Canadian Association of Schools of Nursing
Association canadienne des écoles de sciences infirmières

FINAL REPORT

Public Health Nursing Education at the Baccalaureate Level in Canada today

Submitted by

The Canadian Association of Schools of Nursing (CASN) Task Force on Public Health Education

To

CASN Board of Directors

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Executive Summary

In the fall of 2004, the Canadian Association of Schools of Nursing (CASN) created a Task Force on Public Health Education in Canada. The mandate of this Task Force was to assist CASN members in ensuring that all baccalaureate graduates of Canadian Schools of Nursing meet the expected Canadian entry-level competencies and be aware of the Canadian Community Health Nursing Standards of Practice (CCHNSoP) which have been developed to be met after two years of practice. Throughout this document, the terms public health and community health nursing are used in their broadest sense.

A. Survey

With the collaboration of the Public Health Agency of Canada (PHAC), the Task Force developed a survey to examine the current status of Canadian undergraduate public health nursing education. After the survey tool was finalized, it was sent to all 91 CASN member schools of nursing in May 2005. Deans were sent a letter of invitation along with instructions for survey completion, a glossary, and a link to the online survey. As indicated by the pilot, it was likely necessary for most respondents to consult with colleagues in the schools to gather all of the requested data. Therefore, participants were also provided with a hard copy of the survey as a working copy to assist them. They were asked to enter their responses online if possible or alternatively mail in their responses on paper. Phone reminders were made to increase the response rate. A response rate of 72.5% was obtained, and the results highlighted strengths, issues and gaps in undergraduate nursing curricula with respect to public health content.

Both quantitative and qualitative data were collected through the survey method. The former was analyzed using the analysis tools provided by (SurveyMonkey), the tool utilized to gather the data and further expanded through data sub-analysis in Excel. In the latter, the qualitative analysis tool NVivo was utilized to code and organize the insightful narratives that were provided by the respondents.

Respondents were asked to identify if and how the Canadian Community Health Nursing Standards of Practice (CCHNSoP) were addressed in their curriculum as well as future plans for adding or augmenting the same (See Appendix B for CHNAC Standards). Using the following response categories, they checked whether content for each standard is currently delivered: a) through a core (required) theory course; (b) as required practicum; (c) as a required segment of a course; (d) as a core thread throughout courses; (e) via selected nursing elective; or, (f) not covered-currently; and (g) future plans to add it if not covered/augment what is currently addressed. Basically, categories (a-e) measured the extent to which content for each standard was addressed by identifying the kinds of and number of the modalities used to deliver it in the curriculum. Respondents were provided with a glossary of terms that defined these categories.

In the analysis, response categories (a-e) were collapsed into a larger one that identified which content related to each standard was currently covered in any way in the curriculum regardless of the type and number of its delivery modalities. Categories (f) and (g) were retained as is. As a result, it is acknowledged that the findings for each standard do not describe the *extent* to which any of the content was covered in curricula; only that it was included in some way.

The highest percentage of responses was received from the eastern provinces, the territories, and the Prairie Provinces. The lowest percentages of responses were received from British Columbia, Quebec, and Ontario respectively. These three provinces do however, house the largest number of schools of nursing, and thus even though the percentage of schools was lower, there were a greater number of responses in total from each of these provinces when compared to the areas with higher percentage responses.

The most striking finding is that the majority of standards and their related content for competencies are covered through a required segment or content thread in all programs. In fact, over 90 percent of participating programs covered most of the standards related content. In the generic, collaborative and integrated baccalaureate programs, the majority of competencies related to population health promotion, prevention, health protection (basic epidemiological concepts), building individual capacity, and building relationships were covered by 95-100 percent of institutions. Coverage of these competencies was slightly lower in post-RN programs (occurs in 86-92 percent of them).

There are a number of similarities in the content not covered by a high percentage of Generic and Post RN programs with the health protection subset content area being one example. In addition, social marketing, injury prevention, emergency preparedness, palliation, the Jakarta Declaration, and informatics were main content areas not covered in both types of programs. Standard 1 in the areas of population health promotion and disease prevention were covered to the greatest extent. Overall the Standards content areas were not covered by a higher percentage of Post-RN programs compared to the other programs.

On a regional basis, among the generic, collaborative and integrated programs, there was greater variability amongst the regions, on average; Ontario had the largest number of topics not covered. In the post-RN programs, the regional variability was much less.

While the vast majority of the content areas were covered to some extent, challenges in terms of application of the knowledge to clinical practice continued to be identified by most schools. These challenges included issues related to placements, preceptors, a perception that community health is devalued, lack of faculty preparation, and organizational leadership within the schools. Some schools did identify that they had strong support from both their institution and the health units in their geographic areas.

B. Pan Canadian Symposium

The Pan Canadian symposium on public heath education was the next step towards fulfilling the mandate of the Task Force. Invited participants had knowledge and/or influence in Community Health and/or Public Health Education. The symposium provided CASN members and key stakeholders in public health nursing education with an important venue to dialogue on the issues highlighted from the results of the survey. Participants to the symposium included representatives from more than 60 of the CASN member schools. Some schools supported additional participants to attend. In addition, a meeting of more than 20 Public Health Nursing Managers was meeting simultaneously; the two groups met together for parts of the day. In preparation for the symposium, participants were provided with a work book and asked to answer a set of questions designed to validate and expand the data collected

from the survey. During the symposium, all nursing participants also provided the Task Force with additional qualitative data to expand and enhance the survey results.

The Task Force's specific objectives for the symposium were (i) to present and validate the findings from the survey carried out during the first phase of the Task Force's work; and (ii) to develop key recommendations regarding the future of public health nursing education in Canada.

The data that was collected and analyzed arose from the workbooks distributed prior to the symposium, the round table discussions at the symposium, and responses from two nurse leaders groups representing approximately 125 people. A total of 75 sets of data were collected representing over 200 individuals who contributed to the feedback. There was both English and French speaking representation within the handwritten and verbal responses. All submissions were translated (if necessary) and transcribed into electronic format to be coded and analyzed using HyperRESEARCH analysis program.

Primary Health Care, Epidemiology, Determinants of Health/ Population Health Promotion, Community Development/ Program Planning and Evaluation, and Building Partnerships and Collaboration/Building Relationships were identified by the participants as the key areas of content that should be addressed in the undergraduate curriculum. With the exception of primary health care and determinants of health/ population health promotion there was agreement that the development of skills associated with the aforementioned content areas depends greatly on the practice environments available for community placements. Due to the inconsistency within these placements, the skills may require development in on the job training. On the other hand, two content areas were identified by the respondents with very little agreement as to whether the knowledge and skill need to be taught in undergraduate education or on the job training. The two content area were immunizations; and specific knowledge and skills (e.g. breastfeeding/lactation, physical assessment skills, growth and development, sexual health, STDs, substance use etc).

Challenges identified by participants in relation to integrating community/public health content within the curriculum were factors related to preceptors, practice environment and the educational institution.

C. Recommendations

When all the participants' recommendations and other data were considered, the following are the recommendations of the Task Force to the Board of Directors of CASN.

1. CASN promote enhancements to structures for quality measurements of baccalaureate nursing education:
    a. Direct the Accreditation Bureau to consider the inclusion of targets within the accreditation standards specific to curriculum and resources relative to unique nursing content areas, beginning with community health
        I. Schools demonstrate an equal attention of curriculum (coursework and mandatory clinical practice) and resources to acute/hospital and community nursing education
        II. Schools demonstrate that faculty assigned to specific content portfolios (e.g. community health nursing) have or are encouraged and assisted to acquire current practice knowledge and experience relative to the portfolio

III. Schools demonstrate that competencies such as national and provincial entry-level competencies, as well as specialty competencies e.g. Community health nursing as per CHNAC and Public Health (modified to reflect entry-level) have been addressed in the curriculum
IV. Schools demonstrate that each student has opportunities and completes a mandatory clinical rotation in community health nursing within the upper levels of the program.
V. Schools demonstrate adequate resources to provide comprehensive supervision of students in clinical practice (e.g., faculty/student ratio of 1:8 in ALL practica except preceptorship experiences).
VI. Schools demonstrate that within the program there are opportunities for students to apply the Community Health Nurses' program planning process.

b. Promote the use of community health nursing entry-level standards and competencies in the creation of the Canadian Registered Nursing Examination.

2. CASN promote curricular enhancements in community health nursing of baccalaureate programs of member schools
   a. Produce a position statement on community health content in baccalaureate nursing education
   b. Encourage schools to ensure there is equivalency in curricular emphasis and resources available between acute/hospital care and community health nursing
   c. Serve as a repository of best practices, curricula and resources (e.g., teaching tools) for content topics currently not well covered.
   d. Partner with other stakeholders to create a community health nurse educators network through electronic means
   e. Partner with other stakeholders to facilitate regional and/or national for a for community health nursing educators

3. CASN network with other stakeholders to advocate for provisions of financial and other support for infrastructure for community placements.
   a. Dialogue with PHN leaders to support education
   b. Encourage stakeholders to create/evaluate formal partnerships between education and practice
   c. Promote the increase in number of preceptors in community health nursing, encourage the creation of criteria for selection of community health nursing preceptors, and modification of workloads for those nurses who agree to precept nursing students, and promote the use of incentives for preceptorship participation.
   d. Promote the concept of cross-appointed faculty (practice & academe)
   e. Advocate with health regions and educational institutions to target resources for the purpose of increasing placement opportunities (e.g., assisting with student transportation costs, rural incentives in Newfoundland/Labrador)
   f. Promote relationship and partnership building as legitimate expectations of faculty workload and include as factors in tenure and promotion decisions
   g. Advocate for and contribute to media campaign to highlight community health nurse's work

h. Advocate for increased and sustainable public/community health nursing research chairs
i. Utilize information on best practices in community health clinical placements as may be identified by the findings from the CASN commissioned research studies on clinical placements which are due in the spring of 2007

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Part I

Background

The CASN Task Force on Public Health Education

In the fall of 2004, the Canadian Association of Schools of Nursing (CASN) created a Task Force on Public Health Education in Canada. The *mandate* of this Task Force is to assist CASN members in ensuring that all baccalaureate graduates of Canadian Schools of Nursing meet the expected Canadian entry-level competencies and be aware of the Canadian Community Health Nursing Standards of Practice (CCHNSoP) which have been developed to be met after two years of practice.

The *Terms of Reference* developed to guide this important work are:

- To review the standards for community health nursing practice in the context of undergraduate nursing education programs
- To develop a survey, under the guidance of the CASN Task Force on Databases, on current community health nursing content in nursing education programs that reflects the standards for community health nursing practice
- To develop guidelines to assist baccalaureate nursing program in meeting recognized standards for community health nursing practice
- To represent the CASN position on public health nursing education in national discussions related to public and community health
- Report regularly to CASN Board of Directors and CASN Council.
- To ensure regular communications between the Chair of this Task Force and the Chair of the Standing Committee on Education.

The selected membership includes:

- CASN members with expertise in community health nursing representing the Atlantic, Western, Ontario, and Quebec CASN regions (2 from each region);
- a representative named by Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario (ANDSOOHA);
- a representative named by Community Health Nursing Association of Canada (CHNAC);
- a nursing representative from Canadian Public Health Association (CPHA);
- a representative from Public Health Nurses Leader Council of BC; and
- a representative from the CASN Board of Directors.

With the collaboration of the Public Health Agency of Canada (PHAC), the Task Force developed a survey to examine the current status of Canadian undergraduate public health nursing education. In March 2005, the "Report on the Draft Survey Questionnaire to Examine Current Status of Public Health Content in Canadian Baccalaureate Nursing Programs" was completed and submitted to PHAC. After the survey tool was finalized, it was sent to all 91 CASN member schools of nursing in May 2005. A response rate of 72.5% was obtained which highlighted strengths, issues and gaps in undergraduate nursing curricula with respect to public health content.

The Pan Canadian symposium on public heath education was the next step towards fulfilling the mandate of the Task Force. Invited participants had knowledge and/or influence in Community Health and/or Public Health Education. The symposium provided CASN members and key stakeholders in public health nursing education with an important venue to dialogue on the issues highlighted from the

results of the survey. Participants at the symposium also provided the Task Force with qualitative data to expand and enhance the survey results.

The Canadian Community Health Nursing Standards of Practice (CCHNSoP), Competencies, Skills Enhancement

There are several key documents that identify competencies and standards of practice for Canadian public health practitioners. While these documents are geared primarily to nurses currently in practice, they are relevant to a discussion of undergraduate nursing education because they identify areas of knowledge and skills that need to be acquired at least at a novice level by an entry-level practitioner.

Readers will note the absence of entry-level competencies from the Canadian Nurses' Association in the following discussion.

The CHNAC Standards
The Community Health Nurses Association of Canada (CHNAC) is a voluntary association of community health nurses consisting of public health and home health nurses and provincial/territorial community health nursing interest groups. It is an associate member of the Canadian Nurses Association (CNA) and the national voice of community health nurses used to promote community health nursing and the health of communities.

The objectives of CHNAC are to:

- Promote standards of community health nursing practice
- Promote quality assurance in community health nursing services
- Provide a forum for community health nurses to communicate more effectively, discuss common concerns, and to share knowledge and expertise on a national basis
- Promote research in community health nursing issues
- Promote professional and public awareness of community health nursing practice
- Encourage members to participate in affairs promoting public and community well-being.

In October 2003 the CCHNSoP were published. These standards are set to be met within two years of practice as a community health nurse. The Canadian Nurses Association (CNA) designated community health nursing as a specialty in January 2004.

The purpose of the standards of practice are to:

- Define the scope and expectations of community health nursing practice for safe and ethical care
- Provide a unifying framework for practice and evaluation
- Support the ongoing development of community health nursing through undergraduate curriculum development and continuing education opportunities
- Demonstrate community health nursing as a specialty (profiles quality and expertise)
- Provide a foundation for certification as a specialty with the CNA
- Inspire excellence in and commitment to community health nursing practice
- Direct policy

CNA Certification Competencies

On April 1, 2006 the first intake of community health nurses wrote the CNA specialty certification exam joining their counterparts in 16 other nursing specialties. CHNAC's 5 year journey to the final examination has been guided by CNA's defined process for the development of certification that starts with the development of the standards. From these standards, core competencies are developed and then examination questions from the core competencies. The final step is the administration of the examination. There are quality control measures along the entire process. Assessment Strategies Incorporated (ASI) guides the process with their expertise in developing and managing certification programs in health professions. The CHNAC Core Competency Development Committee approved the final competency report; an Examination Review Committee composed of expert community health nurses approved the blueprint of the core competencies and oversaw the development of the community health nursing certification exam; and several community health nurses from across Canada traveled to Ottawa for one-week periods to participate in "item writing" for the examination. The Examination Review Committee approved the final exam. An examination preparatory guide was developed and distributed to community health nurses (in the Fall of 2005) who signed up to write the certification exam. CHNAC has also developed a certification evaluation committee.

PHAC Core Competencies

The need to strengthen the public health workforce in Canada has been identified by many organizations, governments, public health decision makers and providers. Four key areas related to the public health workforce include:

- Strengthening and stabilizing the public health workforce
- Emphasis on front lines of the public health system
- Development of a competent public health workforce
- National leadership

The Ministers of Health in June 2004 supported a 10-year action plan to strengthen the public health workforce.[1] A flurry of activity has occurred since this time with several federal/provincial and territorial advisory groups leading the way. A Public Health Human Resources Framework has been developed and approved with several components including:

- Development of accreditation standards for public health
- Best practices for education, inter-professional work and recruitment/retention
- Public health workforce data and planning
- Competency development and tools

The Public Health Agency of Canada is leading some of this work with many partners from across Canada. The Office of Public Health Practice is a newly created branch within the Public Health Agency of Canada. In this Office, the Public Health Human Resources Strategy (including the development of core competencies) and continuing education programs, such as the Skills Enhancement for Public Health program, are being spearheaded.

A draft set of 62 core competencies for public health in Canada was developed by the

[1] First Ministers….

Federal/Provincial/Territorial Public Health Human Resource Task Group. After preliminary consultations, this initial set of core competencies was re-drafted for national consultation; there are now 44 draft core competencies statements, grouped into seven themes or "domains":

- Core public health sciences
- Assessment & analysis
- Policy development & program planning
- Partnership, collaboration & advocacy
- Socio-cultural
- Communication
- Leadership

A discussion document has been produced which characterizes the competencies according to proficiency level and frontline versus specialist/consultant.

Core competencies are a set of common cross-cutting skills, knowledge and abilities necessary for the broad practice of public health. They are basic building blocks for workforce development which transcend the boundaries of individual disciplines and are independent of program or topic.

Over the coming months consultations will be held across Canada on this draft set of core competencies and the domains. The purpose of the consultation will be to confirm and validate the public health core competencies. Components of this consultation include: an on-line survey, regional implementation meetings and implementation pilots. The draft pan-Canadian public health core competencies are part of the foundation for public health disciplines to develop discipline-specific core competencies. Several public health discipline groups have started this work already.

PHAC Skills Enhancement

In terms of meeting the core competencies, opportunities for ongoing education will be critical. The Public Health Agency of Canada's Skills Enhancement for Public Health online continuing education program provides practitioners with an opportunity to obtain the knowledge and skills necessary to meet the public health core competencies. The core component of the Program is a series of Internet-based, facilitated modules in English and French. Modules currently available include:

- Introduction to Online Learning
- Basic Epidemiological Concepts
- Measurement of Health Status
- Descriptive Epidemiological Methods
- Epidemiology of Chronic Diseases
- Outbreak Investigation and Management
- Introduction to Public Health Surveillance

A number of other modules are currently being developed including: Applied Epidemiology: Injuries; Introduction to Information Management; Communicating Data Effectively; Evidence-based Planning; Basic Biostatistics; and, Survey Methods. An exciting new module in development is Principles and Practices of Public Health. This is a short module for decision makers in health regions, authorities, and health units who may manage public health programs, but may not have a background in public health. This module will eventually be adapted for orientation of staff new to public health. The vision and

mandate of the Skills Enhancement for Public Health program has expanded since the launch of its first module in May 2003. The initial focus was to fill the gap in knowledge and skills about surveillance, epidemiology and information management. There is an opportunity for the online modules to address other gaps in public health core competencies across Canada.

For more information about Skills Enhancement for Public Health and to register for the Program, visit the website at www.phac-aspc.gc.ca/skills.

For more information about other initiatives of the Public Health Agency of Canada, visit the website at www.phac-aspc.gc.ca.

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Part II

Survey on Public Health Education

Background

A sub-group of five members of the larger Task group met in Ottawa over 2 days to construct the online survey. The survey included: questions pertaining to a) demographics about the nursing program/s b) curriculum content measured in relation to the CHNAC standards of Practice (2003) c) numbers of students and placements in community health settings, d) internal and external influences as well as enabling and challenging influences that impacted community health content in the program, e) unique highlights of their program with respect to community health nursing content, f) plans to make changes with respect to the community health nursing curriculum and, g) their level of interest in participating in a Pan-Canadian forum on this topic.

The survey was pilot tested with approximately 5 member schools and suggested areas for improvements were identified. Edits were made to the survey in response to comments and issues identified in the pilot. Respondents generally found the online survey easy to use; therefore a decision was made to launch the survey in an online and paper version

Overview of data collection and analysis

Deans were sent a letter of invitation along with instructions for survey completion, a glossary and a paper based survey. These materials were also provided on the CASN web site. http://www.casn.ca/Databases/Public_Health_survey.htm The online survey was hosted using surveymonkey.com services. As indicated by the pilot, it was likely necessary for most respondents to consult with colleagues in the school to gather all of the requested data. Therefore, participants were provided with a hard copy of the survey as a working copy to assist them. They were asked to enter their responses online if possible or alternatively mail in their responses on paper. Phone reminders were made to increase the response rate.

Respondents were asked to identify if and how specific content related to the CCHNSoP were addressed in their Generic/collaborative/ integrated "DEC-BAC" and in Post-RN programs as well as future plans for adding or augmenting the same. Using the following response categories, they checked whether content for each standard is currently delivered in each of the programs they offer: a) through a core (required) theory course; (b) as required practicum; (c) as a required segment of a course; (d) as a core thread throughout courses; (e) via selected nursing elective; or, (f) not covered-currently; and (g) future plans to add it if not covered/augment what is currently addressed. Basically, categories (a-e) measured the extent to which content for each standard was addressed by identifying the kinds of and number of the modalities used to deliver it in the curriculum. Respondents were provided with a glossary of terms that define these categories (see appendix B).

In the analysis, we collapsed response categories (a-e) into a larger one that identified which content related to each standard was currently covered in any way in the curriculum regardless of the type and number of its delivery modalities. This decision was made to since the content was overwhelmingly covered by a required segment or core thread with respect to how the Schools of Nursing covered them. Categories (f) and (g) were retained as is. As a result, it is acknowledged that the findings for each standard do not describe the *extent* to which any of the content was covered in curricula; only that it was included in some way.

The analysis was further oriented to capture the content covered/ not covered in different programs because each school offer more than one program. Hence, the analysis was conducted separately per type of program based on the information schools reported on their coverage of each content area within the specific programs they offer. In the findings, the generic, collaborative and integrated “DEC-BAC’ programs are reported on as one category, and Post-RN programs as another category.

Findings of the public health education survey

General Demographics of CASN member schools

The Canadian Association of Schools of Nursing represents 91 universities and colleges (institutions) that offer part or all of an undergraduate or graduate degree in nursing. Undergraduate programs structure varies; some are delivered in whole by universities (as in generic programs); or part by universities and part by colleges (post-RN); or jointly by university-colleges (collaborative/ integrated).
In Quebec, collaborative programs are referred to as integrated college-university programs or abbreviated as (DEC-BAC). They are structured as 5-year integrated curricula. Each of these integrated programs is designed and delivered jointly by a consortium consisting of one university and a group of colleges; the total is nine (9) consortia. The community health nursing competencies content is uniformly delivered in the fourth and fifth year of the programs, and the degree is granted upon program completion by each university. Table 1 indicates the number of schools that offer a generic, collaborative, integrated “DEC-BAC” baccalaureate programs, and a Post-RN baccalaureate Program by province (the B.Sc.N. or BN degree designation varies across provinces).

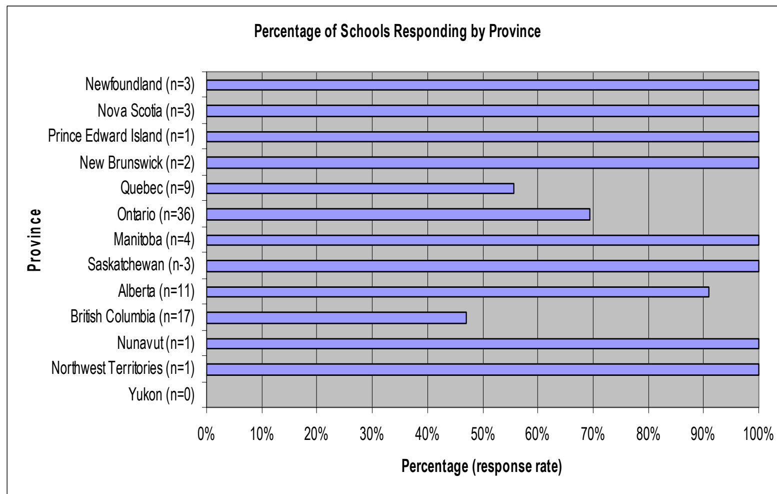
Table 1: Number of CASN member schools that offer a Generic/ collaborative &/or integrated “DEC-BAC” BScN/BN programs, and a Post-RN Program by province

Province	# of schools with BScN or BN Programs	# of schools with Post-RN Programs
Newfoundland	3	1
Nova Scotia	3	2
Prince Edward Island	1	-
New Brunswick	2	2
Quebec	9	9
Ontario	36	10
Manitoba	4	2
Saskatchewan	3	1
Alberta	11	6
British Columbia	17	10
Nunavut	1	-
North West Territories	1	-
Yukon	-	-
Total	91	43

Demographics of survey participants

The survey was sent to all of the 91 schools of nursing that offer all or part of B.Sc.N/BN and/or post-RN program in nursing. A total of 66 completed surveys were received from Schools of Nursing for a response rate of 72.5% with 86.4% of the programs being offered in the English, 9.1% in French and 4.5% bilingual. The distribution of returned surveys by Province is presented in Figure 1 below. The highest percentage of responses was received from the eastern provinces, the territories, and the Prairie Provinces. The lowest percentages of responses were received from British Columbia, Quebec, and Ontario respectively. These three provinces do however, house the largest number of schools of nursing, and thus even though the percentage of schools was lower, there were a greater number of responses in total from each of these provinces when compared to the areas with higher percentage responses.

Figure 1: Percentage of CASN members that responded by province



* The number includes the number of consortia offering integrated programs (see the description in the preceding text)

Standard 1: Promoting Health

1a –Health Promotion

Due to the large number of content areas, Standard 1 has been separated into four subsections: population health promotion; disease prevention; health protection and health maintenance; restoration & palliation. Findings on standard I appear in tables 2 –5 under these subheadings.
As indicated in Table 2, the Population Health Promotion subsection of standard 1 is very well covered. The area of Social Marketing leads the content not covered.

TABLE 2 – Standard 1a: Health Promotion.

	Total (N)		% Program not covered		% Program already cover	
	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN
Community assessment	64	41		2.44	100	97.56
Asset/strength-based approach	63	41	3.17		96.83	100
Determinants of health	64	41			100	100
Health education	64	41			100	100
Personal skill development	64	41	3.13	2.44	96.8	97.56
Creating supporting environments	64	41			100	100
Reorienting health system	62	40	4.84		95.16	100
Strengthening community capacity	63	41	1.59		98.41	100
Healthy public policy	64	41	4.69		95.31	100
Planned change strategies	64	41	3.13	7.32	96.88	92.68
Social marketing	64	41	**12.50**	**26.83**	**87.50**	**73.17**

Note:

- Bolded line highlights the area of the standard not covered by the highest % of programs responding to the question
- Post RN/BN refers to all Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs

1b – Disease Prevention

Content areas within the Disease Prevention subsection of Standard 1 were also very well covered in both programs. Injury prevention shows a small percentage of schools not covering the subject. Also a small percentage does not cover abuse in vulnerable populations and uses and follow up of tertiary care. Chronic disease prevention under primary prevention is not well covered by a number of Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs. The results for the Disease Prevention subsection of Standard 1 are presented in further detail in Table 3.

Table 3: Standard 1b: Disease Prevention:

	Total (N)		% Program not covered		% Program already cover	
	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN
Primary prevention	64	39		2.56	100	97.44.
Chronic disease prevention	64	39		15.38	100.	86.62
Injury prevention	64	**39**	**4.69**	**15.38**	**95.31**	**84.62**
Risk identification and harm reduction	64	39		5.13	100	94.87
Secondary prevention	64	39		10.26	100	98.74
Abuse (vulnerable populations)	**64**	**38**	**1.56**	**13.16**	**98.44**	**86.84**
Tertiary prevention	64	39		2.56	100	97.44
Uses follow up services	**64**	**39**	**3.13**	**5.13**	**96.88**	**94.87**

Note:

- Bolded line highlights the area of the standard not covered by the highest % of programs responding to the question
- Post RN/BN refers to all Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs

Standard 1b – Health Protection

Content within the Health Protection subsection of Standard 1 were covered by the fewest number of generic, collaborative and integrated baccalaureate nursing programs that responded to this question. Emergency Preparedness was not covered by 34.43% of the BN programs and 47.73% by the Post RN/BN/BN schools. Outbreak Investigation & Management were not covered by 21.31% of the BN programs and 26.13% in the Post Basic BN programs. Other areas not covered in this standard in the Post RN/BN/BN courses included screening, communicable disease response and immunization. Given the increased attention and importance accorded to health protection skills in the aftermath of SARS, this lack of coverage is noteworthy. A number of other health protection areas were also not addressed by a number of nursing programs and are outlined in Table 4.

Table 4: Standard 1b - Health Protection:

Note:

	Total (N)		% Program not covered		% Program already cover	
	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN
Basic epidemiological concepts	62	39		2.56	100	97.44
Descriptive epidemiological methods	61	39	9.84	7.69	90.16	92.31
Measurement of health status	61	39	6.56	2.56	93.44	97.44
Screening	62	37	11.29	18.92	88.71	81.08
Surveillance	**61**	**38**	**21.31**	**18.42**	**78.69%**	**81.58**
Communicable disease response	62	38	11.29	15.79	88.71	84.21
Outbreak investigation and management	**61**	**38**	**21.31**	**26.32**	**78.69**	**73.68**
Immunization	62	38	4.84	21.05	95.16	78.95
Emergency preparedness	61	38	**34.43**	**47.37**	**65.57**	**52.63**

- Bolded line highlights the area of the standard not covered by the highest % of programs responding to the question
- Post RN/BN refers to all Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs

1c: Health Maintenance, Restoration and Palliation

The content areas within this final subsection of Standard 1 were not covered in a number of baccalaureate nursing programs as well as post baccalaureate nursing programs. As indicated in Table 5, health and healing in diverse situations, palliation, and home health care were the three areas respectively, which received no coverage by the largest percentage of institutions, and with no plans to add them to the curriculum in the future.

The content areas in this section were not covered by a higher percentage of Post-RN/BN programs when compared to the other programs. Palliation and home health care were not covered by 13.89% of Post-RN/BN programs, and health and healing in diverse situations was not covered by 10.53% of these programs.

Table 5: Standard 1c - Health Maintenance, Restoration and Palliation

	Total (N)		% Program not covered		% Program already cover	
	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN
Home health care	62	36	9.68	**13.89**	90.32	**86.11**
Holistic assessment (individual family community)	62	39			100	100
Adapts nursing techniques to community setting	62	38	1.61	2.63	98.39	97.37
Health and healing in diverse situations (e.g. Critical incident stress debriefing).	62	**38**	**12.90**	10.53	**87.10**	89.47
Palliation	62	36	11.29	**13.89**	88.71	**86.11**

Note:

- Bolded line highlights the area of the standard not covered by the highest % of programs responding to the question
- Post RN/BN refers to all Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs

Standard 2 – Building Individual/Community Capacity

Building individual capacity was addressed by the majority of nursing programs with very few programs missing any of the content area. Group dynamics was not covered in 20.52% Post Rn/Bn programs. Please refer to Table 6 for coverage details.

Table 6: Standard 2 – Building Individual/Community Capacity

	Total (N)		% Program not covered		% Program already cover	
	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN
Partnership/collaboration	62	3	1.61		98.39	100
Public participation	60	**3**	**1.67**		**98.33**	**100**
Enablement/empowerment	62	3	1.61		98.39	100
Community development	62	3	1.61		98.39	100
Group dynamics	**62**	**0**		**20.51**	**100**	**79.49**
Family systems	62	3		7.89	100	92.11
Skills for self-advocacy for individual/family/community	62	3		10.26	100	89.74

Note:

- Bolded line highlights the area of the standard not covered by the highest % of programs responding to the question
- Post RN/BN refers to all Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs

Standard 3: Building Relationships

The content areas in Standard 3 pertaining to Building Relationships were also covered in the vast majority of programs. Power dynamics was the content area receiving no coverage in only 4.84% of them.

There were more content areas within Standard 3 not covered by higher percentage of the Post-RN/BN programs as compared to the other programs. The areas of clarification of personal belief systems and phases of the client-nurse relationship/therapeutic relationships were not covered by 10.26% of the Post-RN/BN programs respectively.

Table 7 describes the coverage for the other Building Relationships content areas.

Table 7: Standard 3: Building Relationships

	Total (N)		% Program not covered		% Program already cover	
	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN
Caring (mutual respect and trust)	62	39		5.13	100	94.87
Clarification of personal belief system	**62**	**38**		**15.79**	**100**	**84.21**
Building networks or relationships	62	39	1.61	2.56	98.39	97.44
Power dynamics	62	**39**	**4.84**	**7.69**	**95.16**	**92.31**
Mobilizing community resources	62	39	1.61		98.39	100
Culturally appropriate communication	62	38			100	100
Phases of client-nurse relationship/Therapeutic Relationships	**62**	**39**		**10.26**	**100**	**89.74**

Note:

- Bolded line highlights the area of the standard not covered by the highest % of programs responding to the question
- Post RN/BN refers to all Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs

Standard 4: Facilitating Access and Equity

The area of the Jakarta Declaration or investment in health/globalization were covered by the fewest nursing programs with the BN program at 25.86% and the Post RN/BN 20.51%. Alternative/ complementary health options was also a subject not covered by 11.29% of BN programs and 26.32 of the Post RN/BN schools.

A number of other topics were also not addressed but by smaller percentage of programs as outlined in Table 8.

Table 8: Standard 4: Facilitating Access and Equity

	Total (N)		**% Program not covered**		**% Program already cover**	
	All BN programs	**Post RN/ BN**	**All BN programs**	**Post RN/ BN**	**All BN programs**	**Post RN/ BN**
Primary health care	62	39			100	100
Jakarta Declaration (investment in health/globalization)	58	**39**	**25.86**	**20.51**	**74.14**	**79.49**
Social Justice in health practice	62	39	4.84	2.56	95.16	97.44
Diversity and equity	62	39	1.61	7.68	98.39	92.31
Accessibility and acceptability	62	39	3.23	2.56	96.77	97.44
Culturally relevant practice	62	39	1.61		98.39	100
Vulnerable populations	62	39		10.26	100	89.74
Informed choice and right to choose	62	39		7.69	100	92.31
Alternative/complementary health options	**62**	**38**	**11.29**	**26.32**	**88.71**	**73.68**

Note:

- Bolded line highlights the area of the standard not covered by the highest % of programs responding to the question
- Post RN/BN refers to all Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs

Standard 5: Demonstrating Professional Responsibility and Accountability

There are three areas in this standard which reflect a lower coverage of subject matter. The content area with the least coverage for both programs is public safety with 14.52% (BN programs) and 15.38% (Post RN/BN). Public health legislation is also not covered by 12.90% (BN programs) and 15.3% (Post RN/BN). Informatics is the other subjects which a number of schools are not covering in their curriculum. Given the importance of public health legislation, which outlines the roles, responsibilities and authority of public health and the ever-increasing reliance of technology and computer systems these areas not covered have implications for graduates working in public health.

Table 9: Standard 5: Demonstrating Professional Responsibility and Accountability

	Total (N)		% Programs NC		% Programs already Cover	
	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN	All BN programs	Post RN/ BN
Advocacy for health public policy	62	39	1.61		98.39	100
Professional integrity	62	39		7.69	100	92.31
Ethical practice	62	39		2.56	100	97.44
Legal obligation (e.g. reporting abuse)	62	39		2.56	100	97.44
Public health legislation	**62**	**39**	**12.90**	**15.38**	**87.10**	**84.62**
Quality of practice environment (e.g. workplace safety)	62	**38**	9.68	**15.79**	90.32	**84.21**
Public safety	**62**	**39**	**14.52**	**15.38**	**85.48**	**84.62**
Participation in research	61	39	3.28	7.69	96.72	92.31
Participation in professional activities	61	39	1.64	5.13	98.36	94.87
Reflective practice	61	39		5.13	100.00	94.87
Informatics	**59**	**38**	**10.17**	**26.32**	**89.83**	**73.68**

Note:

- Bolded line highlights the area of the standard not covered by the highest % of programs responding to the question
- Post RN/BN refers to all Post RN/BN and Integrated Baccalaureate Nursing (DEC-BAC) programs

Community/Public Health Practica

Respondents were asked

"*In community health practica during 2004-2005 academic year, how many students are placed in or work collaboratively with (please enter numeric data):*

Table 10 – Student placement for community health practica

Location of Student placements for Community Practica	Total N of placements in specific locations	% of Placements in specific locations
Public health unit/department (includes Quebec CLSCs* which incorporate Quebec schools health programs)	3082	17.45
Long Term Care Facilities	2289	12.96
Home Health & Visiting nursing services	2239	12.67
Schools (excluding Quebec schools)	2213	12.53
Community agencies	2048	11.59
Primary health care centre	1127	6.38
Hospital based outpatient clinic	1062	6.01
Child Care Centers	758	4.29
Non Government Organizations	599	3.39
Adult care centers	464	2.63
Outreach services	407	2.30
Workplace/e.g. industry	286	1.62
Aboriginal health centers	240	1.36
Community Health Centers (excluding CLSCs*)	188	1.06
International Placements	173	0.98
Homeless shelters	164	0.93
Coalitions	150	0.85
Correctional services	145	0.82
Camps	32	0.18

CLSCs – Centre local de services communities: Local community service centre in Quebec which has the mission to offer, at the primary level of care, basic health and social services of a preventable or curative nature and rehabilitation or reintegration services to the population of the territory it serves. (Source: McGill University Health Centers; Glossary of Terms; http://www.muhs.ca/Construction/documentation/pssc/15/).

Then were then asked to list other community health practica that are not listed above, the following were provided:

- School of Human Kinetics at the University
- Policy Development

- Mental Health Centers
- Perinatal
- Diabetes Education
- Breast-screening
- Addictions
- Community Care Access Centers (Second language classrooms, Parish nursing, Women's drop-in centers; Early Years Centers; University/College Health Clinic).
- Children's Aid Society
- Government (Ministry of Health, Health Promotion Department of Health and Social Services)
- Immigration Centre
- Interprofessional rural placements in small communities
- TB control clinic
- Group homes
- Community Health Fairs for Families

Summary

Table 11 provides a summary comparison of the strengths and gaps in coverage of each of the Standard content areas for the generic, collaborative, integrated baccalaureate programs (collectively) and the Post-RN programs.

The most striking finding is that the majority of standards and their related content for competencies are covered in both types of programs. In fact, over 90 percent of participating programs covered most of the standards- related content. In the generic, collaborative and integrated baccalaureate programs, the majority of competencies related to population health promotion, prevention, health protection (basic epidemiological concepts), building individual capacity, and building relationships were covered by 95-100 percent of institutions. Coverage of these competencies was slightly lower in Post-RN programs (occurs in 86-92 percent of them).

There are a number of similarities in the content not covered by a high percentage of both programs, with the health protection subset content area being one. In addition, social marketing, injury prevention, emergency preparedness, palliation, the Jakarta Declaration, and informatics were main content areas not covered in both types of programs. Standard 1 in the areas of population health promotion and disease prevention were covered to the greatest extent. Overall the Standards content areas were not covered by a higher percentage of Post-RN programs compared to the other programs.

Table 11: Summary: strengths & gaps in coverage of Community Health Nursing Standard for "Generic, collaborative, integrated Baccalaureate Programs" & Post-RN Programs

LEGEND	**Content Areas within standards; C – Covered; NC – Not Covered; FP – Future Plans to Cover**			
Standards & Content Areas	**Baccalaureate Programs**		**Post-RN Program**	
	Strength	**Gaps**	**Strength**	**Gaps**
Standard 1a: Health Promotion	- Majority of areas covered by > 95% of institutions. - Reorienting the health system covered by the highest percentage of institution	*Social marketing*; only 37.5% of institutions with "not covered" have future plans to add it.	Majority of the areas covered by >92% of institutions. - 7 of the related areas covered by 100% of the institutions; all have FP to enhance.	*Social Marketing*; only 26.83% of institutions NC have FP to do so
1b: Disease Prevention	- Majority of the areas covered by > 96% of institution. 100% of institutions N C have FP to do so. - *Uses Follow-Up Services* covered by highest percentage of institutions & with FP to enhance.	*Injury Prevention* NC by 4.69% of institutions	Majority of the areas C by >86% of institutions - 50% of institutions NC Both *Injury prevention* and *secondary prevention* have FP to add it.	*Chronic Disease Prevention* and *Injury Prevention* NC by 15.38% of the institutions
1b: Health Protection	- *Basic Epidemiological Concepts* are C by 100% of institutions. - *Outbreak Investigation and Management* is the highest C with FP to enhance.	*Emergency Preparedness* is N C by 34.43% of institutions with only 28.57% of them have FP to add it; *Surveillance* & *Outbreak investigation/ management* are N C by 21.31% of institutions, & only 23% of them with FP to add it.	*Basic Epidemiological Concepts* only competency C by majority and 100% of those NC have FP to add.	*Emergency Preparedness* NC by 47.37% of institutions & only 16.67% of them with FP to add.
1c: Health Maintenance, Restoration & Palliation	- The majority of the Areas C by > 90% of institutions.	*Health and Healing in Diverse Situations* is NC by 12.9%, while Palliation is NC by 11% of institutions	Majority of the Areas C by >89% of institutions - Two weakest competencies have those that C with FP to enhance.	*Home Health Care* and *Palliation* are NC by 13.89% of institutions with no FP to add.
Standard #2 Building Individual/Community	- The majority of Areas C by > 98% of institutions - Skills for *Self-advocacy for*	*Public Participation* is the highest NC, but only 1.67%.	Majority of Areas C by by > 89% of institutions - 4 of 7 areas 100% C & 7.69% of	*Group Dynamics* NC by 20.51% with no FP to add.

Capacity	*Individual/Family/Community* is the highest C with FP to enhance.		institutions have FP to enhance.	
Standard #3 Building Relationships	- The majority Areas are C by > 98% of institutions. - 6.78% of institutions covering *Power Dynamics* have FP to enhance	*Power Dynamics* is NC by 4.84%.	Majority of the Areas C by >89% of institutions - *Building Networks and Relationship* - 100% of Institutions NC have FP and 5.26% of C have FP to enhance.	*Clarification of Personal Belief System* NC by 15.79 with no FP to add
Standard #4 Facilitating Access & Equity	- The majority of Areas C by > 88% of institutions - 9.09% of C have FP to enhance *Alternative /Complimentary Health Options*.	*Jakarta Declaration* NC by 25.86% institutions with only 26.67 FP to add.	Majority of the Areas C by > 89% of institutions - *Primary Health Care* and *Culturally Relevant Practice* are 100%.	*Alternative/Complementary Health Options* NC by 26.32% institutions with no FP to add; *Jakarta Declaration* NC by 20.51% of institutions with no FP to add.
Standard #5 Demonstrating Professional Responsibility & Accountability	- The majority of the Areas C by > 88% of institutions. - 15.09% C have FP to enhance *Informatics*.	*Public Safety* NC by 14.52% of institutions & only 33% FP to add.	Majority of the Areas C by >84% of institutions - 10.71% of C have FP to enhance *Informatics*.	*Informatics* NC by 26.32% of institutions with no FP to add.

Qualitative and related quantitative analysis

The survey respondents were given the opportunity to discuss what they felt where the external and internal strengths and challenges. Both quantitative examples from the data gathered and quotes from the comments are utilized throughout the analysis to demonstrate the corresponding theme.

Respondents were first asked to *"Please rate the following external influences with respect to their impact on community health content in your program*" and then to "*Comment on the nature of the external enabling and/or challenging influences*". The following analysis provides themes, and, when appropriate, links the narratives provided with the data gathered on rating of the external influences. Participants' comments provide an excellent representation of the themes and therefore quotes are presented to augment them.

The open ended questions were analyzed using NVivo 2 software using constant comparison technique. Answers to survey questions that asked about internal and external influences as well as enabling and challenging influences that impacted community health content in the program are grouped under four headings: 1. External Strengths, 2. External Challenges, 3. Internal Strengths and, 4. Internal Challenges. Major themes were drawn from these questions and minor themes were derived from the responses. Data was chunked into segments of 1 to 3 sentences and coded accordingly. A frequency count of the quotes assigned to each code supported the development of minor themes. Table 4 presents a summary of the major/minor themes that emerged that relate to the four headings. In the section that follows the table, the major and minor themes are expanded upon by quotes and quantitative ratings of internal and external influences from the survey which help to explain and support the themes.

External – Strengths

Five major themes were identified as external strengths that reflected supports from external sources including: 1) supportive community partners, 2) support from health units for curriculum planning, 3) support from cross-appointed faculty, 4) many community placements, and 5) support from a College of Nurses. Only one of these themes 'supportive community partners' - was reported by many respondents. Although the other four themes were reported by very few respondents, they represent ideas that inform us about important successes that should not be ignored.

1) Supportive Community Partners

Many respondents reported that they had very supportive community partnerships, which helped to strengthen community health nursing educational experiences for students.

- "We could not have had such a strong emphasis on community health without our relationship with public health unit the support has been outstanding and they are not one of the teaching health units. They deserve credit for this success …"
- "We have a very good relationship with our community agencies which in turn enable excellent practical experiences for our students." "The Ontario PHRED (Public Health Research Education and Development Program) model has strengthened public health nursing education, research and practice through increased opportunities provided to our students by

the partnerships and experience that faculty have brought from their PHRED joint appointments."

- « La majorité des cours offerts au BACC sont orientés dans une perspective et une vision santé communautaire. Nous offrons également un certificat de santé communautaire.»
- «Notre mission universitaire consiste, entre autres, à former des infirmière au travail en milieu communautaire. L'objectif est clair pour les différents partenaires: Cégep et établissements de santé. »
- "We have a very good relationship with our community agencies which in turn enable excellent practical experiences for our students."

2) Involvement of Health Units in Curriculum Planning

One respondent noted the important contributions from their public health department in curriculum planning.

- "We have an extremely supportive public health department who have worked with us to design the curricula and practicum placements."

3) Support from Cross-appointed faculty

One respondent commented on the strength of having jointly appointed faculty in public health.

- "… one of the enabling factors is the PHRED (Public Health Research Education and Development) program which is an external influence which supports community health education through cross-appointed faculty in clinical settings and education. They support the link between education, research and practice. Similarly these cross appointed faculty are involved in provincial and national public health initiatives which keep them abreast of the trends impacting on community health nursing education."
- "The Ontario PHRED (Public Health Research Education and Development Program) model has strengthened public health nursing education, research and practice through increased opportunities provided to our students by the partnerships and experience that faculty have brought from their PHRED joint appointments."

4) Many community placements

Although most respondents reported having struggles finding enough community placements, one respondent identified having access to multiple placements.

- "Another enabling factor of our program is the multitude of clinical placement opportunities available to students in the community. This allows students to more easily make the connection between theory and "real life" practice."

5) Support from a College of Nurses

One respondent reported that they received support from one of the provincial College of Nurses to incorporate a community health component into the program

- "There is clear support from CRNM (College of Nurses of Manitoba) to incorporate a community health component in the program."

External – Challenges

External challenges reported by respondents are grouped into three major themes including, 1) placement stressors, 2) preceptor stressors and, 3) devaluing of community health. Each major theme is explored in more depth supported by the minor themes that emerged.

1) Placement Stressors

Three minor themes emerged from the data regarding external challenges related to clinical placements including**:** a) increased demand/ reduced supply, b) non-nursing teachers, and c) unique placements.

a) Increased demand/reduced supply: The problems with increased demand/reduced supply of student placements were related to two factors, i) increased competition for placements and, ii) health care restructuring.

i) Increased competition

A number of respondents commented on the increased competition for placements as a result of the increased student numbers from the introduction of college programs and a lack of community resources.

- “Competition for CHN practicum opportunities ie, other college programs, finding suitable preceptors depends on type of agency”
- “The demand for placements often is higher than the community resources can support”
- “The practice environments are deluged with demands for student placement.”
- “…CONSTANT competition for placements and we have to beg for preceptors and sites.”
- “The agencies also perceive that the capacity for student placements in community health is limited and they therefore restrict the number of student placements.”

Survey results supported this theme which indicated the following *challenges* with respect to impact on the community content in their program*:*

- 59% identified that negotiating placements with others was a challenge.
- 46% identified that the nature of practice environment was a challenge.

ii) *Health care restructuring*: Restructuring of health care environments was identified as a challenge that impacted on the supply of community placements and lack of resources to meet students’ needs.

- “The government of this province is restructuring Public Health (PH) into the Hospital Corporation with no protected budget. The future role of PH is of major concern. Because of this restructuring, there is no opportunity at this time, for our students to have placement with PH.”

- “We only have 8 public health placements per year (out of over 150 students and 7 visiting nursing per year). Ten years ago these were the majority of placements, but restructuring and downloading changes have made a difference to these sectors and their accessibility for student placements”
- “Generally there is little political support for partnerships models even though the funding or positions may not always be available”
- “…constant change associated with re-structuring and associated changes in personnel. We are fortunate that we do not have other health care students (LPNs etc.) requiring community placements in this region.”
- “Community placements are often a challenge to secure as they are under funded, and often do not have enough time or people to precept the nursing students. For example, we missed one year at [] the prison for women in [our province] because there were too few nurses [and they] were overworked.”

Survey results indicated the following *challenges* with respect to impact on the community content in their program:

- 47% identified that health care restructuring was a challenge.
- 42% identified that current political climate was a challenge.

b) Non-nursing teachers: The presence of teachers in the community practice setting who are not nurses has created challenges for educators.

- “Community settings can usually accommodate small groups of students, usually one at a time. With increases in enrolment, this presents a challenge to find meaningful community health placements where community health nurses are there to model their role. We are often trying to creatively examine community settings without nurses as settings for practice”

c) Unique placements used to support the demand: The use of unique placements was one strategy used to overcome the lack of traditional community health placements, as described below.

- “The students are able to develop very unique innovative small projects based on a holistic community assessment that looks at both primary and secondary data sources. They assess, plan, implement and evaluate a project and address sustainability of their projects over the two terms.”
- “Community health nursing clinical - use of non-traditional placements provides a unique learning environment. Rural incentive program - provincial funding enables students to complete practica in remote and rural settings.”

2) Preceptor Stressors

Four minor themes describe the challenges that were reported related to receptors including 1) the lack of valuing of the preceptor role, b) a lack of skilled preceptors, c) lack of protected time and compensation, and d) burnout.

a) Lack of valuing of preceptor role: The lack of value that agencies placed on the preceptor role was repeatedly reported by respondents. This challenge was closely linked to the next challenge- lack of skilled preceptors. The lack of protected time provided for the preceptor role, further illustrates the lack of value for the role.

- "One of our great challenges is lack of available traditional community placements or the constraining vision of those managers re not promoting (not allowing their staff) preceptorship of students"
- "We believe that in order for facilities that employ nurses to receive accreditation, that they have to take a certain percentage of students annually, (*some sort of a ratio system) or they do not get accredited. Further, that those that precept, have this valued and affirmed and that a part of their work is taken away so they have the time to do this. It is such a stretch for them and we find it is rare that agencies value preceptorship as much as universities invite them to."

Survey results indicated the following *challenge* with respect to impact on the community content in their program:

- 59% identified that preceptors were a challenge.

b) Lack of skilled preceptors: Another significant challenge related to preceptors was the need for increased knowledge and skills in precepting as well as primary health care principles.

- "There are difficulties in obtaining enough clinical placements and recruiting preceptors who have the background to support students adequately"
- "Additional challenges include a CHN professional populations that does not necessarily have the educational preparation to engage in co-teaching CHN concepts: local CHNs are largely unaware of Primary Health Care principles; Population Health Promotion; may not value participating in student teaching"
- "Challenges are limited to human resources in the delivery of clinical practicum relevant to community health"

c) Lack of protected time and compensation: Lack of financial compensation and protected time to support preceptors was a significant challenge reported by many respondents. This lack of compensation further devalued the role which was related to the role being viewed as a voluntary activity, which added additional workload to already overburdened staff.

- "Community placements are often a challenge to secure as they are underfunded and often do not have enough time or people to precept the nursing students"
- CHNs traditionally view this as an additional workload task and either expect financial compensation for engaging in clinical student teaching (no resources available) or view participation as strictly on a 'volunteer' basis"
- "Time needs to be protected."
- "Due to staffing issues and relatively low university pay, it is not always easy to find community health preceptors

d) Burnout: Since clinical placements are at premium, it is not surprising that many respondents identified burnout with respect to taking in students.

- “Continued use of the same agencies can sometimes result in agency burnout”
- “Few PHNs in province – overload and burnout of preceptors and placements despite several completion dates throughout the school year”

3) Devaluing of Community Health

Many respondents identified a general feeling that community health nursing compared to acute care nursing was undervalued. Three minor themes provide a glimpse into the impact of values on community health education including: a) external devaluing of community health leads to low funding, b) preference for college students, and c) resistance to working with students in community health nursing.

a) External devaluing of community health which leads to low funding: Government preoccupation with the acute care sector and care of individuals rather than communities has impacted reduced opportunities for community health education. A number of respondents supported this minor theme.

- “The current government is fixated on acute care needs and wanting to churn out new grads as fast as possible. There is little attention to the need for more funding to the education or practice settings to increase community health education opportunities.”
- “Funding & expansions seem to be directed towards acute care versus community health.”
- “The focus in nursing remains on illness care and therefore community is devalued at times”
- “The funding and the power are still hospital or individual focused.”

b) Preference for college program students: One respondent commented on the problem associated with government preferences to fund colleges rather than baccalaureate programs.

- “…increased funding goes to nursing education programs at less than the baccalaureate level which impedes the preparation of nurses to practice in the community.”

c) Resistance to working with students in Community Health Nursing: A school reported difficulties in working with community health nurses in their setting since there was no allegiance between the community and the University. This indicates the importance in building strong relationships between local agencies and educational institutions.

- “Most [xx Province] CHNs historically have had no particular allegiance to [xx University], and many are resistant to working with [our] students.

INTERNAL – STRENGTHS

Three major themes outline the findings that relate to internal strengths related to community health content in nursing schools. These included 1) curriculum structure and process, 2) strong community practice education partnerships and linkages, and 3) faculty champions.

1) Supportive Curriculum Structure and Process

Curriculum structures and processes that are seen as internal strengths can be summarized into four minor themes including a) curriculum rooted in the standards of practice, b) sequencing to support CHN throughout the curriculum and c) foundational concepts and d) in a primary health care curriculum.

a) Current curriculum rooted in standards: One school reported having a course that was rooted in the Standards.

- “Our course is completely rooted in the standards, as is our learning plan, and evaluation template and portfolio.”

b) Sequencing to support CHN throughout curriculum: Many respondents described that community health nursing was sequenced throughout the program rather than offered as one stand alone course. This was viewed as an internal strength.

- “Our program has been instrumental in creating/changing the scope of nursing practice within our province. The emphasis of health promotion in year 1 has prepared the students for the exposure to community throughout the current curriculum. By the fourth year's practicum, the students are able to articulate and function within the community health working environments.”
- “Our program is designed with a focus on wellness in the first two years. Our required community health nursing course is scheduled in the second year with a clinical experience that focuses on community assessment. In year four students do as part of their senior nursing course a community health practice experience where they are placed in an agency for one day a week for a period of 6 weeks.”
- “The curriculum we have is based on PHC and the determinants of health thus these are key concepts woven throughout all areas of our program.”
- “Program spaced over 2 terms allows students to really develop a positive relationship with community partners and to develop a small project that addresses specific community needs.”

Survey results indicated the following *strength* with respect to impact on the community content in their program:

- 65% identified that curriculum renewal/revision as a strength.

c) Foundational Concepts (health promotion, caring, primary health care, determinants of health): Some schools reported their programs were strengthened by the inclusion of foundational concepts throughout their curricula.

- "…our curriculum is great! With the foundational concepts of caring, health promotion, critical social theory, feminism, and phenomenology...we are able to integrate and level the community health content."
- "The emphasis of health promotion in year 1 has prepared the students for the exposure to community throughout the current curriculum."
- "In the fall, all [fourth year] students take Families and Communities (as context) both theory and practice. In the winter, they take Health Promotion (Community as Partner) theory & practice. In the spring they do a 6 week practicum in community health."

d) Primary Health Care-based Curriculum: In addition to the foundational concepts above, some schools have developed their curricula based on primary health care which was viewed as a strength with respect to impact on the community content in their program.

- "Due to new program development, faculty have embraced the PHC approach to professional nursing practice and delivery of health care. We aim to work at embedding the principles of PHC and community health into the integrated program."
- "The curriculum we have is based on PHC and the determinants of health thus these are key concepts woven throughout all areas of our program."
- "Because of our setting we include a focus of rural health care reform, primary health care reform and aboriginal health"

2) Faculty Champions

Two minor themes describe the strengths of faculty champions that exist in our nursing schools. Many respondents reported that their schools had faculty members with: a) good preparation, and b) passion and commitment for community health.

a) Faculty preparation: Respondents often commented on the quality of faculty preparation in community health which has been seen as a strength in their programs

- "The faculty believe in partnership models in general and hence we have "buy-in" that communities are partners."
- "The number of faculty members in our department with advanced practice and education in the area of community health nursing. Additionally, those faculty who do not have this background are very receptive to learning more about community health concepts and incorporating these into their classes."
- "Faculty are prepared at the Master's or PhD level."

Survey results indicated the following *strengths* with respect to impact on the community content in their program:

- 64% identified that faculty numbers who teach CHN content was a strength.
- 64% identified that faculty preparation for teaching CHN content was a strength.

- 65% identified that understanding 'community as partner' versus 'community as context' was a strength.

b) Passion and commitment: The high level of preparation reported above relates closely to the next theme- Passion and Commitment which was also reported by a number of respondents.

- "Although the formal Community Health Education occurs at [the educational institution], we have a number of faculty with strong community backgrounds. Their passion for community nursing means that a number of our students have Community experiences with excellent supervision."
- "Faculty are prepared and committed to CHN."

Survey results indicated the following *strengths* with respect to impact on the community content in their program*:*

- 63% identified that faculty commitment to CHN was a strength.

INTERNAL – CHALLENGES

Internal challenges were grouped into four major themes including: 1) problems with curriculum structure and process, 2) lack of qualified faculty for community health nursing, 3) weak organizational leadership for community health and, 4) challenges for students as perceived by faculty.

1) Problems with Curriculum Structure and Process

Two minor themes including, a) dominance and valuing of illness/ acute care focus and b) integration and relatedness of CHN/ PHN components to the rest of the curriculum were identified as internal challenges with respect to the integration of community health content in the curriculum.

a) Dominance and valuing of illness/acute care focus: Building on the external challenge of the devaluing of community health, numerous respondents felt that this devaluing occurred internally as well. The dominance of acute care was also felt in internally in nursing programs. Some even voiced the acute care dominance as a constant threat to community health content calling for vigilance to protect its value.

- "Faculty who do not value community practice are a constant threat. Faculty who value community practice must be constantly vigilant and politically astute."
- "Community health content never seems to be given as much recognition as content such as med-surg which seems to receive more monetary/staff resources for ensuring comprehensive clinical education etc."
- "At times, CHN courses are not viewed as developing transferable skills to other nursing areas (medical/acute care skills valued more)."
- "What challenges us is the power of the dominant voice that insists that nursing students must have more thorough and senior preparation (theory and especially

clinical practice) in acute care/institutional nursing, rather than community practice."
- "There still persists a large body of nurses, including some educators, [who] believe that acute care experiences ought to be the majority."

b) Integration and relatedness of components of Community Health Nursing/Public Health Nursing to the rest of the curriculum: Reduced Internal Fit: A few comments were made related to the importance of ensuring that community/ public health content was taught as a process and was integrated well into the curriculum.

- "There seems to be pressure for courses to be short and intense. That does not work in community health."
- "Community health also needs to be taught as a process rather than a series of topics."

Survey results indicated the following *challenges* with respect to impact on the community content in their program*:*
- 18% identified that curriculum revision was a challenge.
- 12% identified that the accelerated program was a challenge.
- 22% identified that culture of the collaborative program was a challenge.

2) Lack of Qualified Faculty to teach Community Health

Two major themes elaborate on the problems related to faculty teaching community health. They are a) the shortage of faculty who are prepared to teach in community health, and b) the lack of faculty understanding of community health concepts

a) Shortage of faculty prepared to teach community health content: The shortage of faculty who are prepared to teach community health nursing is related to loss of faculty due to retirements and moves, few Master's prepared community health nurses, and few faculty with practical community health experience.

- "Over the years, our Faculty (which used to be known for its community health focus) has lost its strength in this area, due to several factors: *loss of faculty with community health background (to other universities or due to retirement)."
- "Shortage of qualified instructors with a community health background-few at Master's level."
- "Adding to this challenge is instructors who have never worked in the community or having very little practice experience in the community, have poor understanding of key community concepts and then being thrust into this clinical practice setting."

Survey results indicated the following *challenges* with respect to impact on the community content in their program*:*

- 28% identified faculty numbers who teach CHN content was a weakness of their program.
- 15% identify faculty preparation for teaching CHN content was a weakness of their program.

b) Lack of faculty understanding of community health concepts: The reported problem of shortage of faculty who are prepared to teach community health is exacerbated by faculty members' lack of knowledge of current community health issues and concepts.

- "Adding to this challenge is instructors who have never worked in the community or having very little practice experience in the community, have poor understanding of key community concepts and then being thrust into this clinical practice setting."
- "Another challenge that we encounter is a focus on 'strengths based' health. Although some of our courses, Community, Family, Culture and Social Justice specifically focus on strength- based assessments and ways of working with clients at the individual, family, group and community levels, the dominant paradigm continues to be problem based - 'nursing diagnoses'. When faculty discussions focus on 'clinical' the assumption continues to focus on hospital. Many of us are constantly reminding others that clinical includes community placements."

Survey results indicated the following *challenges* with respect to impact on the community content in their program.

- 22% identified understanding of "community a partner" versus "community as context" was a challenge.
- 20% identified faculty commitment to CHN was a weakness of their program.

3) **Weak Community Health Leadership in Educational Organizations**

Respondents' comments indicated that weak community health nursing leadership in educational nursing organizations impacted negatively on the integration of community health content in the program. It was explained by two minor themes: a) budget resource allocation issues, and b) lack of valuing of community health by administrative leads.

a) Budget resource/allocation problems: Numerous factors that related to budget / resource allocation issues were reported to be challenges that impacted the integration of community health content into nursing programs. These were high faculty-student ratios, increased costs of travel, the administrative complexity of offering multiple programs (Post RN/BN, accelerated, collaborative), and space problems. The following quotes expand upon these factors.

- "Challenges to teaching in the community include the ratio of students to instructors in community sites. In the mandatory community blocks courses in third year there is one instructor per 12 students whereas in the hospital the maximum student ratio is 8 students to one instructor. In the community it is not unlikely to have 12 students in 10-12 different sites both in the city and in rural communities

outside of the city. This leads to a lot of driving and not as much time as I would like to have with each student during the three day (8 hours/day) clinical week."

- "Community health content never seems to be given as much recognition as content such as med-surg which seems to receive more monetary/staff resources for ensuring comprehensive clinical education etc."
- "Offering or accelerated options in 4th year and second degree entry option challenges resources (especially faculty to teach)"
- "The variety of program options overburdens the clinical resources."
- "Internal budget cuts (e.g., clinical education facilitators for the 4th-year community health course were the first to be cut)."
- "The numbers of students have increased over the past few years and classroom space is a challenge. There has not been a lot of infrastructure increase to match the increase in the number of students."

Survey results indicated the following *challenges:*

- 40% identified funding as a challenge.
- 61% identified capacity (space) as a challenge.
- 29% identified time (length of program) as a challenge.

b) Lack of Valuing of Community Health by Administrative Leads: A few respondents lamented that there are few nursing program leaders that have community health backgrounds and that programs need to have community health integrated at the organizational/ administrative level.

- "In order to have a strong community health program, it is essential to have an organization that is functioning according to the CHNAC standards at all levels (administratively and at the teaching level). Note from a faculty member in the collaborative program at a community college: It is important to note that our program involves only three years of a four-year BN program. The fourth year is completed at the University. Consequently, we can only reflect part of the community health component of the program. Furthermore, we are not experts in the content of other community health courses."
- "CHN faculty are not represented within the Program Director positions. Program decision makers are unaware of the impact of the province's CHN population profile on our CHN program, therefore are unaware of the unique challenges faculty experience recruiting community partners (nurse preceptors at community sites), collaborating with these partners, and developing the necessary supports for student learning (student health promotion projects; focus on family, aggregates; health promotion rather than medical care; need for bilingual teaching materials)."

4) **Challenges for Students**

A number of minor themes represent faculty members' perceptions about student issues that impact on community health content in nursing programs. These include: a) limited opportunities

for learning, b) transportation problems, c) student complaints of heavy workload, d) students' preferences for hospital placements, and e) students' difficulty in grasping primary health care concepts.

a) Limited opportunities for learning: One respondent spoke about limited opportunities for student learning in community health.

- "The public health agencies are keeping 3rd year students at an observational level and not allowing students to participate in immunizations, well baby assessments, teaching etc. and this is challenging and takes a lot of negotiating on the part of nurse educators."

b) Transportation problems: Although only one respondent reported transportation as an issue for students, this problem was likely underreported.

- "Geographically, the region can be quite a distance and transportation can be an issue."

c) Students' heavy workload: One respondent spoke about students' heavy workload in relation to community nursing and other courses.

- "During accreditation, the student's frustration with community courses [was] identified as a problem. Other aspects that contribute to the problem such as the heavy third year are not considered."

d) Students' preferences for hospital placements: A number of respondents commented on students preferences for hospital placements to guarantee work after graduation and ensure that they have adequate time to learn technical nursing skills.

- "The majority of jobs for new graduates are hospital based so as the students plan their final practice placements, they often choose acute care."
- "Some students don't want to spend 13 required weeks in 2 CHN courses theory/practice (3 half credits) as they feel it takes away from their "nursing/technical skills" in the hospital."
- "We would like to have our community course back to a one year placement but student pressure created us a few years back to drop it to a half year so they could have more time in the hospitals as requested."

e) Students' difficulty in grasping primary health care concepts: A respondent commented on the difficulties students have grasping community health concepts.

- "When the students arrive in 4th year, 'community' 'primary health care' population focused health', 'community as partner' and 'community as context' are relatively new concepts to the students. It often takes the full year before students say they truly understand these concepts.

ACCREDITATION AND APPROVAL PROCESS

Respondents did not identify any relationship between the accreditation and approval processes with respect to its impact on community health nursing content in programs. Only one comment was reported in this regard.

- "Accreditation and approval bodies neither enable [nor] challenge our ability to deliver the community health nursing content."

Survey results corroborated this neutral feeling about the impact of accreditation and/ or approval processes.

- 43% identified that accreditation was not applicable or neutral as an external influence with respect to community content in the program.
- 46% identified the licensing body approval process was not applicable or neutral as an external influence with respect to community content in the program.

TABLE 12: **Summary of Major and Minor Themes from the Qualitative Survey Findings**

*NOTE: Themes marked * were reported by one or few respondents, however they are important to include because they indicate important successes*

External – Strengths Impacting Community Health Content in the Program	**External – Challenges** Impacting Community Health Content in the Program
1) Supportive Community Partners **2) Involvement of from Health Units in Curriculum Planning *** **3) Support from Cross Appointed Faculty*** **4) Many Community Placements *** **5) Support from a College of Nurses ***	**1) Placement Stressors** a) Increased demand/reduced supply, related to i) Increased competition ii) Health care restructuring b) Non-nursing teachers c) Unique placements used to support the demand **2) Preceptor Stressors** a) Lack of valuing of preceptor role b) Lack of skilled preceptors c) Lack of time and compensation for preceptors d) Burnout **3) Community Health Devalued** a) External devaluing of community health which leads to low funding b) Preference for college program students * c) Resistance of working with students in Community Health Nursing (CHN)
Internal – Strengths Impacting Community Health Content in the Program	**Internal – Challenges** Impacting Community Health Content in the Program
1) Supportive Curriculum Structure and Process a) Current curriculum rooted in standards b) Sequencing of CHN c) Foundational concepts d) Primary Health Care based curriculum **2) Faculty Champions** a) Strong faculty preparation in CHN b) Passion and commitment for CHN	**1) Problems with Curriculum Structure and Process** a) Dominance and valuing of illness/acute care focus b) Lack of integration and relatedness of components of Community Health Nursing/Public Health Nursing to the rest of the curriculum: Reduced internal fit * **2) Lack of Qualified Faculty to Teaching Community Health** a) Shortage of faculty prepared to teach community health content b) Lack of faculty understanding of community health concepts **3) Weak Community Health Leadership in Educational Organizations** a) Budget resource/allocation problems b) Administrative leads – lack of commitment to valuing of community health * **4) Challenges for students** a) Limited opportunities for learning * b) Transportation problems * c) Students' of heavy workload * d) Students' preferences for hospital placements e) Students' difficulty in grasping primary health care concepts *

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Part III

Pan Canadian symposium on public health education

Introduction

The second phase of the Task Force's work involved the organization, with the support of the Public Health Agency of Canada, of a two-day 'Pan-Canadian Symposium on Public Health Education.' The symposium brought together key stakeholders in public health nursing education and the public health nursing workforce and provided an opportunity to share reflections and draw on the collective wealth of expertise in shaping the future of public/community health nursing education.

The Task Forces' specific objectives for the symposium were (i) to present and validate the findings from the survey carried out during the first phase of the Task Force's work; and (ii) to develop key recommendations regarding the future of public health nursing education in Canada.

Process

In preparation for discussion at the symposium, workbooks were pre-circulated by e-mail to all participants. The workbooks contained the following five questions:

(1a) Considering the CHNAC Standards, which were developed for the Public Health Nurse and the Home Health Nurse with two years experience, what are the critical areas of content and skills needed in the undergraduate curriculum? (Using the CHNAC Standards and guidelines, think of a new graduate and what would s/he look like with regards to knowledge and skills)?

(1b) What content and/or skills could be learned during the orientation and/or on-the-job learning as opposed to knowledge and skills identified in the undergraduate curriculum (Questions 1(a))?

(2) What are the issues or concerns relative to placing students in clinical placements/agencies to develop the needed competencies? List the challenges and their successful strategies.

(3) What are the organizational barriers and enablers for promoting students' ability to move towards meeting the CHNAC Standards? How are staff nurses encouraged to work with students to acquire the necessary skills and knowledge?

(4a) How does the partnership between community agency managers and nurse educators enhance the student-preceptor relationship?

(4b) How could partnerships between the nurse educators and community health agencies enhance the student, faculty, and the staff nurse experience in developing the competencies during the clinical placement experience?

(5) Considering your responses to questions 1 to 4, what would your recommendations be to the CASN Board of Directors?

Participants were asked to think about these questions and to submit their written responses when they arrived at the symposium. During the first day of the meeting, responses were collected from all the participants. In the evening, members of the Task Force conducted a preliminary scan of the written responses in order to identify major themes. On the second morning, a summary of these themes was used to engage participants in more detailed small- and large-group discussions the following day (see Appendix A for PowerPoint presentation). The results of these discussions were recorded and collated on an on-going basis throughout the day.

Analysis of Symposium Data

The qualitative data that was collected, categorized and described, arose from the workbooks distributed prior to the symposium, the round table discussions at the symposium, and responses from two nurse leaders' groups representing approximately 125 people. A total of 75 sets of data were collected representing over 200 individuals who contributed to the feedback. There was both English and French speaking representation within the handwritten and verbal responses. All submissions were translated (if necessary) and transcribed into electronic format to be coded and analyzed using HyperRESEARCH as the qualitative software. Note: HyperRESEARCH was chosen as it was user friendly and NVivo was not compatible using MAC operating system.

The results of questions 1a and 1b generated listings of content areas that were identified as necessary to be addressed in either undergraduate curriculum or on-the-job training. The analysis involved categorizing specific content areas within each of the standards listed in the CHNAC Standards of Practice (CHNAC - SP) from the original survey. The sub-categories found under each of the standards (Promoting Health; Building Individual Community Capacity; Building Relationships; Facilitating Access and Equity; and Professional Responsibility and Accountability); as identified in the survey results (Section D) were used to code the additional qualitative data obtained from the completed workbooks, round table discussions and nurse leaders' feedback.

Respondents' answers to questions 2, 4a and 4b expanded upon the qualitative data obtained from the original survey regarding the external and internal strengths and challenges influencing community health content, and attempts to gain further insight into the nature of the relationships between student/preceptor/agency/clinical faculty and educational institution. The combined responses were categorized and analyzed building on some of the same themes identified in the original survey, while recognizing variations in the context and intent of the responses. For example; *nature of practice environment* in some circumstances was either an enabler or barrier depending on the explicative context. These variances were captured and analyzed for all the responses in questions 2, 3, and 4 (a) and (b).

Critical Areas of Community Health Content

Using the headings provided by the original survey to code the data, enabled consistency between the results of the survey and the qualitative data from the multiple sources in phase two. There was consistency between most of the content areas however two areas that were not identified by the respondents included: informed choice/ right to choose; and alternative/ complementary health options. On the other hand, there were a number of content areas that were identified by the respondents as important to include in curricula that were not identified in the original survey, these were: program planning and evaluation knowledge and skill; knowledge of specific '*specialized'* community nursing skills (i.e. breastfeeding, wound care, reproductive health, maternal child health etc); evaluation of own nursing practice; and leadership. The results describe these additional categories and their relationship to the survey data.

The respondents agreed that almost all of the *"content areas that are being addressed in undergraduate education related to the CHNAC-SP*' identified in the original survey of, '*were important*' and '*should*' be addressed in undergraduate education. However many of the respondents distinguished between the knowledge or content taught and the skill or competency obtained. The majority of the respondents indicated that Primary Health Care; Epidemiology; Determinants of Health together with Population Health Promotion; Community Development together with Program Planning and Evaluation and Building Partnerships and Collaboration; are highly important content areas that should be addressed in undergraduate curriculum. With the exception of primary health care, the respondents identified challenges for students to obtain the appropriate level of skill or competency to meet the CHNAC-SP for these content areas, due to the quality and quantity of their community clinical experience. The lack of and inconsistent availability of community health placements for undergraduate students has been identified by the respondents to be a major barrier to developing specific community health nursing skills related to the CHNAC-SP in undergraduate education and therefore, by default, the skill was expected to be obtained in on-the-job training.

There was little agreement between respondents on a number of other content areas as to whether the associated skill '*should*' be obtained in undergraduate education or reserved for on-the-job training. The content areas: social justice; immunizations; and *other knowledge and skills* (e.g. breastfeeding/lactation, physical assessment skills, growth and development, sexual health, STDs, substance use etc) were areas that had inconsistencies as to the depth and breadth of the knowledge and skill required in undergraduate nursing education. Of the respondents who identified these as important knowledge areas that should be addressed in undergraduate education; a number of them felt the skills should be obtained during undergraduate education while the others felt the additional '*specialized*' knowledge and skills could be reserved for on-the-job training.

Many respondents identified, for example, gaining knowledge and skills in immunization as an important topic. However, in some provincial jurisdictions, legislation restricts nursing students from providing immunizations in practice; as a result new graduates do not have immunization administration skills. Therefore, some respondents felt that this knowledge and skills fell to the responsibility of employers to include in workplace orientation.

Barriers and Enablers to integrating knowledge and skill of community health nursing practice.

Respondents' answers to questions 2, 3 and 4 contributed to a deeper understanding of the nature of the barriers and enablers to integrating knowledge and skill development of community health nursing in undergraduate education. Respondents identified very few barriers to delivering the content; however major factors were identified that contributed to challenges in developing the skills required to address the CHNAC-SP. Responses from the three sources of data indicated that the most consistent challenge for community health nursing education was the lack of access to appropriate practice settings and preceptors.

There are varied and complex reasons contributing to barriers to access of appropriate resources; most frequently cited reasons included: Lack of preceptors or placement opportunities available to the nursing program; preceptors' perceived additional workload to take on students; the increasing numbers of students

and decreasing numbers of preceptors; and the lack of congruency between the current practice of preceptors with the CHNAC-SP.

In addition to preceptors, the organization/ agency/ manager and or practice environment also posed barriers to enhancing community health nursing education. The major themes included: lack of support of the standards (CHNAC-SP) in practice or lack of recognition in the province, limitations in placement activities (i.e. access to administration of immunizations, access to the care of vulnerable populations); and limited exposure to a variety of placements for students (i.e. public health placements are not available or are only observational).

Finally, the educational institution had a significant role to play that influenced the curriculum and placements in community health nursing. Respondents identified multiple factors that caused negative relationships between faculty and the clinical agency/preceptor. Major barriers included: a disconnect between the agency and the educational institution's clinical expectations; the theory /practice divide; and, a lack of time allotted for students in community clinical placements to develop relationships with communities, therefore many of the placements remain more observational in nature. These factors, combined with the organization/agency/manager and/or practice environment, influenced the availability of preceptors and appropriate practice environments.

A large number of respondents cited, with appropriate and adequate communication between all stakeholders, the multiple competing priorities for both the educational institution and the agency may be addressed and new relationships built. One example of a successful program, described by a respondent, that considered many of the issues from various perspectives and enabled communication between all stakeholders included a multi-pronged approach, key points include; legislation that created a structure for collaboration between education and health sectors; the approach by faculty with nurse leaders/ preceptors being very collaborative in nature; course objectives explained with consultation opportunities with preceptors; and the creation of a formal position supported by the educational institution to help preceptors work with students.

Recommendations from the symposium participants

The final question solicited feedback from respondents who participated in the round table discussion at the symposium as well as the nursing leaders meetings that asked about recommendations to CASN to enhance community health curriculum within educational programs. The following are the most frequently identified recommendations:

1. CASN to network with other stakeholders to advocate strongly for provisions of financial support for infrastructure to develop and maintain community placements.
    a. Dialogue with PHN leaders to support education, (release time for faculty to negotiate)
    b. Create/evaluate formal partnerships with agencies
    c. Promote the concept of cross-appointed faculty (between academe and practice)
    d. Advocate with health regions to increase placements

These recommendations were addressed in responses to questions 2, 3, 4 and 5. Through accreditation and advocacy for community health nursing, the respondents provided examples of how barriers (as identified in Part 2) could be addressed. Some respondents acknowledged the partnership between CASN

and PHAC to provide a context to which dialogue regarding infrastructure to support clinical education at many levels. Many of the respondents felt if the components of the above recommendations were addressed at multiple points in educational institutions and agencies, community health nursing within programs would be recognized.

2. CASN to promote curricular enhancements to baccalaureate programs in member schools (Benchmarks)
   a. Encourage monitoring of balance of community versus acute care placements and curriculum content
   b. Ensure community health has equal value to acute care content in curriculum.
      This recommendation was addressed from various perspectives however the most significant was its relationship to the practice environment. The urgent consideration is for CASN to evaluate the allocation of time and resources for acute care clinical placements and the equitable time allocation and resources for community clinical placements. This recommendation was also identified during the symposium day by one table and was related to the increasing importance of community curriculum to support faculty to develop the relationships necessary to support community partners.

   c. Produce papers on best practice in PH education

3. Make Public Health-Community Nursing a specialty program within the undergraduate curriculum.
   It was identified by the majority of respondents that community health nursing is a specialty within nursing and most indicated that to enhance curricula, students should have the opportunity to choose a community stream within their final year. The rational for this may be twofold; as quality community placements are difficult to find, as well as the time committed to a community practicum within a generic program diminishes, a specialty stream would reduce the number of students requiring placements and increase a designated amount of time to complete important projects (i.e. community development, program planning). The following quote demonstrates the type of responses associated with this recommendation:
   " Advocate for community, public health as practice disciplines requiring specialized skills and development in undergraduate education"

The remaining recommendations as identified from the respondents' perspectives included:

4. Advocate for the standards reflected in national nursing exam
5. Include public health education in accreditation standards
6. Faculty teaching community health nursing must have community health experience
7. Faculty actively involved with the development of community placement opportunities (supported with the administration of the SON for time and resources to develop strong partnerships)
8. Support the development of public health, community health nursing chairs
9. Assist nursing programs to meet CHN standards

Part IV

Task force recommendations

When all the participants' recommendations and other data were considered, the following are the recommendations of the Task Force to the Board of Directors of CASN.

1. CASN promote enhancements to structures for quality measurements of baccalaureate nursing education:
    a) Direct the Accreditation Bureau to consider the inclusion of targets within the accreditation standards specific to curriculum and resources relative to unique nursing content areas, beginning with community health
        I. Schools demonstrate an equal attention of curriculum (coursework and mandatory clinical practice) and resources to acute/hospital and community nursing education
        II. Schools demonstrate that faculty assigned to specific content portfolios (e.g. community health nursing) have or are encouraged and assisted to acquire current practice knowledge and experience relative to the portfolio
        III. Schools demonstrate that competencies such as national and provincial entry-level competencies, as well as specialty competencies e.g. Community health nursing as per CHNAC and Public Health (modified to reflect entry-level) have been addressed in the curriculum
        IV. Schools demonstrate that each student has opportunities and completes a mandatory clinical rotation in community health nursing within the upper levels of the program.
        V. Schools demonstrate adequate resources to provide comprehensive supervision of students in clinical practice (e.g., faculty/student ratio of 1:8 in ALL practica except preceptorship experiences).
        VI. Schools demonstrate that within the program there are opportunities for students to apply the CHN program planning process
    b) Promote the use of community health nursing entry-level standards and competencies in the creation of the Canadian Registered Nursing Examination.

2. CASN promote curricular enhancements in community health nursing of baccalaureate programs of member schools
    a) Produce a position statement on community health content in baccalaureate nursing education
    b) Encourage schools to ensure there is equivalency in curricular emphasis and resources available between acute/hospital care and community health nursing
    c) Serve as a repository of best practices, curricula and resources (e.g., teaching tools) for content topics currently not well covered.
    d) Partner with other stakeholders to create a community health nurse educators network through electronic means
    e) Partner with other stakeholders to facilitate regional and/or national fora for community health nursing educators

3. CASN network with other stakeholders to advocate for provisions of financial and other support for infrastructure for community placements.
    a) Dialogue with PHN leaders to support education
    b) Encourage stakeholders to create/evaluate formal partnerships between education and practice

c) Promote the increase in number of preceptors in community health nursing, encourage the creation of criteria for selection of community health nursing preceptors, and modification of workloads for those nurses who agree to precept nursing students, and promote the use of incentives for preceptorship participation.
d) Promote the concept of cross-appointed faculty (practice & academe)
e) Advocate with health regions and educational institutions to target resources for the purpose of increasing placement opportunities (e.g., assisting with student transportation costs, rural incentives in Newfoundland/Labrador)
f) Promote relationship and partnership building as legitimate expectations of faculty workload and include as factors in tenure and promotion decisions
g) Advocate for and contribute to media campaign to highlight community health nurse's work
h) Advocate for increased and sustainable public/community health nursing research chairs
i) Utilize information on best practices in community health clinical placements as may be identified by the findings from the CASN commissioned research studies on clinical placements which are due in the spring of 2007

Canadian Association of Schools of Nursing
Association canadienne des écoles de sciences infirmières

Appendix

ACRONYMS

English	French
CASN - Canadian Association of Schools of Nursing	**ACESI** - Association canadienne des écoles de sciences infirmières
CHNAC - Community Health Nurses Association of Canada	**ACIISCC** - Association canadienne des infirmières et infirmiers en santé communautaire du Canada
ANDSOOHA - Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario	**ANDSOOHA** - Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario
CPHA - Canadian Public Health Association	**ACSP** - l'Association canadienne de santé publique
PHAC - Public Health Agency of Canada	**ASPC** - l'Agence de santé publique du Canada
CNA - Canadian Nurses Association	**AIIC** - L'Association des infirmières et infirmiers du Canada

GLOSSARY

Definitions are from the Canadian Community Health Nursing Standards of Practice[2] (http://www.communityhealthnursescanada.org/Standards.htm) unless otherwise stated.

Access/Accessibility: Accessibility of health care refers to the extent to which community health nursing and other health services reach people who need them most and how equitably those services are distributed throughout the population (Stanhope & Lancaster, 2001). Accessibility may also refer to the extent to which people have access to material, social and other resources for health [see 'equity'].

Acceptability: The extent to which health programs and delivery methods are acceptable to individuals and communities, responsive to their needs across the life span (CHNAC, 2003).

Advocacy: A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme. (WHO, 1998, p.5)

Caring: Community health nurses recognize that caring is an essential human need but that its expression in practice varies across cultures and domains. The importance of caring in community health nursing is seen as essential and universal. In the Canadian context of community health nursing practice, caring is based on the principle of social justice, in which the nurse brings an awareness of equity and the fundamental right of all humans to accessible, competent health care and essential determinants of health. Caring is expressed through competent practice and the development of a connective relationship that values the individual/community as unique and worthy of a nurse's "presence" and attention. Caring community health nursing practice acknowledges the physical, spiritual, emotional and cognitive nature of individuals, families, groups and communities. Community health nurses enact their belief in caring by preserving, protecting and enhancing human dignity in all of their interactions.

Collaboration: An approach to community care built on the principles of partnership and maximizing participation in decision-making. Collaboration includes shared identification of issues, capacities and strategies. *Intersectoral collaboration:* A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone. (WHO, 1998, p.14)

Community: A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them. (WHO, 1998, p.5)

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[2] Community Health Nurses Association of Canada (CHNAC), "The Canadian Community Health Nursing Standards of Practice," CHNAC, May, 2003.

Community as context : The recipient of care (client) is the individual, family or group (e.g.corrections), who are centred in the community.

Community as partner: The recipient of care (client) is the community or population (e.g immunization protocol for a health region).

Community development: The process is based on the philosophical belief that people and communities are entitled to have control over factors that affect their lives. It is grounded in valuing absolute worth of the individual and starting where they are. It is a process that is used frequently (although not exclusively) with the most disenfranchised groups in society. It is a process of involving a community in the identification and reinforcement of those aspects of everyday life, culture and political activity that are conducive to health. This might include support for political action to modify the total environment and strengthen resources for healthy living, as well as reinforcing social networks and social support within a community and developing the material resources and economic base available to the community. (CPHA, 1990)

Connecting: The establishment of a perception of connection, engagement, attachment, or bonding between the nurse and the family member(s). There are three components: making the connection, sustaining the connection, and breaking the connection. (Davis and Oberle, 1990)

Cultural Competence: A process that begin's with one's willingness to learn about cultural issues, proceeds with the commitment to incorporate at all levels of care the importance of culture, and is operationalized by making adaptations in services to meet culturally unique needs. An awareness and acceptance of cultural differences is required as a first step in the process of becoming a culturally competent individual (Anderson & McFarlane, 2004).

Determinants of Health: The Federal, Provincial, Territorial Advisory Committee on Population Health (1999) identifies the following determinants or prerequisites to health: the determinants of health including social, economic and environmental health determinants: a) income and social status, b) social support networks, c) education, d) employment and working conditions, e) social environments, f) physical environments, g) biology and genetic endowment, h) personal health practices and coping skills, i) healthy child development, j) health services, k) gender, and l) culture (Health Canada, 2000).

Empowerment: Community health nurses recognize that empowerment is an active, involved process where people, groups, and communities move towards increased individual and community control, political efficacy, improved quality of community life, and social justice. Empowerment is a community concept because individual empowerment builds from working with others to effect change and includes the desire to increase freedom of choice for others and society. Empowerment is not something that can be done to or for people, but involves people discovering and using their own strengths. Empowering strategies or environments (e.g. healthy workplaces such as those supporting flex time or exercise) build capacity by moving individuals, groups and communities towards the discovery of their strengths and their ability to take action to improve quality of life.

Epidemiology: The study of the distribution and determinants of health-states or events in specified populations, and the application of this study to the control of health problems.
(Last, J.M., 2000)

Equity: Accessible services to promote the health of populations most at risk of health problems. (Stanhope & Lancaster, 2001) *Equity* means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being; all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health. (WHO, 1998, p.7) Strictly speaking, equity is not the same as equality. Inequity in health refers to a systematic inequality in health (or its social determinants) between more or less advantaged social groups; in other words, a health inequality that is unjust or unfair (Braveman & Gruskin, 2003).

Evidence Based Practice: Nursing practice is based on various types of evidence, including experimental and non-experimental research, expert opinion, and historical and experiential knowledge, shaped by theories, values, client choice, clinical judgment, ethics, legislation, and work environments. Evidence based decision-making is a continuous interactive process involving the explicit, conscientious and judicious consideration of the best available evidence to provide care. (Canadian Nurses Association, 2002b)

Group: People who interact and share a common purpose or purposes. Note: There is no clear distinction between a group and a community except that groups tend to have fewer members than a community. The means used to plan and provide programs or activities for both are similar except for scale.

Health Promotion: Health promotion is the process of enabling people to increase control over, and to improve their health. (WHO, CPHA, Health and Welfare Canada, 1986)

Health Outcomes: A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status. Outcomes may be for individuals, groups or whole populations. (WHO, 1998, p. 20) *Intermediate health outcomes:* Intermediate health outcomes are changes in the determinants of health, notably changes in lifestyles, and living conditions which are attributable to a planned intervention or interventions, including health promotion, disease prevention and primary health care. (WHO, 1998, p.14)

Inter-sectoral cooperation**:** recognizes that health and well-being are linked to both economic and social policy. Inter-sectoral means experts in the health sector working with experts in education, housing, employment, immigration, etc. It also means health professionals from various disciplines collaborate and function interdependently to meet the needs of Canadians. Inter- and intra-sectoral cooperation is needed to establish national health goals or "standards," as well as to the development of healthy public policy and the planning and evaluation of health services. While nursing has adopted primary health care as a method to improve the health of Canadians, it has not become a focus for the Canadian health care system.

Jakarta Declaration: five priorities of the Jakarta Declaration:

- Promote social responsibility for health
- Increase investments for health development
- Expand partnerships for health promotion
- Increase individual and community capacity
- Secure an infrastructure for health promotion.

Quality Practice Environments: Nurses have an obligation to their clients to demand *practice environments that have the organizational and human support allocations necessary for safe, competent and ethical nursing care*. A quality nursing professional practice environment is one in which the needs and goals of the individual nurse are met at the same time as the patient or client is assisted to reach his or her individual health goals, within the costs and quality frame work mandated by the organization where the care is provided. Developing and supporting quality professional practice environments is a responsibility shared by practitioners, employers, governments, regulatory bodies, professional associations, educational institutions, unions and the public. (Canadian Nurses Association Position Statement on Quality Professional Practice Environments for RNs – http://www.cna-nurses.ca/CAN/practice/environment/default_e.aspx)

Maintenance: Designed or adequate to maintain a patient in a stable condition: serving to maintain a gradual process of healing or to prevent a relapse. (Merriam-Webster, 2003)

Nursing Informatics: Integrates nursing science, computer science, and information science to manage and communicate data, information, and knowledge in nursing practice. Nursing informatics facilitates the integration of data, information, and knowledge to support clients, nurses, and other providers in their decision making.

Program Delivery Types:

Standard generic	Entire curriculum is offered and delivered at University site.
Collaborative	A program runs in partnership between a University and another institution.
Compressed	The program is packed together and delivered in a shorter time frame.
Fast track	The program is delivered in a shorter frame, using summer semesters.
Accelerated	Students hold a baccalaureate degree and enroll in a two year program.
Advanced standing	The student is given credit for previous learning and/or experience.
Second-entry level	Mature candidates with both university and life experience enroll in a two-year program.

Public Health Science: Areas of knowledge deemed essential for preparation of community health nurses which include epidemiology, biostatistics, nursing theory, change theory, economics, politics, public health administration, community assessment, management theory, program planning and evaluation, population health and community development theory, history of public health and issues in public health. (Stanhope & Lancaster, 2001)

Restoration: Returning to a normal or healthy condition. (Merriam-Webster, 2003)

SAMPLE OF THE SURVEY IN SURVEY MONKEY

The following is an explanation of the categories of replies to survey questions:

Check all that apply.

	Core (required) theory course	Required practicum	Required segment of course	Core thread throughout courses	Selected nursing elective	Not covered	Future plans to add
Community assessment	☐	☐	☐	☐	☐	☐	☐
Asset/strength-based approach	☐	☐	☐	☐	☐	☐	☐
Determinants of health	☐	☐	☐	☐	☐	☐	☐

Core (required) theory course: content is the entire focus of a course, consisting of a series of lectures, labs, and/or seminars, that is assigned a title, a number, and a specified number of credits as part of the requirements that must be completed for graduation with a baccalaureate degree in nursing

Required practicum: content is covered in a clinical practice course that is assigned a title, a number, and a specified number of credits as part of the requirements that must be completed for graduation with a baccalaureate degree in nursing; this does not include a community health experience that is part of a theory course e.g. observation, community health assessment/development projects

Required segment of course: content is covered as an essential component of a core theory course; it may be part of one or more lectures, labs, and/or seminars or may be an assignment, a module, and/or a problem-based learning case

Core thread throughout courses: content is integrated in more than one course based on the curriculum conceptual framework

Selected Nursing elective: content in an optional university nursing credit course that may be taken as part of the requirements for nursing degree completion; it is chosen by the student rather than imposed by the nursing program, although the choice may need to be approved.

Not covered: the concept is not included in any part of the teaching/learning of the present curriculum.

Future plans to add: discussion has begun regarding changing the curriculum to include this