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Community Health Nursing Practice Education: Preparing the Next Generation

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Community Health Nursing Practice Education: Preparing the Next Generation

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Abstract

Undergraduate nursing practice rotations today are quite different from what many practicing nurses experienced during their own education. This is especially true of community health practice rotations. Increasingly, non-traditional community health sites are being used as practice sites—sites such as schools, homeless shelters, non-profit agencies, and even churches. Increasingly, non-traditional practice experiences are eclipsing traditional practice experiences involving home care and public health. Why has this shift occurred, and what do these experiences offer students? Do these experiences actually prepare nursing students for clinical practice once they graduate? What does preparing the next generation of community health nurses entail?

KEYWORDS: community health nursing, baccalaureate nursing education, entry to practice, service learning

Over the past few years many registered nurses (RNs), particularly community and public health nurses, have noticed that most baccalaureate schools of nursing are using non-traditional placements for undergraduate practice rotations in community health. These placements might include the use of schools, homeless shelters, workplaces, correctional centers, shopping malls, police stations and even churches and synagogues. Such practice experiences are by far eclipsing traditional preceptored placements in homecare and public health. Community health nurses (CHNs), public health nurses (PHNs), managers, nursing students and nursing faculty hold diverse opinions about this shift. In this article, the term 'community health' is used to encompass all areas of practice, including homecare, public health, and other nursing roles within the community setting.

The reasons this shift has occurred internationally are explained, using Canada as an example, and what these non-traditional experiences offer students. Also explored, is whether or not this model prepares students for practice in community health nursing and how academia, community/public health organizations and practice areas might proceed.

COMMUNITY HEALTH PRACTICE EDUCATION: CURRENT REALITIES

A constellation of factors has influenced the shift in the way community health practice experiences are delivered in Canadian undergraduate nursing programs. This move, which represents a global phenomenon, is characterized by fewer preceptored experiences in traditional community placement areas such as home care and public health, and far more different types of community experiences in diverse, non-traditional placements (Cohen & Gregory, 2009; Reimer Kirkham, Hoe Harwood, Terblanche, Hofwegen, & Sawatzky, 2007; Wade & Hayes, 2010). Often, these other experiences occur at agencies not organizationally affiliated with the health care system and at which registered nurses (RNs) are not typically employed.

The move from a traditional preceptored delivery model of community health practice to a non-traditional model has occurred for many reasons, primary being the global shortage of traditional student placements within the community (Cohen, Gregory, & Rauliuk, 2007; Ravella & Thompson, 2001; Reimer Kirkham, Hoe Harwood, & Van Hofwegen, 2005; Smith et al., 2007; Valaitis et al., 2008). This shortage is the result of the natural ebb and flow of demand for RNs as dictated by government, health care restructuring, cuts to community health programs, and increased nursing program enrollments.

Secondly, many schools of nursing have a strong orientation towards community health nursing education, as opposed to community-based nursing education. The Association of Community Health Nursing Educators (ACHNE) (2009) defines community-based nursing as:

the practice of nursing within non-institutionalized, ambulatory clinical settings and where clients live, work and play. The primary client is the individual and the goal of care is to promote effective, meaningful, and efficient health outcomes for individuals and families and the healthcare system. (p. 15)

Community-based nursing tends to focus more on acute, rehabilitative, or chronic nursing care at the individual level (Cohen & Gregory, 2009). Community health nursing, on the other hand, focuses on health promotion and illness/injury prevention at the population level (Cohen & Gregory, 2009). ACHNE describes community health nursing as “the practice of nursing with populations within the context of community systems. The primary client target is a population at health risk and the goal of care is to attain health outcomes that promote public health...” (p. 15). Thus, practice experiences in non-traditional placements provide unique opportunities for students to work at the population level (Wade & Hayes, 2010).

Additionally, there are many benefits associated with using non-traditional sites for community health nursing practice experiences. These include opportunities to incorporate elements of social justice, equity, accessible health care, determinants of health, and vulnerable populations within the curriculum (Boutain, 2008; Reimer Kirkham, Van Hofwegen, & Hoe Harwood, 2005).

Because one-on-one practice experience with practicing RNs is not possible for all students in community settings, a different educational model is required to ensure that students meet the required educational objectives. The model most frequently used has been described as service learning, “a structured learning experience that combines community service with explicit learning objectives, preparation, and reflection” (Seifer & Connors, 2007, p. 9). Under the guidance of nursing faculty, students involved in service learning provide a service to the community while learning about the context in which the service is provided and make conceptual links to their academic coursework. Globally, a wide variety of service learning experiences are currently underway, including: community health assessment projects, community health promotion projects, community development projects, as well as individual screening, health promotion and illness/disease prevention, and primary care (Broussard, 2011; Cohen et al., 2007; Smith & Flint, 2006).

For students in their community health practice rotation, the potential benefits of service learning in non-traditional placements are process-oriented. Students learn how to carry out the community health nursing process, engage in population health promotion and program planning, collaborate with community members in developing inter-sectoral relationships, address the determinants of health, and enact the principles of primary health care. Students also develop leadership skills and cultural competence, appreciate the socioeconomic and political influences on health, and cultivate group process and critical thinking skills (Cohen et al., 2007; Francis-Baldesari & Williamson, 2008; Reimer Kirkham et al., 2007). Occasionally, students are able to develop specialized clinical nursing knowledge and skills, which students highly value and which contributes to their sense of competence (Erickson, 2004).

Service learning in non-traditional community placements has drawbacks, however. Students may not see the value of non-traditional placements in which a nurse is not present and may struggle with the transition from nursing as a hands-on endeavor with patients having health challenges, to a more abstract and broad application of population health concepts (Wade & Hayes, 2010). Moreover, students may view these experiences as second rate and may not be able to develop specialized nursing knowledge and skills or even interact with health care professionals and practicing RNs (Valaitis et al., 2008). The time constraints of the semester artificially compress the community development process, and difficulties may arise within the community if the host agency's expectations are compromised (Cohen et al., 2007; Diem & Moyer, 2005; Erickson, 2004; Laplante, 2007; Seifer & Connors, 2007; Reimer Kirkham et al., 2007). Ultimately, strong empirical evidence that illustrates the benefits of service learning in community health experiences from a student perspective is lacking (Laplante, 2007), and retrospective studies have not been conducted to see if these experiences actually prepared students for practice as new graduates working in community health.

PREPARATION FOR COMMUNITY HEALTH NURSING PRACTICE

There are varied perspectives concerning how well this educational model for community health practice prepares students for community health nursing practice once they graduate. A public health manager, for example, may lament that the kinds of activities in which students participate during these experiences do not reflect the kinds of activities new PHNs actually do. Determining whether students are being prepared for traditional roles in community health practice, then, is dependent upon establishing the nature of foundational and core nursing knowledge in this area of nursing. This is difficult, however, given that

community health nursing is a broad area of nursing that comprises diverse practice areas and role descriptions, including public health nursing, home care nursing, and primary care nursing as the dominant practice areas. From an educational perspective, what students ought to learn, then, is a function of the relevant competencies related to community health nursing as well as role descriptions specific to present and future practice settings.

Relevant competencies articulate the required knowledge and skills of community and public health nurses. In the United States, the ACHNE (2009) has delineated and described the essential core knowledge and competencies for entry level community and public health practice. These essentials focus on core knowledge areas rather than specific content, and under each heading are many basic competencies. In Canada, Public Health Nursing Discipline Specific Competencies (Community Health Nurses of Canada [CHNC], 2009) are independent of program and topic and are not constrained by discipline. Furthermore, Home Health Nursing Competencies (CHNC, 2010) delineate the integrated knowledge, skills, judgment and attributes required of an RN working in home health. While the American and Canadian competencies documents are conceptually structured differently, several core areas that these three documents have in common include: communication; knowledge of (public health, nursing and/or epidemiological) sciences; assessment; analysis; planning; policy development; health promotion; health protection and risk reduction; illness management and health maintenance/restoration/palliation; and, access, equity and social justice. ACHNE also includes: information and health care technology; environmental health; global health; human diversity; and, emergency preparedness, response and recovery. The Canadian competencies additionally include: implementation; evaluation; relationships, partnerships, and collaboration; building capacity; and professional responsibility. Thus, given the breadth of competencies that guide practice, there seems to be considerable latitude for non-traditional practice experiences, including activities that focus on population and aggregate levels, often not involving direct patient care.

Practice settings in which community health nurses work are also an important consideration as nursing programs prepare students for practice. According to Underwood et al. (2009), 34% of Canadian community health nurses work in a public health unit, 21% work in home care, and 19% work in a community health centre/health centre. In the United States, the percentage of nurses working in acute care has decreased from 66% in 1980 to 59% in 2000 (Swiadek, 2009). In China, community health nursing is a relatively new area of practice for nurses (Eddins, Hu, & Liu, 2011).

Community health nurses have a wide range of duties and considerable caseloads, while also battling a nursing shortage. Swiadek believes that “public health nursing will become a dominant mode of health care” (p. 23), in the future, through health promotion and illness prevention that occur in the community. Schoenfeld and MacDonald (2002), in their survey of Saskatchewan PHNs, found that the major focus of care is on individuals and families. Few PHNs were involved with, or were involved to a much lesser degree in community development, policy formulation, research, evaluation, political processes, community empowerment for political processes, and resource management, planning and coordinating. Interestingly, these are the activities in which students are often involved when participating in a non-traditional community health practice rotation. Thus, it seems that there is inconsistency between what nursing students accomplish in their community health clinical experience and what they would be doing following graduation.

CHALLENGES AND OPPORTUNITIES

Several challenges exist with using non-traditional community health practice placements. First, non-traditional experiences, which generally focus on population health, may differ significantly from what community nurses actually do in the practice setting, which usually focuses on care provided at the individual and family level (Wade & Hayes, 2010). A disconnect may exist then, upon graduation, when graduates enter a system of community-based nursing that focuses more on individual and curative care than their community clinical experience, which focused on community health nursing (Cohen et al., 2007).

Secondly, while it is probably not feasible to teach every possible skill in a generalist nursing program, there is some concern that these non-traditional experiences are not providing students with the opportunity to develop traditional entry-level core competencies in community health areas of practice (Cohen et al., 2007). While some competencies can be applicable, albeit indirectly in these settings (such as program planning), many other competencies that comprise the bulk of nurses’ work are not able to be addressed using this model of practice education. Within a competency-based framework, students are able to prepare for community and/or public health nursing practice without ever practicing as, or viewing the actual work of, a CHN or PHN. It can be argued that if nursing faculty carefully shape the service learning experience, in non-traditional practice sites and in the absence of practicing RNs, that students will learn the process of community health nursing rather than specific content areas. With the generalist view of student preparation in mind, this lack may not be significant. However, since practice areas often require a level of specialization and content expertise,

students may feel unprepared for entry into public health, community health, or home care roles upon graduation.

Thirdly, within most health care systems, community and public health sectors are chronically underfunded and undervalued. Governments are preoccupied with acute, individual, and curative care, at the expense of community and population health promotion (Valaitis et al., 2008). Many prominent organizations, including the United States' Pew Health Professions Commission and the Quad Council of Public Health Nursing Organizations, the World Health Organization (WHO), the Canadian Association of Schools of Nursing (CASN), and the National League for Nursing, have long advocated for increased community health and health promotion content in nursing programs (Valaitis et al., 2008). However, without government funding and a fundamental restructuring of existing health care systems to make it happen, this shift will not occur. For example, in Canada, the number of nurses working in the community between 2002 and 2007 has remained fairly constant at around 16%. Despite these numbers remaining consistent, the prognostication of the Canadian Nurses Association (CNA) is that 60% of nurses will work in the community by the year 2020 (Villeneuve & Macdonald, 2006). The CNA (2009) suggests that there will be an increased focus on addressing the determinants of health and on health promotion, and greater collaboration across sectors and health disciplines to enable health for all Canadians, although not as a replacement for illness care and supportive care which will remain a priority. What remains to be seen, perhaps, is how governments, the economy, and privatization will impact upstream (proactive) measures and population health, and whether by community care what is really meant is non-hospital tertiary care as a cost-saving measure.

Future practice realities are also an important consideration. While predictions about the future role of the community health nurse are largely speculative, considering the advancing role of other nursing and health professions, it may be prudent for baccalaureate programs to prepare graduates for advanced practice and primary care roles in addition to registered nurse full scope of practice (Robertson, 2004). We need to reconceptualize how community/public health nurses will meet health care needs and what roles we will occupy in the provision of care (Villeneuve & Macdonald, 2006), to help ensure that RNs continue to have a valuable place in existing and emerging health care systems.

These challenges present tremendous opportunities for community and public health nurses worldwide and for schools of nursing. This is an occasion and time for educators and practice areas to get together and continue to forge a

future for the role of the community/public health nurse. The emerging role must entail full scope and advanced practice competencies, including population health management competencies, and the ability to act as community health specialists (Holloway, Baker, & Lumby, 2009; Robertson, 2004). This may be an opportunity for the nursing profession to clarify community health nurses' roles within health care systems, as enactors of specialized nursing knowledge in all levels of prevention, especially in the areas of health promotion and primary prevention at the population level. It could also be an ideal opportunity to increase the visibility of the work of community health nurses as health promotion specialists who advocate for health care equity and access.

Now is the time to challenge the biomedicalization of health care systems and reorient these systems to the principles of primary health care. Adopted by the WHO as both a philosophy of health care and a model for providing effective health services, the primary health care approach focuses on promoting health and preventing illness through mechanisms such as accessibility of health services, public participation in health care, addressing the social determinants of health, and inter-sectoral cooperation. Such a shift may also be accompanied by a radical restructuring of health care systems that bring health and healing closer to where people live, work and play (Swiadek, 2009). An international example is in East Timor, where nurses and village health care workers were assessed as to their educational needs in the area of primary health care and the requirements of the population (McAuliffe, Grootjans, & Fisher, 2002). The authors found an obligation to increase education regarding primary health care, and build capacity among health care workers for improving population health.

Nursing program educators and administrators may also wish to consider curricular changes that better accommodate a population health perspective. For example, by incorporating public health postnatal home visits within maternal/child or pediatric rotations, and integrating home care visits for the post-surgical or medically unstable patient within medical and surgical rotations, the community health rotation can focus entirely on population health. Shorter, add-on public health and home care experiences, including simulation, would facilitate increased numbers of students rotating through these areas, while helping them make the linkages between acute and community care, yet not compromising the increasingly important population health perspective. Separation of the two types of experiences would also facilitate students being able to focus on population health, without the distraction of psychomotor skills that nursing students tend to center on (Broussard, 2011). In many countries around the world, such as Pakistan, nursing programs are restructuring their programs to better accommodate a community/public health perspective that includes primary health

care principles (Ladhani, 2009). Furthermore, relevant community/public health competencies should directly inform practice course objectives and teaching and learning strategies (Carter, Kaiser, O'Hare, & Callister, 2006; Swider et al., 2006). If necessary, specific core or elective subjects can be added to support the development of community health competencies, such as a course in case management for chronic diseases (Tholcken, Clark, & Tschirch, 2004).

Nursing programs can continue to be innovative in the search for community health experiences. International practice, while costly and logistically complex, can make a significant difference in the lives of the people served and the students (Aarts et al., 2010; Ailinger, Malloy, & Sacasa, 2009; Wros & Archer, 2010). With increasing globalization, the learning these opportunities provide, and the benefit to less fortunate countries, may be significant. For example, students are able to gain global experience by working with an increasing number of refugees in developed countries (D'Lugoff & McCarter, 2005; Lenz & Warner, 2011; Wros & Archer, 2010). Limitless opportunities exist within local communities, community partnerships between non-health care agencies, social outreach agencies, schools, veterans' residences, and so on. These learning experiences can help address health care needs of countless individuals, families and populations while increasing the impact of student community health nursing practice (Ravella & Thompson, 2001; Smith & Flint, 2006). Health fairs also enable students to learn entry level public health competencies (Maltby, 2006). Rural communities that often acutely feel the effects of the shortage of health care providers and limited access to health services, provide students, communities and rural nurses with mutually beneficial partnerships (Van Hofwegen, Kirkham, & Harwood, 2005).

Finally, those in community and public health practice areas have recognized the need for "strong leadership throughout the public health system to create an integrated system and support effective and empowered public health nursing practice (as reflected in government, local organization and management levels)" (Meagher-Stewart et al., 2010, p. 438). More support at all levels is required to allow community nurses to act to their full scope of practice, which includes work at the population level. A much greater investment in the public health sector is necessary at the government and system level to optimize population health outcomes.

It is clear that what should be taught (and how) in undergraduate community health nursing practice courses is dependent upon many complex factors. Consensus in determining what is best and what is possible within today's realities of community health nursing practice is unlikely. The current

nursing student placement shortage, nonetheless, presents the opportunity for involving local and provincial health regions, community agencies, and nursing programs in joint problem solving for the creation of practice experiences, the preparation of students for community health practice areas, and the determination of future roles of community health nurses as change agents within health care systems. The challenge is twofold: to engage nursing students as agents of change within health care systems, so that the system better embodies the principles of primary health care; and to collaborate across sectors as schools of nursing reach out to communities and the world in new ways. The use of non-traditional placements for community health practice education is likely to continue into the foreseeable future. The future direction of health care services and the educational preparation of the next generation of community health nurses, however, rests with us as nurse educators, administrators and practitioners.

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