



MAXIMIZING COMMUNITY
HEALTH NURSING
CAPACITY IN CANADA:
A RESEARCH SUMMARY
FOR DECISION MAKERS

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**REPORT OF THE NATIONAL
COMMUNITY HEALTH
NURSING STUDY**

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TABLE OF CONTENTS

| | |
|---|----|
| Research Team: | 5 |
| Acknowledgements: | 5 |
| Main Messages | 1 |
| Executive Summary | 2 |
| Community health nurses in Canada..... | 2 |
| Enablers for effective community nursing practice | 2 |
| Attributes of Supportive Public Health Employers | 3 |
| Context | 3 |
| Implications | 4 |
| Enablers for Effective Community Nursing Practice | 4 |
| Attributes of Supportive Public Health Organizations | 5 |
| Approach | 6 |
| Results | 7 |
| Community Health Nurses in Canada..... | 7 |
| Enablers for Effective Community Nursing Practice | 9 |
| Work Environment | 11 |
| Community Context | 13 |
| Attributes of Supportive Public Health Organizations | 13 |
| Government and System Attributes | 14 |
| Organizational Culture: Values and Leadership Characteristics | 14 |
| Management Practices | 14 |
| Further Research | 17 |
| References | 18 |
| Appendix A | 20 |
| Public Health Focus Group Participants | 20 |



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MAIN MESSAGES

- ▶ Results of our study provide helpful information for decision makers at all levels to strengthen community health nursing capacity. We have provided a starting point for planning with an overview of the community nursing workforce and the perspectives of approximately 7,000 community nurses on optimal conditions for them to do their jobs effectively.
- ▶ More than 46,000 registered nurses and 7,000 licensed practical nurses work in community health in Canada, about 16% of the nursing workforce. Community nurses are older than the nursing profession in general, and there are fewer younger nurses entering community health. Community health nursing needs to be seen as a desirable and fulfilling career to continue to attract and keep nurses and to meet the growing demand for community-based care.
- ▶ There are limitations for counting CHNs because:
 - Provincial and regional health authorities organize and identify similar programs differently
 - Inconsistent and interchangeable terms are used by CHNs to identify themselves
 - Although attempts have been made to align data collection, regulatory bodies continue to utilize some inconsistent terminology.
- ▶ Careful attention to supports for community nurses to practice their full scope of competencies will improve recruitment and retention, make more efficient use of available community nursing resources and contribute to improved health outcomes in Canada's communities.
- ▶ Community nurses are most effective in workplaces where they share the vision and goals of their organization and work collaboratively in an atmosphere that supports creative, autonomous practice.
- ▶ Community nurses work well together, but need time, flexible funding and management support to sustain relationships with the community and their clients and to build teams with other professionals.
- ▶ Employers and managers should support community nurses to keep up to date with more access to continuing education, policies, procedures, evidence and debriefing sessions, so nurses can maintain their competencies and confidence in their professional abilities.
- ▶ Effective community health leaders (from senior government levels to local managers) publicly acknowledge community health nurses and openly promote their programs and services. These leaders create a culture that encourages creativity and innovation and empowers community nurses and their colleagues to be effective in their roles.

EXECUTIVE SUMMARY

Nursing has always been an integral part of community healthcare, and that role will grow in the future. Rising hospital and long-term care costs, medical breakthroughs and new attitudes toward care are all driving demand for improved home care, public health, primary healthcare and other community care services. This move to community health requires careful human resources planning to ensure adequate skilled staff are available to deliver services and are used to their full potential.

We did this three-part study as a first step toward meeting the information needs of health system administrators, planners and policy makers as they develop human resources policies for community health. We set out to answer three broad questions about community health nursing:

- 1) Who makes up the community nursing workforce and where do they work?
- 2) What are enablers and barriers to community nurses working effectively?
- 3) How can organizations support public health nurses to practise the full scope of their competencies?

COMMUNITY HEALTH NURSES IN CANADA

We started by developing a demographic profile of community. We used a broad definition that encompasses all nurses that work outside hospitals and long-term care institutions, including nurses working in private agencies, educational institutions, government/ associations or self-employed, and if their area of responsibility was community health, public health, home care, ambulatory care, or occupational health. Among community nurses, most registered nurses work in community health centres or home care, and licensed practical nurses typically work in home care and physicians' offices. Most nurse practitioners work in community health centres, nursing stations or physicians' offices.

More than 53,000 registered and licensed practical nurses work in community health in Canada – about 16% of the nursing workforce. The number of registered nurses in community health rose by over 11,000 between 1996 and 2007, to 46,273 in 2007 (18% of all Canadian registered nurses). Far fewer licensed practical nurses are community-based (7,131, or 10% of the total), while half of all nurse practitioners (301) work in the community.

Community nurses are older on average than other nurses. In 2007, 28% of registered nurses who worked in the community were over 55. Younger nurses (under 30) dropped from 9% to 5% between 1996 and 2007. In 2007, 9.5% of community-based licensed practical nurses were over 60, higher than all other health sectors.

ENABLERS FOR EFFECTIVE COMMUNITY NURSING PRACTICE

From survey responses from more than 6,600 community health nurses across Canada, we identified enablers for effective practice in four main themes: professional confidence, good team relationships, supportive workplaces, and supportive communities.

Over 90% of nurses said they are confident they can practice autonomously, communicate decisions to managers and advocate for changes. Most nurses rated teamwork with other nurses highly, and many work well with other professionals. But notably fewer nurses said they have strong relationships with physicians (68% of registered nurses and 70% of licensed practical nurses). Fifty-three percent of registered nurses and 66% of licensed practical nurses agreed that clients understood their roles, worked in partnership or trusted nurses from their agency. Community nurses' feelings about salary and security are mixed, and most nurses would like more learning opportunities, policy and practice information and chances to debrief about work. Nurses consider supportive communities to be those that try to

improve social conditions, but just less than half the registered nurses felt their communities address social determinants of health and even fewer (38%) said clients have timely access to good quality community resources.

ATTRIBUTES OF SUPPORTIVE PUBLIC HEALTH EMPLOYERS

For a more in-depth analysis, we held 23 focus groups to determine organizational attributes that best support nursing practice in public health. We believe these findings are relevant for all community nurses. If organizations offer the right support, their community nurses will deliver effective work and successful programs. The focus groups identified supports at different levels of the system — government, organizational culture and management practices. The most important attributes identified by the focus groups are:

- ▼ *Flexibility*: Flexible funding, program design and job descriptions let nurses respond to community needs and local cultures.
- ▼ *Clarity*: A clear vision for the organization should be based on shared values, and clear planning should be coordinated across jurisdictions and strongly grounded in community needs.
- ▼ *Room for creativity and independence*: Public health nurses need autonomy to work effectively, and they need to be recognized as leaders who can determine the right thing to do for their clients.
- ▼ *Strong leaders and champions*: Nurses work most effectively when their managers and organizations openly promote public health, value their staff's work and invest in professional development.

CONTEXT

Healthcare delivery has changed profoundly in the past two decades and will continue to do so. Canada's population is aging, and this shift is creating many pressures for healthcare. The surge in chronic disease reinforces the need for prevention and community management to keep people out of acute care. There are new and evolving communicable diseases such as H1N1. Our growing understanding of the social determinants of health also has brought awareness that healthcare must work with people at multiple levels and throughout their lives to improve the overall health of Canadians.¹

At the same time, rising costs associated with hospital and long-term care beds, medical breakthroughs and new attitudes toward care are driving demand for improved home care, public health, primary healthcare and other community care services. This move to community health requires careful human resources planning to ensure adequate skilled staff are available to deliver services and are used to their full potential. Nurses have always been an integral part of community care, and their role will grow in the future. The Canadian Nurses Association predicts that 60% of all nurses will be working in the community by 2020.²

Health system administrators, planners and policy makers need solid data to build an effective community nursing workforce and meaningful jobs that take full advantage of nurses' education and experience. However, there is not much research on community nurses, perhaps because community nursing is by nature more diffuse and varied than nursing in large, structured institutions and therefore harder to define and research.

We did this three-part study to begin to fill these information gaps. We started with a demographic profile of today's community nurses, followed by a survey of community health nurses and focus groups within public health to find out about supports for effective nursing practice. Our specific research objectives were to:

- 1) Describe and analyze the demographic characteristics and distribution of community nurses in Canada — by number, workplace, age, employment status, education, gender, position and province/territory.
- 2) Identify and compare, across political jurisdictions and community health sub-sectors, enablers and barriers to community nurses working effectively.
- 3) Determine what organizational attributes support public health nurses to use the full scope of their competencies.

“Community health nurse” is the common title used to describe all nurses who work outside of hospitals or long-term care. In 2007 about 16% of nurses in Canada worked in the community compared to other health sectors. However, determining how many nurses work in the different community sub-sectors and describing their demographics can be complicated. Their job titles and how they describe their workplaces vary from province to province and even from organization to organization and nurse to nurse. We hope this study will provide a baseline analysis about community nurses until more consistent and complete information is available.

Despite the variety of jobs in community nursing, there are skills, knowledge and attitudes common to all of them.³ Community nurses have generally agreed on their roles.⁴⁻⁷ The Core Competencies for Public Health in Canada further clarified the competencies necessary to practise public health.⁸ But nurses may not be able to meet the standards they set for themselves if the organizations they work for don’t adequately support their work. Supporting nurses to work more effectively, on the other hand, should lead to more efficient use of funding, improve the results of community and public health programs (as nurses are the single largest group of public health employees⁹) and prevent more illnesses and injuries. It could also be an important step in encouraging people to take control over improving their own health.

IMPLICATIONS

ENABLERS FOR EFFECTIVE COMMUNITY NURSING PRACTICE

Supporting community nurses to practice their full scope of competencies will improve recruitment and retention and make more efficient use of available community nursing resources. We offer these recommendations for decision makers and policy makers on how this workforce can be used to its full capacity and potential:

Employers and managers:

- ▼ Improve access to continuing education and evidence, and encourage community nurses to keep up to date, maintain their competencies, and maintain their confidence in their professional abilities.
- ▼ Improve northern and outpost nurses’ access to information and provide resources to help them meet their clients’ needs.
- ▼ Assign fair workloads and ensure safe work environments.
- ▼ Increase the organization’s understanding of community nursing practice and roles, including the different roles of registered nurses and licensed practical nurses.
- ▼ Demonstrate trust in nurses, recognize their contributions, and involve them in program planning.
- ▼ Support nurses to work independently, give them flexibility to meet client needs, and provide opportunities for debriefing.

- ▼ Support nurses to build relationships and partnerships with other professionals and with communities; provide training opportunities on successful teamwork.
- ▼ Initiate public relations efforts at local and provincial levels to educate the public about the services that community nurses provide.

Federal, provincial/territorial and community policy makers:

- ▼ Help organizations identify and integrate strategies and services to address the social determinants of health.

ATTRIBUTES OF SUPPORTIVE PUBLIC HEALTH ORGANIZATIONS

The following recommendations for developing organizational supports for public health nursing practice will require integrated action at all levels of the system. Our findings for the public health sub-sector likely have implications for all community health nurses. For policy makers and administrators to make the best use of the community nursing workforce, we also recommend similar investigations in other community health sub-sectors.

Public Health Agency of Canada, provincial/territorial ministries of health and local health authorities:

- ▼ Provide funding to develop leaders and managers at all levels of public health.
- ▼ Coordinate public health planning at every level and across jurisdictions to create a common vision with clear goals and responsibilities, share resources and reduce duplicated services.
- ▼ Collaborate on communication strategies to promote public health and increase understanding of its role in healthcare.
- ▼ Support local health authorities in developing and sharing learning resources with public health educators, paying special attention to the learning and knowledge exchange needs of public health nurses in rural and remote areas.

Employers and managers:

- ▼ Plan nursing services based on evidence of their impact and results, and allow nurses room to be creative and responsive to the community's needs.
- ▼ With practitioners, share responsibility for creating healthy workplaces, based on evidence.
- ▼ Work with academic researchers to gather information and develop staffing models that allow for changing needs — including emergencies, epidemics and the growing prevalence of chronic disease.
- ▼ Understand the role of the public health nurses who work for them and make it possible for nurses to work to the full scope of their competencies.
- ▼ Keep program funding flexible and ensure public health nurses can work autonomously on community development and partnerships to improve health outcomes.
- ▼ Invest in professional development to provide public health nurses with learning opportunities, set clear benchmarks, and support nurses' participation.
- ▼ Collaborate with provincial authorities and educators on recruitment and retention strategies, including integrating internationally educated nurses and ensuring undergraduate education covers community health issues.

APPROACH

The methods we used in our study included a demographic analysis, survey and focus groups. We also used a broad definition of community health nursing (see Figure 1). We had ethics approval from McMaster University, the nursing regulatory bodies that gave us access to their members for the survey, and employers who encouraged participation in the focus groups.

Demographic analysis:

The Canadian Institute of Health Information (CIHI) collates data provided by provincial and territorial regulatory bodies. We analyzed data for 1996 to 2007 for registered nurses and for 2002 to 2007 for licensed practical nurses (data for licensed practical nurses are only available from 2002 in the CIHI database).¹⁰ We supplemented these data with demographic information obtained from our survey of community health nurses (see below).

Survey:

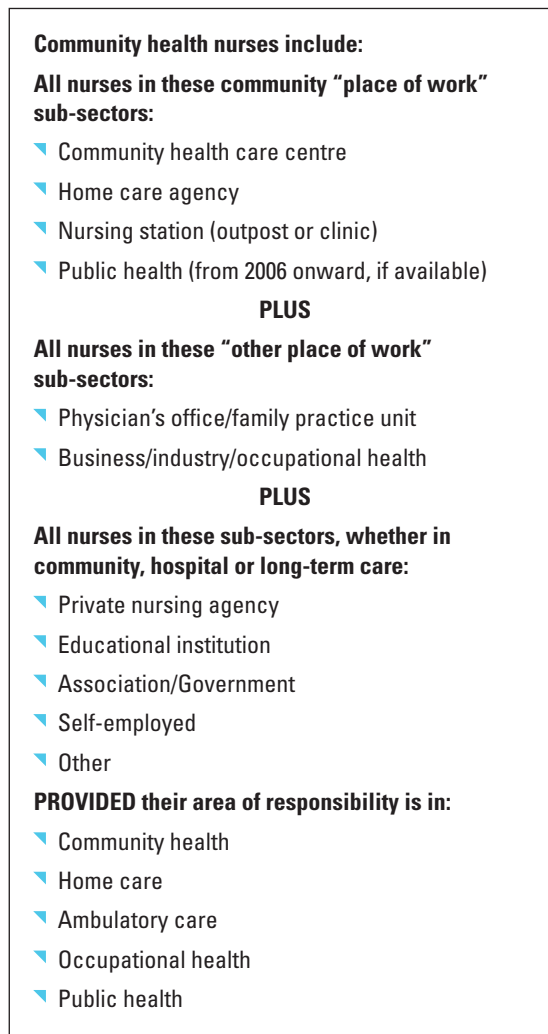
We used the Nursing Health Services Research Unit Community Health Nurses Questionnaire[®] to explore enablers and barriers to effective nursing practice.¹¹ All nurses who identified themselves as a community nurse, whether front-line or management, were eligible for the study if they had agreed to participate in research on their annual nursing registration forms. The survey was available in English, French and Inuktitut. It was sent to a random sample, stratified by province/territory, of 13,772 community nurses (10,358 registered nurses and 3,414 licensed practical nurses). We used Dillman's four-step evidence-based protocol to distribute the questionnaire.¹² There was an overall response rate of 57% (60% of registered nurses and 49% of licensed practical nurses responded). A total of 7,839 nurses completed the questionnaires, but 1,172 did not fit the definition, leaving 6,667 responses that could be used for the analysis. We weighted the responses to compensate for oversampling in Ontario, as well as different population and response rates across provinces and territories.

Exploratory and confirmatory factor analyses revealed factors that were relatively consistent with the themes previously identified in the questionnaire for enablers and barriers. The factors and independent questions were analyzed using one-way ANOVA and Tukey post-hoc tests or Kruskal-Wallis and Mann-Whitney nonparametric tests.

Focus groups

Because of funding and time limits, we focused on one sub-sector of community health — public health nursing — for an in-depth look at organizational attributes that support effective practice. We held 23 focus groups with a total of 156 participants: 12 groups of front-line nurses (working in urban or rural/remote areas) and 11 groups of public health policy makers and managers (also from urban or rural/remote areas) (see Appendix A). Participants came from all provinces and territories, and focus

FIGURE 1. COMMUNITY HEALTH NURSE: A DEFINITION BASED ON THE CANADIAN INSTITUTE FOR HEALTH INFORMATION NURSING CATEGORIES



groups met in six geographic regions: British Columbia, Prairies, Northern Canada, Ontario, Quebec and Atlantic Canada. Nurses who worked in prevention and health promotion in organizations focusing on public health were eligible for the study.

We wanted to uncover the circumstances that help public health nurses work effectively, so we used an “appreciative inquiry” approach.¹³⁻¹⁵ Appreciative inquiry focuses on building on strengths rather than trying to fix what doesn’t work. We asked participants to think of an experience when an intervention by public health nurses worked very well and what factors made it work. After small-group discussions, participants wrote down the organizational attributes that contributed to the successful experience.

We did the qualitative analysis of the feedback in three stages. Using a nominal group process adapted from the Institute for Cultural Affairs methodology,¹⁶ the focus groups discussed the statements they had written, clarified meanings, insights and interpretations, and produced a thematic analysis. Then we used established procedures for thematic analysis¹⁷ to collate, organize, analyze and compare the results from the four categories of focus groups (urban front line, rural/remote front line, urban policy maker/manager, rural/remote policy maker/manager). Finally, we worked with the decision makers on our research team to refine the identified themes, focusing on main messages and recommendations.

RESULTS

COMMUNITY HEALTH NURSES IN CANADA

The community nursing workforce is made up of registered nurses (including nurse practitioners) and licensed practical nurses (called registered practical nurses in Ontario). As the first part of our study, we developed a demographic profile of community health nurses including their number, workplace, age, employment status, education, gender and position.

Number:

Based on the definition in Figure 1, there were 53,404 nurses working in the community in 2007. The proportion of community nurses in the total nursing workforce remained stable at about 16% from 2002 to 2007 (Table 1).

TABLE 1 – NURSES WORKING IN COMMUNITY HEALTH COMPARED TO OTHER HEALTH SECTORS*

| Health Sector | Registered Nurses and Licensed Practical Nurses (%) | | | | | |
|---|---|---------|---------|---------|---------|---------|
| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
| Community | 16.1 | 15.7 | 15.8 | 15.6 | 15.8 | 16.3 |
| Hospital / Long-term care / Other / Not stated | 83.9 | 84.3 | 84.2 | 84.4 | 84.2 | 83.7 |
| Total number of nurses | 291,016 | 304,480 | 310,000 | 316,174 | 320,248 | 327,670 |

*Source: Canadian Institute for Health Information nursing databases, 2002-2007.¹⁰

In 2007, 18% of registered nurses worked in the community. Although the supply of registered nurses in community health rose steadily from 34,696 in 1996 to 46,273 in 2007,¹⁸ the ratio of community nurses to the total supply of nurses peaked in 2001 and then declined slightly until 2006 (Table 1). Just 10% of Canada’s licensed practical nurses (7,131) worked in the community in 2007. Over half of Canada’s nurse practitioners are community-based; from 2003 to 2007 the number of nurse practitioners working in the community more than doubled (349 to 739).¹⁸

Workplace:

According to the CIHI database, most registered nurses work in community health centres or home care. The number of registered nurses in health centres increased over the past 10 years, from 38.5 to 59% of total registered nurses in the community (13,372 to 27,299), but most of the other community sub-sectors had a slight decline in their numbers of registered nurses. Most licensed practical nurses in the community work in home care, but their numbers decreased from 2002 to 2005, while the number working in community health centres increased. One-quarter of licensed practical nurses work in physicians' offices. Nurse practitioners typically work in community health centres, nursing stations or physicians' offices.

As primary healthcare reform continues, more community health centres will likely open.¹⁹ However, the definitions of community health centresⁱ and the services they offer vary across provinces, as do the names of community nurses' workplaces and their job titles. In some provinces people who described themselves as public health nurses were as likely to work in a community health centre as a public health unit. Even in provinces where public health departments are more clearly delineated, some public health nurses said they work in community health centres, though most said they work in public health units. This led us to use the "position in nursing" category rather than "place of work" to determine roles.

Age:

Community nurses on average are older than the general nursing profession. In 2007, 28% of registered nurses who worked in the community were over 55, up from 13% in 1996, and older than registered nurses overall. Between 1996 and 2007 the percentage of community registered nurses under 30 dropped from 9% to 5% while profession-wide, the under-30 age group remained fairly stable at about 10%. The decrease in the number of younger community nurses is substantial and more than a relative decrease due to older nurses staying on. There were only small differences in the age distribution of licensed practical nurses in the community and those in other settings from 2002 to 2007. However, in 2007 the percentage of community-based licensed practical nurses over 60 years was 9.5%, higher than in all other health sectors (7%).

Employment status:

In 2007 more than 54% of community registered nurses had full-time jobs and 31% worked part-time. Our survey of community nurses showed that public health nurses are more likely to work full-time and nurses in home care are more likely to work part-time. Historically, community registered nurses were slightly more likely to work full-time than hospital nurses, but that ratio reversed in 2005, possibly because of a government policy to encourage more full-time hospital jobs. Community health nurses have a slightly greater tendency for more casual work and less part-time work.

The CIHI database showed an increase in the number of full-time jobs among community licensed practical nurses, up from 42% in 2002 to 51% in 2007, but we can't tell if that's because fewer are listed as having unknown job status or there really was an increase. Licensed practical nurses in all sectors appear to be less likely to work full-time than registered nurses, but a significant percentage of practical nurses are listed as "unknown" job status, so there may be some inaccuracy in these estimates. Nurse practitioners are much more likely to have full-time jobs (60% overall), and full-time jobs for nurse practitioners in the community rose from 61% in 2001 to 71% in 2005 (with a noticeable decrease in casual and part-time jobs).¹⁰

ⁱ Community health centres differ across provinces, but they generally provide primary healthcare services, illness and injury prevention, chronic disease management and community development, using a population health promotion approach and a multidisciplinary team. The teams often include physicians, nurses, social workers, dietitians, counsellors and other healthcare providers.

Education:

Community nurses tend to have more education than nurses overall. Registered nurses who work in the community are more likely to have a university degree than nurses in other sectors. This gap is closing, from twice as many in 1996 to 1.5 times in 2007, because registered nurses in most of Canada are now required to have baccalaureate degrees. Public health nurses are most likely to have a degree (81% in our survey did), probably because most provinces have required them to have a baccalaureate in nursing.³

For licensed practical nurses, those in the community are slightly more likely to have a diploma than an equivalency level. Between 2001 and 2005 the percentage of community nurse practitioners with a diploma decreased approximately 18%, while those with a baccalaureate and graduate education increased.¹⁰ Their level of education is similar to all nurse practitioners.

Gender:

Male nurses are the minority everywhere, but there are even fewer in community positions. In 2007, 3.5% of male registered nurses worked in the community, compared to 6% in other health sectors. There also were fewer male licensed practical nurses in the community (4.2%) than in other sectors (7.3%). By 2005, the proportion of male nurse practitioners in the community was lower than in other sectors, but that was a change from 2001–2003.¹⁰

Position:

In 2007 less than 15% of registered nurses in chief nursing officer or chief executive officer positions worked in the community, the lowest proportion since 1996. However, more than 50% of nurse consultants worked in the community, increasing from 30% to 53% in the 10-year study period. There was no information on clinical nurse specialists, nurse midwives or nurse practitioners from 1996 to 2000. The percentage of licensed practical nurses working as community case co-ordinators or managers increased (from 20% in 2002 to 32.7% in 2007).

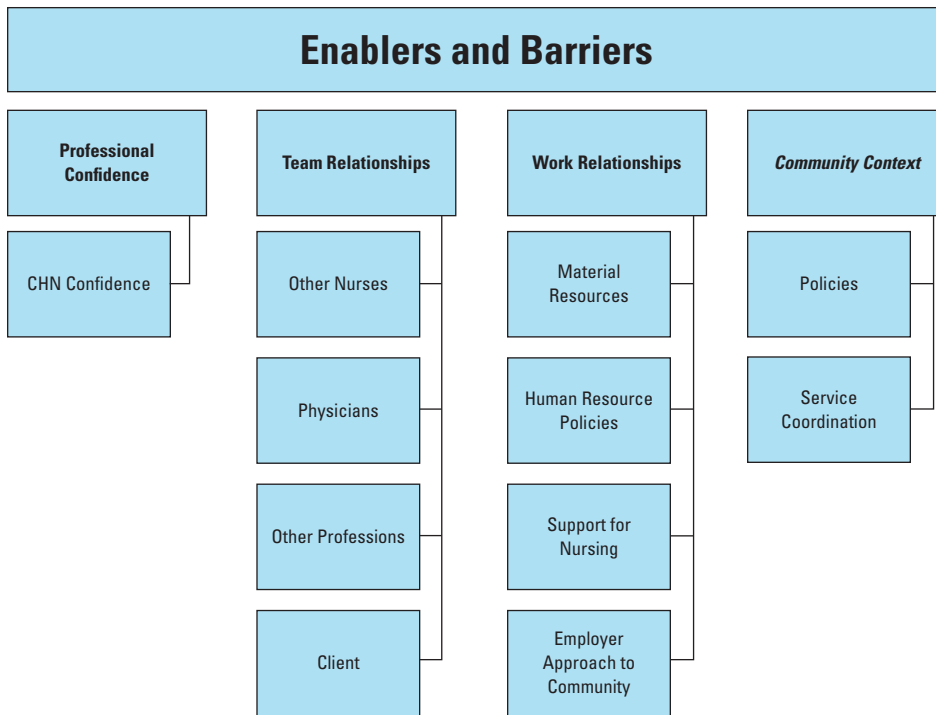
ENABLERS FOR EFFECTIVE COMMUNITY NURSING PRACTICE

The authors of the *Nursing Health Services Research Unit Community Health Nurse Questionnaire*[®] identified four main themes among the enablers and barriers to effective nursing practice: professional confidence, team relationships, workplace environment and community context.¹¹ This thematic framework is shown in Figure 2, and we used these themes for reporting the results of our survey of community nurses (the second part of our study). Table 2 lists selected enablers for community nurses to use their full scope of competencies and shows whether they felt they had these supports in their jobs.

Professional Confidence

There is little empirical evidence, but literature supports the assumption that confidence is important for nurses to achieve successful results.²⁰ Davidhizar defined self-confidence as “the feeling that one knows how to do something and has the power to make things happen.”^{21(p218)} Most community nurses in this study (95% of the registered nurses and 93% of licensed practical nurses) said they had confidence in their ability to practice autonomously, communicate their decisions about clients to managers, and advocate for changes to programs.

FIGURE 2. ENABLERS AND BARRIERS TO EFFECTIVE COMMUNITY NURSING PRACTICE*



*Source: Baumann, A., et al. (2006). *Better data: Better performance. Community health nursing in Ontario.*¹¹ (p16)

Team Relationships

We know collaboration among healthcare professionals improves client satisfaction and clinical outcomes,²² and enhanced teamwork is a human resources goal for healthcare settings throughout Canada.²³ But community nurses don't feel equal bonds with everyone they work with. Most (92% of registered nurses and 88% of licensed registered nurses) agreed they have effective relationships with other nurses, yet just 86% of registered nurses and 83% of licensed practical nurses feel that they have effective relationships with other professionals. The numbers are lower when it comes to doctors: 68% of registered nurses and 70% of licensed practical nurses said they have effective relationships with physicians (though their responses vary by region). Outpost registered nurses, who mostly work in the North, reported better relationships with physicians than other nurses. Public health nurses have less positive relationships with physicians than other community nurses.

Most community nurses feel a collaborative bond with their clients, but only 53% of registered nurses and 66% of practical nurses rated nurse-client relationships "strong" in terms of clients understanding their role, working in partnership and trusting community nurses from their agency.

TABLE 2 – SELECTED SURVEY RESPONSES OF REGISTERED NURSES (RNS) AND LICENSED PRACTICAL NURSES (LPNS)

| Enabler for effective practice | Agreed or strongly agreed* (%) | |
|---|--------------------------------|------|
| | RNs | LPNs |
| Positive relationships with other nurses | 92 | 88 |
| Community nurses have access to policies, procedures and up-to-date information | 85 | 87 |
| Positive relationships with other professionals | 86 | 83 |
| Employer upholds standard of practice | 84 | 85 |
| Organization has nurses in key leadership positions | 76 | 72 |
| Professionals from other community agencies respect the judgment of nurses | 76 | 69 |
| Community nurses can work collaboratively with home care services | 70 | 74 |
| Positive relationships with physicians | 68 | 70 |
| Organization trusts its nurses | 64 | 73 |
| Nurses are able to adapt care plans | 62 | 55 |
| Nurses have a fair and safe workload | 58 | 66 |
| Positive relationships with clients | 53 | 66 |
| Organization uses community-based approach to address social determinants of health | 47 | 42 |
| Community nurses have access to learning resources | 45 | 45 |

*Likert scale mean scores < 2.5 were considered agreement; ratings ranged from 1 (strongly agree) to 5 (strongly disagree).

WORK ENVIRONMENT

Material resources:

Job security and pay: Community nurses’ feelings about salary and security are mixed. Registered nurses are more likely to feel fairly paid than licensed practical nurses, and they also feel more secure in their jobs. Perceptions of fair pay and job security vary by province/territory, and some negative feelings may have been due to labour situations at the time of the survey. For example, nurses in one province were coming to the end of their contract, and in another province physicians had received a large pay increase with no mention of one for nurses.

Full-time community nurses feel more secure in their jobs than those in casual positions. Visiting registered nurses reported less job security than nurse practitioners, public health nurses or chief nursing officers. Visiting licensed practical nurses are less likely to feel secure than those who work as coordinators, case managers or consultants.

Travel and equipment support: For the most part, community nurses are compensated for travel and the equipment they need is provided. Eighty-seven percent of registered nurses said they were compensated for job-related travel. Similarly, 87% of community nurses agreed their organizations supply the equipment they need. Northern and outpost nurses were more likely to be concerned about equipment than nurses in other parts of Canada.

Human resources policies:

Learning environment: Less than half of community nurses feel they have the learning opportunities they need. Just 45% said they have adequate time, money and access to learning resources. Opportunities can vary by province, position or experience. Outpost nurses are least likely to have opportunities for learning. Registered nurses providing direct client services reported less access than nurses in management, as did younger licensed practical nurses compared to those with over 40 years in nursing.

Keeping up to date: A quarter of community nurses feel out of touch, saying they lack access to policies, procedures, protocols and up-to-date information to support client care, ensure employee well-being and handle potential emergencies. About 90% of community nurses, however, have access to a manager or practice consultant they can talk to about client issues.

Nearly 20% of community nurses don't get information from their organizations about recent government policies that affect their practice, and another quarter are not sure whether they do. Community nurses in front-line positions reported less access to government policy information than those in management. Older licensed practical nurses were more likely to agree that they got policy information than younger ones.

Fair workload: About half of community nurses (58%) think their employer assigns a fair workload. Workload perceptions vary among provinces and among registered nurses — coordinators, case managers and outpost nurses were less likely to say their workload is fair than clinical resource nurses, clinical educators and occupational health nurses.

Safe working environment: Most community nurses feel safe on the job. Just 11% of registered nurses and 7% of licensed practical nurses said their employers do not provide a safe working environment, though there are variations by province. Registered nurses reporting unsafe working conditions are often outpost or visiting nurses.

Support for nursing:

Leadership: According to the literature and recent documents such as Ontario's review of public health capacity,²⁴ having nurses in leadership positions in an organization supports optimal nursing practice. Most registered nurses in our survey work for organizations that have nurses in key leadership positions, and feel their leaders understand nursing practice and uphold its standards. Nurses in management agreed more strongly that their leaders understand nursing practice. Licensed practical nurses are more likely than registered nurses to think their organizations understand the differences in their respective roles (66% vs. 51%). Management nurses reported more clarity about the different roles than other community nurses.

Debriefing: Reflecting on practice is a fundamental part of nursing, and community nurses see chances to debrief as a sign of support for their profession.²⁵ However, more than 40% of registered nurses in the community lack opportunities to discuss clinical or program issues with their colleagues or management. Visiting nurses, staff nurses, public health nurses, co-ordinators and case managers have fewer opportunities for debriefing than others.

Trust: Management trust in employees has been linked with improved business results.²⁶ However, community nurses don't feel a lot of trust from their bosses — certainly less than their bosses say they have in their employees. Just 64% of registered nurses and 73% of licensed practical nurses agreed their employer and managers demonstrate trust in their ability to carry out their roles, recognize their achievements and welcome input. Chief nursing officers, chief executive officers and directors indicated more trust in nurses than nurses feel from them; managers, supervisors and administrators said they feel more trust than their outpost nurses reported. This discrepancy suggests managers do not show the confidence and trust they have in their nurses.

Autonomy: Three-quarters of registered nurses said they have flexibility to vary the amount of time they spend with a client, but only 62% feel they can adapt the nursing care plan. Staff nurses and outpost nurses have less opportunity to schedule their daily work than managers. Across the country, licensed practical nurses feel they had more control over their schedules than registered nurses.

Employer approach to community:

Community nursing has its roots in social justice, and its standards of practice include a focus on the determinants of health — the idea that people’s social, economic and physical environments all influence their health.³ Employers that encourage nurses to address inequity and try to improve social conditions are seen as supporting community nurses in their work. Two-thirds of community registered nurses said they feel they have support from their employer to address population needs. Supports include access to resources that are culturally appropriate for their clients or that help clients who face barriers to getting health services, as well as encouragement to provide culturally appropriate approaches to care, network with community physicians and carry out community development activities.

COMMUNITY CONTEXT

Policies:

Community nurses view communities that pay attention to social conditions as supporting their work, but just under half of registered nurses feel their communities address social determinants of health, and even fewer (38%) said they have timely access to good quality community resources for clients. Nurses also feel limited resources make it difficult to meet the needs of their clients, although agencies in their community may co-ordinate services. It could be that resources are co-ordinated but not accessible when needed, or not of good quality.

Just over half of the registered nurses said provincial policies related to their programs help them work with their clients; 35% neither agreed nor disagreed. We could not tell whether nurses don’t know about provincial policies that affect their programs or whether the policies themselves are not helpful.

Service co-ordination:

Seventy percent of registered nurses said they work collaboratively with home care services, but occupational and public health nurses reported less collaboration with them. Licensed practical nurses in the managers, supervisors or administrators group indicated more collaboration with home care than nurse practitioners or public health nurses, likely because collaborating with home care is part of their job.

Three-quarters of the registered nurses said professionals from other community agencies respect the judgment of nurses from their agency, but only half said they are invited to meetings because of their credibility as a nurse. Licensed practical nurses with less than 10 years of experience are least likely to feel respected by professionals from other community agencies.

ATTRIBUTES OF SUPPORTIVE PUBLIC HEALTH ORGANIZATIONS

For the third part of our study, we held focus groups to identify how organizations can support community nurses so their work is most effective and their programs are successful. We focused on public health nurses, one of the largest groups in community nursing, hoping to uncover attributes that would be relevant for all sub-sectors of community nursing. The focus groups gave us in-depth information and understanding of the influence employers can have on public health nurses. They identified organizational attributes at all levels of the public health system:

- ▼ Government and other system attributes
- ▼ Local organizational culture, including values and leadership characteristics
- ▼ Management practices

Participants focused on workplace culture and relationships (such as room to be creative and flexible, opportunities to learn and share information, the need for a shared vision and goals, and partnerships and collaboration) rather than on particular structures or things. Their feelings are in tune with a growing recognition that healthcare systems and organizations are best understood as complex, adaptive systems.^{27, 28}

In complex systems, relationships among the parts are more important than the parts themselves. Change requires integrated action, with each system area incrementally reinforcing and developing other areas.

GOVERNMENT AND SYSTEM ATTRIBUTES

Flexible and adequate funding structures:

Public health funding must be adequate enough to give stable, long-term support for programs and flexible enough to respond to changing needs. In optimal situations, funding is available to assess community needs, build capacity for better health and develop partnerships. Rural groups particularly emphasized the importance of flexible funding that lets them respond to emerging needs.

Champions for public health:

The need to promote public health was a very strong theme. Nurses said governments must champion public health and its place as part of the publicly funded health system. Local boards of health also have to support public health workers for effective health promotion to happen.

Public health planning and co-ordination:

Participants said government and other organizations must co-ordinate public health planning across regions, provinces/territories and the country. They should share infrastructure and resources such as databases, research, evaluation, and standardized educational resources.

ORGANIZATIONAL CULTURE: VALUES AND LEADERSHIP CHARACTERISTICS

Organizational values reflect beliefs about the goals an organization should pursue and shared ideas of how members of the organization should achieve them.²⁹

A shared vision for public health:

Participants emphasized the importance of working in an organization that had a clear vision shared by all. They wanted their organization to be driven by public health values — including a focus on prevention and health promotion, the social determinants of health, population health and community development — and tied to specific needs and goals. Most focus groups stressed that public health policy and practice should be based on research evidence and community issues.

Effective leadership:

All the focus groups said public health nurses need visionary, empowering and motivational leadership if they are to work to their full potential. Effective leadership permeates the organization, so everyone feels empowered and motivated to be effective in their roles. Leadership must respect, trust and value public health.

A culture of creativity and responsiveness:

Policy maker and manager groups said effective leaders have to create a culture that encourages creativity and innovation, and they recognized that this involves taking risks. Front-line workers agreed that management must support and value creativity. Everyone said leadership has to be open to change: according to policy makers, by letting organizations be flexible and responsive, and according to front-line workers, by being open to change and flexible in how they deliver programs.

MANAGEMENT PRACTICES

The focus groups felt that management practices at the front line were by far the most important organizational attributes for optimal public health nursing. Management practices affect the organization's functions and nurses' working conditions, both of which profoundly affect whether public health nurses are using all their competencies.

Clear program planning:

Participants said public health planning must be clear and strongly grounded in community and client needs, which depends on effectively assessing public health and community development needs. All the groups emphasized the importance of clearly defining roles and responsibilities and linking them to overall goals and accountability. Defining roles by what is to be accomplished is important for professional autonomy and independent practice. Front-line groups in particular felt that role definition should be linked to the organization's vision and goals, rather than a description of who does what.

Promoting and valuing public health nursing:

Managers and policy makers said good public relations — including promoting public health nursing to other providers, community partners and the public — are important because the public needs to understand the role of public health nurses. Two groups of rural policy makers and managers said it is strategically important to gain physician support for public health nursing, because physicians are a gateway to the public.

Front-line nurses and policy maker/manager groups stressed that managers must understand and value public health nursing. Managers need to clearly show respect for and be guided by their nurses' experience, knowledge and understanding. One group of rural nurses discussed the difficulty of reporting to a manager who had no background in public health or nursing and could not provide the support and guidance they needed. Everyone thought management needs to publicly acknowledge the contributions public health nurses make.

Supporting autonomous practice:

All the focus groups told us public health nurses need autonomy to work effectively and they need to be seen as leaders who can determine the right thing to do in their assigned activities. Rural groups said autonomy is the ability to be creative and responsive to meeting community needs, while urban groups described autonomy as freedom of action in everyday practice and physical separation from managers and doctors. Front-line nurses said managers must let them be flexible in how they approach their work. Some nurses said autonomous practice needs a broad job description so they're not pigeon-holed into a small area of practice.

Commitment to learning and professional development:

An organization that supports public health nursing supports learning. All the participants valued strong learning environments, with almost every focus group emphasizing the importance of professional development, training, educational opportunities, and organizational investment in education and training so nurses can keep their skills and competencies up to date. Many groups called for practice councils where nurses can discuss issues and learn from each other.

Policy maker/manager groups said new staff need solid orientation programs, and informal knowledge-sharing and mentoring should be encouraged as well. This theme was especially strong in rural focus groups, perhaps because of the challenge of freeing staff to travel to conferences. Front-line groups said they needed information and knowledge exchange, including training and support to keep current with electronic resources (particularly important to rural groups) and access to educational tools and policy manuals to support their practice. Groups of all types said it is helpful for public health nurses to have access to specialists such as epidemiologists, nurse educators, practice experts and social marketers.

Effective human resources planning and adequate staffing:

Participants identified the ability to recruit and keep employees as an important organizational attribute for effective community nursing. The communities served by public health are diverse, and sufficient staffing with knowledgeable nurses is essential to meet their needs. Managers need to build a stable, consistent workforce with the skills to do their jobs effectively, and they need to give public health

nurses time, flexibility in work assignments, and support to build partnerships and involve the community. Front-line nurses also stressed having enough staff to cover vacations, professional development days and other absences.

Supporting partnerships and community development:

Focus groups noted that public health is interdisciplinary and intersectoral, involving collaboration with community groups and other agencies and providers in addition to internal collaboration. Management must allow time for building partnerships and encourage working with others. Front-line participants said they need time to build “trusting, respectful” relationships with clients and their families and to involve them in developing programs.

Effective communication:

Participants discussed communication issues for staff and management, peers and interdisciplinary teams. Policy makers and managers said open and clear communication strategies are important for public health organizations, and involving management and staff in decisions promoted communication. Front-line groups felt that regular information-sharing in the organization helps them work effectively. Rural front-line groups said public health nursing teams work better when they’re given opportunities to review and debrief; northern groups agreed but noted those opportunities can be rare in remote areas.

Healthy workplace policies:

The focus groups highlighted the need for policies to make workplaces healthy. Rural groups said healthy workplaces had family-friendly policies and flexible work hours. Urban groups valued flexible hours but also emphasized the need for safe places to work.

FURTHER RESEARCH

Directions for further exploring the community health nursing workforce and effective nursing practice include:

- ▼ Researchers, employers, managers and practitioners should work together on multi-disciplinary investigations of how to support teamwork in community health, and design training based on the resulting.
- ▼ Researchers should study the extent to which community health organizations address the social determinants of health in policy and practice, and develop methods to account for differences among them.
- ▼ Researchers should investigate the differences in pay and job security community nurses face in different sub-sectors.
- ▼ Nursing regulatory bodies should facilitate their members participating in research.
- ▼ To develop accurate demographic profiles of community nurses and solid data for effective community nursing policy and planning, researchers should:
 - Define the responsibilities of each community sub-sector.
 - Compare community nurses’ responsibilities according to program titles and sub-sectors.
 - Fill gaps in data through a national task force (under the auspices of the Community Health Nurses Association of Canada, with the Canadian Institute of Health Information, Public Health Agency of Canada and other stakeholders) to develop a common classification system for data on what community nurses do and where they work.
 - Establish and test alternative data sources (such as provincial databases derived from employer information) to count community and public health staff.

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APPENDIX A

PUBLIC HEALTH FOCUS GROUP PARTICIPANTS

| Geographic Region | Focus Group | | | | Total Participants (n=23 focus groups) |
|--------------------|---|---|--|---|---|
| | Front Line Rural/ Remote (n=7 focus groups) | Front Line Urban (n=5 focus groups) | Policy maker/ Manager Rural/Remote (n=6 focus groups) | Policy maker/ Manager Urban (n=5 focus groups) | |
| Atlantic | 7 | 8 | 7 | 9 | 31 |
| Quebec | 4 | 4 | 2 | 3 | 13 |
| Ontario | 8 | 8 | 8 | 8 | 32 |
| Prairies | 9 | 11 | 9 | 5 | 34 |
| British Columbia | 6 | 7 | 7 | 4 | 24 |
| North | 9+4 (2 sessions) | n/a | 9 | n/a | 22 |
| Total Participants | 47 | 38 | 42 | 29 | 156 |