT: INCORPORATES CRITICAL INQUIRY AND RELATIONAL PRACTICE TO CONDUCT A CLIENT-FOCUSED ASSESSMENT THAT EMPHASIZES CLIENT INPUT AND THE DETERMINANTS OF HEALTH.

COMPETENCIES: ONGOING COMPREHENSIVE ASSESSMENT

29. Uses appropriate assessment tools and techniques in consultation with clients and the health care team.
30. Engages clients in an assessment of the following: physical, emotional, spiritual, cultural, cognitive, developmental, environmental, and social needs.
31. Collects information on client status using assessment skills of observation, interview, history taking, interpretation of laboratory data, mental health assessment, and physical assessment, including inspection, palpation, auscultation, and percussion.
32. Uses information and communication technologies to support information synthesis.
33. Uses anticipatory planning to guide an ongoing assessment of client health status and health care needs (e.g., prenatal/postnatal, adolescents, older adults, and reaction to changes in health status and/or diagnosis).
34. Analyzes and interprets data obtained in client assessments to draw conclusions about client health status.
35. Incorporates knowledge of the origins of the health disparities and inequities of Aboriginal Peoples and the contributions of nursing practice to achieve positive health outcomes for Aboriginal Peoples.
36. Incorporates knowledge of the health disparities and inequities of vulnerable populations (e.g., sexual orientation, persons with disabilities, ethnic minorities, poor, homeless, racial minorities, language minorities) and the contributions of nursing practice to achieve positive health outcomes.
37. Collaborates with clients and the health care team to identify actual and potential client health care needs, strengths, capacities, and goals.
38. Completes assessments in a timely manner, and in accordance with evidence-informed practice, agency policies, and protocols.

AREA (II) HEALTH CARE PLANNING: WITHIN THE CONTEXT OF CRITICAL INQUIRY AND RELATIONAL PRACTICE, PLANS NURSING CARE APPROPRIATE FOR CLIENTS WHICH INTEGRATES KNOWLEDGE FROM NURSING, HEALTH SCIENCES AND OTHER RELATED DISCIPLINES, AS WELL AS KNOWLEDGE FROM PRACTICE EXPERIENCES, CLIENTS' KNOWLEDGE AND PREFERENCES, AND FACTORS WITHIN THE HEALTH CARE SETTING.

COMPETENCIES: HEALTH CARE PLANNING

39. Uses critical inquiry to support professional judgment and reasoned decision making to develop health care plans.
40. Uses principles of primary health care in developing health care plans.
41. Facilitates the appropriate involvement of clients in identifying their preferred health outcomes.
42. Negotiates priorities of care and desired outcomes with clients, demonstrating cultural safety, and considering the influence of positional power relationships.
43. Initiates appropriate planning for clients' anticipated health problems or issues and their consequences (e.g., childbearing, childrearing, adolescent health, and senior well-being).
44. Explores and develops a range of possible alternatives and approaches for care with clients.
45. Facilitates client ownership of direction and outcomes of care developed in their health care plans.
46. Collaborates with the health care team to develop health care plans that promote continuity for clients as they receive conventional health care, and complementary and alternative therapy.
47. Determines, with the health care team or health-related sectors, when consultation is required to assist clients in accessing available resources.
48. Consults with the health care team as needed to analyze and organize complex health challenges into manageable components for health care planning.

AREA (III) PROVIDING NURSING CARE: PROVIDES CLIENT-CENTRED CARE IN SITUATIONS RELATED TO:

- HEALTH PROMOTION, PREVENTION, AND POPULATION HEALTH;
- MATERNAL/CHILD HEALTH;
- ALTERED HEALTH STATUS, INCLUDING ACUTE AND CHRONIC PHYSICAL AND MENTAL HEALTH CONDITIONS AND REHABILITATIVE CARE; AND
- PALLIATIVE CARE AND END-OF-LIFE CARE.

COMPETENCIES: PROVIDING NURSING CARE

49. Provides nursing care across the lifespan that is informed by a variety of theories relevant to health and healing (e.g., nursing; family; communication and learning; crisis intervention; loss, grief, and bereavement; systems; culture; community development; and population health theories).
50. Prioritize and provide timely nursing care and consult as necessary for any client with co-morbidities, and a complex and rapidly changing health status.

51. Provides nursing care to clients with chronic and persistent health challenges (e.g., mental health, problematic substance abuse, dementia, cardiovascular conditions, stroke, asthma, arthritis, and diabetes).
52. Incorporates evidence from research, clinical practice, client perspective, client and staff safety, and other available resources to make decisions about client care.
53. Supports clients through developmental stages and role transitions across the lifespan (e.g., pregnancy, infant nutrition, well-baby care, child development stages, family planning and relations).
54. Recognizes, seeks immediate assistance, and helps others in a rapidly changing client condition affecting health or patient safety (e.g., myocardial infarction, surgical complications, acute neurological event, acute respiratory event, cardiopulmonary arrest, perinatal crisis, diabetes crisis, mental health crisis, premature birth, shock, and trauma).
55. Applies principles of population health to implement strategies to promote health as well as prevent illness and injury (e.g., promoting hand washing, immunization, helmet safety, and safe sex).
56. Assists clients to understand how lifestyle factors impact health (e.g., physical activity and exercise, sleep, nutrition, stress management, personal and community hygiene practices, family planning, and high-risk behaviours).
57. Implements learning plans to meet identified client learning needs.
58. Assists clients to identify and access health and other resources in their communities (e.g., other health disciplines, community health services, rehabilitation services, support groups, home care, relaxation therapy, meditation, and information resources).
59. Applies knowledge when providing nursing care to prevent development of complications (e.g., optimal ventilation and respiration, circulation, fluid and electrolyte balance, nutrition, urinary elimination, bowel elimination, body alignment, tissue integrity, comfort, and sensory stimulation).
60. Applies bio-hazard and safety principles, evidence-informed practices, infection prevention and control practices, and appropriate protective devices when providing nursing care to prevent injury to clients, self, other health care workers, and the public.
61. Implements strategies related to the safe and appropriate administration and use of medication.
62. Recognizes and takes initiative to support environmentally responsible practice (e.g., observing safe waste disposal methods, using energy as efficiently as possible, and recycling plastic containers and other recyclable materials).
63. Performs therapeutic interventions safely (e.g., positioning, skin and wound care, management of intravenous therapy and drainage tubes, and psychosocial interaction).
64. Implements evidence-informed practices of pain prevention and pain management with clients using pharmacological and non-pharmacological measures.
65. Prepares the client for diagnostic procedures and treatments, provides post-diagnostic care, performs procedures, interprets findings, and provides follow-up care as appropriate.

66. Provides nursing care to meet palliative care or end-of-life care needs (e.g., pain and symptom management, psychosocial and spiritual support, and support for significant others).

AREA (IV) EVALUATION: MONITORS THE EFFECTIVENESS OF CLIENT CARE TO INFORM FUTURE CARE PLANNING.

COMPETENCIES: EVALUATION

67. Uses critical inquiry to monitor and evaluate client care in a timely manner.
68. Collaborates with others to support involvement in research and the use of research findings in practice.
69. Modifies and individualizes client care based on the emerging priorities of the health situation in collaboration with clients.
70. Verifies that clients have an understanding of essential information and skills to be active participants in their own care.
71. Reports and documents client care in a clear, concise, accurate, and timely manner.

ETHICAL PRACTICE

ETHICAL PRACTICE: DEMONSTRATES COMPETENCE IN PROFESSIONAL JUDGMENT AND PRACTICE DECISIONS GUIDED BY THE VALUES AND ETHICAL RESPONSIBILITIES IN THE CNA *CODE OF ETHICS FOR REGISTERED NURSES* (2008) AND THE CARNA DOCUMENT *ETHICAL DECISION-MAKING FOR REGISTERED NURSES IN ALBERTA: GUIDELINES AND RECOMMENDATIONS* (2010). ENGAGES IN CRITICAL INQUIRY TO INFORM CLINICAL DECISION-MAKING, AND ESTABLISHES THERAPEUTIC, CARING, AND CULTURALLY SAFE RELATIONSHIPS WITH CLIENTS AND THE HEALTH CARE TEAM.

COMPETENCIES: ETHICAL PRACTICE

72. Demonstrates honesty, integrity, and respect in all professional interactions.
73. Takes action to minimize the potential influence of personal values, beliefs, and positional power on client assessment and care.
74. Establishes and maintains appropriate professional boundaries with clients and the health care team, including the distinction between social interaction and therapeutic relationships.
75. Engages in relational practice through a variety of approaches that demonstrate caring behaviours appropriate for clients.
76. Promotes a safe environment for clients, self, health care workers, and the public that addresses the unique needs of clients within the context of care.
77. Demonstrates consideration of the spiritual and religious beliefs and practices of clients.
78. Demonstrates knowledge of the distinction between ethical responsibilities and legal obligations and their relevance when providing nursing care.
79. Respects and preserves clients' rights based on the values in the *CNA Code of Ethics for Registered Nurses* and an ethical framework.

80. Demonstrates an understanding of informed consent as it applies in multiple contexts (e.g., consent for care, refusal of treatment, release of health information, and consent for participation in research).
81. Uses an ethical reasoning and decision-making process to address ethical dilemmas and situations of ethical distress.
82. Accepts and provides care for all clients, regardless of gender, age, health status, lifestyle, sexual orientation, beliefs, and health practices.
83. Demonstrates support for clients in making informed decisions about their health care, and respects those decisions.
84. Advocates for safe, competent, compassionate, and ethical care for clients or their representatives, especially when they are unable to advocate for themselves.
85. Demonstrates ethical responsibilities and legal obligations related to maintaining client privacy, confidentiality and security in all forms of communication, including social media.
86. Engages in relational practice and uses ethical principles with the health care team to maximize collaborative client care.

SERVICE TO THE PUBLIC

SERVICE TO THE PUBLIC: DEMONSTRATES AN UNDERSTANDING OF THE CONCEPT OF PUBLIC PROTECTION AND THE DUTY TO PROVIDE NURSING CARE IN THE BEST INTEREST OF THE PUBLIC.

COMPETENCIES: SERVICE TO THE PUBLIC

87. Enacts the principle that the primary purpose of the registered nurse is to practice in the best interest of the public and to protect the public from harm.
88. Demonstrates knowledge about the structure of the health care system at the:
    (a) National level;
    (b) Provincial/Territorial level;
    (c) Regional/Municipal level;
    (d) Agency level; and
    (e) Practice setting or program level.
89. Recognizes the impact of organizational culture on the provision of health care and acts to enhance the quality of a professional and safe practice environment.
90. Demonstrates leadership in the coordination of health care by:
    (a) Assigning client care;
    (b) Consenting to and supervising and evaluating the performance of health-care aides and undergraduate nursing employees in performing restricted activities; and
    (c) Facilitating continuity of client care.
91. Participates and contributes to nursing and health care team development by:
    (a) Recognizing that one's values, assumptions, and positional power affects team interactions, and uses this self-awareness to facilitate team interactions;
    (b) Building partnerships based on respect for the unique and shared competencies of each team member;

(c) Promoting interprofessional collaboration through application of principles of decision-making, problem solving, and conflict resolution;
(d) Contributing nursing perspectives on issues being addressed by the health care team;
(e) Knowing and supporting the full scope of practice of team members; and
(f) Providing and encouraging constructive feedback.

92. Collaborates with the health care team to respond to changes in the health care system by:
(a) Recognizing and analyzing changes that affect one's practice and client care;
(b) Developing strategies to manage changes affecting one's practice and client care;
(c) Implementing changes when appropriate; and
(d) Evaluating effectiveness of strategies implemented to change nursing practice.
93. Uses established communication policies and protocols within and across health care agencies, and with other service sectors.
94. Uses resources in a fiscally responsible manner to provide safe, effective, and efficient care.
95. Supports healthy public policy and principles of social justice.

SELF-REGULATION

SELF-REGULATION: UNDERSTANDS THE REQUIREMENTS OF SELF-REGULATION IN THE INTEREST OF PUBLIC PROTECTION.

COMPETENCIES: SELF-REGULATION

96. Distinguishes among the mandates of regulatory bodies, professional associations, and unions.
97. Demonstrates understanding of the registered nurse profession as a self-regulating and autonomous profession mandated by provincial legislation to protect the public.
98. Distinguishes between the legislated scope of practice and the registered nurse's individual competence.
99. Understands the significance of professional activities related to the practice of registered nurses (e.g., attending annual general meetings, participating in surveys related to review of practice standards, and understanding significance of membership on regulatory committees, boards, or councils).
100. Adheres to the duty to report unsafe practice in the context of professional self-regulation.
101. Understands the significance of fitness to practice in the context of nursing practice, self-regulation, and public protection.
102. Identifies and implements activities that maintain one's fitness to practice.
103. Understands the significance of continuing competence requirements within professional self-regulation.
104. Demonstrates continuing competence and preparedness to meet regulatory requirements by;
(a) Assessing one's practice and individual competence to identify learning needs;

(b) Developing a learning plan using a variety of sources (e.g., self-evaluation and peer feedback);
(c) Seeking and using new knowledge that may enhance, support, or influence competence in practice; and
(d) Implementing and evaluating the effectiveness of one's learning plan and developing future learning plans to maintain and enhance one's competence as a registered nurse.

Appendix B: Home Health Nursing Competencies
(Community Health Nurses of Canada, 2010)

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The **Community Health Nurses of Canada** is a voluntary association of community health nurses and provincial/territorial community health nursing interest groups. We provide a unified national voice to represent and promote community health nursing and the health of communities.

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INTRODUCTION

Home Health Nursing Competencies are the integrated knowledge, skills, judgement and attributes required of a nurse working in home health to practice safely and ethically. Attributes include, but are not limited to attitudes, values and beliefs (adapted from Canadian Nurses Association Code of Ethics, 2008).

A review of the literature provided evidence of the vast array of diverse competencies required for the unique and complex practice of home health nursing2. The review also identified over a dozen organizing frameworks for home health nursing competencies. The existence of so many frameworks speaks to the challenge of organizing competencies in a way that is practical, comprehensive and meaningful. As recommended at the conclusion of the literature review, the Canadian Community Health Nursing Standards of Practice (2008)3 have been used as the organizing framework for the home health nursing competencies contained in this document. The competencies are broad in scope, thereby lending themselves to application within multiple settings and to be further delineated into more specific elements of practice for job descriptions or performance appraisal tools.

ABOUT THE PRACTICE OF HOME HEALTH NURSING

Home health nursing encompasses disease prevention, rehabilitation, restoration of health, health protection and health promotion with the goal of managing existing problems and preventing potential problems. Home health nursing activities include "teaching, curative interventions, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver" (Canadian Home Care Association4, 2008, p. 2) and involve initiating, coordinating, managing and evaluating the resources needed to promote the patient's maximum level of health and function (American Nurses Association, 2008).

Home health nurses practice in a highly independent and autonomous manner. They provide or manage the care of patients with a broad array of diagnoses across the lifespan and the health-illness continuum. Their role is characterized by flexibility, adaptability and creative approaches to situations and problems encountered in the context of service delivery where clients live. Home health nurses incorporate excellence in communication and motivation skills, applying critical thinking and clinical decision- making in the application of the nursing process and work collaboratively with clients and their families/caregivers and as effective members within interprofessional teams.

Home health nurses are committed to the provision of accessible, responsive and timely care which allows people to stay in their homes with safety and dignity. The following list of competencies identifies the knowledge, skills, judgment and attributes required of home health nurses, as they work with clients/families in the community within a complex health system.

FRAMEWORK FOR THE HOME HEALTH NURSING COMPETENCIES

1) **Elements of Home Health Nursing**

    a) Assessment, Monitoring and Clinical Decision Making
    b) Care Planning and Care Coordination
    c) Health Maintenance, Restoration & Palliation
    d) Teaching and Education
    e) Communication
    f) Relationships
    g) Access and Equity
    h) Building Capacity

2) **Foundations of Home Health Nursing**
    a) Health Promotion
    b) Illness Prevention & Health Protection

3) **Quality and Professional Responsibility**
    a) Quality Care
    b) Professional Responsibility

1) ELEMENTS OF HOME HEALTH NURSING

These elements and associated competencies focus on the nursing activities, functions, goals and outcomes that are central to home health nursing practice.

a) Assessment, Monitoring and Clinical Decision Making

The home health nurse is able to…

i. conduct comprehensive autonomous and /or collaborative health assessments to determine the health status, functional and psychosocial need and competence of clients and their families within the context of their environment and social supports
ii. apply critical thinking skills and creative problem-solving analysis when making clinical decisions
iii. analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations
iv. collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services
v. incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum
vi. keep knowledge current and use evidence to inform practice to ensure optimal case management
vii. assess the safety of the home environment with the goal of optimizing client safety and taking actions to support a safe work environment for all members of the home health care team

b) Care Planning and Care Coordination

The home health nurse is able to…

i. plan and prioritize visits to meet the health and scheduling needs of clients
ii. use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care
iii. support clients and families to build on their strengths to attain or maintain a desired health status within available resources
iv. anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc.
v. ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family , health care team and community
vi. promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach

vii. appreciate and understand the roles and responsibilities and the contributions of other regulated and unregulated health workers involved in the client care plan
viii. facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue
ix. collaboratively evaluate care plan interventions through reassessment and ongoing evaluation of results and adapt them to the changing conditions of the client and the client's family

c) Health Maintenance, Restoration & Palliation

The home health nurse is able to**…**

i. assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum
ii. understand and/or educate clients, their families/caregivers and colleagues in the safe and appropriate use and maintenance of various types of equipment, technology and treatments to maintain health and assist clients and families to integrate them into their everyday life/routine
iii. communicate effectively with clients and families while supporting them through the decision making process about end of life issues
iv. use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting
v. recognize when specialized counselling beyond the scope of nursing is required and facilitate an appropriate referral
vi. Respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies
vii. self-identify when their need for assistance when not familiar with care requirements and interventions and how to seek support to assure continued excellence in care

d) Teaching and Education

The home health nurse is able to…

i. assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family
ii. consider and integrate into educational planning the factors that may impact the client/family's ability to learn. For example: environment, readiness, willingness, literacy level, educational background, socioeconomic situation health status etc.
iii. interpret and explain complex information for clients and families
iv. apply appropriate learning principles, teaching methods and educational

theories to educational activities
v. include family, volunteers and caregivers in teaching and education
vi. evaluate the effectiveness of health education interventions

e) Communication

The home health nurse is able to…

i. use effective listening, verbal and non-verbal communication skills to understand the client's perspective and be understood by the client, family and other caregivers involved in the care
ii. use effective interviewing skills and strategies to engage in constructive dialogue with clients and their families
iii. use effective communication skills to engage, connect, appreciate, respond, empathize and empower others
iv. identify and use strategies to overcome language and communication barriers
v. maintain a focused approach amidst multiple distractions within the home environment
vi. employ negotiation and conflict management skills
vii. use techniques that are client-centered, client-driven, and strength-based when counselling clients
viii. use documentation as an effective communication tool
ix. use technology to effectively communicate and manage client care in a confidential manner

f) Relationships

The home health nurse is able to…

i. optimize the health of the client and care giver(s) by establishing and maintaining a therapeutic nurse-client relationship based on mutual trust, respect, caring, and listening within the context of being 'a guest in the house'
ii. acknowledge the contribution that the family/caregiver provides to client health in a way that makes them feel valued and respected and support them to maintain relationships that support effective care
iii. work effectively and non-judgementally in a wide range of environments with varying conditions of cleanliness
iv. use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships
v. involve clients and families as active partners to identify assets, strengths and available resources

g) Access and Equity

The home health nurse is able to…

i. advocate for healthy public policies and accessible, inclusive and integrated services that promote and protect the health and well-being of all individuals and communities
ii. apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities
iii. recognize opportunities to promote social justice and advocate in collaboration with, and on behalf of clients and families on related issues to give voice to the vulnerable
iv. optimize allocation of human, financial, and infrastructure resources in order to provide a safe and accessible health delivery system
v. advocate for the reduction of inequities in health by participating in legislative and policy making activities

h) Building Capacity

The home health nurse is able to**…**

i. mobilize clients, families and others to take action to address health needs, deficits and gaps accessing and using available resources
ii. assist the client and their family to recognize their capacity for managing their health needs according to available resources
iii. assist colleagues, partners and/or clients to support and build on the capacities that are inherent in the individual, families and the communities to influence policy change
iv. demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity
v. adapt and be flexible and responsive to the changing health needs of the client and family

2) FOUNDATIONS OF HOME HEALTH NURSING

These competencies focus on the core knowledge and primary health care philosophy that is central to home health nursing practice.

a) Health Promotion

The home health nurse is able to…

i. facilitate planned change with clients and families by applying and incorporating health promotion theory, primary health care principles and change theory into practice
ii. recognize how the determinants of health influence the health and well-being

of clients and families

iii. assess the impact specific issues may have on the client's health such as; political climate; priorities, values and culture; social and systemic structures and settings

iv. assess the readiness and capacity of the client and family to make changes to promote their health

b) Illness Prevention and Health Protection

The home health nurse is able to**…**

i. apply nursing sciences to practice and evaluate, synthesize and apply knowledge from a broad range of theories, models, frameworks and practice

ii. use critical thinking to consider the ethical, political, scientific, socio-cultural and economic contexts to determine the meaning of information related to client health care needs

iii. support clients and families to identify risks to health and make informed choices about protective and preventive health measures

iv. take action to protect clients, families and groups from unsafe or unethical circumstances

v. participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of clients and families

3) QUALITY AND PROFESSIONAL RESPONSIBILITY

These competencies focus on practice activities and/or strategies by which the home health nurse promotes quality of care and demonstrates professional responsibility.

a) Quality

The home health nurse is able to…

i. initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes

ii. initiate and participate in critical incident reviews

iii. evaluate nursing interventions in a systematic and continuous manner by measuring their effect on clients and families

iv. evaluate programs in relation to determinants of health and health outcomes

v. contribute to the quality of work environments by identifying needs, issues, solutions and actively participating in team and organizational quality improvement processes

vi. understand the financial aspects of care and be accountable for effective, efficient and responsible use of time and resources when delivering care to clients and families

b) Professional Responsibility

The home health nurse is able to**…**

i. demonstrate professionalism, leadership, judgement and accountability in independent practice in multiple settings with multiple stakeholders
ii. practice independently and autonomously providing client centered services in a wide variety of settings where nursing care and services are needed
iii. use reflective practice to continually assess and improve practice
iv. integrate multiple ways of knowing into practice
v. contribute to the development and generation of evidence-informed nursing practice
vi. pursue lifelong learning opportunities to support professional practice
vii. use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies
viii. describe the mission, values and priorities of the health organization where one works
ix. participate in the advancement of home health nursing by mentoring students and new practitioners
x. recognize and understand that one's attitudes, beliefs, feelings and values about health can have an effect on relationships and interventions

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Appendix C: Public Health Nursing Competencies
(Community Health Nurses of Canada, 2009a)

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Introduction

The development of the Public Health Nursing Discipline Specific Competencies Version 1.0 was made possible through the commitment of the Community Health Nurses Association of Canada (CHNAC), the CHNAC board and president, the CHNAC Certification, Standards, Competency Standing Committee as well as the dedicated work of the Expert Group who provided ongoing input and guidance.

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Core Competencies for Public Health in Canada Release 1.0 was distributed in 2007 and helped to define the generic knowledge, skills and attitudes necessary for the practice of public health. Core Competencies transcend the boundaries of specific disciplines and are independent of program and topic. (Public Health Agency of Canada, 2007).

The need to further define discipline specific competencies for public health nurses was identified as a priority by the Community Health Nurses Association of Canada (CHNAC) and the Public Health Agency of Canada (PHAC). Using the Core Competencies for Public Health in Canada Release 1.0 (PHAC, 2007), the Community Health Nursing Standards of Practice (CHNAC, 2008), and the Public Health Nursing Practice in Canada: A Review of the Literature (Hogan, 2008) as a foundation, a Delphi process was used to achieve consensus on the development of the discipline specific competencies for public health nurses. The outcome of this work is the Public Health Nursing Discipline Specific Competencies Version 1.0 .

The “ version 1.0 ” designation is intended to imply that the PHN competencies will evolve and change over time, as nursing and public health practice knowledge evolves.

The Public Health Nursing Discipline Specific Competencies Version 1.0.

Public Health Nursing Competencies are the integrated knowledge, skills, judgement and attributes required of a public health nurse to practice safely and ethically. Attributes include, but are not limited to attitudes, values and beliefs. (Canadian Nurses Association Code of Ethics, 2008)

1 - PUBLIC HEALTH and NURSING SCIENCES

This category includes key knowledge and critical thinking skills related to: the public health sciences (behavioural and social sciences, biostatistics, epidemiology, environmental public health, demography, workplace health, prevention of chronic diseases, infectious diseases, psychosocial problems and injuries) as well as nursing theory, change theory, economics, politics, public health administration, community assessment, management theory, program planning and evaluation, population health principles, community development theory, and the history of public health. Competency in this category requires the ability to apply knowledge in practice.

A public health nurse is able to…

1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services.
1.2 Apply knowledge about the history, structure and interaction of public health and health care services at local, provincial/territorial, national, and international levels.
1.3 Apply public health and nursing sciences to practice and synthesize knowledge from a broad range of theories, models and frameworks.
1.4 Critically appraise knowledge gathered from a variety of sources.
1.5 Use evidence and research to inform health policies, programs and practice:
- contribute to the development and generation of evidence-based nursing
- use available resources to systematically plan and evaluate public health nursing practice

1.6 Pursue lifelong learning opportunities in the field of public health that are consistent with: current public health nursing practice; new and emerging issues; the changing needs of individuals, families, groups and communities; emerging research and evolving information about the impact of the determinants of health.
1.7 Integrate multiple ways of knowing into practice.

2 - ASSESSMENT AND ANALYSIS

This category describes the core competencies needed to collect, assess, analyze and apply information (including data, facts, concepts and theories). These competencies are required to make evidence-based decisions, prepare budgets and reports, conduct investigations and make recommendations for policy and program development. Community members are involved in identifying and reinforcing those aspects of everyday life, culture and political activity that are conducive to health.

A public health nurse is able to…

2.1 Recognize that a health concern or issue exists:

- apply principles of epidemiology
- conduct comprehensive community assessments with individuals, families, groups and communities using quantitative and qualitative strategies
- recognize patterns and trends in epidemiological data and service delivery
- assess the impact of the broad social, cultural, political and economic determinants of health.

2.2 Identify relevant and appropriate sources of information, including community assets, resources and values in collaboration with individuals, families, groups, communities and stakeholders.

2.3 Collect, store, retrieve and use accurate and appropriate information on public health issues.

2.4 Analyze information to determine appropriate implications, uses, gaps and limitations.

2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity.

2.6 Assess the health status and functional competence of individuals, families, groups, communities or populations within the context of their environmental and social supports.

2.7 Determine the meaning of information, considering the ethical, political, scientific, socio-cultural and economic contexts:

- identify attitudes, beliefs, feelings and values about health and their effect on relationships and interventions
- support individuals, families, groups and communities to identify risks to health and make informed choices about protective and preventive health measures
- describe the role of power in relationships by giving voice to the vulnerable
- demonstrate skill in dealing with diversity and high levels of ambiguity.

2.8 Recommend specific actions based on the analysis of information:

- identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach.
- identify short and long term goals
- identify outcome indicators
- identify research questions

2.9 Recognize opportunities to promote social justice.

3 - POLICY AND PROGRAM PLANNING, IMPLEMENTATION AND EVALUATION

This category describes the core competencies needed to effectively choose options, and to plan, implement and evaluate policies and/or programs in public health. This includes the management of incidents such as outbreaks and emergencies.

3(A) - POLICY DEVELOPMENT

A public health nurse is able to…

3A.1 Describe selected policy options to address a specific public health issue.
3A.2 Describe the implications of each policy option, especially as they apply to the determinants of health and recommend or decide on a course of action.
3A.3 Develop a plan to implement a course of action taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies.
3A.4 Implement a policy.
3A.5 Support community action to influence policy change.
3A.6 Build community capacity to improve health and address health inequities.
3A.7 Advocate for healthy public policy and services that promote and protect the health and well-being of individuals, families groups and communities.
3A.8 Advocate for the reduction of inequities in health through legislative and policy making activities.

3(B) - PROGRAM PLANNING

A public health nurse is able to…

3B.1 Describe selected program options to address a specific public health issue.
3B.2 Describe the implications of each option, especially as they apply to the determinants of health and recommend or decide on a course of action.
3B.3 Develop a plan in collaboration with individuals, families, groups and communities to implement a course of action that is responsive to needs taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies.

3(C) - IMPLEMENTATION AND INTERVENTION

A public health nurse is able to…

3C.1 Take action, across multiple levels, to address specific public health issues by using a comprehensive mix of public health strategies to address unique needs and to build individual, family, group and community capacity.
3C.2 Facilitate planned change with individuals, families, groups, communities, systems or population(s) by applying the Population Health Promotion Model, primary health care principles and appropriate change theory.
3C.3 Demonstrate the ability to integrate relevant research and implement evidence informed practice.
3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of individuals, families, groups, communities and populations.
3C.5 Maximize the capacity of the individual, family, group or community to take responsibility for and to manage their health needs according to resources available and personal skills.
3C.6 Set and follow priorities and maximize outcomes based on available resources.
3C.7 Fulfill functional roles in response to a public health emergency.
3C.8 Facilitate access to services in the health sector and other sectors.
3C.9 Adapt practice in response to the changing health needs of the individual, family, group and community and in response to the unique characteristics of the setting.
3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances.
3C.11 Advocate in collaboration with, and on behalf of, and with individuals, families, groups and communities on social justice related issues.

3(D) – EVALUATION

A public health nurse is able to…

3D.1 Evaluate an action, policy or program in a systematic and continuous manner by measuring its effect on individuals, families, groups or communities.
3D.2 Evaluate programs in relation to determinants of health and health outcomes.
3D.3 Evaluate programs in partnership with individuals, families, groups, communities and other stakeholders.

4 - PARTNERSHIPS, COLLABORATION AND ADVOCACY

This category captures the competencies required to influence and work with others to improve the health and well-being of the public through the pursuit of a - common goal. This includes the concepts of: social justice, which is the fair distribution of society's

benefits and responsibilities and their consequences (Canadian Nurses Association, Code of Ethics, 2008); partnership and collaboration which is to optimize performance through shared resources and responsibilities; advocacy which is to speak, write or act in favour of a particular cause, policy or group of people and aims to reduce inequities in health status or access to health services.

A public health nurse is able to…

4.1 Advocate for societal change in support of health for all:
- collaborate with partners to address public health issues and service gaps in order to achieve improved health outcomes
- build coalitions, intersectoral partnerships and networks
- facilitate the change process to impact the determinants of health and improve health outcomes.

4.2 Use skills such as team building, negotiation, conflict management and group facilitation to build partnerships and to support group development.

4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources.

4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.

Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps.

5 - DIVERSITY AND INCLUSIVENESS

This category identifies the competencies required to interact effectively with diverse individuals, families, groups and communities in relation to others in society as well to recognize the root causes of disparities and what can be done to eliminate them (Canadian Nurses Association, Code of Ethics, 2008). It is the embodiment of attitudes and actions that result in inclusive behaviours, practices, programs and policies.

A public health nurse is able to…

5.1 Recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups.

5.2 Address population diversity when planning, implementing, adapting and evaluating public health programs and policies.

5.3 Apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities.

6 – COMMUNICATION

Communication involves an interchange of ideas, opinions and information. This category addresses numerous dimensions of communication including internal and external exchanges; written, verbal, non-verbal and listening skills; computer literacy; providing appropriate information to different audiences; working with the media and social marketing techniques.

A public health nurse is able to…

6.1 Communicate effectively with individuals, families, groups, communities and colleagues:
- use verbal, non verbal and written or graphic communication skills
- speak and write in plain language
- use multi-sensory forms of communication to address unique communication styles
- use culturally relevant communication when building relationships.

6.2 Interpret information for professional, non professional and community audiences.
6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques.
6.4 Use current technology to communicate effectively.

7 - LEADERSHIP

This category focuses on leadership competencies that build capacity, improve performance and enhance the quality of the working environment. They also enable organizations and communities to create, communicate and apply shared visions, missions and values.

A public health nurse is able to…

7.1 Describe the mission and priorities of the public health organization where one works, and apply them in practice.
7.2 Contribute to developing key values and a shared vision to assess, plan and implement public health programs and policies in the community by actively working with health professionals and in partnership with community partners to build capacity.
7.3 Use public health and nursing ethics to manage self, others, information and resources and practice in accordance with all relevant legislation, regulating body standards and codes (e.g. provincial health legislation, child welfare legislation, privacy legislation, Canadian Nurses Association Code of Ethics for registered nurses).

7.4 Contribute to team and organizational learning in order to advance public health goals.
7.5 Contribute to the maintenance of organizational performance standards.
7.6 Demonstrate an ability to build capacity by sharing knowledge, tools, expertise and experience:
- participate in professional development and practice development activities
- mentor students and orient new staff
- participate in research and quality assurance initiatives.

8 - PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY

This category addresses a number of dimensions including the recognition that nurses are accountable for their actions and are responsible for making sure they have the required knowledge and skills needed to ensure the delivery of safe, compassionate, competent and ethical care. It includes the competencies required to maintain quality work environments and relationships needed in a professional practice. Public Health nurses are responsible for initiating strategies that will address the determinants of health and generate a positive impact on people and systems. They are accountable to a variety of authorities and stakeholders as well as to the individual and community they serve. This range of accountabilities places them in a variety of situations with unique ethical dilemmas.

A public health nurse is able to…

8.1 Demonstrate professionalism in independent practice in multiple settings with multiple stakeholders.
8.2 Apply ethical standards and principles taking into consideration appropriate public health and nursing ethics.
8.3 Consult as needed to determine the best course of action in response to: ethical dilemmas, safety issues, risks to human rights and freedoms, new situations and new knowledge.
8.4 Use reflective practice to continually assess and improve practice:
- examine practice in relation to personal and individual, family, group or community attributes, existing knowledge and context
- adapt public health nursing techniques, approaches and procedures to the challenges in a particular community situation or setting.

8.5 Advocate for effective, efficient and responsible use of resources.
8.6 Act upon legal and professional obligations, and practices in accordance with relevant legislation.
8.7 Contribute to the quality of public health nursing work environments by identifying needs, issues, solutions and mobilizing colleagues by actively participating in team and organizational structures and mechanisms.

Mapping the Community Health Nursing Standards to the Public Health Nursing Competencies

For Canadian nurses, the Community Health Nursing Standards define the scope of practice or expectations for acceptable nursing practice while the Public Health Nursing Discipline Specific Competencies define the essential skills, knowledge and abilities necessary for the practice of public health nursing.

Underwood (2007) defines competencies as a "behaviors" and standards as "the level of service intervention or outcome". In other words, competencies describe the activity that a public health professional engages in to meet a standard or set of standards. Both 'standards' and 'competencies' could refer to structure, process or outcomes.

A mapping document was created to highlight the inter-connection between the Community Health Nursing Standards of Practice and the Public Health Nursing Discipline Specific Competencies. Mapping the Community Health Nursing Standards and the Public Health Nursing Competencies document can be found on the Community Health Nurses Association of Canada web site at http://www.chnac.ca

Conclusion

The identification of the required knowledge, skills and abilities is a vital contribution to the development of a strengthened public health nursing workforce. These discipline specific competencies will hopefully guide undergraduate nursing curriculum planning and professional development activities in addition to providing a framework for public health nursing practice evaluation and feedback.

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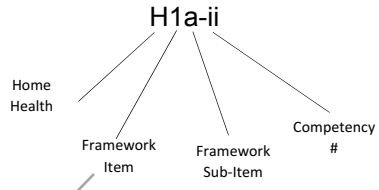
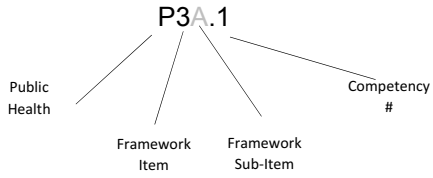
Appendix D: Mapping Entry-to-Practice Competencies (Alberta) to Community Health Nursing Competencies

<table>
<tr><th colspan="2">Introduction and Legend</th></tr>
<tr><th>Home Health Competencies</th><th>Public Health Competencies</th></tr>
<tr><td> 
</td><td> 
</td></tr>
<tr><td>Framework for the Home Health Nursing Competencies
1) Elements of Home Health Nursing
a) Assessment, Monitoring and Clinical Decision Making
b) Care Planning and Care Coordination
c) Health Maintenance, Restoration & Palliation
d) Teaching and Education
e) Communication
f) Relationships
g) Access and Equity
h) Building Capacity
2) Foundations of Home Health Nursing
a) Health Promotion
b) Illness Prevention & Health Protection
3) Quality and Professional Responsibility
a) Quality Care
b) Professional Responsibility</td><td>Framework for the Public Health Nursing Competencies
1) Public Health and Nursing Sciences
2) Assessment and Analysis
3) Policy and Program Planning, Implementation and Evaluation
A. Policy Development
B. Program Planning
C. Implementation and Intervention
D. Evaluation
4) Partnership, Collaboration and Advocacy
5) Diversity and Inclusiveness
6) Communication
7) Leadership
8) Professional Responsibility and Accountability</td></tr>
</table>

CARNA ETPC	Home Health Competency	Public Health Competency
PROFESSIONAL RESPONSIBILITY PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY: DEMONSTRATES PROFESSIONAL CONDUCT AND THAT THE PRIMARY DUTY IS TO THE CLIENT TO ENSURE SAFE, COMPETENT, COMPASSIONATE, ETHICAL CARE.		
1. Represents self by first and last name and professional designation (**protected title**) to clients and the health care team.		
2. Is accountable and accepts **responsibility for own actions** and decisions.	H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders	P8.1 Demonstrate professionalism in independent practice in multiple settings with multiple stakeholders. P8.6 Act upon legal and professional obligations, and practices in accordance with relevant legislation.
3. Recognizes **individual competence** within legislated **scope of practice** and seeks support and assistance as necessary.	H1c-v) recognize when specialized counseling beyond the scope of nursing is required and facilitate an appropriate referral H1c-vii) self-identify when their need for assistance when not familiar with care requirements and interventions and how to seek support to assure continued excellence in care H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	
4. Articulates the **role and responsibilities of a registered nurse** as a member of the nursing and health care team.	H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders	P8.6 Act upon legal and professional obligations, and practices in accordance with relevant legislation.
5. Demonstrates a **professional presence** and models professional behaviour.	H1f-i) optimize the health of the client and care giver(s) by establishing and maintaining a therapeutic nurse-client relationship based on mutual trust, respect, caring, and listening within the context of being 'a guest in the house'	P8.1 Demonstrate professionalism in independent practice in multiple settings with multiple stakeholders.
6. Demonstrates leadership in client care by **promoting healthy and culturally safe practice environments**.	H1g-ii) apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3a-v) contribute to the quality of work environments by identifying needs, issues, solutions and actively participating in team and organizational quality improvement processes	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities. P5.2 Address population diversity when planning, implementing, adapting and evaluating public health programs and policies. P5.3 Apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities. P8.7 Contribute to the quality of public health nursing work environments by identifying needs, issues, solutions and mobilizing colleagues by actively participating in team and organizational structures and mechanisms
7. Displays **initiative**, a beginning **confidence**, self-**awareness**, and encourages collaborative interactions within the health care team.	H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders H3b-x) recognize and understand that one's attitudes, beliefs, feelings and values about health can have an	

CARNA ETPC	Home Health Competency	Public Health Competency
	effect on relationships and intervention	
8. Demonstrates **critical inquiry** in relation to new knowledge and technologies that change, enhance, or support nursing practice.	H1a-ii) apply critical thinking skills and creative problem-solving analysis when making clinical decisions	P1.4 Critically appraise knowledge gathered from a variety of sources. P6.4 Use current technology to communicate effectively. P8.3 Consult as needed to determine the best course of action in response to: ethical dilemmas, safety issues, risks to human rights and freedoms, new situations and new knowledge.
9. Exercises **professional judgment** when using **agency policies and procedures**, or when practising in the absence of agency policies and procedures.	H1a-ii) apply critical thinking skills and creative problem-solving analysis when making clinical decisions H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders	P7.1 Describe the mission and priorities of the public health organization where one works, and apply them in practice. P8.1 Demonstrate professionalism in independent practice in multiple settings with multiple stakeholders.
10. Organizes own **workload** and develops **time management** skills for meeting responsibilities.	H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc.	
11. Demonstrates responsibility in **completing assigned work** and **communicates** about work completed and not completed.	H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H1e-viii) use documentation as an effective communication tool	
12. Uses **conflict resolution** strategies to achieve healthier interpersonal interactions.	H1e-vi) employ negotiation and conflict management skills H1f-iv) use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships	P4.2 Use skills such as team building, negotiation, conflict management and group facilitation to build partnerships and to support group development.
13. **Questions unclear** orders, decisions, or actions inconsistent with client outcomes, best practices, and health safety standards.	H1a-ii) apply critical thinking skills and creative problem-solving analysis when making clinical decisions H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.
14. Protects clients through recognizing and reporting **near misses** and errors (the RN's own and others) and takes action to stop and minimize harm arising from **adverse events.**	H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3a-ii) initiate and participate in critical incident reviews	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances.
15. Takes action on recognized **unsafe health care practices** and workplace safety risks to clients and staff.	H1a-vii) assess the safety of the home environment with the goal of optimizing client safety and taking actions to support a safe work environment for all members of the home health care team H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes H3a-ii) initiate and participate in critical incident reviews	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances.

CARNA ETPC	Home Health Competency	Public Health Competency
16. Seeks out and **critiques nursing and health-related research reports**.	H1a-vi) keep knowledge current and use evidence to inform practice to ensure optimal case management	P1.4 Critically appraise knowledge gathered from a variety of sources. P7.6 Demonstrate an ability to build capacity by sharing knowledge, tools, expertise and experience: • participate in research and quality assurance initiatives.
17. Integrates **quality improvement** principles and activities into nursing practice.	H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes H3a-v) contribute to the quality of work environments by identifying needs, issues, solutions and actively participating in team and organizational quality improvement processes	P7.6 Demonstrate an ability to build capacity by sharing knowledge, tools, expertise and experience: • participate in research and quality assurance initiatives
KNOWLEDGE-BASED PRACTICE		
SPECIALIZED BODY OF KNOWLEDGE: HAS KNOWLEDGE FROM NURSING AND OTHER SCIENCES, HUMANITIES, RESEARCH, ETHICS, SPIRITUALITY, RELATIONAL PRACTICE, AND CRITICAL INQUIRY.		
18. Has a knowledge base about the **contribution of registered nurse** practice to the achievement of positive client health outcomes.	H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum	P6.2 Interpret information for professional, non professional and community audiences.
19. Has a knowledge base from **nursing** and **other disciplines** concerning current and **emerging health care issues** and trends (e.g., the health care needs of older adults, vulnerable and/or marginalized populations, health promotion, obesity, pain prevention and pain management, end-of-life care, problematic substance use, and mental health).	H1a-v) incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum H1a-vi) keep knowledge current and use evidence to inform practice to ensure optimal case management H1g-ii) apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities H1g-iii) recognize opportunities to promote social justice and advocate in collaboration with, and on behalf of clients and families on related issues to give voice to the vulnerable H2b-i) apply nursing sciences to practice and evaluate, synthesize and apply knowledge from a broad range of theories, models, frameworks and practice H3b-iv) integrate multiple ways of knowing into practice H3a-iv) evaluate programs in relation to determinants of health and health outcomes	P1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services. P1.3 Apply public health and nursing sciences to practice and synthesize knowledge from a broad range of theories, models and frameworks. P1.6 Pursue lifelong learning opportunities in the field of public health that are consistent with: current public health nursing practice; new and emerging issues; the changing needs of individuals, families, groups and communities; emerging research and evolving information about the impact of the determinants of health.
20. Has a knowledge base about **human growth** and **development**, and **population health**, including the **determinants of health**.	H1a-v) incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum H3a-iv) evaluate programs in relation to determinants of health and health outcomes	P1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services. P1.3 Apply public health and nursing sciences to practice and synthesize knowledge from a broad range of theories, models and frameworks. P1.6 Pursue lifelong learning opportunities in the field of public health that are consistent with: current public health nursing practice; new and emerging issues;

CARNA ETPC	Home Health Competency	Public Health Competency
		the changing needs of individuals, families, groups and communities; emerging research and evolving information about the impact of the determinants of health. P3C.2 Facilitate planned change with individuals, families, groups, communities, systems or population(s) by applying the Population Health Promotion Model, primary health care principles and appropriate change theory. P5.1 Recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups.
21. Has a knowledge base in the **health sciences**, including anatomy, physiology, pathophysiology, psychopathology, pharmacology, microbiology, epidemiology, genetics, immunology, and nutrition.	H1a-v) incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum H2b-i) apply nursing sciences to practice and evaluate, synthesize and apply knowledge from a broad range of theories, models, frameworks and practice	P1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services. P1.3 Apply public health and nursing sciences to practice and synthesize knowledge from a broad range of theories, models and frameworks. P1.6 Pursue lifelong learning opportunities in the field of public health that are consistent with: current public health nursing practice; new and emerging issues; the changing needs of individuals, families, groups and communities; emerging research and evolving information about the impact of the determinants of health.
22. Has a knowledge base in **nursing** sciences, **social sciences**, **humanities**, and health-related research (e.g., culture, power relations, spirituality, philosophical, and ethical reasoning).	H1a-v) incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum H2b-i) apply nursing sciences to practice and evaluate, synthesize and apply knowledge from a broad range of theories, models, frameworks and practice H2b-ii) use critical thinking to consider the ethical, political, scientific, socio-cultural and economic contexts to determine the meaning of information related to client health care needs	P1.3 Apply public health and nursing sciences to practice and synthesize knowledge from a broad range of theories, models and frameworks. P5.3 Apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities. P6.2 Interpret information for professional, non professional and community audiences.
23. Has a knowledge base about w**orkplace health and safety**, including ergonomics, safe work practices, prevention and management of disruptive behaviour, including horizontal violence, aggressive, or violent behaviour.	H1a-vii) assess the safety of the home environment with the goal of optimizing client safety and taking actions to support a safe work environment for all members of the home health care team H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes H3a-v) contribute to the quality of work environments by identifying needs, issues, solutions and actively participating in team and organizational quality improvement processes	

CARNA ETPC	Home Health Competency	Public Health Competency
24. Has theoretical and practical knowledge of **relational practice** and understands that relational practice is the foundation for all nursing practice.	H3b-iv) integrate multiple ways of knowing into practice H1f-i) optimize the health of the client and care giver(s) by establishing and maintaining a therapeutic nurse-client relationship based on mutual trust, respect, caring, and listening within the context of being 'a guest in the house' H1f-ii) acknowledge the contribution that the family/caregiver provides to client health in a way that makes them feel valued and respected and support them to maintain relationships that support effective care H1f-iv) use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships	P4.1 Advocate for societal change in support of health for all: • build coalitions, intersectoral partnerships and networks P6.1 Communicate effectively with individuals, families, groups, communities and colleagues: • use verbal, non verbal and written or graphic communication skills • speak and write in plain language • use multi-sensory forms of communication to address unique communication styles • use culturally relevant communication when building relationships
25. Has knowledge about emerging community and **global health** issues, population health issues and research (e.g., pandemic, mass immunizations, emergency/disaster planning, and food and water safety).	H1g-i) advocate for healthy public policies and accessible, inclusive and integrated services that promote and protect the health and well-being of all individuals and communities H2a-ii) recognize how the determinants of health influence the health and well-being of clients and families H2a-iii) assess the impact specific issues may have on the client's health such as; political climate; priorities, values and culture; social and systemic structures and settings	P1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services. P1.2 Apply knowledge about the history, structure and interaction of public health and health care services at local, provincial/territorial, national, and international levels. P1.6 Pursue lifelong learning opportunities in the field of public health that are consistent with: current public health nursing practice; new and emerging issues; the changing needs of individuals, families, groups and communities; emerging research and evolving information about the impact of the determinants of health. P3C.7 Fulfill functional roles in response to a public health emergency. P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities. P6.2 Interpret information for professional, non professional and community audiences.
26. Knows how to find **evidence** to support the provision of safe, competent, compassionate, and ethical nursing care, and to ensure the personal safety and safety of other health care workers.	H1a-vi) keep knowledge current and use evidence to inform practice to ensure optimal case management H1a-vii) assess the safety of the home environment with the goal of optimizing client safety and taking actions to support a safe work environment for all members of the home health care team H3b-v) contribute to the development and generation of evidence-informed nursing practice H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes H3a-v) contribute to the quality of work environments by identifying needs, issues, solutions and actively participating in team and	P1.5 Use evidence and research to inform health policies, programs and practice: • contribute to the development and generation of evidence-based nursing • use available resources to systematically plan and evaluate public health nursing practice P3C.3 Demonstrate the ability to integrate relevant research and implement evidence informed practice. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.

CARNA ETPC	Home Health Competency	Public Health Competency
	organizational quality improvement processes	
27. Understands the role of **primary health care** and the determinants of health in health delivery systems and its significance for population health.	H1g-i) advocate for healthy public policies and accessible, inclusive and integrated services that promote and protect the health and well-being of all individuals and communities H2b-ii) use critical thinking to consider the ethical, political, scientific, socio-cultural and economic contexts to determine the meaning of information related to client health care needs H3a-iv) evaluate programs in relation to determinants of health and health outcomes	P1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services. P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P3C.2 Facilitate planned change with individuals, families, groups, communities, systems or population(s) by applying the Population Health Promotion Model, primary health care principles and appropriate change theory. P5.1 Recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups
28. Understands **nursing informatics** and other **information and communication technologies** used in health care.	H1e-ix) use technology to effectively communicate and manage client care in a confidential manner	P6.4 Use current technology to communicate effectively.
COMPETENT APPLICATION OF KNOWLEDGE: DEMONSTRATES COMPETENCE IN THE PROVISION OF NURSING CARE. THE COMPETENCY STATEMENTS IN THIS SECTION ARE GROUPED INTO FOUR AREAS ABOUT THE PROVISION OF NURSING CARE: ONGOING COMPREHENSIVE ASSESSMENT, HEALTH CARE PLANNING, PROVIDING NURSING CARE, AND EVALUATION. THE PROVISION OF NURSING CARE IS AN ITERATIVE PROCESS OF CRITICAL INQUIRY AND IS NOT LINEAR IN NATURE.		
(AREA I) ONGOING COMPREHENSIVE ASSESSMENT: INCORPORATES CRITICAL INQUIRY AND RELATIONAL PRACTICE TO CONDUCT A CLIENT-FOCUSED ASSESSMENT THAT EMPHASIZES CLIENT INPUT AND THE DETERMINANTS OF HEALTH.		
29. Uses appropriate **assessment tools and techniques** in consultation with clients and the health care team.	H1a-i) conduct comprehensive autonomous and /or collaborative health assessments to determine the health status, functional and psychosocial need and competence of clients and their families within the context of their environment and social supports H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family	P2.1 Recognize that a health concern or issue exists: • apply principles of epidemiology • conduct comprehensive community assessments with individuals, families, groups and communities using quantitative and qualitative strategies • recognize patterns and trends in epidemiological data and service delivery • assess the impact of the broad social, cultural, political and economic determinants of health. P2.2 Identify relevant and appropriate sources of information, including community assets, resources and values in collaboration with individuals, families, groups, communities and stakeholders.
30. Engages **clients in an assessment** of the following: physical, emotional, spiritual, cultural,	H1a-i) conduct comprehensive autonomous and /or collaborative health assessments to determine the health status, functional and	P2.1 Recognize that a health concern or issue exists: • apply principles of epidemiology

CARNA ETPC	Home Health Competency	Public Health Competency
cognitive, developmental, environmental, and social needs.	psychosocial need and competence of clients and their families within the context of their environment and social supports H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family H1e-ii) use effective interviewing skills and strategies to engage in constructive dialogue with clients and their families	• conduct comprehensive community assessments with individuals, families, groups and communities using quantitative and qualitative strategies • recognize patterns and trends in epidemiological data and service delivery • assess the impact of the broad social, cultural, political and economic determinants of health. P2.6 Assess the health status and functional competence of individuals, families, groups, communities or populations within the context of their environmental and social supports. P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps.
31. **Collects information on client status** using assessment skills of observation, interview, history taking, interpretation of laboratory data, mental health assessment, and physical assessment, including inspection, palpation, auscultation, and percussion.	H1a-i) conduct comprehensive autonomous and /or collaborative health assessments to determine the health status, functional and psychosocial need and competence of clients and their families within the context of their environment and social supports H1a-iii) analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H3a-iii) evaluate nursing interventions in a systematic and continuous manner by measuring their effect on clients and families H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family H1e-ii) use effective interviewing skills and strategies to engage in constructive dialogue with clients and their families	P2.1 Recognize that a health concern or issue exists: • apply principles of epidemiology • conduct comprehensive community assessments with individuals, families, groups and communities using quantitative and qualitative strategies • recognize patterns and trends in epidemiological data and service delivery • assess the impact of the broad social, cultural, political and economic determinants of health. P2.2 Identify relevant and appropriate sources of information, including community assets, resources and values in collaboration with individuals, families, groups, communities and stakeholders.
32. Uses **information** and **communication technologies** to support information synthesis.	H1e-ix) use technology to effectively communicate and manage client care in a confidential manner	P2.3 Collect, store, retrieve and use accurate and appropriate information on public health issues. P6.4 Use current technology to communicate effectively.
33. Uses **anticipatory planning** to guide an **ongoing assessment of client** health status and health care needs (e.g., prenatal/postnatal, adolescents, older	H1a-iii) analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations	P2.1 Recognize that a health concern or issue exists: • apply principles of epidemiology • conduct comprehensive community assessments with individuals, families, groups and communities

CARNA ETPC	Home Health Competency	Public Health Competency
adults, and reaction to changes in health status and/or diagnosis).	H1b-i) plan and prioritize visits to meet the health and scheduling needs of clients H1b-ix) collaboratively evaluate care plan interventions through reassessment and ongoing evaluation of results and adapt them to the changing conditions of the client and the client's family H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H1h-v) adapt and be flexible and responsive to the changing health needs of the client and family	using quantitative and qualitative strategies • recognize patterns and trends in epidemiological data and service delivery • assess the impact of the broad social, cultural, political and economic determinants of health. P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P3C.9 Adapt practice in response to the changing health needs of the individual, family, group and community and in response to the unique characteristics of the setting.
34. **Analyzes and interprets data** obtained in client assessments to draw conclusions about client health status.	H1a-i) conduct comprehensive autonomous and /or collaborative health assessments to determine the health status, functional and psychosocial need and competence of clients and their families within the context of their environment and social supports H1a-iii) analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations H1b-ix) collaboratively evaluate care plan interventions through reassessment and ongoing evaluation of results and adapt them to the changing conditions of the client and the client's family H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H3a-iii) evaluate nursing interventions in a systematic and continuous manner by measuring their effect on clients and families	P2.1 Recognize that a health concern or issue exists: • apply principles of epidemiology • conduct comprehensive community assessments with individuals, families, groups and communities using quantitative and qualitative strategies • recognize patterns and trends in epidemiological data and service delivery • assess the impact of the broad social, cultural, political and economic determinants of health. P2.4 Analyze information to determine appropriate implications, uses, gaps and limitations. P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions P6.2 Interpret information for professional, non professional and community audiences.
35. Incorporates knowledge of the origins of the **health disparities and inequities** of **Aboriginal** Peoples and the contributions of nursing practice to achieve positive health outcomes for Aboriginal Peoples.	H1g-ii) apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities H3a-iv) evaluate programs in relation to determinants of health and health outcomes H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity	P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity.
36. Incorporates knowledge of the **health disparities and inequities of vulnerable populations** (e.g., sexual orientation, persons with disabilities, ethnic minorities, poor, homeless, racial minorities, language minorities) and the contributions of nursing practice to achieve positive health outcomes.	H3a-iv) evaluate programs in relation to determinants of health and health outcomes H1f-iii) work effectively and non-judgmentally in a wide range of environments with varying conditions of cleanliness H1g-ii) apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities H1g-iii) recognize opportunities to promote social justice and advocate	P1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services. P2.1 Recognize that a health concern or issue exists: • apply principles of epidemiology • conduct comprehensive community assessments with individuals, families, groups and communities

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	in collaboration with, and on behalf of clients and families on related issues to give voice to the vulnerable H2b-ii) use critical thinking to consider the ethical, political, scientific, socio-cultural and economic contexts to determine the meaning of information related to client health care needs	using quantitative and qualitative strategies • recognize patterns and trends in epidemiological data and service delivery • assess the impact of the broad social, cultural, political and economic determinants of health. P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P2.7 Determine the meaning of information, considering the ethical, political, scientific, socio-cultural and economic contexts: • identify attitudes, beliefs, feelings and values about health and their effect on relationships and interventions • support individuals, families, groups and communities to identify risks to health and make informed choices about protective and preventive health measures • describe the role of power in relationships by giving voice to the vulnerable • demonstrate skill in dealing with diversity and high levels of ambiguity. P3C.11 Advocate in collaboration with, and on behalf of, and with individuals, families, groups and communities on social justice related issues. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P5.1 Recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups P5.2 Address population diversity when planning, implementing, adapting and evaluating public health programs and policies.
37. Collaborates with clients and the health care team to **identify actual and potential client health care needs, strengths, capacities, and goals**.	H1a-i) conduct comprehensive autonomous and /or collaborative health assessments to determine the health status, functional and psychosocial need and competence of clients and their families within the context of their environment and social supports H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1b-vi) promote an integrated assessment and develop a unified	P2.4 Analyze information to determine appropriate implications, uses, gaps and limitations. P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps.

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	care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family H3b-ii) practice independently and autonomously providing client centered services in a wide variety of settings where nursing care and services are needed H1e-vii) use techniques that are client-centered, client-driven, and strength-based when counseling clients H1h-i) mobilize clients, families and others to take action to address health needs, deficits and gaps accessing and using available resources H1h-ii) assist the client and their family to recognize their capacity for managing their health needs according to available resources H1h-iii) assist colleagues, partners and/or clients to support and build on the capacities that are inherent in the individual, families and the communities to influence policy change H2a-iv) assess the readiness and capacity of the client and family to make changes to promote their health H2b-v) participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of clients and families	
38. Completes assessments in a timely manner, and in accordance with **evidence-informed practice**, agency policies, and protocols.	H1a-vi) keep knowledge current and use evidence to inform practice to ensure optimal case management H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	P1.5 Use evidence and research to inform health policies, programs and practice: • contribute to the development and generation of evidence-based nursing • use available resources to systematically plan and evaluate public health nursing practice
AREA (II) HEALTH CARE PLANNING: WITHIN THE CONTEXT OF CRITICAL INQUIRY AND RELATIONAL PRACTICE, PLANS NURSING CARE APPROPRIATE FOR CLIENTS WHICH INTEGRATES KNOWLEDGE FROM NURSING, HEALTH SCIENCES AND OTHER RELATED DISCIPLINES, AS WELL AS KNOWLEDGE FROM PRACTICE EXPERIENCES, CLIENTS' KNOWLEDGE AND PREFERENCES, AND FACTORS WITHIN THE HEALTH CARE SETTING.		
39. Uses **critical inquiry** to support **professional judgment** and reasoned **decision making** to develop health care plans.	H1a-ii) apply critical thinking skills and creative problem-solving analysis when making clinical decisions H3b-ii) practice independently and autonomously providing client centered services in a wide variety of settings where nursing care and services are needed	P1.4 Critically appraise knowledge gathered from a variety of sources. P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach.

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		• identify short and long term goals • identify outcome indicators • identify research questions
40. Uses principles of **primary health care** in developing health care plans.	H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H2a-ii) recognize how the determinants of health influence the health and well-being of clients and families H2b-ii) use critical thinking to consider the ethical, political, scientific, socio-cultural and economic contexts to determine the meaning of information related to client health care needs	P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P3B.1 Describe selected program options to address a specific public health issue. P3B.2 Describe the implications of each option, especially as they apply to the determinants of health and recommend or decide on a course of action. P3B.3 Develop a plan in collaboration with individuals, families, groups and communities to implement a course of action that is responsive to needs taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies. P3C.2 Facilitate planned change with individuals, families, groups, communities, systems or population(s) by applying the Population Health Promotion Model, primary health care principles and appropriate change theory. P5.1 Recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups
41. Facilitates the appropriate **involvement of clients** in identifying their preferred health outcomes.	H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family H1f-v) involve clients and families as active partners to identify assets, strengths and available resources H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures	P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions P3B.3 Develop a plan in collaboration with individuals, families, groups and communities to implement a course of action that is responsive to needs taking P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps.
42. **Negotiates priorities of care** and desired outcomes with clients, demonstrating **cultural safety**,	H1b-i) plan and prioritize visits to meet the health and scheduling needs of clients H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed	P2.6 Assess the health status and functional competence of individuals, families, groups, communities or populations within the context of their environmental and social supports.

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and considering the influence of positional power relationships.	upon care plans, negotiating priorities in care with H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1g-ii) apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity H2a-i) facilitate planned change with clients and families by applying and incorporating health promotion theory, primary health care principles and change theory into practice H2a-iv) assess the readiness and capacity of the client and family to make changes to promote their health	P2.7 Determine the meaning of information, considering the ethical, political, scientific, socio-cultural and economic contexts: • identify attitudes, beliefs, feelings and values about health and their effect on relationships and interventions • support individuals, families, groups and communities to identify risks to health and make informed choices about protective and preventive health measures • describe the role of power in relationships by giving voice to the vulnerable • demonstrate skill in dealing with diversity and high levels of ambiguity. P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions P3C.6 Set and follow priorities and maximize outcomes based on available resources. P5.3 Apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities.
43. Initiates appropriate **planning for clients' anticipated health problems** or issues and their consequences (e.g., childbearing, childrearing, adolescent health, and senior well-being).	H1a-iii) analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies	P3B.3 Develop a plan in collaboration with individuals, families, groups and communities to implement a course of action that is responsive to needs taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies.
44. Explores and develops a **range of possible alternatives** and approaches for care with clients.	H1a-iii) analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating	P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach.

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	priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H3b-ii) practice independently and autonomously providing client centered services in a wide variety of settings where nursing care and services are needed H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures	• identify short and long term goals • identify outcome indicators • identify research questions P3B.2 Describe the implications of each option, especially as they apply to the determinants of health and recommend or decide on a course of action.
45. Facilitates **client ownership** of direction and outcomes of care developed in their health care plans.	H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures	P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions P3C.2 Facilitate planned change with individuals, families, groups, communities, systems or population(s) by applying the Population Health Promotion Model, primary health care principles and appropriate change theory. P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps. P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques.
46. Collaborates with the health care team to develop health care plans that promote continuity for clients as they receive **conventional health care**, and **complementary and alternative therapy**.	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community	P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions

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	H1b-viii)facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures H2b-v) participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of clients and families	
47. Determines, with the health care team or health-related sectors, when **consultation** is required to assist clients in **accessing available resources**.	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1b-viii)facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue H1c-v) recognize when specialized counseling beyond the scope of nursing is required and facilitate an appropriate referral H1f-v) involve clients and families as active partners to identify assets, strengths and available resources H3a-iv) evaluate programs in relation to determinants of health and health outcomes H3a-vi) understand the financial aspects of care and be accountable for effective, efficient and responsible use of time and resources when delivering care to clients and families H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1h-i) mobilize clients, families and others to take action to address health needs, deficits and gaps accessing and using available resources H2b-v) participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of clients and families	P3C.5 Maximize the capacity of the individual, family, group or community to take responsibility for and to manage their health needs according to resources available and personal skills. P3C.8 Facilitate access to services in the health sector and other sectors. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources.
48. Consults with the health care team as needed to analyze and **organize complex health challenges** into manageable components for health care planning.	H1a-iii) analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services	P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals

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	H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H1b-viii)facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue	• identify outcome indicators • identify research questions
AREA (III) PROVIDING NURSING CARE: PROVIDES CLIENT-CENTRED CARE IN SITUATIONS RELATED TO: • **HEALTH PROMOTION, PREVENTION, AND POPULATION HEALTH;** • **MATERNAL/CHILD HEALTH;** • **ALTERED HEALTH STATUS, INCLUDING ACUTE AND CHRONIC PHYSICAL AND MENTAL HEALTH CONDITIONS AND REHABILITATIVE CARE; AND** • **PALLIATIVE CARE AND END-OF-LIFE CARE.**		
49. Provides nursing **care across the lifespan** that is informed by a **variety of theories** relevant to health and healing (e.g., nursing; family; communication and learning; crisis intervention; loss, grief, and bereavement; systems; culture; community development; and population health theories).	H1a-v) incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum H1a-vi) keep knowledge current and use evidence to inform practice to ensure optimal case management H3a-iv) evaluate programs in relation to determinants of health and health outcomes H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family H1d-ii) consider and integrate into educational planning the factors that may impact the client/family's ability to learn H1d-iii) interpret and explain complex information for clients and families H1d-iv) apply appropriate learning principles, teaching methods and educational theories to educational activities H1e-i) use effective listening, verbal and non-verbal communication skills to understand the client's perspective and be understood by the client, family and other caregivers involved in the care H1e-ii) use effective interviewing skills and strategies to engage in constructive dialogue with clients and their families H1e-iii) use effective communication skills to engage, connect, appreciate, respond, empathize and empower others	P1.3 Apply public health and nursing sciences to practice and synthesize knowledge from a broad range of theories, models and frameworks. P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions P3C.2 Facilitate planned change with individuals, families, groups, communities, systems or population(s) by applying the Population Health Promotion Model, primary health care principles and appropriate change theory. P5.3 Apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities. P6.1 Communicate effectively with individuals, families, groups, communities and colleagues: • use verbal, non verbal and written or graphic communication skills • speak and write in plain language • use multi-sensory forms of communication to address unique communication styles • use culturally relevant communication when building relationships

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	H1e-iv) identify and use strategies to overcome language and communication barriers H1e-v) maintain a focused approach amidst multiple distractions within the home environment H1e-vi) employ negotiation and conflict management skills H1g-ii) apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities	
50. **Prioritize** and provide **timely** nursing care and consult as necessary for any client with co-morbidities, and a complex and rapidly changing health status.	H1b-i) plan and prioritize visits to meet the health and scheduling needs of clients H1b-viii)facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H1h-v) adapt and be flexible and responsive to the changing health needs of the client and family	P3C.7 Fulfill functional roles in response to a public health emergency. P3C.9 Adapt practice in response to the changing health needs of the individual, family, group and community and in response to the unique characteristics of the setting.
51. Provides nursing care to clients with **chronic and persistent health challenges** (e.g., mental health, problematic substance abuse, dementia, cardiovascular conditions, stroke, asthma, arthritis, and diabetes).	H1a-v) incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H3b-ii) practice independently and autonomously providing client centered services in a wide variety of settings where nursing care and services are needed H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting	
52. Incorporates **evidence** from research, clinical practice, client perspective, client and staff safety, and other available resources to make decisions about client care.	H1a-vi) keep knowledge current and use evidence to inform practice to ensure optimal case management H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies	P1.5 Use evidence and research to inform health policies, programs and practice: • contribute to the development and generation of evidence-based nursing • use available resources to systematically plan and evaluate public health nursing practice

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	H2b-i) apply nursing sciences to practice and evaluate, synthesize and apply knowledge from a broad range of theories, models, frameworks and practice H3b-v) contribute to the development and generation of evidence-informed nursing practice H3b-iv) integrate multiple ways of knowing into practice	P1.7 Integrate multiple ways of knowing into practice. P3B.3 Develop a plan in collaboration with individuals, families, groups and communities to implement a course of action that is responsive to needs taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies. P3C.3 Demonstrate the ability to integrate relevant research and implement evidence informed practice P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P6.2 Interpret information for professional, non professional and community audiences. P7.6 Demonstrate an ability to build capacity by sharing knowledge, tools, expertise and experience: • participate in research and quality assurance initiatives
53. Supports clients through **developmental stages and role transitions across the lifespan** (e.g., pregnancy, infant nutrition, well-baby care, child development stages, family planning and relations).	H1a-v) incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues	
54. Recognizes, seeks immediate assistance, and helps others in a **rapidly changing client condition** affecting health or **patient safety** (e.g., myocardial infarction, surgical complications, acute neurological event, acute respiratory event, cardiopulmonary arrest, perinatal crisis, diabetes crisis, mental health crisis, premature birth, shock, and trauma).	H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H1h-v) adapt and be flexible and responsive to the changing health needs of the client and family H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances	P3C.7 Fulfill functional roles in response to a public health emergency. P3C.9 Adapt practice in response to the changing health needs of the individual, family, group and community and in response to the unique characteristics of the setting. P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances.
55. Applies principles of **population health** to implement strategies to promote health as well as prevent illness and injury (e.g., promoting hand washing, immunization, helmet safety, and safe sex).	H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H1g-i) advocate for healthy public policies and accessible, inclusive and integrated services that promote and protect the health and well-being of all individuals and communities H1g-v) advocate for the reduction of inequities in health by participating in legislative and policy making activities H1g-iii) recognize opportunities to promote social justice and advocate in collaboration with, and on behalf of clients and families on related issues to give voice to the vulnerable H1g-iv) optimize allocation of human, financial, and infrastructure	P1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services. P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical

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	resources in order to provide a safe and accessible health delivery system H2a-ii) recognize how the determinants of health influence the health and well-being of clients and families H2a-iii) assess the impact specific issues may have on the client's health such as; political climate; priorities, values and culture; social and systemic structures and settings	care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions P3B.1 Describe selected program options to address a specific public health issue. P3B.2 Describe the implications of each option, especially as they apply to the determinants of health and recommend or decide on a course of action. P3B.3 Develop a plan in collaboration with individuals, families, groups and communities to implement a course of action that is responsive to needs taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies. P3C.1 Take action, across multiple levels, to address specific public health issues by using a comprehensive mix of public health strategies to address unique needs and to build individual, family, group and community capacity. P3C.2 Facilitate planned change with individuals, families, groups, communities, systems or population(s) by applying the Population Health Promotion Model, primary health care principles and appropriate change theory. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques.
56. Assists clients to understand how **lifestyle factors** impact health (e.g., physical activity and exercise, sleep, nutrition, stress management, personal and community hygiene practices, family planning, and high-risk behaviours).	H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H1c-ii) understand and/or educate clients, their families/caregivers and colleagues in the safe and appropriate use and maintenance of various types of equipment, technology and treatments to maintain health and assist clients and families to integrate them into their everyday life/routine H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family H2a-i) facilitate planned change with clients and families by applying and incorporating health promotion theory, primary health care principles and change theory into practice H2a-ii) recognize how the determinants of health influence the health and well-being of clients and families H2a-iii) assess the impact specific issues may have on the client's health such as; political climate; priorities, values and culture; social and systemic structures and settings	P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P3C.2 Facilitate planned change with individuals, families, groups, communities, systems or population(s) by applying the Population Health Promotion Model, primary health care principles and appropriate change theory. P5.2 Address population diversity when planning, implementing, adapting and evaluating public health programs and policies. P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques.

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	H2a-iv) assess the readiness and capacity of the client and family to make changes to promote their health H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures	
57. Implements learning plans to meet identified **client learning needs.**	H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1c-ii) understand and/or educate clients, their families/caregivers and colleagues in the safe and appropriate use and maintenance of various types of equipment, technology and treatments to maintain health and assist clients and families to integrate them into their everyday life/routine H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family H1d-ii) consider and integrate into educational planning the factors that may impact the client/family's ability to learn H1d-iv) apply appropriate learning principles, teaching methods and educational theories to educational activities H1d-v) include family, volunteers and caregivers in teaching and education H2a-iv) assess the readiness and capacity of the client and family to make changes to promote their health H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures	P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques.
58. Assists clients to **identify and access health and other resources** in their communities (e.g., other health disciplines, community health services, rehabilitation services, support groups, home care, relaxation therapy, meditation, and information resources).	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H1b-viii)facilitate and coordinate access to other members of the	P3C.5 Maximize the capacity of the individual, family, group or community to take responsibility for and to manage their health needs according to resources available and personal skills. P3C.8 Facilitate access to services in the health sector and other sectors. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps. P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques.

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	multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue H1c-i) assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1c-v) recognize when specialized counseling beyond the scope of nursing is required and facilitate an appropriate referral H1f-v) involve clients and families as active partners to identify assets, strengths and available resources H1h-i) mobilize clients, families and others to take action to address health needs, deficits and gaps accessing and using available resources H1h-ii) assist the client and their family to recognize their capacity for managing their health needs according to available resources H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures	
59. Applies knowledge when providing nursing care to **prevent development of complications** (e.g., optimal ventilation and respiration, circulation, fluid and electrolyte balance, nutrition, urinary elimination, bowel elimination, body alignment, tissue integrity, comfort, and sensory stimulation).	H1a-iii) analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations H1a-v) incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies	P2.8 Recommend specific actions based on the analysis of information: • identify a range of appropriate interventions including health promotion; health protection; disease and injury prevention and clinical care using a multi strategy and multi target approach. • identify short and long term goals • identify outcome indicators • identify research questions
60. Applies **bio-hazard and safety principles**, evidence-informed practices, infection prevention and control practices, and appropriate protective devices when providing nursing care to **prevent injury** to clients, self, other health care workers, and the public.	H1a-vi) keep knowledge current and use evidence to inform practice to ensure optimal case management H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.
61. Implements strategies related to the **safe and appropriate administration and use of medication**.	H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances	

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62. Recognizes and takes initiative to support **environmentally responsible practice** (e.g., observing safe waste disposal methods, using energy as efficiently as possible, and recycling plastic containers and other recyclable materials).	H3a-i) Initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes	P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.
63. Performs **therapeutic interventions** safely (e.g., positioning, skin and wound care, management of intravenous therapy and drainage tubes, and psychosocial interaction).	H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting	
64. Implements evidence-informed practices of **pain prevention and pain management** with clients using pharmacological and non-pharmacological measures.	H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting	
65. Prepares the client for **diagnostic procedures** and **treatments**, provides post-diagnostic care, performs procedures, interprets findings, and provides follow-up care as appropriate.	H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting	
66. Provides nursing care to meet **palliative care** or end-of-life care needs (e.g., pain and symptom management, psychosocial and spiritual support, and support for significant others).	H1c-ii) understand and/or educate clients, their families/caregivers and colleagues in the safe and appropriate use and maintenance of various types of equipment, technology and treatments to maintain health and assist clients and families to integrate them into their everyday life/routine H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting	
AREA (IV) EVALUATION: MONITORS THE EFFECTIVENESS OF CLIENT CARE TO INFORM FUTURE CARE PLANNING.		
67. Uses critical inquiry to **monitor and evaluate client care** in a timely manner.	H1b-ix) collaboratively evaluate care plan interventions through reassessment and ongoing evaluation of results and adapt them to the changing conditions of the client and the client's family H3a-iii) evaluate nursing interventions in a systematic and continuous manner by measuring their effect on clients and families H3a-iv) evaluate programs in relation to determinants of health and health outcomes H1b-ix) collaboratively evaluate care plan interventions through reassessment and ongoing evaluation of results and adapt them to the changing conditions of the client and the client's family	P3C.9 Adapt practice in response to the changing health needs of the individual, family, group and community and in response to the unique characteristics of the setting. P3D.1 Evaluate an action, policy or program in a systematic and continuous manner by measuring its effect on individuals, families, groups or communities. P3D.2 Evaluate programs in relation to determinants of health and health outcomes. P3D.3 Evaluate programs in partnership with individuals, families, groups, communities and other stakeholders. P8.4 Use reflective practice to continually assess and improve practice:

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	H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies	• adapt public health nursing techniques, approaches and procedures to the challenges in a particular community situation or setting.
68. Collaborates with others to support **involvement in research** and the **use of research findings** in practice.	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H3b-v) contribute to the development and generation of evidence-informed nursing practice	P1.5 Use evidence and research to inform health policies, programs and practice: • contribute to the development and generation of evidence-based nursing • use available resources to systematically plan and evaluate public health nursing practice P3C.3 Demonstrate the ability to integrate relevant research and implement evidence informed practice P7.6 Demonstrate an ability to build capacity by sharing knowledge, tools, expertise and experience: • participate in research and quality assurance initiatives
69. Modifies and individualizes client care based on the **emerging priorities of the health situation** in collaboration with clients.	H1a-iii) analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H1b-ix) collaboratively evaluate care plan interventions through reassessment and ongoing evaluation of results and adapt them to the changing conditions of the client and the client's family H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting H1c-vi) respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies H1h-v) adapt and be flexible and responsive to the changing health needs of the client and family H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures H3a-iii) evaluate nursing interventions in a systematic and continuous manner by measuring their effect on clients and families H3a-iv) evaluate programs in relation to determinants of health and health outcomes	P3C.9 Adapt practice in response to the changing health needs of the individual, family, group and community and in response to the unique characteristics of the setting. P3D.1 Evaluate an action, policy or program in a systematic and continuous manner by measuring its effect on individuals, families, groups or communities. P3D.2 Evaluate programs in relation to determinants of health and health outcomes. P3D.3 Evaluate programs in partnership with individuals, families, groups, communities and other stakeholders. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques. P8.4 Use reflective practice to continually assess and improve practice: • adapt public health nursing techniques, approaches and procedures to the challenges in a particular community situation or setting.

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70. Verifies that **clients have an understanding** of essential information and skills to be active participants in their own care.	H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1c-ii) understand and/or educate clients, their families/caregivers and colleagues in the safe and appropriate use and maintenance of various types of equipment, technology and treatments to maintain health and assist clients and families to integrate them into their everyday life/routine H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1d-i) assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family H1d-iii) interpret and explain complex information for clients and families H1d-vi) evaluate the effectiveness of health education interventions H1e-ii) use effective interviewing skills and strategies to engage in constructive dialogue with clients and their families H1e-iv) identify and use strategies to overcome language and communication barriers H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures	P6.1 Communicate effectively with individuals, families, groups, communities and colleagues: • use verbal, non verbal and written or graphic communication skills • speak and write in plain language • use multi-sensory forms of communication to address unique communication styles • use culturally relevant communication when building relationships. P6.2 Interpret information for professional, non professional and community audiences. P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques.
71. **Reports and documents** client care in a clear, concise, accurate, and timely manner.	H1e-viii) use documentation as an effective communication tool	P6.1 Communicate effectively with individuals, families, groups, communities and colleagues: • use verbal, non verbal and written or graphic communication skills • speak and write in plain language • use multi-sensory forms of communication to address unique communication styles • use culturally relevant communication when building relationships P6.2 Interpret information for professional, non professional and community audiences.
ETHICAL PRACTICE DEMONSTRATES COMPETENCE IN PROFESSIONAL JUDGMENT AND PRACTICE DECISIONS GUIDED BY THE VALUES AND ETHICAL RESPONSIBILITIES IN THE CNA *CODE OF ETHICS FOR REGISTERED NURSES* (2008) AND THE CARNA DOCUMENT *ETHICAL DECISION-MAKING FOR REGISTERED NURSES IN ALBERTA: GUIDELINES AND RECOMMENDATIONS* (2010). ENGAGES IN CRITICAL INQUIRY TO INFORM CLINICAL DECISION-MAKING, AND ESTABLISHES THERAPEUTIC, CARING, AND CULTURALLY SAFE RELATIONSHIPS WITH CLIENTS AND THE HEALTH CARE TEAM.		
72. Demonstrates honesty, integrity, and respect in all professional interactions.	H1c-vii) self-identify when their need for assistance when not familiar with care requirements and interventions and how to seek support to assure continued excellence in care H3b-x) recognize and understand that one's attitudes, beliefs, feelings and values about health can have an	P8.1 Demonstrate professionalism in independent practice in multiple settings with multiple stakeholders.

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	effect on relationships and intervention	
73. Takes action to minimize the **potential influence of personal values, beliefs**, and positional power on client assessment and care.	H1f-iii) work effectively and non-judgmentally in a wide range of environments with varying conditions of cleanliness H3b-x) recognize and understand that one's attitudes, beliefs, feelings and values about health can have an effect on relationships and intervention	P2.7 Determine the meaning of information, considering the ethical, political, scientific, socio-cultural and economic contexts: • identify attitudes, beliefs, feelings and values about health and their effect on relationships and interventions • support individuals, families, groups and communities to identify risks to health and make informed choices about protective and preventive health measures • describe the role of power in relationships by giving voice to the vulnerable • demonstrate skill in dealing with diversity and high levels of ambiguity. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources.
74. Establishes and maintains appropriate **professional boundaries** with clients and the health care team, including the distinction between social interaction and **therapeutic relationships**.	H1f-i) optimize the health of the client and care giver(s) by establishing and maintaining a therapeutic nurse-client relationship based on mutual trust, respect, caring, and listening within the context of being 'a guest in the house' H1f-ii) acknowledge the contribution that the family/caregiver provides to client health in a way that makes them feel valued and respected and support them to maintain relationships that support effective care	P8.1 Demonstrate professionalism in independent practice in multiple settings with multiple stakeholders.
75. Engages in **relational practice** through a variety of approaches that demonstrate **caring behaviours** appropriate for clients.	H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1e-i) use effective listening, verbal and non-verbal communication skills to understand the client's perspective and be understood by the client, family and other caregivers involved in the care H1f-i) optimize the health of the client and care giver(s) by establishing and maintaining a therapeutic nurse-client relationship based on mutual trust, respect, caring, and listening within the context of being 'a guest in the house' H1f-ii) acknowledge the contribution that the family/caregiver provides to client health in a way that makes them feel valued and respected and support them to maintain relationships that support effective care H3b-x) recognize and understand that one's attitudes, beliefs, feelings and values about health can have an effect on relationships and intervention	P4.1 Advocate for societal change in support of health for all: • build coalitions, intersectoral partnerships and networks P6.1 Communicate effectively with individuals, families, groups, communities and colleagues: • use culturally relevant communication when building relationships.
76. Promotes a **safe environment** for clients, self, health care workers, and the public that addresses the unique needs of clients within the context of care.	H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H1c-iv) use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting H1c-vii) self-identify when their need for assistance when not familiar with care requirements and interventions and how to seek support to assure continued excellence in care	P2.6 Assess the health status and functional competence of individuals, families, groups, communities or populations within the context of their environmental and social supports. P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.

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	H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances	P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps. P8.7 Contribute to the quality of public health nursing work environments by identifying needs, issues, solutions and mobilizing colleagues by actively participating in team and organizational structures and mechanisms
77. Demonstrates consideration of the **spiritual** and **religious beliefs and practices** of clients.	H1g-ii) apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity	P5.2 Address population diversity when planning, implementing, adapting and evaluating public health programs and policies.
78. Demonstrates knowledge of the distinction between **ethical responsibilities** and **legal obligations** and their relevance when providing nursing care.	H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P7.3 Use public health and nursing ethics to manage self, others, information and resources and practice in accordance with all relevant legislation, regulating body standards and codes (e.g. provincial health legislation, child welfare legislation, privacy legislation, Canadian Nurses Association Code of Ethics for registered nurses). P8.6 Act upon legal and professional obligations, and practices in accordance with relevant legislation.
79. Respects and preserves **clients' rights based on the values** in the *CNA Code of Ethics for Registered Nurses* and an ethical framework.	H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H2b-ii) use critical thinking to consider the ethical, political, scientific, socio-cultural and economic contexts to determine the meaning of information related to client health care needs H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P5.2 Address population diversity when planning, implementing, adapting and evaluating public health programs and policies. P7.3 Use public health and nursing ethics to manage self, others, information and resources and practice in accordance with all relevant legislation, regulating body standards and codes (e.g. provincial health legislation, child welfare legislation, privacy legislation, Canadian Nurses Association Code of Ethics for registered nurses). P8.2 Apply ethical standards and principles taking into consideration appropriate public health and nursing ethics. P8.3 Consult as needed to determine the best course of action in response to: ethical dilemmas, safety issues, risks to human rights and freedoms, new situations and new knowledge.
80. Demonstrates an understanding of **informed consent** as it applies in multiple contexts (e.g., consent for care, refusal of treatment, release of health information, and consent for participation in research).		P2.7 Determine the meaning of information, considering the ethical, political, scientific, socio-cultural and economic contexts: • identify attitudes, beliefs, feelings and values about health and their

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		effect on relationships and interventions • support individuals, families, groups and communities to identify risks to health and make informed choices about protective and preventive health measures • describe the role of power in relationships by giving voice to the vulnerable • demonstrate skill in dealing with diversity and high levels of ambiguity.
81. Uses an **ethical reasoning and decision-making process** to address ethical dilemmas and situations of ethical distress.	H1a-ii) apply critical thinking skills and creative problem-solving analysis when making clinical decisions H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances	P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P8.2 Apply ethical standards and principles taking into consideration appropriate public health and nursing ethics. P8.3 Consult as needed to determine the best course of action in response to: ethical dilemmas, safety issues, risks to human rights and freedoms, new situations and new knowledge.
82. Accepts and provides care for all clients, **regardless of gender, age, health status, lifestyle**, sexual orientation, beliefs, and health practices.	H1f-iii) work effectively and non-judgmentally in a wide range of environments with varying conditions of cleanliness H1g-ii) apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity	P5.2 Address population diversity when planning, implementing, adapting and evaluating public health programs and policies. P5.3 Apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities.
83. Demonstrates support for **clients in making informed decisions** about their health care, and **respects** those decisions.	H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-iii) support clients and families to build on their strengths to attain or maintain a desired health status within available resources H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity H2b-iii) support clients and families to identify risks to health and make informed choices about protective and preventive health measures	P2.7 Determine the meaning of information, considering the ethical, political, scientific, socio-cultural and economic contexts: • identify attitudes, beliefs, feelings and values about health and their effect on relationships and interventions • support individuals, families, groups and communities to identify risks to health and make informed choices about protective and preventive health measures • describe the role of power in relationships by giving voice to the vulnerable • demonstrate skill in dealing with diversity and high levels of ambiguity. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources.
84. **Advocates** for safe, competent, compassionate, and ethical care for clients or their representatives, especially when they are unable to advocate for themselves.	H1c-iii) communicate effectively with clients and families while supporting them through the decision making process about end of life issues H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P3C.11 Advocate in collaboration with, and on behalf of, and with individuals, families, groups and communities on social justice related issues.

CARNA ETPC	Home Health Competency	Public Health Competency
	H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances	P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities.
85. Demonstrates **ethical responsibilities** and **legal** obligations related to maintaining client **privacy, confidentiality** and security in all forms of communication, including social media.	H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P7.3 Use public health and nursing ethics to manage self, others, information and resources and practice in accordance with all relevant legislation, regulating body standards and codes (e.g. provincial health legislation, child welfare legislation, privacy legislation, Canadian Nurses Association Code of Ethics for registered nurses). P8.3 Consult as needed to determine the best course of action in response to: ethical dilemmas, safety issues, risks to human rights and freedoms, new situations and new knowledge.
86. Engages in **relational practice** and uses ethical principles with the health care team to maximize **collaborative client care**.	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach H1f-ii) acknowledge the contribution that the family/caregiver provides to client health in a way that makes them feel valued and respected and support them to maintain relationships that support effective care H1h-iv) demonstrate cultural competency when addressing client care issues and when working in an environment where there may be levels of ambiguity H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	P3B.3 Develop a plan in collaboration with individuals, families, groups and communities to implement a course of action that is responsive to needs taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies P3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of individuals, families, groups, communities and populations P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps. P8.2 Apply ethical standards and principles taking into consideration appropriate public health and nursing ethics. P8.3 Consult as needed to determine the best course of action in response to: ethical dilemmas, safety issues, risks to human rights and freedoms, new situations and new knowledge.
SERVICE TO THE PUBLIC DEMONSTRATES AN UNDERSTANDING OF THE CONCEPT OF PUBLIC PROTECTION AND THE DUTY TO PROVIDE NURSING CARE IN THE BEST INTEREST OF THE PUBLIC.		

CARNA ETPC	Home Health Competency	Public Health Competency
87. Enacts the principle that the primary purpose of the registered nurse is to practice in the **best interest of the public** and to **protect the public from harm**.	H1c-vii) self-identify when their need for assistance when not familiar with care requirements and interventions and how to seek support to assure continued excellence in care H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances	P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities. P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques. P8.3 Consult as needed to determine the best course of action in response to: ethical dilemmas, safety issues, risks to human rights and freedoms, new situations and new knowledge.
88a. Demonstrates knowledge about the structure of the health care system at the **national level**.		P1.2 Apply knowledge about the history, structure and interaction of public health and health care services at local, provincial/territorial, national, and international levels. P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of individuals, families, groups, communities and populations
88b. Demonstrates knowledge about the structure of the health care system at the **provincial/territorial level**.		P1.2 Apply knowledge about the history, structure and interaction of public health and health care services at local, provincial/territorial, national, and international levels. P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of individuals, families, groups, communities and populations
88c. Demonstrates knowledge about the structure of the health care system at the **regional/municipal level**.		P1.2 Apply knowledge about the history, structure and interaction of public health and health care services at local, provincial/territorial, national, and international levels. P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of individuals, families, groups, communities and populations P6.2 Interpret information for professional, non professional and community audiences.
88d. Demonstrates knowledge about the structure of the health care system at the **agency level**.	H3b-viii)describe the mission, values and priorities of the health organization where one works	P6.2 Interpret information for professional, non professional and community audiences. P7.1 Describe the mission and priorities of the public health organization where one works, and apply them in practice. P7.2 Contribute to developing key values and a shared vision to assess, plan and implement public health programs and policies in the community by actively working with health professionals and in partnership with community partners to build capacity.
88e. Demonstrates knowledge about the structure of the health care system at the practice setting or **program level**.	H3b-viii)describe the mission, values and priorities of the health organization where one works	P6.2 Interpret information for professional, non professional and community audiences.

CARNA ETPC	Home Health Competency	Public Health Competency
		P7.1 Describe the mission and priorities of the public health organization where one works, and apply them in practice. P7.2 Contribute to developing key values and a shared vision to assess, plan and implement public health programs and policies in the community by actively working with health professionals and in partnership with community partners to build capacity.
89. Recognizes the impact of organizational culture on the provision of health care and acts to **enhance the quality of a professional and safe practice environment**.	H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes H3a-v) contribute to the quality of work environments by identifying needs, issues, solutions and actively participating in team and organizational quality improvement processes	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities. P8.7 Contribute to the quality of public health nursing work environments by identifying needs, issues, solutions and mobilizing colleagues by actively participating in team and organizational structures and mechanisms
90a. Demonstrates leadership in the coordination of health care by **assigning client care**.	H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach	P6.2 Interpret information for professional, non professional and community audiences.
90b. Demonstrates leadership in the coordination of health care by **consenting to and supervising and evaluating** the performance of **health-care aides** and **undergraduate nursing employees** in performing restricted activities.	H H1b-vii) appreciate and understand the roles and responsibilities and the contributions of other regulated and unregulated health workers involved in the client care plan 3b-ix) participate in the advancement of home health nursing by mentoring students and new practitioners	P7.6 Demonstrate an ability to build capacity by sharing knowledge, tools, expertise and experience: • mentor students and orient new staff
90c. Demonstrates leadership in the coordination of health care by facilitating **continuity of client care**.	H1b-ii) use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care H1b-vi) promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach	
91a. Participates and contributes to nursing and health care team development by recognizing that one's **values, assumptions, and positional power affects team interactions**, and uses this **self-awareness** to facilitate team interactions.	H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies H1f-iv) use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships H3b-x) recognize and understand that one's attitudes, beliefs, feelings and values about health can have an effect on relationships and intervention	P2.7 Determine the meaning of information, considering the ethical, political, scientific, socio-cultural and economic contexts: • identify attitudes, beliefs, feelings and values about health and their effect on relationships and interventions • support individuals, families, groups and communities to identify risks to health and make informed choices about protective and preventive health measures • describe the role of power in relationships by giving voice to the vulnerable • demonstrate skill in dealing with diversity and high levels of ambiguity.

CARNA ETPC	Home Health Competency	Public Health Competency
91b. Participates and contributes to nursing and health care team development by building **partnerships based on respect** for the unique and shared **competencies of each team member**.	H1b-vii) appreciate and understand the roles and responsibilities and the contributions of other regulated and unregulated health workers involved in the client care plan H1f-iv) use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships H2b-v) participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of clients and families H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders	P3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of individuals, families, groups, communities and populations
91c. Participates and contributes to nursing and health care team development by promoting **interprofessional collaboration** through application of principles of **decision-making, problem solving, and conflict resolution**.	H1a-ii) apply critical thinking skills and creative problem-solving analysis when making clinical decisions H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-vii) appreciate and understand the roles and responsibilities and the contributions of other regulated and unregulated health workers involved in the client care plan H1e-vi) employ negotiation and conflict management skills H1f-iv) use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships H2b-v) participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of clients and families H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders	P3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of individuals, families, groups, communities and populations P4.2 Use skills such as team building, negotiation, conflict management and group facilitation to build partnerships and to support group development.
91d. Participates and contributes to nursing and health care team development by contributing **nursing perspectives** on issues being addressed by the health care team.	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-vii) appreciate and understand the roles and responsibilities and the contributions of other regulated and unregulated health workers involved in the client care plan H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders	P7.4 Contribute to team and organizational learning in order to advance public health goals. P8.1 Demonstrate professionalism in independent practice in multiple settings with multiple stakeholders.
91e. Participates and contributes to nursing and health care team development by knowing and supporting the **full scope of practice of team members**.	H1b-vii) appreciate and understand the roles and responsibilities and the contributions of other regulated and unregulated health workers involved in the client care plan H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders	
91f. Participates and contributes to nursing and health care team development by providing and encouraging **constructive feedback**.	H1f-iv) use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships	
92a. Collaborates with the health care team to respond to changes in the health care system by	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine	P3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health

CARNA ETPC	Home Health Competency	Public Health Competency
recognizing and analyzing changes that affect one's practice and client care.	appropriateness and availability of required services H1b-viii)facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue H2b-ii) use critical thinking to consider the ethical, political, scientific, socio-cultural and economic contexts to determine the meaning of information related to client health care needs H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes	of individuals, families, groups, communities and populations P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P8.4 Use reflective practice to continually assess and improve practice: • adapt public health nursing techniques, approaches and procedures to the challenges in a particular community situation or setting.
92b. Collaborates with the health care team to respond to changes in the health care system by **developing strategies to manage changes** affecting one's practice and client care.	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1b-viii)facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue H2b-v) participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of clients and families H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes	P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P8.4 Use reflective practice to continually assess and improve practice: • adapt public health nursing techniques, approaches and procedures to the challenges in a particular community situation or setting.
92c. Collaborates with the health care team to respond to changes in the health care system by **implementing changes** when appropriate.	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H1b-v) ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community H1h-iii) assist colleagues, partners and/or clients to support and build on the capacities that are inherent in the individual, families and the communities to influence policy change	P3C.4 Participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of individuals, families, groups, communities and populations P8.4 Use reflective practice to continually assess and improve practice: • adapt public health nursing techniques, approaches and procedures to the challenges in a particular community situation or setting.
92d. Collaborates with the health care team to respond to changes in the health care system by **evaluating effectiveness of strategies** implemented to change nursing practice.	H1a-iv) collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services H3a-iii) evaluate nursing interventions in a systematic and continuous manner by measuring their effect on clients and families	P8.4 Use reflective practice to continually assess and improve practice: • adapt public health nursing techniques, approaches and procedures to the challenges in a particular community situation or setting.

CARNA ETPC	Home Health Competency	Public Health Competency
93. Uses established **communication policies and protocols** within and across **health care agencies**, and with **other service sectors**.	H1b-viii)facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue H1e-viii) use documentation as an effective communication tool H1e-ix) use technology to effectively communicate and manage client care in a confidential manner H3b-i) demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders	P4.1 Advocate for societal change in support of health for all: • collaborate with partners to address public health issues and service gaps in order to achieve improved health outcomes • build coalitions, intersectoral partnerships and networks P6.3 Mobilize individuals, families, groups and communities by using appropriate media, community resources and social marketing techniques. P6.4 Use current technology to communicate effectively.
94. Uses **resources in a fiscally responsible** manner to provide safe, effective, and efficient care.	H1b-iv) anticipate the need for and creatively problem solve in planning for alternative ways of providing service to overcome obstacles in delivering client care i.e. weather, lack of resources etc. H1b-viii)facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue H1g-iv) optimize allocation of human, financial, and infrastructure resources in order to provide a safe and accessible health delivery system H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes H3a-vi) understand the financial aspects of care and be accountable for effective, efficient and responsible use of time and resources when delivering care to clients and families	P3C.6 Set and follow priorities and maximize outcomes based on available resources. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps. P7.3 Use public health and nursing ethics to manage self, others, information and resources and practice in accordance with all relevant legislation, regulating body standards and codes (e.g. provincial health legislation, child welfare legislation, privacy legislation, Canadian Nurses Association Code of Ethics for registered nurses). P8.5 Advocate for effective, efficient and responsible use of resources.
95. Supports healthy **public policy** and principles of **social justice**.	H1g-i) advocate for healthy public policies and accessible, inclusive and integrated services that promote and protect the health and well-being of all individuals and communities H1g-iii) recognize opportunities to promote social justice and advocate in collaboration with, and on behalf of clients and families on related issues to give voice to the vulnerable H1g-v) advocate for the reduction of inequities in health by participating in legislative and policy making activities H1h-iii) assist colleagues, partners and/or clients to support and build on the capacities that are inherent in the individual, families and the communities to influence policy change H2b-ii) use critical thinking to consider the ethical, political, scientific, socio-cultural and economic contexts to determine the meaning of information related to client health care needs	P2.5 Assess impact of specific issues on health such as; political climate and will; values and culture; social and systemic structures; settings; as well as the individual, family, group, and community's readiness and capacity. P2.9 Recognize opportunities to promote social justice P3A .1 Describe selected policy options to address a specific public health issue. P3A .2 Describe the implications of each policy option, especially as they apply to the determinants of health and recommend or decide on a course of action. P3A .3 Develop a plan to implement a course of action taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies. P3A .4 Implement a policy. P3A .5 Support community action to influence policy change. P3A.6 Build community capacity to improve health and address health inequities. P3A .7 Advocate for healthy public policy and services that promote and protect the health and well-being of individuals, families groups and communities.

CARNA ETPC	Home Health Competency	Public Health Competency
		P3A .8 Advocate for the reduction of inequities in health through legislative and policy making activities. P3C.11 Advocate in collaboration with, and on behalf of, and with individuals, families, groups and communities on social justice related issues. P4.1 Advocate for societal change in support of health for all: • collaborate with partners to address public health issues and service gaps in order to achieve improved health outcomes • build coalitions, intersectoral partnerships and networks • facilitate the change process to impact the determinants of health and improve health outcomes. P4.3 Mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources. P4.4 Advocate for healthy public policies and services that promote and protect the health and well-being of individuals and communities. P4.5 Involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps. P7.2 Contribute to developing key values and a shared vision to assess, plan and implement public health programs and policies in the community by actively working with health professionals and in partnership with community partners to build capacity. P7.4 Contribute to team and organizational learning in order to advance public health goals.
SELF-REGULATION UNDERSTANDS THE REQUIREMENTS OF SELF-REGULATION IN THE INTEREST OF PUBLIC PROTECTION.		
96. Distinguishes among the mandates of **regulatory bodies, professional associations, and unions**.	H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	P7.3 Use public health and nursing ethics to manage self, others, information and resources and practice in accordance with all relevant legislation, regulating body standards and codes (e.g. provincial health legislation, child welfare legislation, privacy legislation, Canadian Nurses Association Code of Ethics for registered nurses).
97. Demonstrates understanding of the registered nurse profession as a **self-regulating and autonomous profession** mandated by provincial **legislation to protect the public**.	H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	P7.3 Use public health and nursing ethics to manage self, others, information and resources and practice in accordance with all relevant legislation, regulating body standards and codes (e.g. provincial health legislation, child welfare legislation, privacy legislation, Canadian Nurses Association Code of Ethics for registered nurses). P7.5 Contribute to the maintenance of organizational performance standards. P8.6 Act upon legal and professional obligations, and practices in accordance with relevant legislation.
98. Distinguishes between the **legislated scope of practice** and the registered nurse's **individual competence**.	H1c-v) recognize when specialized counseling beyond the scope of nursing is required and facilitate an appropriate referral H1c-vii) self-identify when their need for assistance when not familiar with care requirements and interventions	P8.6 Act upon legal and professional obligations, and practices in accordance with relevant legislation.

CARNA ETPC	Home Health Competency	Public Health Competency
	and how to seek support to assure continued excellence in care H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	
99. Understands the significance of **professional activities** related to the practice of registered nurses (e.g., attending annual general meetings, participating in surveys related to review of practice standards, and understanding significance of membership on regulatory committees, boards, or councils).	H2b-v) participate in collaborative, interdisciplinary and intersectoral partnerships to enhance the health of clients and families H3b-vii) use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies	P7.5 Contribute to the maintenance of organizational performance standards. P8.6 Act upon legal and professional obligations, and practices in accordance with relevant legislation.
100. Adheres to the **duty to report unsafe practice** in the context of professional self-regulation.	H3a-i) initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances H3a-ii) initiate and participate in critical incident reviews	P3C.10 Take action to protect individuals, families, groups and communities from unsafe or unethical circumstances.
101. Understands the significance of **fitness to practice** in the context of nursing practice, self-regulation, and public protection.	H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances	
102. Identifies and implements activities that **maintain one's fitness to practice**.	H2b-iv) take action to protect clients, families and groups from unsafe or unethical circumstances	
103. Understands the significance of **continuing competence** requirements within professional self-regulation.	H3b-iii) use reflective practice to continually assess and improve practice H3b-vi) pursue lifelong learning opportunities to support professional practice	
104a. Demonstrates continuing competence and preparedness to meet regulatory requirements by **assessing one's practice** and individual competence to identify learning needs.	H3b-iii) use reflective practice to continually assess and improve practice H3b-vi) pursue lifelong learning opportunities to support professional practice	P7.6 Demonstrate an ability to build capacity by sharing knowledge, tools, expertise and experience: • participate in professional development and practice development activities P8.4 Use reflective practice to continually assess and improve practice: • examine practice in relation to personal and individual, family, group or community attributes, existing knowledge and context
104b. Demonstrates continuing competence and preparedness to meet regulatory requirements by **developing a learning plan** using a variety of sources (e.g., self-evaluation and peer feedback).	H3b-iii) use reflective practice to continually assess and improve practice H3b-vi) pursue lifelong learning opportunities to support professional practice	P1.6 Pursue lifelong learning opportunities in the field of public health that are consistent with: current public health nursing practice; new and emerging issues; the changing needs of individuals, families, groups and communities; emerging research and evolving information about the impact of the determinants of health. P8.4 Use reflective practice to continually assess and improve practice: • examine practice in relation to personal and individual, family, group or community attributes, existing knowledge and context
104c. Demonstrates continuing competence and preparedness to meet regulatory requirements by	H1a-vi) keep knowledge current and use evidence to inform practice to ensure optimal case management	P1.6 Pursue lifelong learning opportunities in the field of public health that are consistent with: current public health nursing

CARNA ETPC	Home Health Competency	Public Health Competency
seeking and using new knowledge that may enhance, support, or influence competence in practice.	H3b-iii) use reflective practice to continually assess and improve practice H3b-vi) pursue lifelong learning opportunities to support professional practice	practice; new and emerging issues; the changing needs of individuals, families, groups and communities; emerging research and evolving information about the impact of the determinants of health. P7.6 Demonstrate an ability to build capacity by sharing knowledge, tools, expertise and experience: • participate in professional development and practice development activities P8.4 Use reflective practice to continually assess and improve practice: • examine practice in relation to personal and individual, family, group or community attributes, existing knowledge and context
104d. Demonstrates continuing competence and preparedness to meet regulatory requirements by **implementing and evaluating the effectiveness of one's learning plan** and developing future learning plans to maintain and enhance one's competence as a registered nurse.	H3b-iii) use reflective practice to continually assess and improve practice H3b-vi) pursue lifelong learning opportunities to support professional practice	P8.4 Use reflective practice to continually assess and improve practice: • examine practice in relation to personal and individual, family, group or community attributes, existing knowledge and context

Appendix E: Data Collection Instrument

Please note: This survey was primarily delivered online, using extensive skip/display logic so respondents only saw the questions that were applicable to them. For the paper surveys utilized with nursing students, only the questions that applied to them were included in the survey.

Community Health Nursing Competencies

Q2 Title of Research Study: Achievement of Community Health Competencies through Undergraduate Clinical Experiences: A Gap Analysis

Q5 NOTE: THIS SURVEY CANNOT BE COMPLETED USING A MOBILE DEVICE/iPHONE. IT MUST BE COMPLETED ON A COMPUTER. CONSENT Please make sure you have read the Research Information Sheet. Please make sure you have read the Letter of Invitation.

Q4 If you have any questions prior to your participation, please email em.pijlzieber@uleth.ca or call Em at 403.715.6310.

Q6 By clicking AGREE below, you are indicating that you:

- understand that you have been asked to participate in a research study
- received and read a copy of the attached research information sheet
- understand the benefits and the risks of participating in this study
- are aware of to whom questions about this study are to be directed, should you have any
- understand that you are free to refuse to participate or withdraw from the study at any time
- understand how the issue of confidentiality will be managed
- understand who will have access to the information

Q7 ELECTRONIC CONSENT: Please select your choice below. Clicking on the "AGREE" button below indicates that: You have read the above information You voluntarily agree to participate You are at least 18 years of age If you do not wish to participate in the research study, please decline participation by clicking on the "disagree" button.

❍ AGREE (1)
❍ Disagree (2)

If AGREE Is Selected, Then Skip To Please note that due to the way the s...

Answer If Disagree Is Selected

Q21 Are you sure?

❍ I do not wish to participate in this study (1)
❍ I made a mistake and do want to participate in the study (2)

If Yes. I do not wish to parti... Is Selected, Then Skip To End of Survey

Q22 CONSENT Please make sure you have read the RESEARCH INFORMATION SHEET.

Q24 ELECTRONIC CONSENT: Please select your choice below. Clicking on the AGREE button below indicates that: You have read the above information You voluntarily agree to participate You are at least 18 years of age If you do not wish to participate in the research study, please decline participation by clicking on the "disagree" button.

❍ AGREE (1)
❍ Disagree (2)

If Disagree Is Selected, Then Skip To End of Survey

Q65 Please note that due to the way the survey is built, you will not always be able to use the BACK button during the survey.

Q10 What is your primary role at present?

- ❍ Nursing student (pre-registration, in a program leading to BN or BScN) (1)
- ❍ Community health nurse (public health, home care, clinic, primary health care, etc.) (2)
- ❍ Manager or Educator in a community health setting (3)
- ❍ Faculty at an undergraduate (BN or BScN) nursing program (4)
- ❍ New graduate working in community health setting (6 months or less practice experience) (5)
- ❍ Other (please specify) (6) _____

Answer If Nursing student (pre-registration, in a program leading to BN or BScN) Is Selected

Q27 In which part of your BN/BScN program are you right now?

- ❍ Year 1-3 of a 4-year program (1)
- ❍ Year 4 of a 4-year program (2)
- ❍ Year 1 of a 2-year program (3)
- ❍ Year 2 of a 2-year program (4)
- ❍ Preceptorship (5)
- ❍ Other (please specify) (6) _____

Answer If Preceptorship Is Selected

Q28 In which area of community health is your preceptorship?

- ❍ Home care or home health (1)
- ❍ Public health (2)
- ❍ Primary health care or clinic (3)
- ❍ Other (please specify) (4) _____
- ❍ My preceptorship is not in any area of community health (5)

Answer If Nursing student Is Selected And Preceptorship Is Selected And My preceptorship is not in any area of community health Is Not Selected

Q36 As a result of your preceptorship experience in community health, to what degree do you feel prepared to work as a registered nurse in community health?

- ❍ I don't know (0)
- ❍ Not at all (1)
- ❍ Not very (2)
- ❍ Somewhat (3)
- ❍ Quite (4)
- ❍ Very (5)

Answer If Nursing student (pre-registration, in a program leading to BN or BScN) Is Selected Or New graduate in community health setting Is Selected

Q11 What type of community health clinical rotation did you experience in your nursing education? Please select all that apply.

- ❑ 1:1 with public health nurse for half or all of the semester (1)
- ❑ 1:1 with home care nurse for half or all of the semester (2)
- ❑ 1:1 with primary care nurse or clinic nurse for half or all of the semester (3)
- ❑ Community project at an agency (e.g. working with schools, non profits, determinants of health, etc.) (4)
- ❑ Community health was embedded in other clinicals, such as pediatric home visits, or otherwise embedded throughout my education (5)
- ❑ I did not have a community health rotation (6)
- ❑ I had a final preceptorship in a community health area (public health, home care, clinic, etc.) (8)
- ❑ Other (please specify) (7) _____

Answer If I did not have a community health rotation Is Not Selected And Nursing student Is Selected

Q37 As a result of your community health clinical rotation/experiences, to what degree do/did you feel prepared to work as a registered nurse in community health?

- ❍ I don't know (0)
- ❍ Not at all (1)
- ❍ Not very (2)
- ❍ Somewhat (3)
- ❍ Quite (4)
- ❍ Very (5)

Answer If I did not have a community health rotation Is Selected

Q12 Will you have a community health clinical rotation before your preceptorship?

- ❍ Yes (1)
- ❍ No (2)
- ❍ I don't know (0)

Answer If What type of community health clinical rotation did you … Is Selected

Q33 In your community health clinical rotation, did you learn traditional nursing knowledge and skills? Please check all that apply.

- ❑ Immunizations (1)
- ❑ Comprehensive school health (2)
- ❑ Well baby visits/clinics and new mom visits (3)
- ❑ Case management (4)
- ❑ Wound care (5)
- ❑ Community assessment (6)
- ❑ Health assessment (7)
- ❑ Patient teaching and health coaching (8)
- ❑ Palliative care (9)
- ❑ Aging in place (10)
- ❑ Other (please specify) (11) _____

Answer If Community health nurse, Manager or Educator in a community health setting, Or New graduate working in community health setting Is Selected

Q29 In which area of community health is your current practice role?

- ❍ Home care or home health (1)
- ❍ Public health (2)
- ❍ Primary health care or clinic (3)
- ❍ Other (please specify) (4) _____
- ❍ I do not work not in any area of community health (0)

Answer If New graduate in community health setting Is Selected

Q38 How many months have you worked as a new graduate in community health?

- ❍ Less than a month (1)
- ❍ 1-2 months (2)
- ❍ 2-4 months (3)
- ❍ 4-6 months (4)
- ❍ 6 months to 1 year (5)
- ❍ Over a year (0)

Answer If Over a year Is Not Selected And What is your primary role at present? New graduate in community health setting Is Selected

Q40 Prior to starting work as a registered nurse in community health, did you work elsewhere as a registered nurse?

- ❍ No (1)
- ❍ Yes (2)

Answer If Yes Is Selected

Q41 In what type of clinical areas did you work as a registered nurse, prior to working in community health? Please select all that apply.

- ❑ Medical (1)
- ❑ Surgical (2)
- ❑ Psychiatry (3)
- ❑ Longterm care (4)
- ❑ Maternal/child, labour and delivery (5)
- ❑ Pediatrics (6)
- ❑ Palliative care (7)
- ❑ Other (please specify) (8) _____

Answer If Community health nurse, Manager or Educator in a community health setting Or Faculty at an undergraduate nursing program Is Selected

Q16 For how many years have you worked in this capacity?

- ❍ Less than 2 years (1)
- ❍ 2-5 years (2)
- ❍ 6-10 years (3)
- ❍ 11-15 years (4)
- ❍ Over 15 years (5)

Answer If Community health nurse, Manager or Educator in a community health setting Or Faculty at an undergraduate nursing program Is Selected

Q17 What is the highest level of education you have achieved?

- ❍ Diploma (1)
- ❍ Bachelors degree (2)
- ❍ Master's degree (3)
- ❍ Doctoral degree (4)
- ❍ Prefer not to answer (5)

Answer If Community health nurse, Manager or Educator in a community health setting Or New graduate in community health Is Selected

Q19 What is your primary responsibility?

- ❍ Teaching (1)
- ❍ Direct patient care (2)
- ❍ Case management (3)
- ❍ Community development (4)
- ❍ Planning (5)
- ❍ Management or administration (6)
- ❍ Other (please specify) (7) _____

Answer If Faculty at an undergraduate nursing program Is Selected

Q20 Over the past year, primarily which nursing courses did you teach at the undergraduate level? Please select all the apply.

- ❑ Community health theory (1)
- ❑ Community health clinical (2)
- ❑ Supervision of preceptorship students in community health (3)
- ❑ I don't teach community health theory or clinical, nor do I supervise preceptorship students in community health (4)
- ❑ Other (please specify) (5) _____

Answer If Faculty at an undergraduate nursing program Is Selected

Q32 What type of community health clinical rotations do students in your program experience? Please select all that apply.

- ❑ 1:1 with public health nurse for between half and all of the semester (1)
- ❑ 1:1 with home care nurse for between half or all of the semester (2)
- ❑ 1:1 with primary care nurse or clinic nurse for between half or all of the semester (3)
- ❑ Fewer than 5 shadow shifts (buddy shifts) with public health nurse, home care nurse, or primary care/clinic nurse (4)
- ❑ Community project at an agency (e.g. working with schools, non profits, determinants of health, etc.) (5)
- ❑ Community health is embedded in other clinicals, such as pediatric home visits (6)
- ❑ Final preceptorship in community health is an option for students (such as public health, home care, primary health care, clinic, etc.) (7)
- ❑ Our program does not have a community health rotation (8)
- ❑ Other (please specify) (9) _____

Answer If Answer If Community health nurse, Manager or Educator in a community health setting Or Faculty at an undergraduate nursing program Is Selected

Q18 How many senior nursing students, preceptorship students or new nursing graduates have you been able to observe or supervise, in a community health setting, in the past year?

- ❍ None (1)
- ❍ 1-2 (2)
- ❍ 3-5 (3)
- ❍ 6-10 (4)
- ❍ 10-20 (5)
- ❍ 21-30 (6)
- ❍ Over 30 (7)

Q50 Please indicate within which Alberta Health Services zone you are currently working or receiving your undergraduate nursing education.

- ❍ NORTH zone (1)
- ❍ EDMONTON zone (2)
- ❍ CENTRAL zone (3)
- ❍ CALGARY zone (4)
- ❍ SOUTH zone (5)
- ❍ Don't know (0)

Q43 In the following sections you will be asked to describe two levels of performance of new grads/senior students: **Desired level of performance** and **Observed level of performance**.

Answer If Community health nurse, Manager or Educator in a community health setting Or Faculty at an undergraduate nursing program Or Other Is Selected

Q42 DESIRED PERFORMANCE LEVEL of senior nursing students and/or new grads In this first list of entry-to-practice competencies for new registered nurses, please indicate at what level you DESIRE TO SEE senior nursing students and/or new graduates demonstrating each competency in the community health context.

Answer If Nursing student Or New graduate in community health setting Is Selected

Q46 DESIRED PERFORMANCE LEVEL of senior nursing students and/or new grads In this first list of entry-to-practice competencies for new registered nurses, please indicate at what level you personally think a senior nursing student and/or new graduate should demonstrate each competency in the community health context. In other words, for what level of preparation for practice should new graduates be?

Q58 Please indicate in the matrix below the desired level of performance: (MATRIX ON NEXT PAGE OF APPENDIX)

Answer If Community health nurse, Manager or Educator in a community health setting Or Faculty at an undergraduate nursing program Or Other Is Selected

Q44 OBSERVED PERFORMANCE LEVEL of senior nursing students and/or new grads In this second list of entry-to-practice competencies for new registered nurses, please indicate at what

level you ACTUALLY OBSERVE senior nursing students and/or new graduates demonstrating each competency in the community health context.

Answer If Nursing student Or New graduate in community health setting Is Selected

Q59 OBSERVED PERFORMANCE LEVEL of senior nursing students and/or new grads In this second list of entry-to-practice competencies for new registered nurses, please indicate at what

level you ACTUALLY OBSERVE senior nursing students and/or new graduates demonstrating each competency in the community health context.

Q60 Please indicate in the matrix below the observed level of performance:

	Unaware (1)	Aware (2)	Understands (3)	Demonstrates with Assistance (4)	Demonstrates Independently (5)
PROFESSIONAL RESPONSIBILITY 1. Demonstrates leadership in client care by promoting healthy and culturally safe practice environments. (1)	❍	❍	❍	❍	❍
KNOWLEDGE BASED PRACTICE 2. Has a knowledge base from nursing and other disciplines concerning current and emerging health care issues and trends (e.g., the health care needs of older adults, vulnerable and/or marginalized populations, health promotion, obesity, pain prevention and pain management, end-of-life care, problematic substance use, and mental health). (2)	❍	❍	❍	❍	❍
3. Has a knowledge base about human growth and development, and population health, including the determinants of health. (3)	❍	❍	❍	❍	❍
4. Has a knowledge base in nursing sciences, social sciences, humanities, and health-related research (e.g., culture, power relations, spirituality, philosophical, and ethical reasoning). (4)	❍	❍	❍	❍	❍
5. Has knowledge about emerging community and global health issues, population health issues and research (e.g., pandemic, mass immunizations, emergency/disaster planning, and food and water safety). (5)	❍	❍	❍	❍	❍
6. Knows how to find evidence to support the provision of safe, competent, compassionate, and ethical nursing care, and to ensure the personal safety and safety of other health care workers. (6)	❍	❍	❍	❍	❍
7. Understands the role of primary health care and the determinants of health in health delivery systems and its significance for population health. (7)	❍	❍	❍	❍	❍
Assessment 8. Engages clients in an assessment of the following: physical, emotional, spiritual, cultural, cognitive, developmental, environmental, and social needs. (8)	❍	❍	❍	❍	❍
9. Collects information on client status using assessment skills of observation, interview, history taking, interpretation of laboratory data, mental health assessment, and physical assessment, including inspection, palpation, auscultation, and percussion. (9)	❍	❍	❍	❍	❍
10. Uses anticipatory planning to guide an ongoing assessment of client health status and health care needs (e.g., prenatal/postnatal, adolescents, older adults, and reaction to changes in health status and/or diagnosis). (10)	❍	❍	❍	❍	❍
11. Analyzes and interprets data obtained in client assessments to draw conclusions about client health status. (11)	❍	❍	❍	❍	❍
12. Incorporates knowledge of the health disparities and inequities of vulnerable populations (e.g., sexual orientation, persons with disabilities, ethnic minorities, poor, homeless, racial minorities, language minorities) and the contributions of nursing practice to achieve positive health outcomes. (12)	❍	❍	❍	❍	❍
13. Collaborates with clients and the health care team to identify actual and potential client health care needs, strengths, capacities, and goals. (13)	❍	❍	❍	❍	❍
Planning 14. Uses principles of primary health care in developing health care plans. (14)	❍	❍	❍	❍	❍
15. Facilitates the appropriate involvement of clients in identifying their preferred health outcomes. (15)	❍	❍	❍	❍	❍
16. Negotiates priorities of care and desired outcomes with clients, demonstrating cultural safety, and considering the influence of positional power relationships. (16)	❍	❍	❍	❍	❍
17. Explores and develops a range of possible alternatives and approaches for care with clients. (17)	❍	❍	❍	❍	❍
18. Facilitates client ownership of direction and outcomes of care developed in their health care plans. (18)	❍	❍	❍	❍	❍
19. Determines, with the health care team or health-related sectors, when consultation is required to assist clients in accessing available resources. (19)	❍	❍	❍	❍	❍

Provision of Nursing Care 20. Provides nursing care across the lifespan that is informed by a variety of theories relevant to health and healing (e.g., nursing; family; communication and learning; crisis intervention; loss, grief, and bereavement; systems; culture; community development; and population health theories). (20)	❍	❍	❍	❍	❍
21. Prioritize and provide timely nursing care and consult as necessary for any client with co-morbidities, and a complex and rapidly changing health status. (21)	❍	❍	❍	❍	❍
22. Incorporates evidence from research, clinical practice, client perspective, client and staff safety, and other available resources to make decisions about client care. (22)	❍	❍	❍	❍	❍
23. Recognizes, seeks immediate assistance, and helps others in a rapidly changing client condition affecting health or patient safety (e.g., myocardial infarction, surgical complications, acute neurological event, acute respiratory event, cardiopulmonary arrest, perinatal crisis, diabetes crisis, mental health crisis, premature birth, shock, and trauma). (23)	❍	❍	❍	❍	❍
24. Applies principles of population health to implement strategies to promote health as well as prevent illness and injury (e.g., promoting hand washing, immunization, helmet safety, and safe sex). (24)	❍	❍	❍	❍	❍
25. Assists clients to understand how lifestyle factors impact health (e.g., physical activity and exercise, sleep, nutrition, stress management, personal and community hygiene practices, family planning, and high-risk behaviours). (25)	❍	❍	❍	❍	❍
26. Assists clients to identify and access health and other resources in their communities (e.g., other health disciplines, community health services, rehabilitation services, support groups, home care, relaxation therapy, meditation, and information resources). (26)	❍	❍	❍	❍	❍
Evaluation 27. Uses critical inquiry to monitor and evaluate client care in a timely manner. (27)	❍	❍	❍	❍	❍
28. Modifies and individualizes client care based on the emerging priorities of the health situation in collaboration with clients. (28)	❍	❍	❍	❍	❍
29. Verifies that clients have an understanding of essential information and skills to be active participants in their own care. (29)	❍	❍	❍	❍	❍
ETHICAL PRACTICE 30. Engages in relational practice through a variety of approaches that demonstrate caring behaviours appropriate for clients. (30)	❍	❍	❍	❍	❍
31. Promotes a safe environment for clients, self, health care workers, and the public that addresses the unique needs of clients within the context of care. (31)	❍	❍	❍	❍	❍
32. Respects and preserves clients' rights based on the values in the CNA Code of Ethics for Registered Nurses and an ethical framework. (32)	❍	❍	❍	❍	❍
33. Demonstrates support for clients in making informed decisions about their health care, and respects those decisions. (33)	❍	❍	❍	❍	❍
34. Advocates for safe, competent, compassionate, and ethical care for clients or their representatives, especially when they are unable to advocate for themselves. (34)	❍	❍	❍	❍	❍
35. Engages in relational practice and uses ethical principles with the health care team to maximize collaborative client care. (35)	❍	❍	❍	❍	❍
SERVICE TO THE PUBLIC 36. Demonstrates knowledge about the structure of the health care system at the national level, provincial/territorial level, regional/municipal level, agency level, and program level. (36)	❍	❍	❍	❍	❍
37. Participates and contributes to nursing and health care team development by promoting interprofessional collaboration through application of principles of decision-making, problem solving, and conflict resolution. (37)	❍	❍	❍	❍	❍
38. Collaborates with the health care team to respond to changes in the health care system by recognizing and analyzing changes that affect one's practice and client care. (38)	❍	❍	❍	❍	❍

39. Collaborates with the health care team to respond to changes in the health care system by developing strategies to manage changes affecting one's practice and client care. (39)	❍	❍	❍	❍	❍
40. Uses established communication policies and protocols within and across health care agencies, and with other service sectors. (40)	❍	❍	❍	❍	❍
41. Uses resources in a fiscally responsible manner to provide safe, effective, and efficient care. (41)	❍	❍	❍	❍	❍
42. Supports healthy public policy and principles of social justice. (42)	❍	❍	❍	❍	❍
SELF-REGULATION 43. Demonstrates continuing competence and preparedness to meet regulatory requirements by seeking and using new knowledge that may enhance, support, or influence competence in practice. (43)	❍	❍	❍	❍	❍

Q49 To what degree do you think these established Competencies reflect the work of a community health nurse in Alberta?

- ❍ I don't know (0)
- ❍ Very Poor (1)
- ❍ Poor (2)
- ❍ Fair (3)
- ❍ Good (4)
- ❍ Very Good (5)

Q48 Thank you for your responses. The survey is almost complete!

Answer If Community health nurse Or Manager or Educator in a community health setting Or Faculty at an undergraduate nursing program Or Other Is Selected

Q50 In your opinion, how important are the following for new graduates working in your community health area:

- knowledge (possessing nursing knowledge relevant to your area of practice)
- skills (having the psychomotor skills relevant to your area of practice)
- attitudes (having the right attitude relevant to your area of practice)

Answer If Nursing student Or New graduate in community health setting Is Selected

Q52 In your opinion, how important are the following for new graduates working in community health settings:

- knowledge (possessing nursing knowledge relevant to community health practice)
- skills (having the psychomotor skills relevant to community health practice)
- attitudes (having the right attitude relevant to community health practice)

Q61 Please indicate your values regarding the relative importance of knowledge, skills and attitudes, in the area of community health nursing, here:

Knowledge (1) ☆☆☆☆☆

Skills (2) ☆☆☆☆☆

Attitudes (3) ☆☆☆☆☆

Q55 Is there anything else you would like to add about how nursing students can be better prepared for community health nursing practice?

Q64 To make sure you are a real person and not a spam computer, please enter the words you see in the space below. This security step is necessary to enter your data. If you cannot decipher it, please hit the refresh button beside it until you see something that you can type accurately. If there are TWO terms you enter, please enter a SPACE between the two words/terms.

Q9 Thank you for participating in this survey. This is the end of the survey. Please click the Next >> button below to submit your responses. You will then be automatically re-directed to another site at which, if you like, you can enter your name and contact information into the draw to win one of four Kindle e-readers. The draw entry form is entirely separate from the survey, and your name and contact information will be used only for the lottery, and will then be destroyed.

Appendix F: Amendments to Instrument during Data Collection

DATE (2014)	ISSUE	Q#	FIX
April 1 (prior to pilot completion)	EDIT TO ADD educator role to list of options and skip/display logic—added to "manager OR educator…" and then further separate by tasks (e.g. educate)	Q10	Added EDUCATOR to survey options (beside manager to preserve dataset; further differentiated later in survey) and literature
	Text box in error!! Should link to new site	Q9	Now links to new lottery site
July 3, 2014	2 respondents of 71 confused re: print consent form > abandoned survey	Q8	Removed "print consent form" and left it as a basic consent
July 3, 2014	10 respondents of 71 confused by instructions > abandoned survey BEFORE section comparing competencies DESIRED vs OBSERVED.	15/45	Combined instructions onto same page as actual matrix, not having to click "NEXT" to get to matrix, which was being bypassed.
July 3, 2014	Lottery only filled in by 38 of 71 respondents		Instead of "click this link", which terminates the survey, respondents now advance to next page and are automatically re-directed to the lottery site.
July 23	2 respondents quit at AHS map		Changed question to m/c for zones as map may have been too big for screen leading to confusion/inability to see "next" screen advance. Bypassed the hot spot question with display logic (blocking it) and put in muiltiple zone question instead.
Aug 8	Attrition still at matrix (25%)	Q42 Q46 Q58	Removed definitions. Removed excess directions. Retained only scant and used underscore and color
Aug 9	Discussed with one respondent re: attrition. She stated the matrix looked "overwhelming"; suggested adding headers.		Added headers as per headings on ETPCs.
Sept 2	Attrition still high at matrix. ? iPhone? (won't work for matrix). But instructions say already you can't use iPhone/handheld.		Made that more clear.
Nov.	Lack of responses from students and faculty		Re-send survey through appropriate channels. Sample senior nursing students at U of L and U of A (have access) with paper surveys and $10 gift cards (amended budget re: WNRCASN)

DATE (2014)	ISSUE	Q#	FIX
			Add on focus groups – faculty U of L, students U of L, faculty U of A, students U of A Amend ethics at U of L, U of A, and South Zone AHS
	Lack of responses (although highest response rate was from CHNs)		AHS not returning calls or emails and therefore I am unable to access the population. Add south focus group if I can gain local access.
Dec. 24	Online survey closed.		

Appendix G: Letter of Invitation to Participate in Research—Survey

Letter of Invitation to Participate in Research

UNIVERSITY OF ALBERTA
Faculty of Nursing
Level 3, Edmonton Clinic Health Academy
11405 87 Avenue Edmonton AB T6G 1C9
Toll Free Telephone: 1.888.492.8089
Fax: 780.492.2551

March 21, 2014

LETTER OF INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

Study Title: Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Gap Analysis

Greetings,

My name is Em Pijl-Zieber. I am a doctoral candidate in the Faculty of Nursing at the University of Alberta.

I am conducting a research study as part of the requirements of my degree in nursing, and I would like to invite you to participate. This study is partially funded by Western Northwestern Region of Canadian Association of Schools of Nursing (WNRCASN). This study has been reviewed and received ethics clearance through the University of Alberta Human Research Ethics Board [Pro00045649].

Through this study I am hoping to assess the degree to which senior nursing students, preceptored students, and new nursing graduates are prepared for practice in community health nursing. If you decide to participate, you will be asked to complete a survey about the level of performance of nursing students, in the community health nursing context, according to a set of competencies that align with the Entry-to-Practice Competencies for the Registered Nurses Profession in Alberta (as put forth by the College and Association of Registered Nurses of Alberta).

In particular, you will be asked to rate both the observed and desired performance level of students and/or new graduates with whom you have worked. The survey will take approximately 30 minutes to complete. The survey is online.

You do not have to answer any questions that you do not wish to. Although you probably won't benefit directly from participating in this study, we hope that we can reveal the strengths and weakness of baccalaureate nursing education, as it relates to graduate preparation for community health nursing. Participation is confidential. Study information will be kept in a secure location at the University of Lethbridge Faculty of Health Sciences, where the student primary investigator is employed. The results of the study may be published or presented at professional meetings, but your identity will not be revealed.

Taking part in this study is your decision. You do not have to be in this study if you do not want to. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering. If you are a nursing student or preceptored student, your participation, non-participation or withdrawal will not affect your grades in any way.

We are interested in hearing from you if **you are a**:

Registered Nurse	New Graduate	Nursing Student	Manager or Educator	Faculty Member
WHO	WHO	WHO	WHO	WHO
☑ Currently works in public health, home care, a community health centre, primary health care or a clinic in Alberta ☑ Has over 2 years of experience in community health ☑ Has had opportunity to observe and/or work with new graduates and/or students in community health settings	☑ Graduated from an undergraduate nursing program in Alberta 6 months ago or less ☑ Currently works in public health, home care, a community health centre, primary health care or a clinic in Alberta	☑ Is in their final year (4th year of a 4-year program, or 2nd year of a 2-year after-degree program) of a baccalaureate nursing program in Alberta **-or-** ☑ Is currently being preceptored in a community health setting in Alberta	☑ Works in a community health setting and works with community health nurses in Alberta ☑ Has had opportunity to observe and/or work with new graduates and/or students in community health settings	☑ Teaches community health nursing in an undergraduate nursing program in Alberta **-or -** ☑ Supervises students who are being preceptored in a community health setting in Alberta

If you choose, you may enter your name and contact information into a separate online form, if you would like to be eligible to win one of four Kindle e-readers, as a token of appreciation for your time, at the closure of the study. Your contact information will be not be associated with your data, and is only used for the lottery, after which your contact information will be destroyed.

We will be happy to answer any questions you have about the study. You may contact me at 403.715.6310 or em.pijlzieber@ualberta.ca, or my supervisor (Dr. Sylvia Barton, at 780.492.6253 or sylvia.barton@ualberta.ca) if you have study related questions or problems. If you have any questions about your rights as a research participant, you may contact the Research Ethics Office at the University of Alberta at 780.492.0459.

Thank you for your consideration. If you would like to participate, please go to this website and click on the link that says "RESEARCH". http://scholar.ulethbridge.ca/em_pijlzieber/
This link will take you to the research survey, which begins with a detailed introduction to the study and an online consent form.

With kind regards,

Em M. Pijl-Zieber, Principal Researcher
Faculty of Health Sciences
University of Lethbridge
4401 University Dr., Lethbridge, T1K 3M4

Dr. Sylvia Barton, Supervisor
Associate Professor, Faculty of Nursing
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Appendix H: Research Information Sheet and Consent Form

RESEARCH INFORMATION SHEET

Title of Research Study: Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Gap Analysis

Background

It is anticipated widely that in Canada, nursing practice and health care are moving from acute care into the community. What has yet to be established, however, is the degree to which baccalaureate nursing students are actually being prepared for community health nursing practice in their undergraduate education in general, and their community health clinical rotations in particular. The competence of new nurses has direct implications for patient safety and individual, family, and public health.

There has been a recent change in how undergraduate, pre-registration nursing students learn about and experience community health clinical practice. In the past, nursing students in their community health rotation were often partnered with a registered nurse working in home care, public health or community health centre. Now, with the shortage of community placements and fewer community nurses able to take students, many Canadian nursing programs are using non-traditional placements and engaging students in non-nursing activities to teach the principles of community health nursing practice. At these non-traditional sites, which range from schools to churches and even shopping malls, students carry out a variety of health-related projects and activities but do not work with community health nurses or carry out restricted nursing acts. How well this newer delivery method prepares students for registered nursing practice in the community has never been quantified.

Purpose of the Study

The objectives of this project are:

- To understand the competencies required of nursing students** from a stakeholder* perspective.
- To understand the level of satisfaction of stakeholders* as it relates to the acquisition of competencies by nursing students**.
- To understand the nature of the gap between desired and observed competency level.

*Stakeholders include: (1) Practicing community health nurses, educators and nurse managers in community health; (2) Faculty who teach community health clinical or supervise preceptored students in community health sites; (3) Senior level (4th year) university-enrolled nursing students who have had their community health clinical rotation as well as nursing students being preceptored in community health; and, (4) new (<6 months) baccalaureate nursing graduates working in community health.

**Nursing students: This category includes senior level (4th year) university-enrolled nursing students who have had their community health clinical rotation, nursing students being preceptored in community health, and new (<6 months) baccalaureate nursing graduates working in community health.

Your Involvement

If you choose to participate, you can access the survey by going to this website:

http://scholar.ulethbridge.ca/em_pijlzieber

Follow the link that says "RESEARCH".

An online survey will ask several brief multiple choice questions about your experience as a community health nurse *or* as a student. Then, you will be asked to rate the *desired* performance level of nursing students/new graduates (with less than 6 months practice) in community health, and the *observed* performance level of nursing students/new graduates in community health. You will be asked to rate performance (*desired* and *observed*) based on 43 Entry-to-Practice Competencies (College and Association of Registered Nurses of Alberta, 2013a) that align with the Home Health Competencies and the Public Health Competencies (Community Health Nurses of Canada, 2009b, 2010).

The survey should take approximately 30 minutes to complete. The study will remain open for 8 months.

As a thank you for your participation, if you choose, you may enter your name and contact information into a separate online form, after you have completed the survey, to win one of four Kindle e-readers, as a token of appreciation for your time, at the closure of the study. The odds of winning are one in fifty. The draw is online but completely separate from the survey and your personal information will not be connected in any way. Your contact information will only be accessed if you win; the information will then be destroyed.

Participation in this study is voluntary. You may choose not to answer some of the questions or not to participate in some parts of the research.

Confidentiality

Your identity and all information you provide will be kept strictly confidential. All documents and data files will be identified by case number only and retained in a password protected digital file. The survey platform itself is encrypted. The survey platform (Qualtrics) has physical and environmental controls in place to protect data. Data is backed up daily on the Qualtrics servers. Paper and electronic information collected will be retained for 5 years, after which it will be destroyed. Only researchers associated with this project will have access to the information you provide. Your name will not appear in any publication or presentation resulting from this research project and your identity will be well disguised and the data aggregated.

Ethics Approval

This study has been reviewed for its adherence to ethical guidelines and approved by the University of Alberta Ethics Review Board.

Potential Risks and Benefits

No foreseeable harm or risk should come to you as a result of your participation in this research. Your participation will contribute to the advancement of scholarly knowledge in the area of how well baccalaureate nursing students are being prepared, through their educational experiences, for community health nursing practice. We anticipate that the research findings will provide direction to both university schools of nursing and provincial health services in relation to preparing students for nursing practice.

Contact Information

If you have any questions or concerns about this study at any time, please contact me or my supervisor, Dr. Sylvia Barton, at the Faculty of Nursing, University of Alberta. Our contact information is included below. We would be happy to address any questions or concerns you may have. In the event you have concerns about the study and would prefer to contact someone who is not directly involved in the study, you may contact the University of Alberta Faculty of Graduate Studies, at 780.482.1111. If you have any questions about your rights as a research participant, you may contact the Research Ethics Office at the University of Alberta at 780.492.2615.

If you have any questions prior to your participation, please email em.pijlzieber@uleth.ca.

Thank you!

Em M. Pijl-Zieber, RN, BScN, MEd
Doctoral Student
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Appendix I: Letter of Invitation to Participate in Research—Focus Group

Letter of Invitation to Participate in Research

UNIVERSITY OF ALBERTA
Faculty of Nursing
Level 3, Edmonton Clinic Health Academy
11405 87 Avenue Edmonton AB T6G 1C9
Toll Free Telephone: 1.888.492.8089
Fax: 780.492.2551

December 11 2014

LETTER OF INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

Study Title: Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Gap Analysis

Greetings,

You are invited to participate in a research study to explore the degree to which senior nursing students, preceptor students, and new nursing graduates are prepared for practice in community health nursing roles. Study participation involves one focus group interview that will be a maximum of one and a half hours in duration.

You have been invited to participate for <u>one of the following reasons</u>:

- ❑ You are a **practicing registered nurse working in a community context (as a nurse, manager, or educator)**, you have over 2 years of experience in community health, and you have had the opportunity to observe and/or work with new graduates and/or students in community health settings.
- ❑ You are a **nursing student in their final year of a baccalaureate nursing program** in Alberta or you are currently in a preceptorship in a community health setting in Alberta
- ❑ You are a **faculty member who teaches community health nursing** in an undergraduate nursing program in Alberta or who **supervises students in community health** preceptorships.
- ❑ You are a **newly graduated registered nurse working in a community context**, you graduated from an undergraduate nursing program in Alberta 6 months ago or less, and you currently work in public health, home care, a community health centre, primary health care or a clinic in Alberta.

This study is part of the requirements of my doctoral degree in nursing and is partially funded by Western Northwestern Region of Canadian Association of Schools of Nursing (WNRCASN). This study has been reviewed and received ethics clearance through: the University of Alberta Research Ethics Board (PRO 000454649); the University of Lethbridge Human Subject Research Committee (2014-021); and, Alberta Health Services South Zone.

Through this study I am hoping to assess the degree to which senior nursing students, preceptor students, and new nursing graduates are prepared for practice in community health nursing. If

you agree to take part in the study, you will be interviewed during a focus group about preparation of nursing students for community health practice roles. You will be asked to talk about:

- How schools of nursing are preparing students for community health practice
- To what degree nursing students should be prepared for community health roles, through their undergraduate programs and clinical experiences
- Some of the reasons why different stakeholder groups (faculty, nurses, managers, and students) often view readiness for practice differently

You do not have to answer any questions that you do not wish to. Although you probably won't benefit directly from participating in this study, we hope that we can reveal the strengths and weakness of baccalaureate nursing education, as it relates to graduate preparation for community health nursing.

Participation is confidential. Study information will be kept in a secure location at the University of Lethbridge Faculty of Health Sciences, where the primary investigator is employed. The results of the study may be published or presented at professional meetings, but your identity will not be revealed.

Taking part in this study is your decision. You do not have to be in this study if you do not want to. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering. If you are a nursing student or preceptor student, your participation, non-participation or withdrawal will not affect your grades in any way.

We will be happy to answer any questions you have about the study. You may contact me at 403.715.6310 or em.pijlzieber@ualberta.ca, or my supervisor (Dr. Sylvia Barton, at 780.492.6253 or sylvia.barton@ualberta.ca) if you have study related questions or problems. If you have any questions about your rights as a research participant, you may contact the Research Ethics Office at the University of Alberta (780.492-2615) or at the Office of Research Ethics at the University of Lethbridge (403.329.2747), depending on at which institution you are participating.

If you wish to participate, please contact me so that I can add you to the focus group.

Thank you for your consideration.

With kind regards,

Em M. Pijl-Zieber, Principal Researcher
Faculty of Health Sciences
University of Lethbridge
4401 University Dr., Lethbridge, T1K 3M4

Dr. Sylvia Barton, Supervisor
Associate Professor, Faculty of Nursing
Level 3, Edmonton Clinic Health Academy
11405 87 Avenue
University of Alberta
Edmonton Alberta T6G 1C9

Appendix J: Research Information Sheet—Focus Group

UNIVERSITY OF ALBERTA
Faculty of Nursing
Level 3, Edmonton Clinic Health Academy
11405 87 Avenue Edmonton AB T6G 1C9
Toll Free Telephone: 1.888.492.8089
Fax: 780.492.2551

RESEARCH INFORMATION SHEET

Research Study: Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Gap Analysis

Background

It is anticipated widely that in Canada, nursing practice and health care are moving from acute care into the community. What has yet to be established, however, is the degree to which baccalaureate nursing students are actually being prepared for community health nursing practice in their undergraduate education in general, and their community health clinical rotations in particular. New nurse preparation has direct implications for patient safety and individual, family, and public health.

There has been a recent change in how undergraduate, pre-registration nursing students learn about and experience community health clinical practice. In the past, nursing students in their community health rotation were often partnered with a registered nurse working in home care, public health or community health centre. Now, with the shortage of community placements and fewer community nurses able to take students, many Canadian nursing programs are using non-traditional placements and engaging students in non-nursing activities to teach the principles of community health nursing practice. At these non-traditional sites, which range from schools to churches and even shopping malls, students carry out a variety of health-related projects and activities but do not work with community health nurses or carry out restricted nursing acts. How well this delivery method prepares students for registered nursing practice in the community has never been quantified.

Purpose of the Study

The objectives of this project are:

- To understand the community health competencies required of nursing students from multiple perspectives (students, new graduates, community health nurses and managers, and faculty);
- To understand the level of satisfaction regarding the acquisition of competencies by nursing students, from multiple perspectives; and
- To understand the nature of the gap between desired and observed competency level.

Your Involvement

If you agree to take part in the study, you will be interviewed during a focus group by a researcher. You will be asked to talk about:

- How schools of nursing are preparing students for community health practice
- To what degree nursing students should be prepared for community health roles, through their undergraduate programs and clinical experiences
- Some of the reasons why different stakeholder groups (faculty, nurses, managers, and students) often view readiness for practice differently

Study participation involves one focus group interview that will be a maximum of one and a half hours in duration. The session will be audio-recorded for analysis but your participation and identity will be kept confidential.

As a thank you for your participation, you will receive a $10 gift card for Starbucks or Tim Hortons.

Confidentiality

We will ask all participants of the focus group to not reveal what was discussed outside of the focus group; however, we cannot control what other participants do with the information discussed. Otherwise your participation and identity will be kept confidential. Your name and any identifying information will be removed from the transcript of the focus group. Your transcript sections will be identified only by a code number assigned to you by the researcher. Only the research team will have access to the recordings and transcriptions; the recordings and transcriptions will be stored in a locked filing cabinet to which only the researcher has a key. The recordings and transcriptions will be destroyed five years from the end of the study. The recordings will be deleted and the transcriptions will be shredded by a confidential waste management company. Electronic files will be password protected and will be deleted using appropriate file deletion software. The findings of the research will be published in a doctoral dissertation and disseminated in other academic publications and presentations. Your name will not appear in any publications or presentations.

Ethics Approval

This study has been reviewed for its adherence to ethical guidelines and approved by the University of Alberta Ethics Review Board, the University of Lethbridge Human Subject Research Committee, and Alberta Health Services South Zone.

Potential Risks and Benefits

No foreseeable harm or risk should come to you as a result of your participation in this research. Your participation will contribute to the advancement of scholarly knowledge in the area of how well baccalaureate nursing students are being prepared, through their educational experiences, for community health nursing practice. We anticipate that the research findings will provide direction to both university schools of nursing and provincial health services in relation to preparing students for nursing practice. A report of the findings will be sent to all institutions from which respondents came forward. As well, a report will be posted on the researcher's website at the end of the study:
http://scholar.ulethbridge.ca/em_pijlzieber/

Contact Information

If you have any questions or concerns about this study at any time, please contact me or my supervisor, Dr. Sylvia Barton, at the Faculty of Nursing, University of Alberta. Our contact information is included below. We would be happy to address any questions or concerns you may have. In the event you have concerns about the study and would prefer to contact someone who is not directly involved in the study, you may contact the University of Alberta Faculty of Graduate Studies, at 780.482.1111. If you have any questions about your rights as a research participant, you may contact the Research Ethics Office at the University of Alberta (780.492.2615) or the Office of Research Ethics at the University of Lethbridge (403.329.2747), depending on at which institution you are completing this survey.

If you have any questions prior to your participation, please email em.pijlzieber@uleth.ca.

Thank you!

Em M. Pijl-Zieber, RN, BScN, MEd
Doctoral Candidate
Principal Researcher
Faculty of Nursing, University of Alberta
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Dr. Sylvia Barton, RN, PhD
Doctoral Supervisor, Associate Professor
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University of Alberta, Faculty of Nursing
Email: sylvia.barton@ualberta.ca

Appendix K: Consent Form—Focus Group

University of Alberta
Faculty of Nursing

Focus Group Interview Consent Form

Title of Research Project: Achievement of Community Health Nursing Competencies through Undergraduate Clinical Experiences: A Gap Analysis

Purpose: You are invited to participate in a research study to explore the degree to which senior nursing students, preceptor students, and new nursing graduates are prepared for practice in community health nursing roles. Study participation involves one focus group interview that will be a maximum of one and a half hours in duration.

You have been invited to participate for one of the following reasons:

- ❑ You are a **practicing registered nurse working in a community context (as a nurse, manager, or educator)**, you have over 2 years of experience in community health, and you have had the opportunity to observe and/or work with new graduates and/or students in community health settings;
  or
- ❑ You are a **nursing student in their final year of a baccalaureate nursing program** in Alberta or you are currently in a preceptorship in a community health setting in Alberta;
  or
- ❑ You are a **faculty member who teaches community health nursing** in an undergraduate nursing program in Alberta or who **supervises students in community health** preceptorships;
  or
- ❑ You are a **newly graduated registered nurse working in a community context**, you graduated from an undergraduate nursing program in Alberta 6 months ago or less, and you currently work in public health, home care, a community health centre, primary health care or a clinic in Alberta.

Study procedures: If you agree to take part in the study, you will be interviewed during a focus group by a researcher. You will be asked to talk about:

- How schools of nursing are preparing students for community health practice
- To what degree nursing students should be prepared for community health roles, through their undergraduate programs and clinical experiences
- Some of the reasons why different stakeholder groups (faculty, nurses, managers, and students) often view readiness for practice differently

Potential risks: There are no known risks to this research.

Potential benefits: Although you probably won't benefit directly from participating in this study, if you agree to participate we hope that we can reveal the strengths and weakness of baccalaureate nursing education, as it relates to graduate preparation for community health nursing. A report of the findings will be sent to all institutions from which respondents came forward. As well, a report will be posted on the researcher's website at the end of the study: http://scholar.ulethbridge.ca/em_pijlzieber/.

Confidentiality: We will ask all participants of the focus group to not reveal what was discussed outside of the focus group; however, we cannot control what other participants do with the information discussed. Otherwise your participation and identity will be kept confidential. The focus group will be audio-recorded and then transcribed for analysis. Your name and any identifying information will be removed from the transcript of the focus group. Your transcript sections will be identified only by a code number assigned to you by the researcher. Only the research team will have access to the recordings and transcripts; the recordings and transcripts will be stored in a locked filing cabinet to which only the researcher has a key. Electronic files will be password protected and will be erased using appropriate file deletion software. The recordings and transcripts will be destroyed five years from the end of the study. The recordings will be deleted and the transcripts will be shredded by a confidential waste management company. You can withdraw from the study at any time, and can withdraw your responses which will then be destroyed. The findings of the research will be published in a doctoral dissertation and disseminated in other academic publications and presentations. Your name will not appear in any publications or presentations.

Compensation: As a thank you for your participation, you will receive a $10 gift card for Tim Hortons or Starbucks.

Contact for information about the study: Before you sign this form please ask any remaining questions you have about the study. If you have any questions or concerns about this study at any time, please contact me or my supervisor, Dr. Sylvia Barton, at the Faculty of Nursing, University of Alberta. Our contact information is included below. We would be happy to address any questions or concerns you may have. In the event you have concerns about the study and would prefer to contact someone who is not directly involved in the study, you may contact the University of Alberta Faculty of Graduate Studies, at 780.482.1111. If you have any questions about your rights as a research participant, you may contact the Research Ethics Office at the University of Alberta (780.492.2615) or the Office of Research Ethics at the University of Lethbridge (403.329.2747), depending on at which institution you are completing this survey.

Thank you!

Investigators:

Em M. Pijl-Zieber, RN, BScN, MEd
Doctoral Candidate
Principal Researcher
Faculty of Nursing, University of Alberta
Email: em.pijlzieber@ualberta.ca

Dr. Sylvia Barton, RN, PhD
Doctoral Supervisor, Associate Professor
Supervisor
University of Alberta, Faculty of Nursing
Email: sylvia.barton@ualberta.ca

Consent: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time. You may also withdraw your contributions at a later date.

Your signature indicates that you give permission for the information provided in interviews to be used for publication in research articles/journals/books, and/or teaching materials. Additionally, your signature indicates that you have received a copy of the consent form.

Name of person consenting (Please print): _____

Signature: _____ Date: _____

Appendix L: Recruitment Poster for Focus Group

Are BN Students Being Prepared for Community Health Nurse Roles?

I would like to invite you to take part in a focus group (small discussion group) about how well you think baccalaureate nursing students are being prepared for community health nursing roles through their undergraduate experiences. The focus group should last no longer than one and a half hours.

In particular, we would like to know:

- How are schools of nursing preparing students for community health practice?
- To what degree should nursing students be prepared for community health roles?
- What are some of the reasons why different stakeholders view readiness for practice differently?

More information will be sent to those confirming attendance before the focus group.

We would like to hear from you if you are:

- A **registered nurse** who works in community health
- A new **graduate** nurse who works in community health
- A **senior nursing student** (4th year or preceptorship)
- A community health **manager** or **educator**
- **Faculty** who teach or supervise students in community health

If you would like to participate, please contact Em Pijl-Zieber: em.pijlzieber@uleth.ca or 403-332-5232.

MORE INFORMATION:
http://scholar.ulethbridge.ca/em_pijlzieber/pages/research-3

Em M. Pijl-Zieber BScN, MEd, RN, PhD (Candidate)
Faculty of Nursing, University of Alberta
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UNIVERSITY OF ALBERTA

Appendix M: Prompting Questions for Focus Groups

- Tell me what you/the students learn(ed) in community health clinical.
- How are schools of nursing preparing students for community health practice?
- To what degree should nursing students be prepared for community health roles, through their undergraduate programs and clinical experiences? What does it mean to you to be "ready for practice"?
- What are some potential reasons why different stakeholder groups (such as faculty, nurses, managers, and students) often view readiness for practice differently?
- How can students be best prepared for community practice roles?

Appendix N: Tips for Teaching and Organizing Community Health Practice/Clinical Courses

Practical Tips for Instructors, Administrators and Organizers of Innovative/Non-Traditional Community Health Clinical Experiences

Tips for Teaching and Organizing Community Health Practice/Clinical Courses

Practical Tips for Instructors, Administrators, and Organizers of Innovative/Non-Traditional Community Health Clinical Experiences

Compiled by Em M. Pijl-Zieber RN, MEd, PhD Candidate
September 2014 – March 2015
University of Lethbridge

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We cannot solve our problems
with the same thinking we used
when we created them.

Albert Einstein

Preamble

Schools of nursing need to continually find new and sustainable ways to engage students in community health practice. Despite the fact that service learning is widely used in nursing education, and despite some excellent reports on the use of this delivery model in Canada, extant literature provides little insight or prescriptive guidance in the following areas: the nature of foundational knowledge in community health nursing; faculty workload associated with a service learning model in community health clinical education; whether service learning in community *health* style projects prepare students for community *based* nursing practice; logistical issues in structuring service learning experiences in community health nursing clinical education; the shortcomings of service learning for clinical education; and how to bridge the theory/practice gap in non-traditional clinical experiences. While answering these questions is beyond the scope of this document, the tips offered herein should provide community health clinical instructors some tools to begin to address the theory-to-practice gap.

The Canadian Association of Schools of Nursing (CASN) Sub-Committee on Public Health has published a set of guidelines for undergraduate community health experiences (2010). These guidelines, which are readily available online for schools of nursing to utilize in the development of community health practice experiences, should provide the basis of all baccalaureate nursing education for community health practice. **The tips in this document expand on CASN's Guidelines, are derived from the literature, my own teaching experience, my research into community health clinical experiences, and discussions with faculty across Canada who teach community health clinical practice courses**.

Acknowledgements

Thank you to Dr. Chris Hosgood, Dean of the Faculty of Health Sciences at the University of Lethbridge, who permitted and provided resources for a review of current practice and development of potential solutions. Thank you also to my outstanding community health nursing colleagues at the University of Lethbridge, and my esteemed colleagues in community health nursing across Canada. Thank you to my PhD supervisory committee—Dr. Sylvia Barton, Dr. Jill Konkin, and Dr. Olu Awosoga—for their support in my research into this topic. Thank you to the Western Northwestern Region of the Canadian Association of Schools of Nursing for partially funding my research through the graduate research award.

Community Health Nursing Identity

- ❑ Develop, with your community health clinical education team, a statement that describes the role of the community health clinical instructor, particularly as it relates to the roles of project manager and learning experience facilitator.
- ❑ Ensure students have access to community health role models that are registered nurses, through shadow shifts and preceptor arrangements to promote both socialization into community health nursing and appreciation of its unique role responsibilities.
- ❑ Incorporate strong community health case studies that require prioritization of care and case management, in which students can integrate specialized nursing knowledge and skills.
- ❑ Create an orientation toolkit for new instructors that includes key documents and recommended tips for organizing the learning experience.
- ❑ Have regular meetings with teaching faculty to shape the learning experiences and problem solve clinical issues as a team.
- ❑ Engage with community health practice areas to stay involved and maintain relationships in the practice area.
- ❑ Find ways to enable students to experience a variety of community health nursing activities and populations. Ensure students are exposed to the two biggest areas of community health nursing: home care and public health.
- ❑ Facilitate the placement of clinical instructors into areas about which they are interested, passionate, proficient, knowledgeable and, if possible, experienced (Collier, 2010), to make the learning richer and more relevant for students. Capitalizing on faculty expertise and interests reduces workload and

Community Health Nursing Identity

ESSENTIAL:

- Faculty advisor/clinical instructor has knowledge of the Canadian Community Health Nursing Standards of Practice, primary health care principles, public health sciences and nursing science.
- Faculty advisor/clinical instructor is able to translate the community placement experience so that students can understand the community health nursing role.

PREFERRED:

- Faculty advisor/clinical instructor has current community health nursing practice experience.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 2)

stress, ignites students' passion and interest, and builds bridges with the agencies.

COMMUNITY HEALTH NURSING SCOPE OF PRACTICE

- ❑ Reconsider the length and duration of the clinical experience required for students to meet the course objectives and for entry-to-practice competence (CNA, 2005). Reconsider mandated clinical hours (Manchester, 2006). Reducing required hours may increase student opportunities as more preceptors will be available.

- ❑ Consider a competency-based approach to clinical learning. The traditional approach to practice education through clinical rotations is time-based and relies on the 'tea steeping' effect. It is premised on the assumption that any student placed in a clinical setting for a set number of hours should have learned enough by the end of the rotation. Rotation-based learning is not competency-based (Holmboe, Ginsburg, & Bernabeo, 2011; Saucier, Paré, Côté, & Baillargeon, 2012). A competency-based approach may reduce the number of student-hours in the clinical site, thus making room for more students to be exposed to community health practice roles and role models. Additionally, when students *are* in actual community health practice areas, their learning is more directly relevant to developing competencies for practice.

- ❑ Facilitate ways students can observe the role of the public health nurse and home care nurse. If direct observational experiences are not available, a video documentary project should be considered, similar to the ground-breaking documentary on street nursing, *Bevel Up*, a perennial favorite of nursing students (Wild, 2006). Similar videos could be made highlighting the role of the public health nurse and home care nurse for use in classrooms.

- ❑ Consider a curricular change that would make community health into a combined 6-credit theory and clinical course that weaves together both experiences. If clinical experiences lack direct contact with community health nurses, foundational concepts such as population health and the community health nursing process may make greater sense as part of the theory

Community Health Nursing Scope of Practice

ESSENTIAL:

- There is potential for students to work with clients at group and/or community levels.
- There is potential for exposure to broad determinants of health, citizen engagement, population health, and primary health care principles.
- There is exposure to multiple community health nursing strategies (e.g. building healthy public policy; developing personal skills; strengthening community action; creating supportive environments; reorienting health services).
- There are opportunities for practical experience where students can see the results of their actions and move toward independent practice.
- There are opportunities to develop collaborative relationships/partnerships.

PREFERRED:

- There are opportunities for the student to engage in practice with community as client.
- Students will experience being part of an interprofessional and potentially intersectoral team.
- Rural, remote and international placements are available.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 2)

course, not existing as a separate, time-intensive clinical course.

- ❑ Review Canadian nursing curricula in light of health care system realities. Consider the degree to which undergraduates should be prepared for community health roles as proportional to the percentage of graduates actually working in these areas directly after graduation.

- ❑ Review Canadian nursing curricula in light of the shift to the NCLEX-RN.

- ❑ Maximize faculty expertise, such as the possibility of rotating students through multiple experiences with different instructors teaching in their area of expertise, to broaden the students' exposure to community health practice roles and role models.

- ❑ Find ways to enable students to experience a variety of community health nursing activities and populations. Arrange job-shadowing events if possible. Ensure students are exposed to the two biggest areas of community health nursing: home care and public health.

- ❑ Balance community *health* nursing with community *based* nursing competencies and the need to prepare students for practice in the community, including the use of specialized nursing knowledge and skills. Incorporate these opportunities into the service learning experience to ensure that students have exposure to both general and specific competencies for community health practice.

- ❑ Ensure students participate in annual and pandemic (as they arise) immunization clinics. Training by faculty and/or the health authority is valuable for student learning and extra hands-on-deck can be helpful for the clinics. These opportunities must be coordinated with the relevant health authority.

- ❑ Utilize skills and simulation labs that relate to the public health and home care. Students and practicing nurses place a high value on hands-on skills, which can act as a springboard to deeper learning. Employ OSCEs where appropriate to ensure students are skilled and knowledgeable for competent, safe patient care. Simulation has been shown to greatly enhance the clinical capabilities and clinical

reasoning abilities of nursing and health professions students (Berragan, 2013; Cook, Brydges, Zendejas, Hamstra, & Hatala, 2013; Katowa-Mukwato et al., 2014; Shin, Park, & Kim, 2015).

- ❑ Arrange opportunities for direct nursing care, if possible (health assessment, foot care, immunization clinics, fall prevention and assessment, etc.). Explore opportunities with housing agencies, seniors' homes, seniors' centres, homeless shelters, non-profit groups, and so on, so that students can acquire and utilize uniquely nursing knowledge and skills and develop both general and specific competencies for nursing practice.

- ❑ Create public health opportunities that follow from an obstetric or pediatric rotation. Create home care opportunities that follow from a medical or surgical rotation. Use of "field visits, "hub and spoke" or "targeted clinical home community settings" methods of creating experiences for students in the community (Cummins et al., 2010; Farasat & Hewitt-Taylor, 2007; Williams-Barnard, Sweatt, Harkness, & DiNapoli, 2004). Alternately, conducting heart failure patient follow-ups in the community, based on a medical surgical rotation, can provide a meaningful experience for both students and patients (Wheeler & Plowfield, 2004).

Competent Well-Prepared Preceptor

- ❑ Establish a common language and understanding of terms and concepts regarding community health, standards of practice, general and specific competencies, preparation for practice, and service learning among community health clinical (and theory) instructors and community partners.

- ❑ Develop a statement of intent for both the community health theory course and community health clinical course. Articulate the goal of the clinical course in terms of preparation for practice and methods, community-based nursing versus community health nursing, how this is a valuable experience, and how specific public health and home care competencies will be met. This statement could be included in the course outline. Delineate the general and specific competencies students will have opportunity to obtain during the experience. As well, the university calendar description for the clinical course should reflect what the clinical experience actually offers.

- ❑ Align the theory and clinical courses. Consider a concept map assignment as a tool to bridge theory and practice. Consider secondary assessment data or project portfolio as possible assignments for the theory course.

- ❑ Find ways to make preceptorship work in community health by re-opening discussions with practice areas. Practice areas face numerous barriers to preceptoring, including invisibility, dual roles, mandated preceptoring, and workload. However, preceptoring remains an important role in developing students into community health professionals. A climate of preceptorship should be fostered by health authorities and well-supported by educational institutions despite current challenges (Hjälmhult, Haaland, & Litland, 2012).

- ❑ Promote education-practice collaborations such as undergraduate nurse positions, which foster

Competent Well-Prepared Preceptor

ESSENTIAL:
- There are organizational supports to precept, especially in the form of time to effectively support students.
- The preceptor has a positive attitude toward preceptorship and life-long learning.
- The preceptor has experience working in and/or with communities.
- The preceptor has the ability to help students apply theory into practice.

PREFERRED:
- Formal preceptor orientation is provided collaboratively by the community organization and the academic institution, e.g. preceptor workshop or module.
- The preceptor is a nurse with community health nursing experience and knowledge of the Canadian Community Health Nursing Standards of Practice, primary health care principles, public health sciences and nursing science.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 2)

socialization into the RN role and a strong clinical background.

- ❑ Where resources are scarce, reserve community health placements for students who actually want to be there.

Supportive Environment for Student Learning

Structuring the Experience

- ❑ Define both the objectives and structure of the clinical experience to support student learning (CNA, 2005). Determine appropriate learner outcomes and competencies (general and specific), and design service learning to meet those outcomes so that the service learning experience fosters achievement of objectives and competencies.

- ❑ Ensure there is sufficient structure to the learning experience and not an excess of discovery learning. Increased structure makes students feel safe and can be accomplished through scheduled clinical conferences, structured group meetings led by the instructor, intentional facilitation of learning using established tools and documents, and clearly describing the students role in concrete terms. The Canadian Association of Schools of Nursing is compiling a resource of teaching tools for public health nursing.

- ❑ Ensure community health clinical experiences are strongly related to nursing roles and that when they resemble teaching roles, that students are provided with the skills to do so and are able to develop and use uniquely nursing knowledge. Increase students' opportunities to build the foundations of nursing practice through the development of general and specific competencies for professional practice and opportunities to participate in nurses' work.

- ❑ Reframe service learning as first and foremost a learning experience for students, not product development for the agency. Reconsider the nature of deliverables and how complete or 'polished' deliverables should be. Ensure the agency is clear on the parameters and have the agency sign off on expectations.

- ❑ Consider the use of both project/alternative placements and preceptor experiences, as both have

Supportive Environment for Student Learning

ESSENTIAL:
- In a preceptored learning situation, there is ongoing, regular communication between faculty, preceptors and students, with at least one verbal contact.
- The community placement setting has a caring and welcoming attitude towards student mentoring.
- Student orientation to the placement setting is provided.
- Attention is paid to student safety.

PREFERRED:
- In a preceptored learning situation, there is verbal communication at least at the beginning, middle and end of the experience involving faculty, preceptors and students.
- Student preference in placement choice should be given consideration.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 2)

something unique to offer student learning. One method of having both approaches is to divide the rotation into two parts with a switch at midpoint.

- Define, delineate and articulate the parameters of a 'good service learning experience' to guide the negotiation and pursuit of opportunities (Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010). Review entry-to-practice competencies, national community health competencies, and community health nurse practice requirements to create guiding criteria for clinical experiences. Match the curriculum and course outcomes.

- Balance abstract and concrete components, population health and individual health, and population health with contact with the population. Nursing students are primarily concrete learners who appreciate the opportunity to do 'real things with real people' and who work their way from concrete tasks to the bigger picture (D'Amore, James, & Mitchell, 2012; Hauer, Straub, & Wolf, 2005; Shinnick & Woo, 2015).

- Examine and alter the parameters for structuring the experience (location, number of students in a team, amount of computer/desk work, degree of structure, nature of group work, etc.) to foster sustainability—from both the instructor workload perspective and the agency point of view. Find agencies and experiences that can accommodate greater numbers of students so that team size can be increased and/or the entire group accommodated at 1 or 2 geographic locations or clinical sites. For example, for a clinical group of 12, consider:
  - 4 teams of 3 students each, all in one clinical agency
  - 4 teams of 3 students each, 2 teams in one agency and 2 in another related/nearby agency

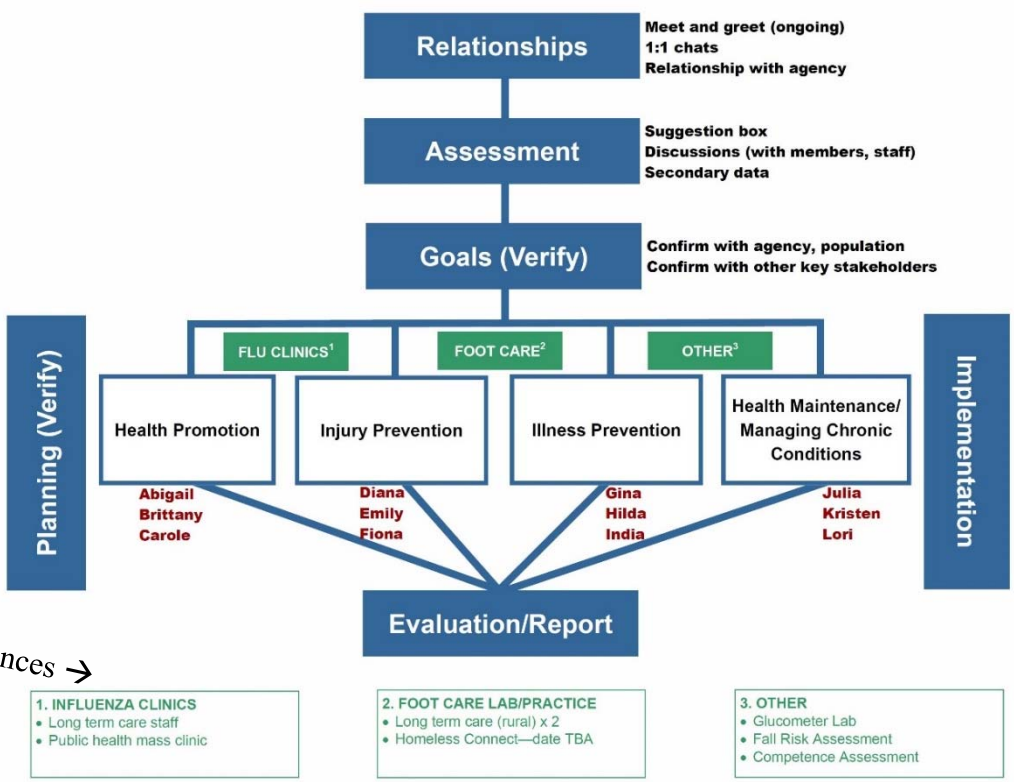
  By having all students at one location, structured clinical conferences or built-in teaching time are easy to have as standing appointments during which students reflect on past work, plan future work, and weave in theoretical concepts into their work, guided by the instructor.

  If clinical groups have more than 8 students, consider reducing the number of students (optimal number is 7 or 8), so it is analogous to acute care clinical group size. This reduction will directly reduce workload, which tends to

become unwieldy at higher numbers. It will also increase the amount of attention students get and increase the serendipitous learning opportunities.

- Organize students to optimize learning and manageability. I find this works best if I have my whole clinical group (n=12) at one site. (Or at most, have two different but related sites i.e. serving the same population.) Ideally, the agency will have a meeting room/working space for the entire group. The benefits?
    - Less driving for the instructor
    - More opportunities for direct supervision of students
    - More instructor engagement with student learning
    - Facilitates regular built-in teaching time to consolidate learning
    - Students' work is interrelated with each other's, so everyone can contribute to rich ideas
    - Implementation of common learning activities and related discussions
    - Easy sharing of resources and ideas between students
    - Greater focus on the population, the nursing process, and collaboration, instead of individuals working separately
    - The focus of the experience is on learning, not on product development
    - Enables face-to-face planning and reporting, instead of written reporting (which need to be read and marked outside of clinical time)

  For example, a clinical group might be at a senior citizens organization. Divide the group by levels of prevention and organize the experience along the lines of the community health nursing process.



- ❑ Find ways to make this non-traditional clinical experience a satisfying learning experience, not just a way to keep students busy for eight hours. Maximize the opportunities for students to develop specific and general competencies for community health nursing practice.

- ❑ Find ways to create a 'hook' in projects to get students' interest and to connect with students' concrete needs to create accessible points of connection with the experience.

- ❑ Incorporate specific nursing knowledge, concrete nursing skills, and patient contact to enhance students' connection with and appreciation of the learning experience, and to maximize opportunities for students to develop specific and general competencies for nursing practice.

- ❑ Keep health as a central and obvious theme in chosen projects. While it is often 'the process' students are learning through these experiences, students' interest and motivation is piqued when the experience/project has obvious connections to nursing and requires them to use specialized nursing knowledge that is distinct from social work, education, and other disciplines. Students seem to struggle

more and require more morale boosting and coaching (which is time-intensive and emotionally draining) for experiences with less obvious health links and minimal patient contact.

- Scale down the scope of student projects to make room for consolidating learning and structured reflection and planning, either through less intense deliverables or through a decreased focus on community development and capacity building.

- Establish, via a collaborative process among community health clinical faculty, consistent parameters to be implemented in every clinical group within a given nursing program. The following items should be consistent and standardized across all concurrent sections of the course: all forms and evaluation processes; level of supervision to be utilized; accountability process; number of required clinical hours and how those hours are to be reported by students to faculty; how time is to be used in clinical groups (such as not completing class work during clinical time, the use of pre/post conferences, etc.); and the degree of appeal and diversity of experiences.

- Make student orientation to the experience relevant. During the first two or three clinical days, strategically orient students in the clinical group to the experience, so team building and pre-contemplation can begin and so orientation is specific to the agency at which they are stationed. Include in orientation to the components that will actively prepare students for working with the agency and for having positive interactions with agency staff despite their personal feelings and thoughts. Include direct guidance, practice and coaching on the effective use of both verbal and email communications. Include opportunities to pre-contemplate issues that may arise with the agency. Include cultural inculcation whenever possible (such as sweat lodges, listening to elders, meet and greets with the population, etc.).

- Utilize the nursing program's standard clinical performance evaluation tool to evaluate student performance. Increase the alignment of community health clinical objectives with required competencies for community health; align these items with the nursing program's standardized evaluation tool. Clearly articulate what is required for a passing grade

(performance, product or deliverable quality, completion of required elements, completion of required hours, etc.). To make competency statements observable and measurable, consider implementing *entrustable professional activities* as demonstrations of competence (ten Cate, 2014; ten Cate & Scheele, 2007; ten Cate & Young, 2012) .

- ❑ Consider the nature of the outcome or deliverables in light of, first and foremost, learning potential for students. Limit the scope of deliverables, if they are required. Limit end-of-project reports to a set number of pages, and only if they are absolutely required. Otherwise, reduce closure documents to a single-page letter explaining what was done and what was learned by the students.

- ❑ Consider outcomes research to assess the consequences of service learning, community health and/or community-based nursing education on clinical competence, critical thinking skills, socialization into nursing, team functioning, and ability to function fully in the work setting.

- ❑ Standardize the experience across the program so that every student has a similar experience and broad exposure to community health nursing. Minimize disparities across experiences within a program.

- ❑ Examine the undergraduate nursing/pre-registration curriculum to ensure community health content is adequately and proportionally represented. Content such as pathophysiology, assessment, case management, and epidemiology are foundational to basic nursing practice in the community and an important aspect of community health. Opportunities and time to integrate specialized nursing knowledge and skills are also important. Examine the clinical assignments to ensure students are getting the skills and knowledge they need. Provide multiple intentional opportunities for students to make the connections between theory, clinical and practice, and to develop general and specific competencies for nursing practice.

- ❑ Utilize sites and target population groups not formally served by traditional health care services. This utilization enhances care for all.

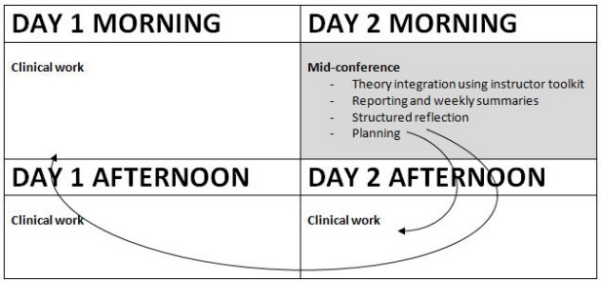
- ❑ Examine the undergraduate nursing/pre-registration curriculum and consider a curriculum that considers workplace realities. Consider possibilities such as a final residency or internship (Reagor, 2010) as an option for students, or additional courses for students interested in community health nursing to equip them with the specialized nursing knowledge and skills required for actual practice.

- ❑ Continually evaluate what we do as educators, why we do it, and whether it is effective for student learning, student engagement, student competence, and practice-readiness.

INCORPORATE BUILT-IN TEACHING TIME

- ❑ Foster strong and intentional pedagogy in community health courses so that students are better able to make links between theory, clinical, and RN practice. Good pedagogy should be shared with colleagues. The Canadian Association of Schools of Nursing is currently coordinating the development of a national resource of teaching strategies for public health.

- ❑ Enhance the learning experience through regularly scheduled teaching time in the form of clinical conferences. For example, in a 13-week clinical rotation, with 2 days per week, regularly schedule a 'mid-conference' on the morning of the second day. This time is used to:
  - Enable students' structured reflection and reporting on what they accomplished on the previous week's Day 2 afternoon and current week's Day 1.
  - Enable students' structured planning and reporting on what they will accomplish on Day 2 afternoon and Day 1 of the following week.
  - Help students integrate community health concepts into their clinical experience.
  - Utilize structured learning activities in an otherwise fairly unstructured clinical learning environment.
  - Enable real-time reporting, planning and idea-sharing between students, enhancing learning for all.
  - Facilitate real-time reflection, thus eliminating time the instructor spends outside of clinical time marking journals, reflections and planning documents.



- Enable students to peer-review each other's work and have input into the planning of their peers, strengthening learning for all. Students who are preparing workshops, teaching sessions, interventions, or presentations can present their work to peers, during a structured teaching/learning time, via laptop and data projector. The rest of the group can give their input. (Not only does this help everyone learn together and test ideas in a safe place, it means the instructor doesn't have to mark these items outside of clinical time.)
- Use a program-specific conference toolkit for clinical instructors to facilitate learning activities during the structured teaching time. Advance preparation maximizes the ability of the faculty advisor to capitalize on teachable moments. (Note: Teaching time is not for giving students more theory content. This time should not require instructor preparation, aside from standard items in the toolkit; the toolkit is a collection of strategies to help students pull the theoretical learning into their clinical work.)
- Facilitate verbal reflection through prompting questions or structured activities. Examples include: reflective questions; questions to guide future actions; games, speakers or activities relevant to community experience; and a review of objectives and Community Health Nursing Standards of Practice and competencies, with application to how students are implementing them in the clinical experience.
- Provide opportunity for students to reflect upon and complete a clinical evaluation tool, as it reflects their own practice and learning needs.

❑ Consider the weekly project summary (Diem & Moyer, 2005) as a teaching/learning tool and balance its use in light of the amount of faculty feedback required. Consider verbal reports during weekly mid-conferences instead of written reports, which require extensive time for students to prepare and for faculty to mark (outside of clinical time). Consider asking students these questions in real-time:

- What did you accomplish this week? Describe what you did, how long it took, what was involved, and what each team member did. Did you accomplish what you intended to? Why or why not? Are you on track with your timeline?

- What is your plan for next week? What activities do you anticipate? How much time will this take? Who is involved and how?
- What community health concepts are you utilizing in your practice? What concepts are you seeing 'in action' (e.g. determinants of health, intersectoral collaboration, primary health care, levels of prevention, etc.)?
- What community health nursing competencies are you using? How is it demonstrated in your practice?
- What are key future dates of which I (the instructor) need to be aware?
- What were some memorable moments this week? Frustrations?
- How is your group process and team work? What are the challenges, and how are you addressing them?
- What do you need from me at this point?

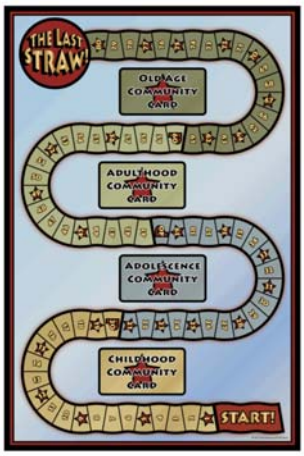
- ❑ Instead of disparaging students' focus on skills and tasks, try building on it by giving them the skills and opportunities to practice, so they can be unencumbered to attend to the patient in the clinical encounter, so that they are able to contribute meaningfully using specialized nursing knowledge and skills, and so that they get a sense of being different than teachers, social workers and event planners—roles that students often feel they are engaging in during non-traditional community health clinical. This skills-first type of developmental approach would foster students' growth from concrete to more abstract and integrative and will enable them to feel they are giving effectual nursing care at the individual level. Students with skill mastery are more likely to be competent, which will enhance their confidence, and increase their sense of belonging on the nursing unit due to their enhanced ability to participate meaningfully in the nursing work of the unit (Katowa-Mukwato et al., 2014; Levett-Jones & Lathlean, 2009).

- ❑ Consider the use of the skills laboratory for teaching psychomotor skills associated with public health and home care (and perhaps advanced practice nursing). Rotate faculty through these teaching positions so each faculty person can teach in their area of knowledge and teach the same content area to different cohorts. This may require a change with the nursing program's provincial regulatory body. Possible topics include: immunization (including

influenza), wound care, foot care, well baby assessment, maternal assessment, home care assessment and fall risk assessment. Consider aligning these components with the theory course timeline. Simulation has been shown to greatly enhance the clinical capabilities and clinical reasoning abilities of nursing and health professions students (Berragan, 2013; Cook et al., 2013; Shin et al., 2015). Employ OSCEs where appropriate to ensure students are skilled and knowledgeable for competent, safe patient care.

- ❑ Integrate concepts related to the determinants of health, problem solving, and levels of prevention into all clinical placements.

- ❑ Use *The Last Straw*, the Canadian board game on the social determinants of health (http://www.thelaststraw.ca/). It's a great learning tool for orientation to the community health practice rotation. This game is helpful to promote discussion about the social determinants of health; to help players build empathy with marginalized people and gain an awareness of players' own social location; and to encourage learning in a fun and supportive environment. The instructor follows a guidebook and observes and facilitates the game. Groups of up to 12 students can play very meaningfully. The game promotes watershed learning moments.



- ❑ Print and cut out on colored paper the course objectives or competencies for community health. Have students in pairs each blindly draw one or two out of an envelope. In pairs, have them discuss three ways that they have each been enacting that objective or competency and what they could do to further accomplish that objective. Then, have each pair share aloud with the group. Specific points include: How are you achieving this objective? How is it evident (that you are achieving this)? How do you know you are being successful? What are the challenges? What are the rewards? How does the population benefit? (See Appendix A.)

- ❑ Create a bingo game that aligns level of action (individual, family, community, sector/system and society) against the level of prevention (health promotion, primary prevention, etc.). The community health nurses' actions can be filled in by students for each square. (See Appendix B.)

- Align the students' learning with the community health nursing process (Diem & Moyer, 2005) by making intentional connections and by structuring the clinical experience to follow this process.

- Discuss with colleagues the buzzwords like *critical thinking* and how their development is best fostered. The term *clinical reasoning* reflects the integrative nature of knowledge, skills and experience required in practice (Cerullo & da Cruz, 2010). Clinical reasoning embodies critical thinking along with the application of knowledge and expertise to clinical practice (Banning, 2008). Victor-Chmil (2013) describes critical thinking as "the cognitive processes used for analyzing knowledge"; clinical reasoning as "the cognitive and metacognitive processes used for analyzing knowledge relative to a clinical situation"; and clinical nursing judgment as "the cognitive, psychomotor, and affective processes demonstrated through action and behaviours" (p. 34). By distinguishing these commonly conflated terms, instructors can have a clearer vision for what they are trying to accomplish through assignments and clinical activities.

- Utilize Bloom's Taxonomy in the development of activities and questions.

Logistical Issues

- Consider ways to resolve the unique challenges surrounding the use of remote placements. For example, have one whole clinical group at one location, with one day spent remote and one day on campus to prepare for the following (remote) day.

- Ensure students understand their role in the clinical placement in concrete terms.

- Restrict the clinical experience to the designated days and times. Be strict about not allowing students to do clinical work on non-clinical days, because when they're 'on,' you're 'on.' For example, for a Monday/Tuesday clinical group, have a strict 0830-1630h policy, no exceptions. Sometimes the agency will want to meet on non-clinical days for a board meeting. Have the students prepare a

written or video submission instead. Maintain these boundaries and make sure instructors model them.

- ❑ Encourage instructors to maintain boundaries around cell phone use, texting, email response time, agency contact time, and activities that occur on non-clinical days.

- ❑ Gain program-level support for community health clinical faculty through the provision of funds, technology (iPhones, data projectors, laptops, etc.), and funded annual debriefing and planning workshops.

- ❑ Establish an annual workshop at year end for instructors to debrief, problem solve, and plan future clinical experiences. Review and further develop course processes and documents. Discuss what worked and what didn't work and solve problems as a team.

- ❑ Create a community health clinical placement facilitator role to organize and secure the community health clinical rotation/sites. Periodically evaluate the job description and time requirements for this role to see if they have evolved and if either requires amendment to accommodate new roles or parameters. If instructors must go out and secure their own placements, the workload is magnified significantly (especially in rural communities) and site competition and learner collision will become an issue. Ensure this community health clinical placement facilitator is familiar with community health nursing in current and future role capacities and is able to secure opportunities that allow students to develop general and specific competencies for community health nursing practice.

- ❑ At the level of the school of nursing, ensure a centralized web-based clinical placement inventory database is in place to help identify and track clinical placement in community sites.

- ❑ Allow faculty to return to the agencies with which they are familiar. This supports the relationship-building process, which can take years, and enables a degree of familiarity from semester to semester.

- ❑ Develop a statement on the level of supervision in community health clinical, one that fosters accountability and independence in students, and that equally fosters manageability of faculty workload. As needed, coach faculty on the implementation of a supervision model that is sustainable.

- ❑ As a community health clinical team, develop a code of conduct that includes channels of communication, roles and responsibilities, and methods of fostering a positive team atmosphere.

- ❑ Discuss end-of-course evaluations specific to the clinical rotation to better understand student experiences and to find ways to enhance experiences while also managing faculty workload.

- ❑ Ensure that clinical evaluation methods and tools are sufficient to determining competence (Levett-Jones, Gersbach, Arthur, & Roche, 2011). Challenges such as the nebulousness of experiences and the absence of the instructor present considerable challenges that must be addressed. Medical education is finding ways to bridge the gap between theory and clinical practice through the delineation of *entrustable professional activities* (ten Cate, 2005; ten Cate & Scheele, 2007; ten Cate & Young, 2012).

- ❑ Avoid clinical experiences or projects that require ethics approval.

- ❑ Clarify guidelines and limitations for students through formal documents that outline expectations for professional behavior, safety issues, and so on. Students could be required to sign this document (Seifer & Connors, 2007, p. 28). Concomitant with this set of expectations, consider increasing student independence and accountability (particularly for time usage), through the use of log sheets for time accountability; the need for this monitoring may decrease over time.

- ❑ Have a community health clinical experience fund that instructors can access for clinical supplies used by students. Sometimes it helps if the instructor does the purchasing, as bills can be submitted directly and no money changes hands with students, which is cumbersome. Articulate, in writing,

the parameters for its use by clinical instructors so it is not used for classroom products and activities.

- ❑ Ensure placements are sustainable in terms of workload for faculty, pressures on host agencies, and opportunities for student learning. Host sites may be overloaded. Ensure the host site is assessed for impact of the student placement.

- ❑ Ensure there is consistency across sections regarding the type of work the students will be doing, the supervision level and the time requirements.

- ❑ Encourage faculty advisors to work smarter with Smartphones. For example, an iPhone can share applications and data with a desktop so no information is ever lost if the iPhone goes missing. (Make sure the iPhone is password protected with a 1-minute lockout.) The following features are very useful for clinical teaching:
    - **Camera**. (1) On the first day of clinical, take students' photos while they hold up a sign with their name on it. You can use these photos to learn their names. Also, you can use the photo in your Outlook contact for the student, so when s/he phones, texts or emails you, you have a visual of the student. (2) Throughout the clinical rotation, take photos of student work for your teaching dossier and annual professional activities report.
    - **Dropbox**. This online file repository can be accessed from any computer by logging in. With the Dropbox app on both your desktop and iPhone, you can access your files readily from either desktop or iPhone. For example, if you have a useful document a student can use, email it directly from your iPhone to the student without leaving your seat.
    - **Write2**. This app lets you take notes. You can use it to record mileage (dates and miles and destination), keep a student absence record, record policies and procedures, and myriad other tasks. It synchronizes wirelessly and automatically with Dropbox so nothing can ever be lost.
    - **Calendar**. Your Outlook calendar is based on your university's server but can be viewed on your desktop or iPhone. Schedule in your clinical days by copying and pasting as appointments (I schedule a morning and afternoon separately on all clinical days), and then, under the 'notes' section of each

'appointment', put in notes about what you want to help students with or what they're doing on a given day.

- **Outlook**: On your desktop, set up an Outlook contact profile for each student with their contact information, photo and other relevant information. Put a prefix before the student's name that tells you what term or section the student is in. For example: "**F13b Sally Waters**" would be a student in Fall, 2013, Section B (if you have more than one section). This way, you can easily text the entire clinical group by searching for F13 and selecting respondents. Also, if students phone or text, you know which group they're in and who they are. At the end of the semester, you just need to go to your collection of "F13s" and delete them all.

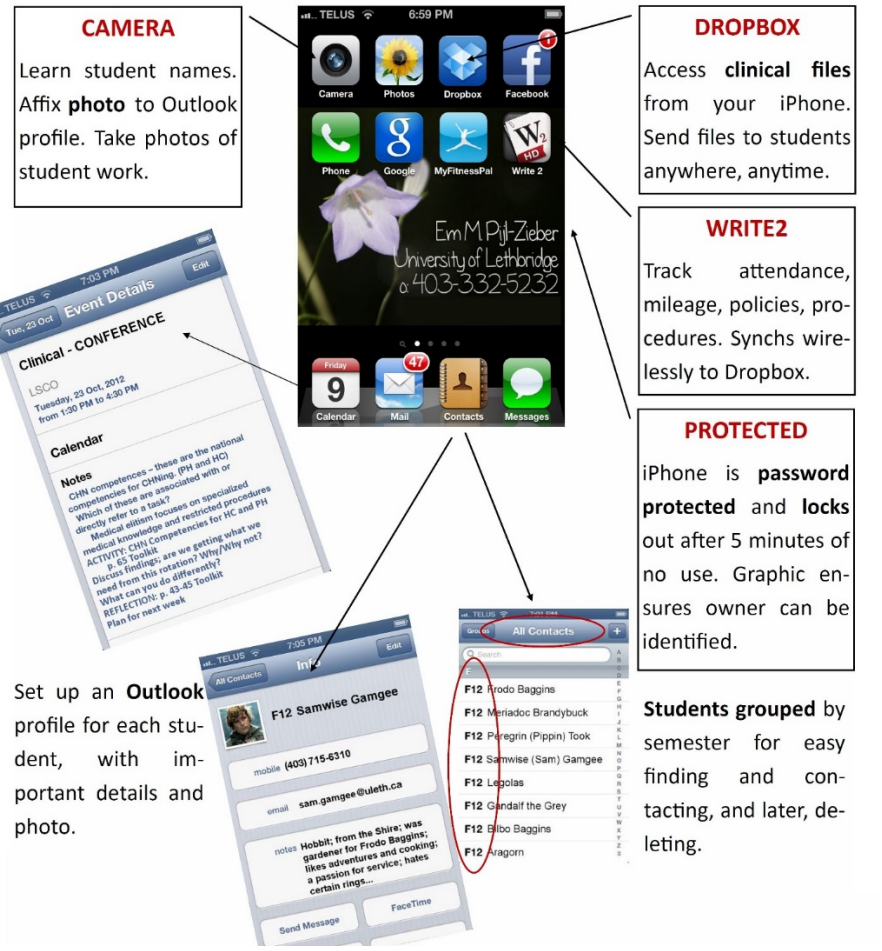


Figure: Example of using an iPhone in community clinical teaching.

- Participate in provincial and national forums pertaining to community health clinical practice placements and experiences. For example, at the Community Health Nurses of Canada annual conference, a clinical educators' forum is held to discuss issues related to clinical teaching in community health.

- Consider the development of clinical learning units (CLUs). A CLU is a collaboration of students, faculty, and health care team members that are actively involved in bridging the gap between academic and practice roles in a health care setting by working together to achieve learning objectives (BC Academic Health Council, 2007). Eggertson (2013) argues that schools of nursing often fail to utilize highly competent direct-care practitioners, who could be instrumental in helping bridge the theory-to-practice gap.

COMMUNITY-ACADEMIC PARTNERSHIP

- Engage in joint problem solving regarding clinical placements with health region, community agencies, and the University. Smith et al. (2007), in their report on clinical placements for CASN, stated that "Strong relationships and good-will between educational institutions and clinical sites, and clinical placements committees and consortiums were the most common enablers for clinical placements" (p. 5). Specifically discuss with health authorities how students can be prepared for practice and establish the health authorities' role in that process. Find ways to ensure students get exposure to nursing-specific community health knowledge and skills. Find ways to enable students to at least observe several of the community health/public health nursing roles.

- Enable faculty practice through joint appointments (Darbyshire, 2010; Rahnavard, Nodeh, & Hosseini, 2013) and a faculty practice model (Aquadro & Bailey, 2014; Barzansky & Kenagy, 2010; Dobalian et al., 2014) so that faculty remain in touch with practice and trust is re-built and relationships maintained with the units.

- Advocate for a re-integration of education and practice areas to rebuild the trust and collaborative relationship that was once there. Collaborations between academe and practice have been shown to ease graduates' transition to practice (Burns & Poster, 2008).

- Promote discussion with the health authority about ways to enable faculty competence in community health areas so that faculty can participate in the work of the unit.

- Engage the health authority in discussions about ways to allow nursing students and instructors to participate in nurses' work in community health practice rotations.

- Participate in regional, provincial or national web-based forums for discussing clinical experiences, challenges and solutions (Smith et al., 2007).

- Articulate a set of fundamental assumptions regarding the clinical experience, including: that University faculty are not responsible for final products of learning; that University

Community-Academic Partnership

ESSENTIAL:
- Formalized agreements (e.g. MOU, signed contract) exist between the community organization and the academic institution.
- Clearly defined roles and expectations are agreed to by the community organization and the academic institution.
- Formal recognition of preceptor contribution is provided.

PREFERRED:
- Formalized cross-appointments exist between the community organization and the academic institution.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 3)

faculty may not be expert practitioners in the area in which students are having their rotation; and, that this is primarily a learning experience, not a product development service or consultant service. In the negotiation process, preserve and promote the ultimate goal, which is student learning.

- Clearly define, in writing, the roles and responsibilities of agency partners, particularly as they related to the role they will play in facilitating student learning. Ensure budgetary considerations and deliverable parameters are clearly stipulated in the project outline. Ensure clear guidelines and parameters exist that include the importance of having only *one* mentor or preceptor who is the point person to whom students go for input into their work.

- Evaluate community partnerships using the 'partnership assessment tool' (Seifer & Connors, 2007, pp. 35-41).

- Establish boundaries with the host agencies regarding: the private nature of the learning experience (and thus the confidentiality of the learning management system forums and the weekly project summaries, which are un-sanitized learning tools). Establish ways of engaging in joint learning with the agency via face-to-face meetings between students and the agency during pre-arranged meeting times during the clinical day. Clearly articulate, in writing, the contact parameters for faculty and students and the limits for the hours and days at the agency.

- Ensure support for the agency in meeting their needs and students' learning needs. Provide the same supports for both nursing and non-nursing mentors/preceptors. Consider ways the nursing program can express gratitude for the partnerships.

- Create stronger links with agencies, such as through evaluation, orientation and information sessions, and end-of-year luncheons.

- Ensure all University-developed documents are free of esoteric language or academic vernacular, to promote connection and understanding.

- Increase involvement with schools, in terms of teaching the health curriculum and the sexual health curriculum and screening. Deliverables are small and ongoing, and teachers

are generally happy to offload this content, which students are very adept at delivering.

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APPENDIX A: Competencies Activity

HOME HEALTH COMPETENCIES **a) Assessment, Monitoring and Clinical Decision Making** The home health nurse is able to… i. conduct comprehensive autonomous and /or collaborative health assessments to determine the health status, functional and psychosocial need and competence of clients and their families within the context of their environment and social supports	HOME HEALTH COMPETENCIES **a) Assessment, Monitoring and Clinical Decision Making** The home health nurse is able to… i. apply critical thinking skills and creative problem-solving analysis when making clinical decisions
HOME HEALTH COMPETENCIES **b) Care Planning and Care Coordination** The home health nurse is able to… i. plan and prioritize visits to meet the health and scheduling needs of clients	HOME HEALTH COMPETENCIES **c) Health Maintenance, Restoration & Palliation** The home health nurse is able to… i. understand and/or educate clients, their families/caregivers and colleagues in the safe and appropriate use and maintenance of various types of equipment, technology and treatments to maintain health and assist clients and families to integrate them into their everyday life/routine
HOME HEALTH COMPETENCIES **h) Building Capacity** The home health nurse is able to**…** i. mobilize clients, families and others to take action to address health needs, deficits and gaps accessing and using available resources	PUBLIC HEALTH COMPETENCIES **1 - PUBLIC HEALTH and NURSING SCIENCES** A public health nurse is able to… 1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services.
PUBLIC HEALTH COMPETENCIES **2 - ASSESSMENT AND ANALYSIS** A public health nurse is able to… 2.2Identify relevant and appropriate sources of information, including community assets, resources and values in collaboration with individuals, families, groups, communities and stakeholders.	PUBLIC HEALTH COMPETENCIES **3(A) - POLICY DEVELOPMENT** A public health nurse is able to… 3A.2 Describe the implications of each policy option, especially as they apply to the determinants of health and recommend or decide on a course of action.
PUBLIC HEALTH COMPETENCIES **3(B) - PROGRAM PLANNING** A public health nurse is able to… 3B.1 Describe selected program options to address a specific public health issue.	PUBLIC HEALTH COMPETENCIES **3(B) - PROGRAM PLANNING** A public health nurse is able to… 3B.2 Describe the implications of each option, especially as they apply to the determinants of health and recommend or decide on a course of action.

APPENDIX B: Levels of Prevention BING☺

Primary Prevention		**Secondary Prevention**		**Tertiary Prevention**
Health Promotion	Specific Protection	Early Diagnosis and Prompt Treatment	Disability Limitation	Rehabilitation

Replacing pop machines in elementary schools with water machines	Childhood immunization	Pap tests	Treatment for cervical cancer	Drug rehabilitation after crystal meth addiction
Instead of handing out Halloween candy, giving out swimming passes	Protecting the water supply of your community	Screening diners at a restaurant who may have been exposed to Hepatitis A	Treatment for Hepatitis A	Living well with Hepatitis C from drug using
Advocating for low income and affordable housing	Disaster preparedness	Regular physical exam	Lumpectomy	Learning how to use an oxygen tank, now that you have COPD from smoking
Regular exercise because it's super fun and makes you feel awesome	Harm reduction for injection drug users such as using clean needles	Regular breast exam	Treatment for breast cancer	Gradual return to work after radical mastectomy
Advocating for walking trails and recreation areas	Taking a back care program at work (teaching you how to move patients)	H1N1 screening clinic for people who had symptoms	Coronary artery bypass graft surgery to re-route circulation to the heart muscle	Cardiac rehabilitation (exercise and education)
Healthy and safe activities for youth	Blood and body fluid policy at work	Vascular risk assessment	Surgery to stabilize spinal cord injury	Helping quadriplegics learn how to live with new limitations