Development of a Public Health Nurse Professional Practice Model Using Participatory Action Research

by

Cheryl Cusack

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University of Manitoba

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Abstract

Public health nurses (PHNs) are ideally situated to reduce health inequities and based on documents articulating their role, should be working upstream to promote equity, prevent chronic diseases, and improve population health outcomes. In reality however, numerous barriers contribute to lack of role clarity for PHNs, and this goal has not been attainable in practice. A common vision for PHN practice based on discipline specific competencies and full scope of practice has been identified as a priority by Canadian experts.

The intention of this study was to develop a model to support PHN practice in an urban Canadian city. This study used a participatory action research approach, grounded in local experience and context. The action was the development of a professional practice model. Data were gathered using semi-structured interview guides during audio-recorded research working group (RWG) meetings from November 2012 to July 2013. A researcher reflexive journal and field notes were kept. The data were analyzed using qualitative methods. A significant feature was full participant involvement throughout the course of the study.

A professional practice model was a key organizational tool that provided the framework to develop an autonomous PHN role and the structures necessary to support PHN practice within the health system. The professional practice model fostered full scope of practice and role clarity, with a focus on population health and equity, so that a consistent and evidence-based practice was attainable. The result was that RWG participants reported a shift in their practice, with greater awareness of theory. Participatory action research was essential in developing the framework and common language, and is a research methodology that should continue to be explored with nurses in Canada.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Focus and Framing

This dissertation describes an action research study. Action research dissertations can differ from traditional scientific reports, while meeting the needs of academic institutes (Stringer, 2014). I have followed recommendations from Stringer during the process, and structured the dissertation based on his recommendations. In chapter 1, I provide focus for the research questions by framing the study within the broader global context. Since the study was participative, chapter 2 offers a preliminary literature review, exploring current evidence specific to the public health nurse (PHN) role. The participatory action research methodology and philosophical underpinnings are described in chapter 3. In chapter 4, study findings are presented in three sections: participant stories, their interpretation, and the action that was developed. The final discussion in chapter 5 situates the voice of study participants within current evidence on PHN practice and participatory action research, as well as drawing implications and conclusions.

Significance of the Research

In 2008, the World Health Organization final report of the Commission on Social Determinants of Health described growing and avoidable health inequities and posed the challenge to improve the social, political, and economic conditions that perpetuate inequities within one generation (Commission on Social Determinants of Health, 2008). A health inequity is an inequality or difference that exists between individuals, groups, and populations that is not fair or just; and most importantly can be prevented and avoided (Braveman & Barclay, 2009; Labonte & Laverack, 2008). The Commission stated inequities are a social injustice and declared that action on the social determinants must become an ethical imperative for governments, civil society, and all global organizations and agencies.

The public health sector in particular should assume leadership in addressing the social determinants in Canada (Public Health Agency of Canada, 2008; Standing Senate Committee on Social Affairs Science and Technology, 2009). In his inaugural report, the chief public health officer stated that the goal of public health programs was to improve population health and societal well-being, through collaborative efforts that address inequities and the root causes of poor health (Public Health Agency of Canada, 2008). The challenge is that many factors contributing to health are outside the health sector; and a broader focus, or a "whole of government approach" is essential in influencing the social determinants and impacting population level changes (Standing Senate Committee on Social Affairs Science and Technology, 2009, p. 1). The chief public health officer advocated that solutions to inequities were possible through individual and collective action, and ultimately healthy public policy (Public Health Agency of Canada, 2008).

For public health nurses (PHNs) , the largest group of public health practitioners, action on the social determinants of health and the promotion of equity has been foundational to the role (Community Health Nurses of Canada, 2011a, 2011b; Reutter & Kushner, 2010). Specific actions highlighted as solutions within the Commission on the Social Determinants of Health report present an opportunity for PHNs to contribute to this important global movement. The Standing Senate report (Standing Senate Committee on Social Affairs Science and Technology, 2009, p. 21) stated:

> "the subcommittee has been looking at coordination from the top-down. We, however, are convinced that coordination must also be implemented from the bottom up. A top-down commitment and bottom-up input into the delivery system would be a commitment that would work"

PHNs in the Winnipeg Regional Health Authority (WRHA) could assume a leadership role by developing options to reorient their practice in accordance with the direction provided by the Commission on the Social Determinants of Health. Areas cited within the report where PHNs could have potential influence include: 1) Improving daily living conditions with a focus on early childhood development; 2) Enhancing knowledge by measuring inequities and equity enhancing activities; and 3) Tackling the structural drivers of inequity. Despite being ideally situated to address these public health priorities, a gap exists between the current and recommended PHN practice. The purpose of this research was to develop a model to support PHNs practice. By practicing at full scope with a focus on equity, PHNs could improve population health outcomes and tackle inequities.

Improving Daily Living Conditions with a Focus on Early Childhood

The critical role of prenatal and early childhood development. Within the overarching goal of improving daily living circumstances, the Commission on the Social Determinants of Health advocates for "equity from the start," recognizing the potent effect that early childhood development has on future lifelong success (Commission on Social Determinants of Health, 2008, p. 3). The prenatal and early childhood periods are unprecedented times for brain development and physical, emotional, and cognitive growth; representing opportunities to influence or damage well-being over the trajectory of the life course (National Forum on Early Childhood Program Evaluation & The National Scientific Council on the Developing Child, 2007; Public Health Agency of Canada, 2009; Robert Wood Johnson Foundation, 2014). Health is promoted when one's early experiences are nurturing and predictable, but when those experiences are burdened by chaos and neglect, a different life trajectory is patterned (Shonkoff, 2010).

A life-course perspective links health in adulthood to previous early childhood experiences (Braveman, 2013). Brain and biological development peak in early childhood, declining as a child grows into adulthood (Hertzman & Boyce, 2010). The neurons in the brains of infants are random, and the connections are developing (Maggi, Irwin, Siddiqi, & Hertzman, 2010). During this time, neural circuits essential for normal development are extremely sensitive (Canadian Association of Family Resource Programs, 2011; Heikkinen, 2010; Hertzman & Boyce, 2010; Mustard, 2009). Epigenetic regulation describes critical periods in the wiring of the brain necessary for future learning (Hertzman, 2009; Hertzman & Boyce, 2010; National Forum on Early Childhood Program Evaluation & The National Scientific Council on the Developing Child, 2007). When damaging exposures take place a process called biological embedding results, causing long-term alterations in learning, behaviour, and developmental trajectories (Hertzman & Boyce, 2010; Maggi et al., 2010; National Forum on Early Childhood Program Evaluation & The National Scientific Council on the Developing Child, 2007).

Early experiences can cause instantaneous, delayed, or long-term effects, which can be cumulative or compounded, based on the duration and intensity of exposures (Hertzman & Boyce, 2010; Irwin, Siddiqi, & Hertzman, 2007; Matthews, Gallo, & Taylor, 2010; National Forum on Early Childhood Program Evaluation & The National Scientific Council on the Developing Child, 2007; Public Health Agency of Canada, 2009; Raphael, 2011). These toxic stressors contribute to genetic alterations and the development of vulnerabilities that necessitate enormous societal investments in the long-term (Williams, Bennett, Clinton, Francoeur, Hertzman, Johnson et al., 2013). There is a lack of understanding regarding the exact mechanisms that impact brain development so interventions can be targeted, but significant literature has documented an association to poverty in the early childhood period (Brownell,

Fransoo, & Martens, 2010; Chartier, Walker, & Naimark, 2010; Conroy, Sandel, & Zuckerman, 2010; Health Council of Canada, 2010; Hernandez, Montana, & Clarke, 2010; Hertzman, 2009; Jutte, Brownell, Roos, Schippers, Boyce, & Syme, 2010; Kolb, 2009; Masuda, Zupancic, Poland, & Cole, 2008; Moore & Oberklaid, 2010; Raphael, 2011).

Growing up in poverty has been negatively linked to increased morbidity and mortality over the life course (Buckner-Brown, Tucker, Rivera, Cosgrove, Coleman, Penson, & Bang, 2011; Health Council of Canada, 2010; Matthews et al., 2010; Raphael, 2010a; Stringhini, Sabia, Shipley, Brunner, Nabi, Kivimaki, & Singh-Manoux, 2010). Controlling for negative health behaviours, a population level comparison in England demonstrated a relationship between poverty and reduced mortality (Stringhini et al., 2010). Individuals from deprived early childhood environments have displayed altered neural responses to emotional stimuli, compared to those from advantaged environments (Matthews et al., 2010). One hypothesis is that a combination of poor health habits and chronic stress, in addition to genetic predisposition, damages biological systems (Matthews et al., 2010). Alternatively, health threatening behaviours such as smoking, poor diet, and alcohol use, may be mediating factors resulting from the need for psychological and personal control (Raphael, 2011).

One of the barriers to addressing the determinants that cause inequities has been the continued responsibility placed on individuals in determining their health status, motivation, and risk behaviours (Raphael, Curry-Stevens, & Bryant, 2008). Recently there has been growing appreciation for the importance of going beyond the individual, to better understand the role that the broader environment plays in contributing to inequities (Reading & Wien, 2009). The effect is a gradient one, with environments of extreme poverty being the most health damaging (Hertzman & Boyce, 2010; Marmot & Bell, 2011; Matthews et al., 2010), and better health

outcomes linked with each increase in socioeconomic status (Brownell, Derksen, Jutte, Roos, Ekuma, & Yallop, 2010). For children, gradients can be caused by interactions between the child who is highly vulnerable at certain times, and environmental factors they encounter (Hertzman & Power, 2004). Social factors create risks and opportunities to foster resilience or vulnerability at each life stage (Braveman, 2013). To reduce inequities, the gradients must be "levelled up," by fostering healthy early childhood development across society (Hertzman, Siddiqi, Hertzman, Irwin, Vaghri, Houweling et al., 2010).

The development of nurturing environments. The prenatal and early childhood periods have been cited as the most critical developmental phases to break cycles of poverty and poor health in adults (Hertzman, 2009; Public Health Agency of Canada, 2009; Reading & Wien, 2009; Siddiqi, Irwin, & Hertzman, 2007). Founded on the United Nations International Children's Emergency Fund, the Convention on the Rights of the Child advises that every child is entitled to health and well-being (UNICEF., 2009). Fundamental human rights for children include basic necessities for development and survival including food, shelter, clean water, education, healthcare, culture, recreation; protection from neglect, cruelty, exploitation, injury and abuse; and the right to participate in social, cultural, and family activities (UNICEF., n.d.). These fundamental rights depict that a child's health is shaped not only by their family, but by broader social and material features of their community (Cummins, Curtis, Diez-Roux, & Macintyre, 2007). In urban centres, though vulnerable children live in close proximity to services, many still lack these basic necessities, and their hardships are hidden and perpetuated (UNICEF., 2012). Factors such as race, class, income, education, status, and gender constitute the building blocks of health inequities (Kelly, Morgan, Bonnefoy, Butt, & Bergman, 2007).

The concept of "equity from the start," advocates the important role that interventions in the early childhood period play in improving health, and averting negative long-term outcomes. Biology, genetics, and socio-economic factors are highly influential, but nurturing relationships are the most significant aspect of early childhood development (Siddiqi et al., 2007).Yet experiences affect individuals differently. It has been argued that about 15% of babies are highly sensitive to their environments (Hertzman & Boyce, 2010). For biologically sensitive infants, those born into poverty live in contexts of greater risk, while privileged environments provide protective mechanisms. Though support and programs focusing on early childhood development are beneficial for all, benefits are greatest for those who are most disadvantaged (Hertzman et al., 2010).

Promoting the quality of the caregiver-child relationship in the first three years is particularly important across income levels (Benoit, Coolbear, & Crawford, 2008; Standing Senate Committee on Social Affairs Science and Technology, 2009). Positive parenting practices hold the greatest potential to buffer the effects of poverty (Canadian Association of Family Resource Programs, 2011; Moore & Oberklaid, 2010; Westbrook & Harden, 2010). Healthy child development is promoted by maternal factors that include positive mental and physical health, ability to cope with stress, a positive parenting style, and adequate housing and neighbourhoods to live (Maggi et al., 2010). Parents with education and better mental health are more likely to meet the needs of their children by engaging in positive interactions, activities, and disciplinary practices (Yamauchi, 2010).

A longitudinal study linked early maternal support to hippocampal development in children (Luby, Barch, Belden, Gaffrey, Tillman, Babb et al., 2012). The authors claimed this was the first prospective human study to replicate the strong foundation built from the animal sciences.

The hippocampus is an area of the brain important for healthy stress, memory, social, and emotional development. The participants were 92 preschool children who participated in a study on depression, and later underwent magnetic resonance brain imaging at school age. Maternal support measured during mildly stressful early childhood tasks was found to be "a powerful predictor of larger hippocampal volume in both hemispheres at school age" (p.2855), in children who were not depressed. In depressed children, the protective benefit of maternal support appeared to be impeded. The authors concluded that parenting support to foster healthy early childhood development is a modifiable risk factor, which could be a prolific public health and social investment.

Brain development is influenced by interaction with caregivers and play (Cummins et al., 2007; Hertzman, 2009; Hertzman & Boyce, 2010; Irwin et al., 2007; Kolb, 2009). Exchanges that are mutually satisfying promote infant physical, social, and emotional development (Black & Oberlander, 2011). Protective factors such as a secure attachment and proactive, sustained, interactions with a caregiver set a positive childhood trajectory (Benoit et al., 2008; Hertzman, 2009; Hertzman & Power, 2004; Holden, 2010; Irwin et al., 2007; Kolb, 2009; Williams et al., 2013). Other relatively simple public health strategies with proven effectiveness include the promotion of breastfeeding, immunization, and prenatal nutrition; as well as prevention of injuries from common safety risks that include sleeping, shaking, falls, burns, poisoning, choking, suffocation, and drowning (Canadian Paediatric Society, 2011; Public Health Agency of Canada, 2009).

The context of nurturing environments for Aboriginal families. Many Aboriginal families in Canada are struggling to provide their children with nurturing environments and a healthy life in early childhood. Aboriginal health and parenting practices must be considered

within broader social, political, and historical contexts (Greenwood, 2005). Colonialism has created intergenerational trauma, oppression, discrimination, and dependency on the state (Alfred, 2009; National Collaborating Centre for Aboriginal Health, 2009-10c). Historical impacts of residential schools continue to be influential, and school systems have not always been sensitive to supporting Aboriginal students to succeed (Reading & Halseth, 2013). The multiple inequities experienced by Aboriginal people are disproportionate to other Canadian families; resulting in poverty, poorer health and education status, violence and substance abuse (Reading & Wien, 2009; Reading & Halseth, 2013).

Inequities experienced by Indigenous people are especially disproportionate for women, who not only experience discrimination due to race and class, but also due to gender (Halseth, 2013). In the last two generations, these community and structural risk factors have lessened the strength of Aboriginal families (National Collaborating Centre for Aboriginal Health, 2009-10d; Tousignant & Sioui, 2009). Lost traditional parenting practices, language, kinship, and culture, have been replaced by models of neglect and abuse (Bombay, Matheson, & Anisman, 2009). The intergenerational effects of trauma have perpetuated lack of trust; substance use; negative parenting styles; and disrupted relationships within families, communities, and society (Bombay et al., 2009; Haskell & Randall, 2009; Tousignant & Sioui, 2009). Research has highlighted the role systemic factors such as poverty, inadequate housing, and substance use continue to have for Aboriginal families (National Collaborating Centre for Aboriginal Health, 2009-10a, 2009-10b).

The context of nurturing environments for Immigrant families. While immigrants also tend to be a social group with significant inequities, findings suggest that the risk for mortality is lower compared to the Canadian population ,while mortality rates for Indigenous people are higher (Pampalon, Hamel, & Gamache, 2010). A significant difference is that the historical

experiences of Aboriginal people have been beyond their control and without their input; while the culture, traditions, and languages of immigrants remain in their countries of origin (Commission on Social Determinants of Health, 2008). However, the process of resettlement creates challenges that may include loss of language and culture, marginalization, stigmatization, in addition to finding adequate housing, employment and supports (Srivastava, 2014).

Regardless of culture, the Commission on the Social Determinants of Health highlights child poverty as a powerful determinant that perpetuates intergenerational inequities, and acts as a barrier to population level health improvements (Commission on Social Determinants of Health, 2008). Reading states"…child poverty is family poverty, is community poverty, is generational poverty. That is, poverty never affects just one individual, at one time, but is an issue that transcends age, time, and space" (Reading, 2009, p. A6).

Enhancing Knowledge by Measuring Inequities and Equity Enhancing Activities

The impact of poverty on Canadian women and families. The Commission on the Social Determinants of Health states that there has to be increased understanding of the social determinants of health, as well as the impact and extent of health inequities (Commission on Social Determinants of Health, 2008). A current research gap is the lack of methods to measure and monitor program and policy effectiveness, particularly interventions to create population level improvements. Barriers are created for people in poverty, by placing the onus on the individual to navigate across complex programs and systems (Lynam, Loock, Scott, Wong, Munroe, & Palmer, 2010). Canada's chief public health officer estimated that 12% of the nation's children live in poverty (Public Health Agency of Canada, 2009), although there is lack of consensus regarding a specific measure or definition (Albanese, 2010; Collin, 2007). Lack of an official measure of poverty allows government claims of poverty reduction to remain unclear

(Manitoba Campaign 2000 Network, 2010). Data collected on families in the WRHA defined financial difficulties as use of social assistance, or maternal self-report of insufficient resources to meet basic needs (Winnipeg Regional Health Authority, 2010). For the purposes of this dissertation, the WRHA definition will be adopted and terms such as poverty, financial difficulties, vulnerable, and social disadvantage will be used interchangeably.

Women and children living in poverty are particularly at risk for inequities in the postpartum period (Kurtz Landy, Sword, & Ciliska, 2008; Shonkoff, 2010). Four studies were located that considered the issue of poverty immediately following the birth of a newborn (Kurtz Landy et al., 2008; Kurtz Landy, Sword, & Valaitis, 2009). An Ontario study reported women of lower socio-economic status were more likely to be discharged from hospital earlier compared to socio-economically advantaged women, often within 24 hours of birth. In addition, they had poorer health status and were less likely to receive recommended levels of community-based follow-up (Kurtz Landy et al., 2008). These women reported feeling overwhelmed and having difficulties adjusting to parenting (Kurtz Landy et al., 2009). Mothers in poverty have been reported to experience the greatest effects of depression (Black & Oberlander, 2011); and mental health issues such as postpartum depression have been strongly linked to later childhood problems (Leve, Kerr, Shaw, Ge, Neiderhiser, Scaramella et al., 2010).

Socio-economic disadvantage impacts early childhood development (Public Health Agency of Canada, 2009; Raphael, 2010a). Poverty is characterized by constant stress, greater exposure to environmental toxins (Standing Senate Committee on Social Affairs Science and Technology, 2009) and inadequate nutrition (Conroy et al., 2010; Leiss & Kotch, 2010). Children are more susceptible to environmental toxins and experiences than adults, particularly prenatally (Moore & Oberklaid, 2010). Exposure to urban crime and violence may also interfere

with development and contribute to anxiety, depression, aggression, and poorer academic abilities (UNICEF., 2012). Poverty has been strongly correlated with low birth weight, and disproportionate infant morbidity and mortality (Brownell, De Coster, Penfold, Derksen, Au, Schultz, & Dahl, 2008; Jutte, Roos, Brownell, Briggs, MacWilliam, & Roos, 2010; Public Health Agency of Canada, 2008; Raphael, 2010a). Universal injury prevention programs and policies have reduced hospitalizations in higher socio-economic groups, but rates have increased for children most at risk (Brownell, Derksen, et al., 2010). Living situations which are overcrowded and unsanitary, in addition to lower rates of immunization enhance the spread of communicable diseases, contributing to increased morbidity and mortality (UNICEF., 2012).

For a country considered wealthy, Canada has substantive infant mortality and morbidity (Raphael, 2010a). Compared to similar countries, Canada has high rates of childhood obesity, mental health problems, children involved with protective and justice services, and inadequate childcare spaces to support parents (Fisher & Santos-Pais, 2009). Gross delays in early childhood contributes to chronic and acute stress as the child enters school, causing additional negative long-term health repercussions from hormone, immune, and nervous system disturbances (Maggi et al., 2010). There is also substantive tooth decay and dental surgery, lack of high school completion, and teen pregnancy (Public Health Agency of Canada, 2009). By the time adulthood is reached, there are disproportionate rates of mental health issues, suicide, premature death, and diabetes (Public Health Agency of Canada, 2008, 2009).

Failure to adequately support early childhood development has increased inequities in Canada, and resulted in considerable numbers of children with substantive but preventable learning disabilities, mental health issues, emotional, and social disabilities (Halfon, 2009). By age five, there are significant differences in physical, social/emotional, and language/cognitive

development based on level of income, education, and parenting (Hertzman & Boyce, 2010). Readiness for kindergarten is one method of assessing the adequacy of early childhood experiences (Hertzman & Power, 2004; Public Health Agency of Canada, 2009). The Early Development Instrument assesses key indicators that include physical, social cognitive, emotional and language skills (Hertzman, 2009). Research using the Early Development Instrument in Manitoba and British Columbia found that close to 30% of the kindergarten population was delayed in at least one area (Kershaw & Anderson, 2009). While approximately 5% of infants have detectable developmental limitations at birth, Early Development Instrument scores ranged from 5-70% based on neighbourhood diversity. Inadequate access to education programs to promote early childhood learning contributes to inequities for children living in poverty (UNICEF., 2012).

Outcomes are particularly troubling for Canadian Aboriginal people; countless numbers experience poor health for their entire life, contributing to a reduced life expectancy rate that is comparable to third world countries (Standing Senate Committee on Social Affairs Science and Technology, 2009). The population is young and growing, with 50% of Aboriginal people being less than 25 years old (Standing Senate Committee on Social Affairs Science and Technology, 2009). From 1996 - 2006, the Aboriginal population increased 45%, compared to a growth rate of 8 % in the non-Aboriginal population (Statistics Canada, 2010). Funding to Aboriginal people has not kept up with population growth, further increasing the gap between Aboriginal and non-Aboriginal people (National Collaborating Centre for Aboriginal Health, 2009-10b). While more mobile growing numbers of Aboriginal people predominantly reside in urban Canadian cities (Place, 2012). Place (2012) argues that poorer health outcomes and lack of attention to the

social determinants necessitate a continued and deliberate policy and planning focus, to develop culturally safe services.

Rates of child poverty for Aboriginal families are particularly high (Public Health Agency of Canada, 2008; Raphael et al., 2008; Reading & Wien, 2009; UNICEF, 2009). Although Aboriginal infant mortality has declined, rates remain significantly higher than for non-Aboriginal people (Public Health Agency of Canada, 2008; Simonet, Wassimi, Heaman, Smylie, Martens, Mchugh et al., 2010). There are also more Aboriginal children in government care today than during peak times of the residential school system (UNICEF, 2009).

Health equity impact assessment. To reduce the current gap in health that exists between the poor and the wealthy, programs and activities must be examined from an equity perspective (Rice, 2011). Health services should be allocated based on population needs, founded on principles of social justice so areas of greater need are resourced adequately, while maintaining universal services for all (Pritchard & de Verteuil, 2007). Equity, from the perspective of health systems, pertains to the organization of services that reduce barriers and are accessible to individuals across social gradients (Ontario Ministry of Health and Long-Term Care, North East, Toronto Central, & Waterloo Wellington Local Health Integration Network, 2011). A health equity impact assessment is a process to assess equity, incorporate evidence, and bridge the gap between research and policy (Public Health Advisory Committee, 2005/updated 2011). Health equity impact assessment is one method that can promote “whole of government thinking” (Health Council of Canada, 2010, p. 15).

Health equity impact assessment evaluates unintended health consequences for vulnerable groups, both positive and negative, based on health policies and programs (Ontario Ministry of Health and Long-Term Care et al., 2011). The approach is participative and consultative, and

aimed at creating population level improvements (Public Health Advisory Committee, 2005/updated 2011). Health equity impact assessment can be used retrospectively to design new programs, or as a framework to evaluate the mix of initiatives to estimate benefits across populations, versus the risk of widening gaps for those most vulnerable (Ontario Ministry of Health and Long-Term Care et al., 2011). In the United Kingdom a health equity audit was implemented to assess the distribution of PHN home visiting resources and the impact on child poverty (Pritchard & de Verteuil, 2007).

Health equity impact results should be considered by decision makers in developing policies and programs (Ontario Ministry of Health and Long-Term Care et al., 2011). When inequities in the uptake of services are identified relative to the need, changes may be necessary to improve access and outcomes for vulnerable groups (Goyder, Blank, Ellis, Furber, Peters, Sartain, & Massey, 2005). The National Collaborating Centre for Healthy Public Policy website contains a variety of tools and resources to promote health equity, but few examples where the tools have been used in Canada. A workbook was developed by the Ontario Ministry of Health (Ontario Ministry of Health and Long-Term Care et al., 2011). In Manitoba, the Health Council of Canada identified the piloting of an equity-focused health impact assessment tool as an emerging practice (Accreditation Canada, 2013). These types of assessments are important to continue to test to establish an evidence-base that pertains to Canadian health services.

Tackling the Structural Drivers of Inequities

The function of public policy in promoting early childhood development. Canadian policies have contributed to family poverty and declines in the health of children (Hertzman, 2009). Founded on the Convention for the Rights of the Child, the House of Commons resolved to eradicate poverty for children by the year 2000 (Collin, 2007). More than a decade past that

target date, Canada has fared poorly to comparable countries (Bryant, Raphael, Schrecker, & Labonte, 2011), and public policy has been a contributing factor (Canadian Paediatric Society, 2012). Canada is one of the world's three wealthiest countries, along with the United Kingdom and the United States, that rank at the bottom of the infant mortality league tables (UNICEF, 2013).

Societal structures and the distribution of resources that produce inequities are amenable to change using social policy (Marmot & Bell, 2011; Reutter & Kushner, 2010). Investments, policies, and targeted social programs must support those who are most vulnerable (Organisation for Economic Co-operation and Development, 2014). While the importance of social inequities has been well documented in Canada, there has been lack of political will to address child poverty and other social issues (Campaign 2000, 2013; Kershaw & Anderson, 2009; Raphael, 2010c; Raphael et al., 2008; Raphael, Labonté, Colman, Hayward, Torgerson, & Macdonald, 2006; Siddiqi et al., 2007). The incentive to establish public policy is ultimately based on a perception of the issue being a societal versus an individual responsibility (Raphael, 2014). Tax cuts and medical care have been higher political priorities (Kershaw & Anderson, 2009). In 2010, there was an estimated $192 billion in expenditures to healthcare, accounting for the largest portion of public spending (Health Council of Canada, 2010). Additional investments in health care are unlikely to improve early childhood development and population level outcomes (Siddiqi & Hertzman, 2007).

There are several indicators that politics and bureaucracy represent the largest obstacle to effective early childhood development services (Albanese, 2010; Braveman & Barclay, 2009; Siddiqi et al., 2007). Canada supports a biomedical approach which focuses on individual actions as the root of health problems, rather than broader systemic structures (Rice, 2011). Canada is

one of the top spenders on health (Raphael, 2010b), but one of the lowest on social transfers to families based on level of income (Phipps, 2010). Countries with the lowest incidence of child poverty expend the highest amount of their Gross National Product to support social programs; Canada ranks 13 out of 22 nations (Raphael, 2010c). Countries with more optimal early childhood development outcomes offer significant monetary or in-kind benefits such as childcare, housing, and education opportunities to those in the lowest income levels (Raphael, 2010c). Social democratic countries such as Sweden, Denmark, and Norway, value universalism and structure public policies to address social issues and promote population health (Raphael, 2010b).

Parenting and health services should be coordinated to support healthy and equitable pregnancy and early childhood development (Kershaw & Anderson, 2009). The Prime Minister has been lobbied to advance the early childhood development agenda through the creation of a Minister of State, a national advisory council on children, and a pan-Canadian policy framework (Keon, 2009; The Standing Senate Committee on Social Affairs Science and Technology, 2009). This would have included passing legislation that complied with the Convention on the Rights of the Child; establishment of an independent commissioner to maintain early childhood development on policy agendas; a budget; and detailed analysis and reporting structures to monitor progress and ensure accountability (Fisher & Santos-Pais, 2009). However, investments in early childhood and public policy have been intermittent, uncoordinated and inadequate to create the long-term changes necessary for population level improvements (Williams et al., 2013; Williams & Hertzman, 2009).

In 2010, the federal government allocated $5.25 million from the Department of Justice Victims Fund to develop child advocacy centres (Department of Justice, 2012). Child advocacy

centres aim to provide multidisciplinary and coordinated responses, to support the needs of children who have been victims or witnessed crime. In June of 2011, the government issued a press release regarding the opening of Manitoba's first centre (Manitoba Government, 2011). The government offered provincial funding of $339,000 annually, to match two years of annual federal funds in the amount of $350,000. The Office of the Children's Advocate is an independent branch of the Manitoba Legislative Assembly, tasked with promoting the Convention of Rights outlined by the United Nations and representing the best interests of children involved with Child & Family Services (Children's Advocate, n.d.-b). Activities include case, system, and community advocacy; case reviews, and special investigations (Children's Advocate, n.d.-a). It is hopeful that there continues to be a body designated to advocate for the rights of children in Manitoba; however, the impact achievable within such meagre funding remains to be seen.

All levels of government play fundamental roles in creating nurturing environments through policies that provide sufficient income; employment opportunities; health care; early childhood resources; education; food security; safe neighbourhoods; and adequate housing. To promote the health of children, a combination of universal and targeted policy approaches are important (Sharp & Filmer-Shankey, 2010). However, policies must be assessed on effect, unintended effect, and impact across different groups (Morestin, Gauvin, Hogue, & Benoit, 2010). Universal policies and programs are intended to improve the health of populations, but may foster inequities and widen social gradients for those in the lowest income groups (Martens, Brownell, Au, MacMillan, Prior, Schultz et al., 2010; Stringhini et al., 2010). To reduce gaps, policy makers and program planners use targeted strategies to increase the health of those least

well off (Martens et al., 2010). Evidence-based targeted programs can work upstream to address root causes of disadvantage (Rice, 2011).

The necessity of inter-professional collaboration. Collaboration among differing professionals to address the social determinants of health has been a global priority since the early 1990's (Reeves, Lewin, Espin, & Zwarenstein, 2010; World Health Organization, 2010). Inter-professional collaboration can be an efficient approach when multiple providers are involved with the same client (Banks, Dutch, & Wang, 2008; Begun, White, & Mosser, 2011; Claiborne & Lawson, 2005; Freeth, 2001). Due to the specialization among disciplines, collective decision-making can produce more holistic and client-centered care (Axelsson & Axelsson, 2006; Bowen, Stewart, Baetz, & Muhajarine, 2009; Soklaridis, Oandasan, & Kimpton, 2007). Health and social systems are also increasingly pressured to reduce costs through service coordination (Begun et al., 2011). As the majority of determinants contributing to inequities fall outside the domain of health, healthcare providers must have skills to work with other disciplines and sectors (Ndumbe-Eyoh & Moffatt, 2013; Pelaseyed & Jakubowski, 2007).

Coordinated action and shared responsibility are believed to be essential in promoting health equity and creating population level improvements (Fawcett, Schultz, Watson-Thompson, Fox, & Bremby, 2010; Hernandez et al., 2010; Horwath & Morrison, 2011; McFadyen, Webster, Maclaren, & O'neill, 2010; Moore & McArthur, 2007; Standing Senate Committee on Social Affairs Science and Technology, 2009; World Health Organization, 2010). A competency-based model developed in Canada defines inter-professional collaboration as "the process of developing and maintaining effective working relationships with learners, practitioners, patients/clients/families and communities to enable optimal health outcomes. Elements of

collaboration include respect, trust, shared decision-making, and partnerships" (Orchard, Bainbridge, Bassendowski, Casimiro, Stevenson, Wagner et al., 2010, p. 8).

Fostering the skills to work collaboratively requires extensive nurturing and support, because of the levels of specialization that have developed across disciplines (Axelsson & Axelsson, 2006; Cameron, Lart, Bostock, & Coomber, 2013; D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). A predominant theme has been understanding how professionals socialized to discipline-specific foci throughout their education programs develop collaborative relationships outside of their areas of expertise (D'Amour et al., 2005). As such, inter-professional education for collaborative patient centred practice has been a federal priority (Cameron, 2011; Gillespie, Whiteley, Watts, Dattolo, & Jones, 2010; Health Canada, 2008). Areas to advance inter-professional education have focused on policy and system changes (Public Health Agency of Canada, 2013.). Unfortunately, the presumption that inter-professional learning will improve collaboration following graduation has yet to be documented (McFadyen et al., 2010). For this reason, there is a desire to strengthen models of inter-professional learning, practice, evaluation, and theory to address the determinants of health (Barr, 2010; World Health Organization, 2010). In spite of the investment of resources, there has been little evidence evaluating the impact of inter-professional collaboration on community health outcomes (Hicks, Larson, Nelson, Olds, & Johnston, 2008), and collaborative practice models focused on target populations (Fleet, Kirby, Cutler, Dunikowski, Nasmith, & Shaughnessy, 2008), such as children living in poverty.

The role of interprofessional collaboration in child health. The complexities associated with poverty highlight the advantages of inter-professional collaboration in promoting and protecting the health and development of children (Feng, Fetzer, Chen, Yeh, & Huang, 2010;

Halfon, 2009; Marcellus, 2005; Watkin, Lindqvist, Black, & Watts, 2009). The most tragic situations are preventable childhood deaths; yet inquests into childhood fatalities typically cite inter-professional and inter-agency collaboration as system failures (Corby, Young, & Coleman, 2009; Gillespie et al., 2010; Watkin et al., 2009). Current structures have rigid funding and eligibility criteria; creating gaps, service duplication, and system fragmentation that are not responsive to the needs of children and families with complex health and social needs (Halfon, 2009; May-Chahal & Broadhurst, 2006; Schmied, Mills, Kruske, Kemp, Fowler, & Homer, 2010). There tends to be a reactive focus on crises which results in episodic treatment; as opposed to services that are preventative, comprehensive, and family-centred (Halfon, 2009). Reports in the United Kingdom have repeatedly highlighted the importance of targeted and integrated preventative services for children in poverty (Sharp & Filmer-Shankey, 2010).

As a federal priority, inter-professional collaborative demonstration projects have been funded in Canada (Bowen et al., 2009) however; few have focused on the area of early childhood development. A synthesis of inter-professional projects in Canada reported 31 published peer reviewed studies that focused on interventions post-licensure. Of the studies, 22 took place in urban hospital settings, the others in primary care (Suter & Deutschlander, 2010). One study with a focus on family health was done across six primary care teaching sites in Ontario, and included nurses and social work students (Soklaridis et al., 2007). Soklaridis and colleagues reported a lack of clear definitions and understanding of professional roles among students. A second project in British Columbia included nursing, social work, and education students focused on case-based scenarios with vulnerable families (Gillespie et al., 2010). These authors identified the need for a coordinated education and research agenda to advance inter-professional collaboration in child welfare.

Professionals may differ in approach, but each can play a role in strengthening family capacity and reducing the likelihood of childhood harm (Darlington, Healy, & Feeney, 2010; Feng et al., 2010). However, there continues to be a lack of inter-professional collaboration documented that optimally supports vulnerable families. A recent Australian study found that rather than being client centred services for children and their families were organized around professionals, who each thought they were the most appropriate care provider but lacked understanding of other roles (Psaila, Schmied, Fowler, & Kruske, 2014).

To improve the health of children, Canadian policies and programs must be reoriented to be holistic and better coordinated, to produce an array of resources for families (Canadian Association of Family Resource Programs, 2011; Canadian Paediatric Society, 2009; Sharp & Filmer-Shankey, 2010). An essential component is appreciating the history of First Nations people and working collaboratively to reorient policy and practice through a process of decolonialism, and revitalization of Aboriginal communities and culture (Hackett, 2005; National Collaborating Centre for Aboriginal Health, 2009-10d; Ten Fingers, 2005). To reduce inequities experienced by vulnerable families, enhancing preventative interventions and service coordination by changing funding structures and organizational culture have been suggested (Smith, Peterson, Jaglarz, & Doell, 2009).

Summary

To set the background for the study, in the first chapter, I used applicable aspects of the Commission on the Social Determinants of Health report as a guiding framework to present the Canadian public health context. Actions identified by the report relevant to PHN intervention included improving daily living conditions with a focus on early childhood development; enhancing knowledge by measuring health inequities and health equity actions; and working

collaboratively to tackle the structural drivers of inequities. PHNs can foster population health improvements by focusing their practice on the determinants of inequities, particularly in early childhood, and working with others to address root causes. In the following section, I review literature specific to PHN practice.

Chapter 2: Literature Review

When using an action research approach, the literature chapter offers a preliminary review of published literature regarding the topic, theoretical perspectives, and gaps (Stringer, 2007). In the next section, I have summarized recent literature regarding PHN practice, using a framework for nurses proposed by Canadian authors (Reutter & Kushner, 2010).

Search Strategy

The literature search was completed primarily using the Scopus database. As a reference, Pubmed was checked for comparison. In Pubmed, using the search term "public health nurs,*" and applying filters for English documents in the last five years, 375 articles were found. The same search in Scopus identified 693 documents. Limiting the search using the terms Canada and nursing, the search returned 32 articles. A variety of search terms were therefore used, depending on the extent of articles found. For instance, where there was little information using PHN, the term nurs* was used. Various terms were also used in association. This included home-visit,* equity, inequity, theory, early child dev,* child dev*, model, service delivery, post-partum, maltreatment, role, and poverty. Abstracts were scanned and full articles obtained if appropriate. When reviewing full articles, others were accessed using reference lists if they appeared relevant. Google was used to access government websites and key reports, such as policy documents from nursing and other professional organizations.

The Role of the PHN in Promoting Healthy and Equitable Early Child Development

A nursing model developed in Canada provides a helpful framework to guide PHN practice (Reutter & Kushner, 2010). The authors argue that nurses can address inequities at individual and community levels by ensuring access to health and healthcare. Access can be promoted by providing sensitive and empowering care; addressing root causes to improve

underlying conditions; appreciating the extent of inequities, and working collaboratively to tackle them. Policy analysis and advocacy are essential in promoting health equity. First steps include increasing awareness of the social determinants of health among key stakeholders, including health providers, decision-makers, and the public (Reutter & Kushner, 2010).

Although working collaboratively is not explicitly outlined in the model, the authors cite intersectoral collaboration and partnering as essential components of policy advocacy. Nurses can advocate for clients at the individual level, however a main action should be policy advocacy to increase awareness among the public, health professionals, and policy-makers. The framework provides a useful model to examine the literature related to the PHN role due to its consistency with PHN theory and practice. An aspect that appears to be missing is an evaluation component, or the measurement of PHN activities to reduce inequities. Considering this framework within a participatory action approach would incorporate evaluation based on the cyclical nature of action research. Using this framework, PHNs could increase awareness of these issues by changing the delivery of their services, with a focal point on improving the health of groups experiencing inequities (Pelaseyed & Jakubowski, 2007).

Barriers and Facilitators that Promote Access to Health and Health Care

Ensuring access to health. The literature depicts a significant PHN role in facilitating access to health and the promotion of equity. Public health involves the organized efforts of society to keep people healthy and prevent injury, illness and premature death (Public Health Agency of Canada, 2008). The Public Health Agency of Canada describes it as a combination of programs, services and policies that protect and promote the health of all Canadians. Public health includes activities like immunization, healthy eating and physical activity programs, infection control measures in hospitals, along with the detection, lab testing and regulation that

support these activities. By helping to keep Canadians healthy, public health can relieve some of the pressure on the health-care system (Public health Agency of Canada, 2011b). Investing in these types of public health strategies has been proven to promote health and reduce healthcare spending (Robert Wood Johnson Foundation, 2013b).

The field of public health nursing is unique, in that it represents the fusion of public health sciences with the theory and practice of nursing (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009; Keller, Strohschein, & Schaffer, 2011; Schoon, 2008; Swider, Krothe, Reyes, & Cravetz, 2013). While health care is mainly focused on the individual, the goal of public health is to improve health across populations (Public Health Agency of Canada, 2011a). Population health approaches are based on the implementation of cost-effective and evidence-based interventions, in response to surveillance data (Rivara & Johnston, 2013).

In Canada, public health responsibilities are shared between federal, provincial, and regional governments, as well as Aboriginal organizations (Canadian Public Health Association, 2010). Public health services are often delivered by diverse professionals with on the job training and limited education specific to the field, resulting in varied perspectives when complex program decisions are required (Brownson, Fielding, & Maylahn, 2009). Following the global outbreak of severe acute respiratory syndrome or SARS, a plan to strengthen and coordinate the public health workforce was deemed necessary to prepare for future pandemics and public health emergencies, as well as to influence chronic disease prevention and health disparities (The Joint Task Group on Public Health Human Resources, 2005). In 2005, this plan titled “Building the public health workforce for the 21st century: A pan Canadian framework for public health

human resources planning" was released by the Public Health Agency of Canada, to support the regions in delivering population based services.

PHNs work in complex and bureaucratic health systems, which influence PHN services and programs (Baldwin, Lyons, & Issel, 2011). The Canadian Public Health Association describes PHN practice founded on principles of population health, evidence, prevention, and the social determinants of health (Canadian Public Health Association, 2010). In the United States, and Norway, similar values and beliefs are described as cornerstones of PHN practice (Glavin, Schaffer, Halvorsrud, & Kvarme, 2014; Keller et al., 2011). The range of healthcare systems and provider roles within those systems may account for some of the diversity in the literature, making application between and across settings challenging. In the United Kingdom, PHNs are called health visitors and work within interprofessional teams that include a well established system of midwifery (Machin, Machin, & Pearson, 2012). PHNs in the United States are described as disadvantaged, and less visible compared to their counterparts in the medical or hospital system (Issel, Bekemeier, & Kneipp, 2012).

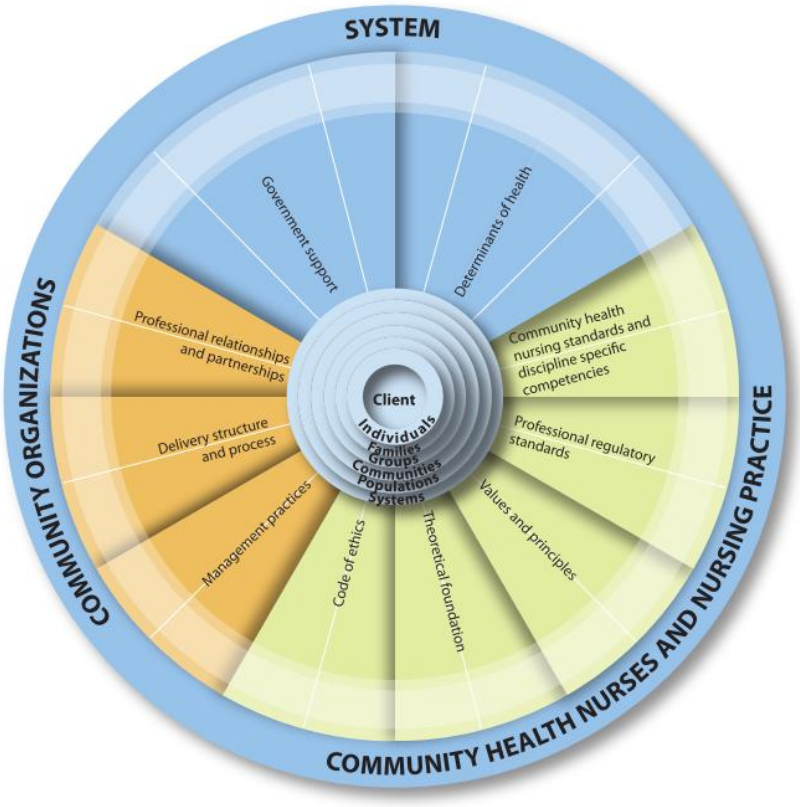
Strengthening the public health workforce remained a federal priority, and grants were made available to further develop the roles of public health practitioners. Through a number of Public Health Agency of Canada funded projects, the Community Health Nurses of Canada has played a central role in articulating the scope of PHN practice. The Community Health Nurses of Canada is a voluntary organization that represents the voice of PHNs (Community Health Nurses of Canada, n.d.). Based on reviews of the literature and Delphi methodology with expert community health nurses, the Community Health Nurses of Canada has developed several key documents.

Standards of practice for PHNs were originally released in 2003. In 2011, the standards were revised for the third time and published with elements of a professional practice model. The standards exemplify "a vision for excellence" to guide all aspects of PHN practice, research, education, and management (Community Health Nurses of Canada, 2011b, p. 7). This publication describes standards in the areas of: health promotion, prevention, and maintenance; building capacity and promoting access and equity; professional relationships, accountability and responsibility. The standards are broad in scope, intended for PHNs and other classifications of nurses working in community-based settings. To further define PHN practice, in 2009, Community Health Nurses of Canada released discipline specific competencies (Community Health Nurses of Canada, 2009). Competencies were identified in eight main areas: public health nursing sciences; assessment; policy and program planning; collaboration and advocacy; diversity; communication; leadership; and professionalism. In 2010, the Canadian Public Health Association and Community Health Nurses of Canada released a document describing roles and activities of PHN practice. All documents are complementary and intended to guide PHN practice.

The most recent publication of the Community Health Nurses of Canada is a professional practice model (See Figure 1). The professional practice model depicts three broad categories, each containing a number of components that support PHNs in promoting the health of the client. The graphic is circular, with the client at the centre, implying that each area is equally important in contributing to well-being. As depicted in the graphic, a number of features define a unique PHN scope and function. These include Community Health Nurses of Canada standards and competencies; professional regulatory standards; the Canadian Nurses Association Code of Ethics; PHN theoretical foundation; and values and principles. The category of community

organizations includes the delivery of PHN services; PHN professional relationships and partnerships; and management practices. The category of system refers to government support and determinants of health. In the centre of the graphic, the concept of client pertains to "individuals, families, groups, communities, populations and systems" (Community Health Nurses of Canada, 2013a, p. para 13).

Figure 1: Community Health Nurses of Canada Professional Practice Model



PHN practice must be examined for congruence with the Community Health Nurses of Canada standards of practice (Lind & Smith, 2008) and other theoretical documents. A clear vision for PHN practice is articulated which is broad, and emphasizes the PHN role in the promotion of equity. However, this body of literature is based on expert opinion and has not been empirically tested. Working to full scope has been cited as imperative to practicing PHNs, who

highlighted the importance of fostering partnerships; community development; flexibility; and role development (Meagher-Stewart, Underwood, MacDonald, Schoenfeld, Blythe, Knibbs et al., 2010).

Conversely, literature on PHN practice depicts a lack of clear vision in Canada and elsewhere, and advocates for role clarity (Keller et al., 2011; Schofield, Ganann, Brooks, McGugan, Dalla Bona, Betker et al., 2011; Truglio-Londrigan & Lewenson, 2011). A main reason is the evidence base to guide PHN practice. An extensive review of the literature found 12 PHN conceptual models, but most had not been tested or used in practice (Bigbee & Issel, 2012). The authors recommended these models be further developed or consolidated to establish a foundation of PHN specific theory. There is a need to link PHN specific interventions with outcomes (Baisch, 2012; Bigbee & Issel, 2012). The application of PHN competencies in practice and across client settings also must be examined (Swider et al., 2013). Four areas prioritized for a PHN research agenda in the United States were "PHN intervention models, quality of population-focused PHN practice, metrics of/for PHN, and comparative effectiveness and PHN outcomes" (Issel et al., 2012, p. 1). At a recent forum, opportunities to optimize PHN practice in the United States included development and dissemination of a shared vision; development of new PHN practice and education models; new strategic partnerships, leadership development; and continued development of a PHN evidence base (Robert Wood Johnson Foundation, 2013a). Although American data are beneficial, the need for Canadian information is also imperative.

The Community Health Nurses of Canada and Canadian Nurses Association convened experts to establish priorities for community health nursing (Schofield et al., 2011). A qualitative descriptive approach was used, to collect interview data from ten key informants and four focus

groups from diverse regions and positions. These experts acknowledged numerous issues threatening the sustainability of PHN practice; reporting a current crisis, devaluing, lack of research, and inadequate understanding of the role. Population health was identified as a driving force in moving forward; founded on the well-being of individuals, families, and communities. The first suggested priority was development of a common vision for community health nursing, based on the discipline competencies and full scope of PHN practice (Schofield et al., 2011).

Incongruence in practice represents a significant theory-practice gap for Canadian PHN practice (Cohen & Reutter, 2007; Lind & Smith, 2008). There are continued PHN reports of a growing disconnect between the desired practice and their daily activities (Beaudet, Richard, Gendron, & Boisvert, 2011). Beaudet and colleagues interviewed 69 PHNs and managers in Quebec and found PHNs were largely focused on clinical services and individual level behaviour modification, to the detriment of population level health promotion. The population level practice was constrained by under-resourced organizational structures that prioritized clinical and curative services. The PHNs were worn out by the extent of changes in health delivery and "critical of their lack of involvement in the planning and implementation of the reforms" (p.E9), resulting in few practice changes.

Ensuring access to health care. Community services that promote family health may contribute to child development and improve life course trajectories (Shah & Austin, 2014). Home visiting is a key strategy highlighted by the Public Health Agency of Canada to promote access to health care, healthy early childhood development, and positive parenting practices (Public Health Agency of Canada, 2009). Families living in poverty and other complex social situations have high numbers of missed appointments with universal healthcare services, however PHNs maintain contact through home visits or other community based activities

(Woodman, Brandon, Bailey, Belderson, Sidebotham, & Gilbert, 2011). PHNs play a critical role in identifying family risk factors and ensuring access to services that promote health (Sharp & Filmer-Shankey, 2010; Tinker, Postma, & Butterfield, 2011).

While PHNs have historically visited vulnerable families in their homes, many universal PHN home visiting programs were implemented across Canada in response to earlier postpartum discharge practices (Cusack, Hall, Scruby, & Wong, 2008). Although there is no standard approach, PHN home visiting is believed to reduce risk and improve long-term health and social outcomes for mothers and young children (Leighton & Shiell, 2010; National Collaborating Centre for Determinants of Health, 2009). Home visiting has been associated with improved breastfeeding rates; maternal postpartum emotional and physical recovery; parenting knowledge; child health and development; and greater use of community resources (Leighton & Shiell, 2010). A recent review of home visiting programs in the United States reported improved health use and immunization rates, as well as fewer negative measures such as emergency visits and hospitalization among vulnerable families (Avellar & Supplee, 2013)

A study from the United States reported on the role of PHN home visiting and the theory of "advancing maternal development" (Atkinson & Peden-McAlpine, 2014).' The sample consisted of 30 PHN's in Minnesota, who submitted two or three stories each (n=64), describing their interactions with pregnant adolescents. The grounded theory contained three main themes with multiple subthemes. The stages identified were "incomplete, intermediate, and advanced maternal development." Within each stage, interventions described support provided by PHNs that increased adolescent awareness and self-efficacy. The most reported PHN interventions were case management and consultation. PHN activities to promote capacity and self-care

included assisting adolescents to generate solutions to issues such as education, employment, and use of community resources (Atkinson & Peden-McAlpine, 2014).

The most extensive research on long-term home visitation is based on the Nurse-Family Partnership program in the United States, which has documented sustained positive outcomes decades later (Hill, Uris, & Bauer, 2007; Leighton & Shiell, 2010; MacMillan, Wathen, Barlow, Fergusson, Leventhal, & Taussig, 2009; Monsen, Fulkerson, Lytton, Taft, Schwichtenberg, & Martin, 2010). The program has three intended goals: improved prenatal health to enhance birth and infant outcomes; enhanced child growth and development; and improved maternal future self-sufficiency (Dawley, Loch, & Bindrich, 2007). Random control trials have demonstrated benefits that include academic and economic achievement; improved mental health; less substance use and criminal activity; and lower rates of subsequent pregnancy (Eckenrode, Campa, Luckey, Henderson, Cole, Kitzman et al., 2010; Kitzman, Olds, Cole, Hanks, Anson, Arcoleo et al., 2010). Based on longitudinal evidence, the Nurse-Family Partnership has been cited as one of the most optimistic strategies in reducing the incidence of child maltreatment in the past three decades (Donelan-McCall, Eckenrode, & Olds, 2009; MacMillan et al., 2009; Scribano, 2010).

The Nurse-Family Partnership is implemented using strict criteria, which are important in maintaining the program's evidence base and outcomes. Women must be young first-time mothers of low socio-economic status and before 29 weeks gestation (Jack, 2010). Nurses deliver the program, incorporating competency-based training built upon discipline specific skills and knowledge (Kemp, Anderson, Travaglia, & Harris, 2005 162). In Canada, a pilot project based on the Nurse-Family Partnership program has been ongoing in Ontario since 2008

(Jack, 2010). The program has also been implemented in British Columbia, and is currently undergoing scientific investigation of its effectiveness (Nurse-Family Partnership, n.d.).

Attempting to replicate the Nurse-Family Partnership, costs and shortages of nurses have led many policy makers and public health programs to use paraprofessional home visitors to deliver parenting programs (O'Brien, 2005). Home visiting by paraprofessionals has shown some benefits, but outcomes in trials using nurses have shown long lasting effects that have not been found in other programs (Thomas, 2005). Generally the size of positive effect associated with paraprofessionals is smaller, compared to visiting programs employing nurses (O'Brien, 2005). Often home visiting is a public health strategy to deliver services or provide health care, rather than founded on a theoretical and evidenced based approach known to improve the overall health of participants (Howard & Brooks-Gunn, 2009).

In the literature, there is lack of agreement regarding the role of postpartum home visiting and its contribution to public health in the absence of well-defined program parameters (Machin et al., 2012). A recent Cochrane review examined twelve randomized control trials, incorporating data for more than 11,000 women (Yonemoto, Dowswell, Nagai, & Mori, 2013). The main finding was that postnatal home visits may benefit newborn health and maternal satisfaction however; conclusions could not be drawn regarding time, frequency, and intensity or duration of visits. The challenge is the wide-range of programs with differing structures, philosophies, and staff levels of education (Adams, Howard, Tucker, Appleton, Taylor, Chittleborough et al., 2009; Donelan-McCall et al., 2009). A pan-Canadian inventory of home visiting programs detailed this considerable diversity (Leighton & Shiell, 2010). Many, but not all provinces and territories, had action plans that included standardized home visiting curricula, screening, and assessment tools. Programs were delivered by a variety of practitioners that included nurses, allied health

professionals, and paraprofessionals. More evidence is needed to determine what programs and resources are most effective, but an array of innovative approaches are likely necessary (Kurtz Landy et al., 2008; Westbrook & Harden, 2010).

Providing sensitive empowering care. The PHN role has historically incorporated a human rights perspective (Kelly, 2014). In the early 1900's, PHN led preventative programs were developed in Canada to respond to increased morbidity and mortality associated with childhood communicable diseases (Porr, Drummond, & Olson, 2012). Porr and colleagues stated that nurses with advanced skills in working with families, were specifically chosen by health departments to deliver these programs. The ability to foster therapeutic relationships with vulnerable and complex clients to promote health, continues to be a pillar of PHN programs, receiving considerable attention in the literature (Falk-Rafael, 2001; Heaman, Chalmers, Woodgate, & Brown, 2007; Jack, DiCenso, & Lohfeld, 2005b; Oliveira & Marcon, 2007). Trust is essential before the PHN can work with clients to promote their health; the process Reutter and Kushner (2010) defined as providing sensitive empowering care.

At individual and community levels, PHNs must consider several aspects in providing sensitive empowering care. Cultural safety refers to respect for cultural differences and other worldviews and traditions (Wilson & Neville, 2009). Families may have differing values, beliefs, and cultures; producing behaviors that do not conform to societal norms (Starr & Wallace, 2009). PHNs are strength-based by interacting in ways that are respectful of other's social, cultural, and personal beliefs and circumstances (Aston, 2008). Protection involves respecting the knowledge of vulnerable populations and preventing exploitation, by not imposing the dominant context and culture (Wilson & Neville, 2009). Several theories based on empirical studies were located that outlined distinct elements to assist PHNs in developing and maintaining therapeutic relationships

with vulnerable mothers (Falk-Rafael, 2001; Jack et al., 2005b; Norris, Howell, Wydeven, & Kunes-Connell, 2009). Lack of training, time, and resources have been identified as barriers to the delivery of culturally competent care by PHNs (Starr & Wallace, 2009).

In Nova Scotia, a grounded theory study with 15 PHNs and 21 vulnerable mothers described the development of relationships within short time frames (Porr et al., 2012). 'Vulnerable' referred to single mothers experiencing challenges due to financial, social, environmental or other issues related to poverty. There were 60-90 minute long individual interviews conducted, using a semi-structured discussion guide. Additionally, the authors collected data by coding the nonverbal interactions of 14 participant dyads during home and office visits. Of these participants, 7 mothers were low income and 7 were high income. Writing memos of key thoughts, questions, and observations, tested the accuracy of ideas. The substantive theory of "targeting essence: pragmatic variation of the therapeutic relationship" was identified. The authors described six steps that enabled mothers to engage and trust the PHN. Initially the PHNs had to strategically engage the mothers using positive talk and a focus on the child. The mothers assessed the PHN to decide if they would trust them, and allow the relationship to progress to the point where disclosure of personal information and capacity building was possible. The final stages established an ongoing relationship or open door, whereby PHN led contact was discontinued, but the client could re-establish the therapeutic relationship at any time.

Also using a grounded theory approach, an Ontario study explored maternal engagement of 20 mothers receiving PHN and lay home visitor services (Jack et al., 2005b). Purposeful sampling was used to identify mothers considered high risk due to socioeconomic factors. Data were collected during 29 in-depth interviews. Three steps emerged in the process of developing a

therapeutic relationship. First, the mothers had to overcome their fears of being monitored or judged. In the second phase, mothers built trust, which increased commitment to improving their parenting abilities and allowed for open communication. Finally, the mothers sought mutuality, in which the collaborative trusting relationship allowed for goal setting and a meaningful, respectful exchange. The authors reported that the mothers felt vulnerable because they associated health providers as a potential threat to their family structure and functioning (Jack, DiCenso, & Lohfeld, 2005a)

Adeline Falk-Rafael proposed a mid-range theory of empowered or critical caring, based on the development of a trusting and reciprocal relationship between the nurse and client (Falk-Rafael, 2001, 2005; Falk-Rafael & Betker, 2012a). The study was an exploratory descriptive design consisting of two phases: focus groups with PHNs and individual interviews with 6 clients. Empowerment resulted through the clients' active participation. Aspects included establishing a mutual and trusting relationship, education, developing personal skills, advocacy, and increasing client capacity. A reciprocal relationship developed in which the PHN shared her clinical expertise, and incorporated theoretical and empirical evidence into practice. The theory was rooted in equity, social justice, and feminism. This was the only theory that extended beyond the individual; acknowledging the importance of the PHN role in upstream actions such as the development of supportive physical, economic, social and political environments (Falk-Rafael, 2005).

The theory of critical caring was examined for congruence with PHN practice (Falk-Rafael & Betker, 2012b). The study consisted of 11 qualitative interviews with expert PHNs. Findings supported the theory of critical caring, in that PHN practice was guided by caring and social justice. Themes were: the "moral imperative," "in pursuit of social justice" and "barriers to moral

agency.” The first two themes focused on the PHN role in addressing health equity, while the third described organizational and government barriers. The barriers created “moral distress” for PHNs, highlighting the important role that organizations play in supporting PHN practice (Falk-Rafael & Betker, 2012b)

In a later study, the relevance of critical caring was examined based on PHN practice (Falk-Rafael & Betker, 2012a). The study consisted of 10 individual interviews and 2 focus groups, for a total sample of 26 PHNs. The data advanced the theory of critical caring, identifying seven “carative health promoting processes” that experienced PHNs used to develop and maintain client relationships. An interesting observation was that legal and organizational factors affected attainment of the theory in practice (Falk-Rafael & Betker, 2012a).

The above literature provides an empirical basis to consider when PHNs are working with vulnerable families, highlighting the complexities associated with developing trusting relationships and engagement. A recent publication described processes and adaptations to a Registered Nurses’ Association of Ontario best practice guideline on client-centred care to make it applicable to PHNs (Athwal, Marchuk, Laforet-Fliesser, Castanza, Davis, & Lasalle, 2014). Values and beliefs consistent with PHN practice were articulated, depicting a strong social justice approach. The need to adapt a Canadian nursing guideline highlights that although client centeredness is a tenet of nursing practice, PHN practice is unique.

Several of the studies were completed in Canada, which is a strength of this body of literature. While Canadian studies are likely more relevant than American studies, the applicability in the WRHA remains unknown. The studies all used qualitative methods, highlighting that data based on relationships are less amenable to quantitative approaches. The lack of consistency in terminology and definitions may reflect the emergent nature of qualitative

approaches undertaken in different jurisdictions. However, it is difficult to know how clients defined as vulnerable in these studies compare to the population of clients in the WRHA.

While the studies provide guidance in developing relationships, they do not specify how PHNs promote health equity and the extent that this intensive individual level work contributes to population level improvements. These are clearly complex and long-term processes, founded on the premise that this will not be possible unless the PHN remains engaged with the client. Improving the health care experiences of vulnerable families could promote early childhood development and ultimately life-long effects (Baisch, 2012). To improve health outcomes for vulnerable families, there must be recognition that historic allocation of resources for PHN home visiting services based on numbers alone is likely to contribute to inequities (Pritchard & de Verteuil, 2007).

Changing underlying conditions. In addition to providing care that is sensitive and empowering, PHNs must work upstream to address social and environmental conditions which perpetuate inequities (Reutter & Kushner, 2010). PHNs must view circumstances holistically; recognizing the impact of political, social, historic and economic factors (Browne, Hartrick Doane, Reimer, MacLeod, & McLellan, 2010; Reutter & Kushner, 2010). Documents guiding practice emphasize the PHN role in promoting equity through action at multiple levels that include the individual, community, and government (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b).

Supporting access to services and resources are PHN actions that can change underlying conditions (Cawley & McNamara, 2011; Cohen & Reutter, 2007; Hazard, Callister, Birkhead, & Nichols, 2009; Johns, 2010; Young, 2009). Social justice involves redistribution of resources to improve health outcomes for disadvantaged populations (Bell & Hulbert, 2008; Boutain, 2005).

The Canadian Nurses Association (2010) Social Justice Gauge identifies ten defining attributes. Nurses can promote equity and access to health care and other human rights; build capacity, work to reduce poverty, promote enabling environments, advocate for human rights, and develop partnerships to create change\Principles of equity and social justice are central to providing effective and culturally appropriate care (Cohen & Reutter, 2007; Pacquiao, 2008; Starr & Wallace, 2009). Literature advocates for the promotion of equity for childbearing women, through incorporation of a social justice lens (Clingerman & Fowles, 2010; Logsdon & Davis, 2010; Pacquiao, 2008; Pauly, MacKinnon, & Varcoe, 2009; Walker & Chesnut, 2010).

A framework developed in the United Kingdom by Blackburn in the early 1990's was adapted by Canadian nurse researchers. The framework outlined three areas of action for PHNs (Cohen & Reutter, 2007). Cohen and Reutter suggested that PHNs could monitor and gauge the impact of poverty and policies in meeting the needs of low-income families. Health assessment data could be used, as well as evaluating the impact of services, resources, and policies. The second role, alleviating and preventing poverty, assists families in mitigating the negative effects of poverty. PHNs could be helpful in accessing services and resources, working in partnership with families and advocating for their needs where appropriate. This role is consistent with the concept of social justice outlined by Canadian Nurses Association above. The third area of suggested action was the creation of social change by working with clients, inter-professional and inter-sectoral teams, local communities, and multi levels of governments. The authors described nurses as well suited for policy advocacy, based on numbers, political knowledge, and organizational infrastructure (Cohen & Reutter, 2007).

The above literature provides a theoretical basis regarding the role PHNs could play in working to change underlying conditions that perpetuate poverty for families. Yet there are a

lack of empirical studies substantiating this role in PHN practice (Cohen & Reutter, 2007). A qualitative study using an appreciative inquiry approach with 15 PHNs in Ontario explored their role in addressing poverty (Dunne, 2011). The findings reported PHNs were mainly promoting individual lifestyle interventions; although addressing poverty was within their role and mandate, organizational leadership and political support were needed. Two Canadian reports involving key informants interviews from multiple and different locations, documented increasing public health program activities focused on behaviour and lifestyle approaches using educational interventions (Beaudet et al., 2011; National Collaborating Centre for Determinants of Health, 2011). Despite being an imperative role, processes and structures that marginalize PHNs may create limitations to attaining these functions in practice (Pauly, 2013). Organizational support to enhance the knowledge and ability of PHNs in addressing child poverty and other underlying conditions could foster PHN development in this important area (Cohen & Reutter, 2007).

Understanding the context of inequities. PHNs must critically examine the social and political issues that promote and sustain inequities locally, nationally, and globally (Reutter & Kushner, 2010). Understanding the context of inequities is essential in promoting health and should form the basis of public health programs. In the literature, beyond development of a trusting relationship, little is known about how PHNs work with complex families and understand the context of their inequities (Browne et al., 2010).

In rural and northern British Columbia, a qualitative interpretative study examined the processes and clinical skills PHNs used with vulnerable families in contexts of risk (Browne et al., 2010). Multiple forms of data were collected that included PHN observation; in addition to in-depth individual and focus group interviews with PHNs, families, and lay home visitors. Three main themes emerged: (i) contextualizing complexities associated with families' lives, (ii)

balancing risk and capacity; and (iii) working with families under surveillance. PHNs assisted families to navigate the system and to meet their needs. These PHNs believed it was more effective for mothers and families to be involved in the development of a plan to report child protection concerns, rather than the PHN reporting in isolation. This study provides greater understanding of the processes used by PHNs when child protection issues exist. These PHNs maintained relationships and promoted the health of clients, within the context of inequities the families were experiencing.

A distinguishing feature of the PHN role is the prominence of primary prevention activities to reduce inequities and prevent development of future problems (Canadian Public Health Association, 2010; Keller et al., 2011). Public health services must be founded on demonstrated effectiveness of program activities and based on data that are reliable and valid (Baisch, 2012; Issel et al., 2012). Community health assessment data should inform practice (Canadian Public Health Association, 2010). Tenets of evidence-based public health include use of peer-reviewed sources; systematically collecting data with information systems; using program planning frameworks founded on theory; community engagement; evaluation; and knowledge translation (Brownson et al., 2009).

Currently there are no tools that measure PHNs' unique contributions to population health (Bigbee & Issel, 2012; Issel et al., 2012). In Taiwan, a scale measuring PHN competencies was developed and found to be reliable and valid (Lin, Hsu, Li, Mathers, & Huang, 2010). Competencies were identified in the areas of basic care, community health management, teaching, and self-development. These competencies do not seem to be consistent with the Canadian context, and would need to be assessed for applicability. Participants of a consensus conference in the United States agreed that population level indicators for quality PHN practice

must be established (Issel et al., 2012). Population based nursing necessitates that evidence-based interventions improve health outcomes for target populations (Cupp Curley, 2012).

A growing body of literature citing individual level PHN activities with vulnerable groups is offsetting the lack of evidence and theory to guide system and population level health interventions (Bigbee & Issel, 2012; Issel et al., 2012). Although understanding the context of inequities for individuals and providing healthcare is important, there may be limited impact on population health outcomes (Cupp Curley, 2012). PHNs must function within complex health systems, work effectively in inter-professional teams, and practice at system and population levels (Levin, Cary, Kulbok, Leffers, Molle, & Polivka, 2008). Although practice may be influenced by program specific funding, PHNs have an obligation to assess evidence and consider multiple options to achieve desired goals (Brownson et al., 2009). PHN population based practice extends beyond the individual and family, to include communities; systems; and groups (Bigbee & Issel, 2012; Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2011b). Public health is the only agency with the "statutory and fiduciary responsibility for the health of the people" (Scutchfield & Howard, 2011, p. 581).

Due to the complexity associated with PHN practice, the United States Association of Community Health Nursing Educators advocates for the preparation of PHNs with graduate level education at the doctoral level (Levin et al., 2008). Advanced preparation is believed necessary for PHNs to positively influence current global and societal changes (Levin et al., 2008). A skilled and educated workforce that understands the context of inequities is necessary to measure, monitor, and improve inequities at individual and population levels.

Tackling inequities. The PHN role must focus on the social determinants that affect health, not only on health risks or disease (Canadian Public Health Association, 2010). Reutter

and Kushner (2010) cite policy analysis and advocacy as fundamental in tackling health inequities. Policy analysis is understanding the effect of policy and governance structures in contributing to inequities (Reutter & Kushner, 2010). The authors argue that public policies failing to address the social determinants of health are the root causes of inequities. Strategies to increase awareness among health professionals, policy and decision-makers, and the public are essential. Nurses are ideally situated for this role based on their daily involvement with clients in their homes and community, but must recognize that policy advocacy and tackling inequities is most effective when working collaboratively (Reutter & Kushner, 2010).

To promote healthy pregnancy and early childhood development, health and social services should be coordinated, equitable, and accessible (Kershaw & Anderson, 2009). Through actions such as collaboration, advocacy and political lobbying, PHNs can contribute to social justice and promote change at the organizational, local, national, and global levels (Canadian Nurses Association, 2010; Cohen & Reutter, 2007). Nurses can advocate for shifts in policy to be respectful, nonjudgmental, and to prevent further marginalization of vulnerable populations (Pauly et al., 2009). Nurses can promote compassionate care, and advocate for the development of cultural competence across sectors (Pacquiao, 2008). Nurses can cultivate social inclusion and provide evidence of the negative impacts of poverty on physical and emotional health (Reutter, Stewart, Veenstra, Love, Raphael, & Makwarimba, 2009). Lastly, nurses can suggest that basing staffing and service delivery models on principles of social justice might benefit from a health equity audit, to ensure that populations most in need are adequately resourced (Pritchard & de Verteuil, 2007).

Canadian nursing researchers have highlighted the importance of collaboration and the need to strengthen inter-professional collaboration in public health practice (Browne et al., 2010;

Cohen & Reutter, 2007; Cusack et al., 2008; Jack, 2010; Meagher-Stewart et al., 2010). In particular, the need for collaboration and a comprehensive multisectoral approach to child maltreatment in Canada has been identified (Jack, 2010). Fewer PHN home visits have been documented in the United Kingdom when models of service delivery were team based (Cowley, Caan, Dowling, & Weir, 2007).

One of the few Canadian studies describing the promotion of equity for vulnerable families via inter-professional collaboration evaluated the role of a nurse practitioner (Lynam et al., 2010). The study took place on the Downtown Eastside of Vancouver. The nurse practitioner attended places where people gathered and provided primary care; as well as coordinated services to promote early childhood development that included referrals for mental health and developmental delays. Barriers such as access, fear, stigma, and lack of knowledge, were cited as reasons families had not obtained services. The nurse practitioner collaborated with PHNs, social workers, and other professionals to facilitate equity and promote access to housing, health care, income, and other community resources. Families had complicated issues, which required highly individualized and inter-professional responses. The authors stated a population-based approach was limited for "children on the social and material margins," where as a targeted, responsive, and integrated community based service was able to reduce barriers (Lynam et al., 2010, p. 343). I would argue these authors have described PHN practice, since PHNs provide these same services with referrals to primary care. This raises issues regarding effective use of healthcare resources, when there is a lack of empirical evidence substantiating the role and function of PHNs. Regardless of the professional involved, these authors have documented specific inequities created by universal approaches, and the relevance of targeted approaches to reduce gaps for children living in poverty.

Attributes in the areas of government, organization, and systems have been identified as necessary characteristics to support PHN practice in Canada (Meagher-Stewart et al., 2010). Frontline management support and organizational culture were critical. Essential components were a shared vision that was responsive to community needs and evidence based. Strengths of the study included pan-Canadian representation undertaken with direct practice PHNs, managers, and policymakers in urban, rural, and remote regions. The study also had a large and diverse sample for a qualitative study, composed of 156 participants across 6 diverse regions. Analysis was completed in three stages and included processes for data accuracy and the involvement of a large team of skilled researchers. Lastly, this study demonstrated that action research with PHNs was a method to identify opportunities for policy change (Meagher-Stewart et al., 2010).

In this section, I have summarized theoretical and empirical literature regarding PHN practice using a Canadian health equity framework. In the following section, I describe the local context.

The Local Context for PHN Practice

The Manitoba government developed the Healthy Child Manitoba Strategy in the year 2000 (Healthy Child Manitoba, 2013a). The strategy was created by the Healthy Child Committee of Cabinet to coordinate cross-departmental policies and programs for families, children, and youth. In 2007, the government took additional steps to strengthen this commitment through establishment of The Healthy Child Manitoba Act. Manitoba is fortunate, as this is the only Cabinet committee in Canada, with a specific focus on healthy child development (Healthy Child Manitoba, 2013a). PHNs in the Winnipeg Regional Health Authority (WRHA) are directly involved in a number of these programs and initiatives.

Ensuring access to health and health care. The largest region in Manitoba, the WRHA,[1] is subdivided into 12 separate community health areas. Teams of generalist PHNs provide services within each community health area. A new PHN position description was implemented in the fall of 2011, based on the Community Health Nurses of Canada discipline specific competencies. The position description highlights the PHN role in collaboration, reducing inequities, and addressing the social determinants of health (Winnipeg Regional Health Authority, 2011b). Conversely, approximately 80% of PHN time is allocated to postpartum work, and the WRHA has invested considerable resources to support PHN skill development and breastfeeding knowledge. Based on WRHA postpartum standards, all mothers discharged within 48 hours of a vaginal delivery and 72 hours of a caesarean are contacted within 24 hours and offered a home visit (Winnipeg Regional Health Authority, 2003). PHNs often continue to support breastfeeding through ongoing home visits. An audit of 302 charts completed in 2007 reported an average of 6.6 PHN contacts in the initial postpartum period. In the literature, an author cites examples of nurses confusing the concept of individual focused health education with health promotion (Whitehead, 2006, 2009, 2011). Given the intensity and short time frame of PHN involvement, it is more likely PHNs are providing individualized health care and education, rather than working upstream to change underlying conditions.

Breastfeeding is a well documented health promoting strategy with numerous benefits for maternal and infant health (Winnipeg Regional Health Authority, 2010). Martens and colleagues reported that in urban Manitoba, breastfeeding initiation rates in lower socio-economic areas had improved, and rates were narrowing between socio-economic groups (Martens et al., 2010). However, breastfeeding rates are higher in affluent neighbourhoods and among mothers who are

[1] In the province of Manitoba, as in many jurisdictions in Canada, the delivery of health services is integrated into Regional Health Authorities (RHAs). PHNs are employed by the RHA, and work within the Population & Public Health division.

older (Brownell et al., 2008). Although the reasons are likely multi-factorial, one component may be related to the increased knowledge of PHNs and the support provided in client homes. Conversely, breastfeeding rates in Downtown, Inkster, and Point Douglas, and among Aboriginal women remain lower than provincial averages (Brownell et al., 2008; Manitoba Health, 2011; Martens et al., 2010).

There are many questions regarding the PHN role in providing breastfeeding support. Based on the demographic characteristics of breastfeeding women, it has not been documented whether PHN home visiting to support breastfeeding is an effective utilization of public health human resources, and whether these individual level PHN interventions are improving population level outcomes. A recently published large Australian study suggested that universal telephone screening and clinic visits may be the most cost-effective approach, based on their findings that the type of health provider contact in the first ten days did not impact breastfeeding duration at 3 months (Brodribb & Miller, 2013).

Understanding the context of inequities. It is important to understand the causes of inequities, so that interventions can be targeted. A population-based study in the WRHA followed 4667 infants born in 1984 to compare the impact of social versus biological indicators (Jutte, Brownell, et al., 2010). Biologic indicators were birth weight, gestational age, and 5 minute Apgar score; social factors were mother's age, marital status, and socio-economic status. These factors were compared against high school graduation and hospitalizations over 19 years. The study reported that social risk factors such as poverty were more common and stronger predictors of poor long-term health and education attainment than biological factors alone. In addition, focusing only on biological factors, resulted in risk factors associated with poorer health outcomes being overlooked in 65% of the sample.

Vastly different health outcomes have been found for children living in the lowest socio-economic areas of Manitoba. Infants from the lowest income quintiles had the highest rates of pre and post-term weights, were small and large for gestational age; had more admissions to special care nursery following birth; and the highest rates of readmission after discharge (Heaman, Kingston, Helewa, Brownell, Derkson, Bogdanovic et al., 2012). Some of the highest rates of neonatal, infant, and childhood deaths across Canada, were in the lowest Manitoba income quintiles (Brownell, Chartier, Santos, Ekuma, Au, Sarkar et al., 2012; Heaman et al., 2012). Families receiving income assistance had children who displayed the greatest vulnerabilities on assessments for school readiness, using the Early Developmental Instrument (Santos, Brownell, Okechukwu, Mayer, & Soodeen, 2012). Rates of children taken into care by Child & Family Services, and those receiving supportive and protective services were also highest in the lowest income quintiles (Brownell et al., 2012).

More can be done to support the health of women and children in Manitoba. Many women do not access prenatal care, and one out of every seven reported alcohol consumption during pregnancy; the highest rates of alcohol and tobacco use were among Aboriginal women (Manitoba Health, 2011).While national rates of smoking during pregnancy are decreasing, rates in Manitoba continue to increase and be well above national averages (Public Health Agency of Canada, 2013). Each year there are about 100 deaths in infants under 1 year of age, and 100 deaths in children ages 1 to 5 years, largely from preventable causes (Manitoba Health, 2011). In children less than 5 years of age, 24% of deaths were in the lowest income quintiles (Martens et al., 2010).

The greatest concentrations of teens giving birth were in the poorest areas of Winnipeg. Teen mothers were more likely to have low and high birth weight infants and report unhealthy

behaviours during pregnancy (Healthy Child Manitoba Office, 2013). One-third of teens reported drinking alcohol; one in five used illegal drugs; and close to 50% smoked cigarettes (Healthy Child Manitoba Office, 2013). Using the Families First screen administered by PHNs, two thirds of teens were determined to be high risk (Healthy Child Manitoba, 2013b). Teen pregnancy is an equity issue; and universal interventions have widened the gap between higher and lower socioeconomic areas. For instance, teen pregnancy rates dropped 17.6% in the lowest socio-economic area of Winnipeg, compared to a decline of 48.4% in the highest socio-economic status area, accounting for a nine-fold difference (Martens et al., 2010). The numbers of teen mothers in Downtown, Point Douglas and Inkster with Grade 12 education were far below the Winnipeg average (Winnipeg Regional Health Authority, 2010). Inequities faced by teen mothers include lower income, difficulty finding employment, inadequate housing, poorer health outcomes and less graduations from high school (Healthy Child Manitoba Office, 2013). This quantitative data paints a bleak picture regarding the extent of inequities in these communities.

Manitoba has growing rates of of child poverty that are among the highest in Canada, with estimates of 84,000 affected children in 2014 (Social Planning Council of Winnipeg, 2014). Rates of socioeconomic inequity have been reported to be increasing for premature mortality, diabetes, ischemic heart disease, as well as for suicide attempts and deaths (Martens et al., 2010). It is pertinent to mention that Winnipeg's poorest areas contain large numbers of Aboriginal people. Winnipeg has the highest proportion of Aboriginal people per capita in Canada, disproportionately affected by poverty, suicide, and family breakdown (Healthy Child Manitoba, 2013a).

Providing sensitive empowering care and changing underlying conditions. The importance of PHN home visiting and the principles of working with vulnerable populations are

reflected in the WRHA mission statement and the program titled Healthy Parenting and Early Childhood Development is a service priority. A main government and WRHA intervention to improve family health and address inequities was the implementation of the Families First Home Visiting Program. Since 1999, a component of the PHN role has been screening all women prenatally or postpartum, and offering the home visiting program for those who qualify..

Families First is a targeted home visiting program aimed at reducing child maltreatment and improving outcomes for families based on identifiable risk factors (Brownell, Santos, Kozyrskyj, Roos, Au, Dik et al., 2007). Families First Home Visitors are paraprofessionals trained to deliver a curriculum that promotes positive parenting and a nurturing environment (Ek & Frankel, 2006). The Families First Home Visitor works in conjunction with a PHN lead role and PHN case manager. The lead role provides weekly reflective supervision during case reviews, and supports the visitor to deliver the curriculum. The primary PHN acts as a case manager to the family, maintaining regular and ongoing contact, and working collaboratively with the Families First Visitor. The program is intended to reduce the risk of child maltreatment by building on parent's strengths, reducing stress, increasing support, and being nonjudgmental (Ek & Frankel, 2006).

A 3 year outcome evaluation indicated that the Families First Program was associated with improvements in health and well-being for participating children and families (Healthy Child Manitoba, 2010). The Families First screening form was proven to be effective in identifying risk factors in 77% of children who ended up in the care of Child & Family Services, while 83% without identified risk factors did not end up in the custody of Child & Family Services (Brownell, Chartier, Au, & Schultz, 2010). However, 20% of families were not screened; and families not screened were twice as likely to be linked with Child & Family Services (Brownell,

Chartier, Santos, Au, Roos, & Girard, 2011). The community areas of Downtown, Point Douglas, and Inkster, with the poorest health outcomes (Brownell et al., 2008) had the lowest rates of enrolment in the Families First Program.

For families that decline, or those unable to follow the Families First Program as intended, PHNs have limited guidance to support their practice. PHNs have expressed concern that home visitors lack the skills, preparation, and ability to effectively work with high risk clients and to deliver the program (Woodgate, Heaman, Chalmers, & Brown, 2007). PHNs value the contributions of home visitors, but identified adequate education and on-going training as critical to program success (Heaman, Chalmers, Woodgate, & Brown, 2006). Additional research can assist in understanding reasons that families decline the Families First Program (Heaman et al., 2007). Through a qualitative research project in Inkster Community Health Area, 35 parents were interviewed to understand their experiences (Marchessault, 2011). A variety of suggestions were offered that could be utilized across the WRHA to improve program outcomes. Research is also needed to determine the extent of PHN involvement with families identified as high risk using the screening process, but not amenable to the Families First Program. It would be interesting to learn more about these complex families and their challenges, as well as the role that PHNs assume in promoting health equity and early childhood development.

A qualitative descriptive study utilizing five focus groups with 23 PHNs in the WRHA documented the role of PHNs working with families and children living in poverty (Cohen & McKay, 2010). PHNs reported a bleak image of the effects of poverty, and expressed frustration that families experienced social exclusion due to barriers such as stigma, language, culture, and trust. These PHNs believed that poverty interfered with optimal child development and the health of parents, and spoke about the impact of the social determinants of health. Interestingly, these

PHNs believed that the region should provide leadership in addressing poverty and suggested actions of increasing awareness, advocating for policy change, and lobbying for funding to expand programs. This suggests the need for leadership in assisting PHNs to work to the full scope of their practice.

Tackling inequities. Data collected using the Families First screen highlights the importance of inter-professional collaboration in preventing child maltreatment in Manitoba. Consistent with other Canadian literature, PHNs in the WRHA reported a lack of system coordination, and responsiveness to the needs of complex families (Cohen & McKay, 2010). Mothers with risk factors that included low education, lack of supports, financial difficulties, and previous involvement with Child & Family Services were 3-6 times more likely to have their infant taken into care (Brownell et al., 2007). Mothers with risk factors that included teen pregnancy, financial difficulties, inadequate supports, smoking, low education attainment, and an existing Child & Family Services file were 1.5 to 20 times more likely to receive Child & Family Services assistance. Interestingly, mothers experiencing depression and parents with substance abuse issues were not linked with Child & Family Services (Brownell et al., 2011). However financial issues, low levels of education, previous involvement with Child & Family Services, alcohol use during pregnancy, and lack of prenatal care were strongly associated with apprehensions (Brownell et al., 2011). The importance of inter-professional collaboration in addressing the social determinants of health has been recognized by PHNs in the WRHA, but organizational conflicts have been cited as barriers to being proactive and collaborative (Cohen & McKay, 2010).

Consistent with other Canadian literature, PHNs in the WRHA have reported an emphasis on individual health, largely using strategies of education and health behaviour change (Cohen &

McKay, 2010). In earlier qualitative studies, PHNs in Manitoba reported the desire to foster population level improvements through activities such as health promotion and community development, but again cited organizational barriers to these activities (Cohen, 2006a). While PHNs have acknowledged the importance of tackling inequities through policy advocacy and analysis, they reported this was not a critical component of their role (Cohen & McKay, 2010). Early postpartum discharge polices, and the need to respond to immediate medical and breastfeeding needs, were identified as main factors contributing to the erosion of population based activities such as health promotion and community development (Cusack et al., 2008).

Summary

In this chapter, I have reviewed literature pertinent to PHN practice, using an equity framework proposed by Canadian authors. The first section provided a broad overview, based on analysis of information within and outside of Canada. The New Public Health movement highlights the importance of moving beyond individual level education and health promotion, to tackle the structural determinants of inequities, through collaboration among sectors and agencies (Baum, 2008). To create system change and long-term health improvements, providers and society need to look beyond health care (King, 2011). Action on the social determinants necessitates organizational approaches that prioritize populations, based on the distribution of disease and positive characteristics (Baum, 2008; National Collaborating Centre for Determinants of Health, 2011). System reorientation requires critical and creative thinking, situating the client within the full continuum of health and social services (Jackson & Ellis, 2010). Cupp Curley (2012) states “while clinical decision-making related to individual patients is important, it has little impact on overall health outcomes for populations. Interventions at the population level have the potential to improve overall health across communities” (p.1). PHNs

must consider how to work more upstream in priority setting, to address the structural causes of poor health (National Collaborating Centre for Determinants of Health, 2014).

The second section detailed the context within Manitoba and the WRHA. Gaps were identified and research objectives stated. A whole system, non-linear approach is needed to fully respond to the complexity of modern families (Jackson & Ellis, 2010). A system approach is client centred, collaborative, integrated, creative, adaptive, and holistic. Traditional healthcare systems are provider and/or organization centred; professionals work in silos, are task-oriented and resistant to change; care is disjointed and driven by policy reform (Jackson & Ellis, 2010). Based on empirical data, PHNs in the WRHA are functioning within a traditional system. Conversely, key Canadian documents (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b) define a broad scope where PHNs play multiple roles in promoting health equity and a whole system approach that improves population level outcomes. Schofield and colleagues (2011) report a looming crisis, because practice is narrowing to a focus on clinical care and health education; there is an inability to practice to full scope; lack of understanding regarding the role; and PHNs are feeling devalued and powerless to promote change (Beaudet et al., 2011; Cohen & McKay, 2010; Cusack et al., 2008; Dunne, 2011; Keller et al., 2011; Meagher-Stewart et al., 2010; Schofield et al., 2011). Although the theoretical role of the PHN is well articulated, models to guide the delivery of PHN services are a clear gap in current literature.

Approaches to advance population health and to promote equity are most effective when led by the community (Standing Senate Committee on Social Affairs Science and Technology, 2009). Based on the framing provided by the Commission on Social Determinants of Health (Commission on Social Determinants of Health, 2008), and the review of the literature, PHNs in

the WRHA could assume a leadership role to reorient their practice to address these complex health issues using a participatory action approach. Through a focus on population health and equity, PHNs could improve health across income gradients and begin to close the equity gap. In the next chapter, I describe the study methodology and approach.

Chapter 3: Methodology

In this chapter, I describe the research objectives and methodology used in the study. I begin with research objectives. Methodological assumptions that provide justification for choosing participatory action research as well as the philosophical underpinnings are discussed. I describe the participatory action research approach, participants, myself as the researcher, as well as ethical considerations. Methods of data generation, analysis, and rigor are explained. Lastly, knowledge translation is discussed.

Research Objectives

This study had the following two objectives:

1. To develop a service delivery model to support PHNs in an urban Canadian health region to practice to their full scope, especially in relation to promoting healthy early childhood development and health equity.
2. To explore the utility of a participatory action research approach in developing a model to clarify the role of PHNs.

Methodological Assumptions and Philosophical Underpinnings

I used a participatory action research approach. Action research is a systematic method of investigation that assists individuals to discover resolutions to issues they experience in daily life (Stringer, 2007). Action research extends beyond the usual goal of investigating phenomena, with the aim of improving and creating change through participant engagement (Munten, Van Den Bogaard, Cox, Garretsen, & Bongers, 2010). In comparison to traditional approaches that study participants, the group articulates their research needs and develops strategies to address them (Corbett, Francis, & Chapman, 2007; Koch & Kralik, 2006; Sharp, 2005). Creating a process of change that contributes to organizational learning is best achieved through full

engagement and participation of front line staff (Bellman, 2012a; Glasson, Chang, & Bidewell, 2008). Through the process, the group develops meaningful solutions to concerns that most affect them (Bowling, 2009). The researcher and study participants work in partnership to define the problem; the methods to collect, analyze, and integrate research findings; and to create change (Bellman, 2012a; Corbett et al., 2007; Polit & Beck, 2012).

Action research is an exploratory, creative, and innovative method that has become increasingly popular in health care as a strategy to improve organizations, practice, and client care (Bellman, 2012a; Koshy, Koshy, & Waterman, 2011; Williamson, 2012a). Modern day health professionals are balancing workload demands, increasing complexity of services, and crises outside of their areas of expertise, that didn't exist in the past (Stringer, 2007). By engaging in a process of developing greater depth of understanding and reconstructing meaning, the potential to revolutionize practice emerges (Corbett et al., 2007; Williamson, 2012b). Action research is frequently used with groups or communities oppressed or controlled by a more dominant group or culture (Polit & Beck, 2012).

Action research is a broad category consisting of various types and classifications of methods (Munten et al., 2010). Initiated in 1940, participatory action research is one category of action research with roots in social psychology (Polit & Beck, 2012). Participatory action research validates the knowledge, understanding, and lived experience of those involved (Balogh, Markwell, & Watson, 2007; Corbett et al., 2007). It cultivates personal development, sustainable health care services, and creates social change to enhance equity and social justice (Koch & Kralik, 2006). As equal partners, those being investigated are often named as co-researchers (Munten et al., 2010). As co-researchers, group members may be trained to participate in various research activities including individual and focus group interviews,

surveys, data analysis, and education sessions (Chui, 2008). The process of inclusiveness contributes to practice advancement, fostering a sense of belonging and empowerment among participants (Corbett et al., 2007).

Participatory action research creates the opportunity for transformation related to the group's situation or structure (Corbett et al., 2007; Williamson, 2012b). In health care environments, the basis for self-determination is reflecting and learning about one's practice through a reciprocal and collaborative process (Corbett et al., 2007; Koch & Kralik, 2006). The discussion and collaboration generates motivation, self-esteem, and cohesion (Polit & Beck, 2012; Spalding, 2009). Through exploration of inequities, empowerment may be an outcome where participants are able to find their voice (Corbett et al., 2007). The premise is that increasing knowledge and awareness among a group experiencing oppression can contribute to political activism and the ability to exert power on the dominant culture (Polit & Beck, 2012). As participants discuss and gain deeper understanding, they begin to recognize taken for granted factors that link to organization and professional influences (Stringer, 2007). The process of reflection increases understanding of power imbalances; and further validates participant skills and practice (Corbett et al., 2007).

Various philosophical underpinnings have been described. Stringer (2007) depicts action research as incorporating phenomenology, interpretation, and hermeneutics. Phenomenology is integrated through the focus on participants' lived experience; interpretation by acknowledging participant's views and perceptions; and hermeneutics through participants application of meaning. Participatory action research methods have been described as incorporating feminist and critical theoretical approaches (Koch & Kralik, 2006; Polit & Beck, 2012). Feminist research seeks to understand how patriarchal structures and social orders shape women's lives (Polit &

Beck, 2012). Feminist theory is related to critical theory, but focuses on power differentials and oppression based on gender (Williamson, 2012b). Critical theory highlights the issue of social domination, where groups with more power or higher stature exert control over another group, and limit their ability to attain their full potential (Williamson, 2012b). Critical theorists highlight the transformative nature of increasing consciousness of historical elements, by prioritizing participant's expertise (Polit & Beck, 2012). It is the critical examination of traditional rules, practices, and beliefs that generates emancipatory knowledge, or greater awareness of hierarchal influences on nursing practice (Corbett et al., 2007).

Critical and feminist theories have relevance in nursing and public health. Traditional biomedical approaches, based on experts telling individuals what to change, have achieved limited success (Koch & Kralik, 2006). With a similar premise, organizational bureaucracy creates hierarchal structures, founded on assumptions that those in decision-making positions have more knowledge (Stringer, 2007). Nursing is a predominantly female profession with a long history of subservience to medicine and systematic oppression by organizations and governments. As a result, for nurses, change is often imposed (Beaudet et al., 2011; Spalding, 2009). In public health, while providers may be influenced to create change through theories grounded in public health, they are simultaneously constrained by political and organizational structures, as well as personal views (Chui, 2008). In Canada, PHNs' scope of practice has been impacted by the values and priorities of others (Falk-Rafael & Betker, 2012a). Groups with higher status such as managers, directors, governments, and medical officers of health, who do not have the content expertise, often make decisions influencing PHN practice. Ethical dilemmas have been reported, when PHN practice is not supported by organizational and government structures (Falk-Rafael & Betker, 2012b).

In the nursing literature, participatory action research is having increasing success in generating clinical practice improvements and system transformation (Corbett et al., 2007; Glasson et al., 2008). The principles of participatory action research are congruent with concepts of primary health care, collaboration, and empowerment (Glasson et al., 2008); concepts integral to the delivery of effective PHN services. Participatory action research has produced system changes and increased understanding of theory, practice, and outcomes related to service delivery (Spalding, 2009). Changes are cyclical, with theory guiding practice, and practice informing and leading to theory development (Koshy et al., 2011).

Traditional research approaches are not suitable for complex healthcare interventions, such as improving service delivery and changing professional behaviours (Seers, 2007). Additionally, programs constructed with input of those directly affected, rather than predetermined by those in positions of authority, are more likely to succeed (Stringer, 2007). Participatory action research is being used in healthcare systems in the United Kingdom to address hierarchal structures and historic difficulties influencing nursing practice (Corbett et al., 2007). In Wales and Scotland, governments are promoting its' use based on successes in creating system change and promoting evidence-based practice (Balogh et al., 2007; Sharp, 2005). Corbett and colleagues argue that participatory action research is not only relevant, but should be the first choice for nurses seeking to critically address health service issues. For PHNs, strategies such as participatory action research may foster empowerment and build capacity, to create the system changes necessary to tackle inequities and address the broader determinants of health (Chui, 2008).

The Research Design

In developing this study, I explored processes used by a number of action and participatory action researchers in nursing and healthcare. Due to the emergent nature of participatory action

research, the processes were diverse. Participatory action research is broad, and methods have to be adapted to the uniqueness of each situation (Glasson et al., 2008). A consistent theme however was the influence of Stringer (2007), an action researcher in the field of education. Stringer developed the action cycle: 'Look, Think, Act,' which appears to have been used and adapted broadly. This cyclical approach has been supported by nurse researchers because of its structure and flexibility (Koch & Kralik, 2006; Polit & Beck, 2012; Williamson, 2012b). Though the steps of the cycle are distinct, in reality, the lines are less clear and a shift in understanding occurs over time based on reflection (Koch & Kralik, 2006). This action cycle will be described in greater detail during the discussion of data generation.

Procedural steps. Due to the complexity of action research, an organizing framework is beneficial. The following distinct stages have been proposed: entry, getting to know each other, generating concerns, participatory action, acting on concerns expressed, and reflection and evaluation (Ritchie, 1996). I have framed the discussion below within these distinct stages.

Entry and getting to know one other. The initial steps in participatory action research consist of entry and getting to know one other. While working on my PhD, I was employed full-time as a clinical nurse specialist in Population & Public Health program. In my role as a clinical nurse specialist, I had lead responsibilities to support the structure, function, and progress of the PHN nursing practice council. In this section, I will therefore describe the role and function of the nursing practice council, and the process used to explore a participatory action research study within this organizational structure.

Nursing practice councils were implemented in Manitoba to create structural changes following twelve paediatric deaths at the Health Sciences Centre. The inquest into the cardiac program deaths stated:

> ...the experiences and observations of the nursing staff involved in this program led them to voice serious and legitimate concerns. The nurses, however, were never treated as full and equal members of the surgical team. This treatment mirrored the way in which nurses believed recent changes in hospital organization had reduced the status of their profession (Sinclair, n.d., p. vii).

Nursing practice councils are formalized structures for nurses to have input into practice issues. In the Population & Public Health program, the nursing practice council is composed of PHN staff representatives from the 12 community areas in Winnipeg, as well as the centralized programs of Tuberculosis and Healthy Sexuality & Harm Reduction. PHNs in the WRHA are classified as Nurse IV positions based on the occupational classification system for registered nurses in Manitoba (Manitoba Nurses Union, n.d.-a). The classification system describes registered nurse positions that range from Nurse II-V based on job duties and nursing preparation. The majority of nursing positions are classified as Nurse II's, or "general duty" (p.233), with associated wage and responsibility increases for higher classifications.

A main objective of the nursing practice council is to address practice issues and to promote evidence-informed practice across the population of PHNs. The nursing practice council meets monthly, and is co-chaired by two PHN council members. Other representatives include four clinical nurse specialists and a team manager. In 2004, when the nursing practice council was first initiated, the director of Population & Public Health co-chaired. For approximately the last 3 years, the director has not regularly attended meetings, allowing the group greater autonomy and ownership. However, the director meets monthly with me and the co-chairs to discuss nursing practice council agendas, working groups, and relevant issues. Any PHN can develop an issue paper identifying a practice concern, using a standardized template. The office representative speaks to issue papers on their teams' behalf, and council members develop a plan to address it. For issues that are complex, the latter half of every second meeting is dedicated to

working groups. Working groups used to be led by clinical nurse specialists but, with the ongoing development of the council, about two years ago PHN representatives began taking a more active role, with clinical nurse specialists providing support and guidance.

Structures for communication have been developed, within and beyond the nursing practice council. The community area representative is the nursing practice council liaison and spokesperson for their PHN team, the broader population of PHNs in the WRHA. The nursing practice council terms of reference outline communication as a two-way process, where the representatives update their team regarding nursing practice council issues, and conversely provide their team's feedback during nursing practice council meetings (Nursing practice council, 2011). Using the established communication processes, resolved issue papers are distributed for information, consultation, or approval. Issues outside the scope of PHN practice are directed to the appropriate organizational group using this structure. For example, the team manager representative takes operational issues to the management team, and provides information back to the nursing practice council. When resolved, the issue papers are updated with key findings and closed. All issue papers are tracked, sorted, and accessible on the intranet.

As I was doing my course work, I worked with the nursing practice council to successfully move forward two key and controversial initiatives. The first was the distribution of products; the other was initiating a process for Baby Friendly accreditation. Because of this work, there was agreement to discontinue accessing samples of free formula regularly provided to teams by company representatives. The procedure was lengthy and difficult; however, it was my observation that through the process of discussion and challenging historic patterns, there was increased awareness among PHNs, based on best practice, ethics, and evidence.

Generating concerns. In 2006, an issue paper was submitted to nursing practice council regarding the PHN service delivery model. The issue paper identified that teams across the city functioned differently; some used neighborhood based models while others used referral systems. In August 2007, a document with recommendations was developed in response to a staff survey. Recurrent themes were the need to articulate the PHN role and to determine priorities, as well as repeated references for additional staff. The director was unsure how to respond to the survey, given that PHN input had been sought, but adding PHN positions was not realistic (L. Tjaden, personal communication, 2012). In 2008, there was discussion about using an appreciative inquiry approach, with the support of the WRHA Research & Evaluation Team. It is my understanding that there were some working group meetings, and nursing practice council members' recall being shown a DVD about appreciative inquiry, however, the issue failed to move forward again.

Setting the stage for participatory action research may include explaining ideas, garnering participation, identifying a working group, and obtaining agreement (Balogh et al., 2007). During monthly planning meetings with the Population & Public Health program director, the nursing practice council co-chairs repeatedly expressed the need to address the 2006 issue paper. It was one of the only outstanding issues, despite being one of the first and several unsuccessful attempts. I broached the idea separately with the co-chairs first and then the director. Both supported the idea of a participatory action research study, using the established nursing practice council processes. It is critical that organizational leaders are supportive of participatory action research (Bellman, 2012a).

Following my expression of interest and discussion with the director and co-chairs, the co-chairs asked the nursing practice council if there was interest in re-establishing a working group

on this topic. At the February 2012 meeting, five nursing practice council members agreed to participate. Many of the nursing practice council members had changed because of the time lapse, so there was discussion about the relevance and intent of the original issue paper. When embarking on a participatory action research study in public health, the importance of exploratory workshops to explain the process, seek feedback, and gain commitment has been previously documented (Chui, 2008). I shared the idea to move forward within the context of my PhD work using a participatory action research approach, pending willingness of the group. I also spoke of the option to be co-researchers. The group expressed interest in participating and in being co-researchers. Consistent with the nursing practice council structure, two of the PHNs agreed to be co-leads, and to work in collaboration with me as the facilitator. While the group was enthusiastic, they also expressed trepidation in not fully understanding the process and expectations.

Setting the stage and engaging participants is a critical step in developing a communicative space for participatory action research. Wicks and Reason (Wicks & Reason, 2009) suggest that co-researchers will want to increase their understanding of emotional, task, and organizational concerns to feel comfortable proceeding. ‘Emotional issues’ refer to individual’s understanding and sense of group belonging. The goal of the facilitator is to establish comfort and willingness to participate, while simultaneously challenging the group. ‘Task issues’ are participant’s feelings as to whether the group will meet their needs. The facilitator can frame the approach for participants to understand the purpose, while ensuring flexibility so that participants assume ownership. Lastly, participants may express ‘organizational’ concerns, regarding time commitments and managing within their existing workload. The facilitator must negotiate a

process that will work for participants (Wicks & Reason, 2009). Appendix A contains a chronological summary of all events and relevant documents associated with the project.

Though participatory action research is participative, action approaches do not begin with a blank page; rather there is often initial investigation, development of ideas, evaluation of current practice and discussion of opportunities for change (Balogh et al., 2007). A project planning sheet has been suggested as a helpful initial activity (Koshy et al., 2011). I therefore developed an action research planning sheet, as the basis for discussions with the working group at the April 2012 nursing practice council meeting. Four nursing practice council members participated and made recommendations that were incorporated into the document contained in Appendix B. The planning sheet was shared with the full nursing practice council at the June 2012 meeting, as well as distributed to the PHNs teams. In action research, the group must be involved in setting the research agenda, which consists of identifying objectives, tasks, and prioritizing (Bowling, 2009).

Spalding (2009) initiated three meetings prior to engaging in the action research process. Prior to the hour-long meetings, the researchers developed the agendas and shared literature summaries as well as other relevant data. During the meetings, the presenters focused on issues they believed were important. The initial meetings were used to refine the research idea, determine the research methods, agree on the group's autonomy, and to formulate the plan based on the action research cycle. During another study in the field of public health, participants were also provided with information to increase their awareness of key issues (Chui, 2008). Consistent with these approaches, at the June 2012 nursing practice council meeting, I provided a power-point presentation that summarized current literature pertinent to PHN practice on health inequities, early childhood development, and participatory action research.

The June meeting was also used to discuss objectives and ground rules. Developing shared goals and priority objectives is a key aspect of improving service delivery and practice (Spalding, 2009). The importance of background information, as well as establishing ground rules that promote safety, honesty, group cohesion, and reduce conflict, have been documented (Balogh et al., 2007; Spalding, 2009). Ground rules may include being non-judgemental and respectful of differing opinions; not interrupting; maintaining confidentiality of personal shared information; and agreement that all questions are important (Koch & Kralik, 2006). Participants should be accountable for their own learning, be comfortable being challenged, and agree to how personal values, attitudes, and beliefs will be addressed (Dewar & Sharp, 2006). This was important because the PHNs were work colleagues, who in many cases had well established relationships that spanned several years. Individuals may have differing expectations, and group consensus about ground rules can reduce conflict (Balogh et al., 2007). Appendix C contains the agenda used during the June Working Group meeting. Seven nursing practice council members participated in this working group meeting.

Participatory action. The process of engaging in the research is the third distinct area (Ritchie, 1996). In my study, participants consisted of members of nursing practice council who agreed to participate in a working group to develop a PHN service delivery model (primary participants). For the purposes of data generation, this group was called the Research Working Group (RWG). This form of qualitative sampling is called a convenience or a volunteer sample; though it is simple and efficient (Polit & Beck, 2012).

The study included primary, secondary, and tertiary participants. Data were collected during RWG meetings with primary participants, but because there was potential for the data to be influenced by discussions at the nursing practice council and team levels, all PHNs were

invited to sign consent forms. The nursing practice council representatives from each of the PHN teams who did not participate in the RWG were secondary participants. The secondary participants contributed their team's feedback during nursing practice council discussions, and informed their team of the nursing practice council discussion and perspectives of the other teams. The non- nursing practice council PHNs from the community and centralized teams were tertiary participants, who could provide feedback to the RWG through the secondary participants. PHNs not wishing to be involved could opt out of discussions regarding the practice model and attend to their daily work.

The study was initiated in partnership with the nursing practice council, and therefore a researcher letter to invite nursing practice council participation was not necessary. However, the consent forms and letters of invitation for the tertiary participants were sent out using the regular processes for nursing practice council communication. This involved e-mail distribution to the nursing practice council representatives from an administrative assistant. The public health management team, consisting of team managers, community area directors, and medical officers of health, were also part of the nursing practice council distribution list. Additionally the program director organized a meeting for me to present to interested members of the management team. There were approximately 12 individuals who attended. Appendix D contains a summary of the process for data generation, which will be further described below.

Prior to beginning the formal component of the research project, the appropriate approvals and consents were obtained. The University of Manitoba Research Ethics and Compliance Committee and the WRHA Research Review Committee both approved the study. A researcher agreement to protect confidentiality was signed. A letter inviting tertiary participant involvement was distributed (Appendix E) and informed consent was obtained for the primary, secondary,

and tertiary participants (Appendices F, G, H). A brief demographic questionnaire was also distributed, to better understand the PHNs who agreed to participate in the RWG (Appendix I). Lastly, the transcriptionists signed agreements of confidentiality.

Protection of participants and ethical considerations. Informed consent was obtained for primary, secondary, and tertiary participants. I reviewed the intent of the study, the consent form, confidentiality, and the voluntary nature of PHN participation. Throughout the process the work was transparent and open to feedback (Balogh et al., 2007). Documents were shared with the RWG and other stakeholders, which is one method of promoting transparency (Koshy et al., 2011).

The data were managed based on ethical principles for research. Efforts to maintain confidentiality were taken, minimizing the risk that participants could be identified (Polit & Beck, 2012). The RWG interviews were audio-recorded and transcribed verbatim, with names and identifying information removed. Participants were advised that direct quotations would be used, and that within the process of developing the audit trail, other co-researchers may see the raw data (Streubert & Carpenter, 2011b).

Confidentiality was included in the consent form. I discussed this issue with participants, and discouraged discussions that could breech confidentiality outside of the RWG. I will keep the raw data (field notes, recordings, transcripts, and consent forms) in a secure cabinet for seven years, and then will destroy them. Research should benefit participants and should not cause harm (Polit & Beck, 2012). Since the PHNs agreed to volunteer within their role on nursing practice council, they received their regular pay and participated within their regular workday. The anticipated risks would be considered minimal, or no greater than experiences encountered in daily circumstances (Polit & Beck, 2012).

Data generation and analysis. Koch and Kralik (2006) propose that data generation and analysis during participatory action research consists of five steps. These steps are 1) Reading the full transcripts; 2) Organizing the data using the 'Look, Think, Act' framework; 3) Eliciting feedback from participants; 4) Collaboratively agreeing to a plan for action; and 5) Facilitating and outlining changes. Data were collected during seven RWGs that took place from November 2012 to July 2013. The RWGs were recorded and the audio-recordings were transcribed verbatim. The first RWG took place on November 21st, 2012. A semi-structured interview guide (Appendix J) formed the basis for the discussion, which focused on the RWG's perception of their practice, gaps, and opportunities for improvement. During the 'Look' stage of the action cycle, the goal is to gather qualitative data to understand the experience of participants, and define the issue in a manner that is meaningful to them (Stringer, 2007). Qualitative data are particularly relevant in participatory action research, to collect data that reflects the richness and nuances of each situation (Koshy et al., 2011). Data generation differs from traditional approaches as objectivity is not the main goal, rather the researcher and participants seek to subjectively develop greater understanding about how and why the issues exist (Stringer, 2007). The research questions were intended to assist participants with the process of reflection (Koshy et al., 2011).

In analyzing the data from the initial RWG, I followed the steps outlined by Koch & Kralik (2006). I read the transcripts over several times to become familiar with the words and order. To optimize group time, I categorized and coded the data into central themes and created two summary documents. In the first one, I organized interview data by grouping concepts under the discussion guide questions. As I grouped the data, categories became apparent. I reduced the number of categories by grouping the broader headings together (Appendix K). In a second

document, I further reduced and organized the data under the headings of the action cycle: 'Look, Think, Act,' and suggested themes that emerged from the data (Appendix L). The outcome was development of a set of concepts and ideas that assisted participants in understanding their challenging issues, and alternate ways the information could be viewed (Stringer, 2007). Both documents were distributed prior to the 2nd RWG for validation, and to form the basis for ongoing RWG discussions and subsequent action. In understanding the transcripts, I was paying attention to meaning, as well as the participant experiences (Stringer, 2007). The impact of group dynamics and ways data could be affected were analyzed in my reflective journal entries.

Acting on concerns. The elements and categories that emerged during the initial RWG outlined key areas for action. For the remaining RWGs, participants worked collaboratively to interpret the information and to develop an action plan (Stringer, 2007). Habitual ways of practicing were challenged (Koch & Kralik, 2006). Group discussion about power and the processes for organizational decision-making promotes deliberate learning, as participants begin to recognize the influence held by various stakeholder groups, and reframe options for future action (Dewar & Sharp, 2006). Clarifying activities under investigation and participants' understanding about how issues pertain to their situation, is a key activity in participatory action research (Koch & Kralik, 2006; Stringer, 2007).

The agendas and documents prepared for RWG meetings from January to May 2013 are contained in Appendices M-R. During this time period, the group's reflections assisted in interpreting their experiences and in developing solutions for action (Balogh et al., 2007; Dewar & Sharp, 2006). Individuals will have differing styles of learning, reflecting, and synthesizing information. Learning takes place as participants discuss and make sense of their experiences

(Balogh et al., 2007). The process of thinking assisted in deconstructing events, and challenging routine assumptions that may have been taken for granted (Koch & Kralik, 2006). Action learning is a structured method of reflecting on one's values and beliefs regarding nursing practice (Dewar & Sharp, 2006).

During this process, data may be altered based on the emergence of new themes, a process known as co-construction. In this case, although the RWG set out to develop a service delivery model, it became apparent during discussions that service delivery had to be framed within a professional practice model. The professional practice model will be summarized in the next section. Co-construction allows ongoing concerns to be elicited, and also enhances study rigor through validation (Koch & Kralik, 2006). Since participatory action research is iterative and emergent, information regarding the process of acting, reflecting, and evaluating is further described in the findings section.

Reflection and evaluation. The final area described by Ritchie (1996) is reflection and evaluation. Participative research consists of working together to create positive change and to develop reports, presentations, and publications that can be shared with key stakeholders (Koster, Baccar, & Lemelin, 2012). The documented plan can identify organizational changes and methods for sustainability (Koch & Kralik, 2006). The participatory action research process is consistent with the approach used by Patton, called utilization focused evaluation (Patton, 2008). Patton advises that evaluation should be founded on primary user utility, and incorporate end-user engagement throughout the process. The final point of data generation was a process and outcome evaluation during the July 2013 RWG meeting (Appendix S). The outcome evaluation was intended to assess whether the project objectives were reached; while the process evaluation explored successes, challenges, learning for future projects, and unanticipated findings (Patton,

2008). Group benefits, knowledge gained, and lessons learned were included (Koshy et al., 2011).

Participant Action – Development of a Professional Practice Model

The outcome associated with the research project was development of a report, outlining a professional practice model for PHNs in the WRHA. Professional practice models have been identified as key organizational tools to support nursing practice (Betker, 2010; Community Health Nurses of Canada, 2011b; MacPhee, Wardrop, Campbell, & Wejr, 2011), by identifying activities that nurses have direct control and responsibility for (MacPhee et al., 2011), and articulating a nursing philosophy based on specific knowledge, skills, and competencies for autonomous practice (George & Lovering, 2013; Ives Erickson & Ditomassi, 2011; Schlotfeldt, 1989). Professional practice models assist nurses with practice decisions and change (Ives Erickson & Ditomassi, 2011), as well as promote nursing excellence, innovation, and quality client care (American Nurses Credentialing Center, 2014).

A professional practice model has been conceptualized as a rope, which is strongest when the individual strands are woven together (Hoffart, 1996). The following essential components have been identified (Community Health Nurses of Canada, 2011b; Hoffart, 1996):

1. Values and Principles – Form the collective belief system and foundation for PHN practice and professional development. The values and principles create focus for the remaining four components and assist with prioritization.
2. Professional Relationships and Partnerships – Describe PHN beliefs and attitudes, relational skills, and interactions that promote client care within the health system.
3. Delivery Structure and Processes – Articulate PHN service delivery to optimize client care and population outcomes.

4. Management Practices – Outline the organizational structures and processes for decision-making and supporting autonomous PHN practice.
5. Rewards and Recognition– Describe formal and informal organizational structures and acknowledgements based on nursing attributes and employee motivation.

A copy of the final RWG report is contained in Appendix T. Detailed information about the model and its development are reported in sections II and III of the findings section.

Quality of Research

Several activities were undertaken throughout the process, to ensure the quality of the research. To start with, I recognized that research within one's own organization required multiple approaches to reduce bias and promote accuracy of the findings (Creswell, 2009). Maintaining a reflexive journal or notes regarding the construction of knowledge and the researcher's impact is one strategy to increase objectivity (Polit & Beck, 2012). A reflexive journal also promotes rigour by contributing to the audit trail (Bradbury-Jones, 2007; Friedemann, Mayorga, & Jimenez, 2010).

To provide a framework for the journal, I adapted 'The three step model of reflection' to promote nursing leadership development (Sherwood & Horton-Deutsch, 2008). The framework and journal can be seen in Appendix U. Reflection can increase personal awareness, promote learning, and enhance outcomes (Bradbury-Jones, Hughes, Murphy, Parry, & Sutton, 2009). Persistent observation pertains to the researchers' focus on situational components and applicability to the phenomena being analyzed (Polit & Beck, 2012). In addition to recording events, I documented my feelings, and subjectivity (Bradbury-Jones, 2007). Being an insider, it was important to consider the potential impacts I may have inflicted on the process and participants (Wainwright & Sambrook, 2010).

Action research must demonstrate trustworthiness or rigor recognized through establishment of credibility, transferability, dependability, and confirmability (Stringer, 2007). Credibility is the extent that findings are truthful and interpreted accurately (Loiselle, Profetto-McGrath, Polit, & Beck, 2011). An important way to promote credibility is through the researchers' immersion in the subject area (Streubert & Carpenter, 2011b). I have worked in the field of public health for close to 20 years, and been immersed in this topic through my Master's and Doctoral work. Credibility in action research is also achieved through data triangulation. Triangulation is a process of using multiple sources of information to validate research conclusions (Balogh et al., 2007; Polit & Beck, 2012). Method triangulation was achieved by use of semi-structured interviews, field notes and the reflexive journal entries (Polit & Beck, 2012).

Credibility was also promoted through the process of collaboration with RWG, the nursing practice council, and the PHN teams. Findings are intended to correlate to individuals interpretations, but also to expand their understanding of their reality (Balogh et al., 2007). Reflexive validity refers to constant analysis so the researcher is confident that the story of participants has been told (Streubert & Carpenter, 2011b). Validity examines the accuracy, quality, and interpretation of the data (Koshy et al., 2011). Using the participatory action research process, findings were continually shared with participants, reflected upon, and revised based on participant interpretation (Koshy et al., 2011). Thus, RWG member checking contributed to credibility throughout development of the model (Streubert & Carpenter, 2011b).

Confirmability is objectivity or congruence between independent researchers (Polit & Beck, 2012). Analyzing qualitative data is complex, and working with experienced researchers is recommended to increase comfort and expertise (Streubert & Carpenter, 2011b). Investigator triangulation consists of the involvement of two researchers or more in the collection of data,

coding, and decisions related to analysis (Polit & Beck, 2012). I worked closely with my advisor as a subject matter expert, as well as my committee who are experienced researchers. Through the process of the research and writing the dissertation, an audit trail was developed. The audit trail consists of the systematic collection of data and supporting documents that will allow independent researchers to draw their own conclusions (Loiselle et al., 2011; Polit & Beck, 2012; Streubert & Carpenter, 2011b). Peer debriefing consists of a process of experienced researchers engaging in discussion about research quality (Polit & Beck, 2012). This took place during the research proposal and dissertation defences.

Dependability is assessment of credibility, or the reliability of the data if the study was to be replicated in similar situations (Polit & Beck, 2012; Streubert & Carpenter, 2011b). In the absence of dependability, the research will not be credible (Loiselle et al., 2011). Clearly defined rules for decision-making and categorizing of the data promotes consistency (Polit & Beck, 2012). These rules have been outlined above. An inquiry audit consists of analysis of data, documents and processes for decision-making by an external reviewer (Loiselle et al., 2011; Polit & Beck, 2012). The PhD defences contributed to the inquiry audit and study dependability.

Transferability is the extent findings are applicable or transferable to other settings or meaningful to individuals in similar situations (Polit & Beck, 2012; Streubert & Carpenter, 2011b). Transferability was created using thick descriptions so that others may assess how the findings apply in their contexts (Streubert & Carpenter, 2011b). Qualitative findings should always be viewed with caution beyond the group studied; however the previously reviewed evidence regarding public health nursing in Canada implies that this study may be of interest and applicable outside the WRHA.

Strengths and limitations. A participatory action research approach has strengths, as well as benefits for participants and the organization. This is the first participatory action research study with PHNs in Canada. Based on my dual role as a researcher and insider, the opportunity for this approach emerged. The planning and preparation for the project contributed to the development of a trusting and mutually beneficial relationship with the RWG.

Action research in health care with the assistance of experienced researchers, has resulted in service delivery improvements not otherwise possible (Spalding, 2009). Academic support can contribute to innovative client centred outcomes, and increase the likelihood of project completion (Bellman, 2012a). This project had limited success since 2006; however because the research was a component of my PhD, there has been academic support and increased rigor that has likely contributed to its success. Although the research is complete, the project is continuing to move forward at nursing practice council and within the WRHA. It is common for participatory action projects to continue after the research is complete, because the learning and activities have become entrenched in practice (Balogh et al., 2007).

A main strength has been the interest and enthusiasm generated among the primary, secondary, and tertiary participants. Traditional research methods identify problems and a process for investigation, but do not assist those for whom the issue exists, to incorporate the findings (Balogh et al., 2007). Sharp (2005, p.2) argues that "many public service systems are data-rich, but knowledge poor, because available evidence fails to be integrated into practice". Participatory action research is immediately relevant however, because the goal is to assist participants in developing meaning within their complex context and clinical environment (Koch & Kralik, 2006). Action research is also logical for nurses because it is similar to the nursing process (Bellman, 2012a).

The professionalism and commitment of the RWG were definitely strengths. There were a couple of new people at the beginning of the project, but otherwise membership was stable and there was 100% attendance at meetings. As an insider with knowledge of current PHN practice, organizational functioning, and current literature, my role as a researcher was also a strength. Action research should not be judged on traditional research criteria, but rather on its own merits (Coghlan, 2011). This study was based on a systematic method of inquiry and the outcome was based on theory and research. I was able to offer suggestions to the RWG to facilitate their learning and to navigate organizational issues, as a direct result of my position as a clinical nurse specialist within the organization.

While rich data were obtained, the study has certain limitations that should be considered. In health research, the legitimacy of participatory action research may be questioned, particularly by the "dominant medical paradigm" (Koch & Kralik, 2006, p. 13). To meet the needs of academics, organizations, and participants, acknowledging assumptions and clarifying expectations is essential (Mohammed, Walters, LaMarr, Evans-Campbell, & Fryberg, 2012). I have tried to be transparent and have provided evidence-based rationale throughout.

Participatory action research is based on context specific situations so that the process is meaningful to those involved (Spalding, 2009). As a result, generalizability beyond the study may be limited. The data were elicited at the RWG meetings, consisting of a small number of PHNs. The process was iterative, incorporating RWG, nursing practice council, and team feedback. However, there is the possibility that the data reflects the opinions of the RWG, and other voices have not been adequately represented. Additionally because processes were inductive, there is the slight risk that participants may not have been fully aware of what they were consenting to (Bellman, 2012b).

The data were emergent, based on qualitative interviews that I facilitated. Quantitative data, more structured interviews, and more skilled facilitation may have elicited different information. While I tried to be reflective, and ensure rigor, there is the risk that my role as an organizational insider biased the RWG and the data. There was a balance in maintaining RWG commitment, stability, and workload capacity, while providing adequate information to facilitate informed decision-making and project timelines. Lastly, to be of real value, the participants require professional judgement and the ability to control their nursing practice within the authority of the organization (Glasson et al., 2008). While the study was supported and the RWG reported positive benefits, the ability to fully actualize the professional practice model within the WRHA remains to be seen.

The role of the researcher and credentials. Leadership in participatory action research consists of facilitating organizational and operational change, as opposed to controlling it (Stringer, 2007). The researcher is responsible to systematically organize and support the process, to assist with identification of the research problem and solutions, and to generate group consensus and successes (Bowling, 2009; Chui, 2008; Koster et al., 2012). Transformation is dependent upon adequate time, space, as well as reflection on practice and future actions (Sharp, 2005).

As the facilitator, I promoted a safe space for participants to share diverse opinions and experiences, and jointly construct meaningful actions (Corbett et al., 2007; Stringer, 2007). Participants must feel secure to share their views, experiences, and reservations in a mutually supportive manner, without fear of embarrassment or intimidation (Bellman, 2012a). The researcher must take care not to perpetuate oppression by imposing the majority will (Williamson, 2012b). Suggested approaches to reduce hierarchies include group agreement on

the development of meaning, reinforcing the participatory nature of involvement, and sharing experiences (Koch & Kralik, 2006).

As the researcher, I promoted integrity of the process and ensured participants' voices were heard. The researcher assists with establishing the overall context, and builds capacity of participants to assess, interpret, and apply evidence (Sharp, 2005). The researcher aims to empower the group by creating knowledge and developing a plan for improvement, as well as influencing culture and socio-political action (Polit & Beck, 2012). A key role is assisting participants to understand where their own behaviours, attitudes, and values may not be congruent with best practice (Sharp, 2005). Maintaining commitment relies on feedback and goal setting that is consistent with the overarching framework, planning action, and evaluation (Chui, 2008). To reach the intended goal, the researcher uses a variety of skills that include detailed planning, observation, listening, evaluation, and reflection (Koshy et al., 2011). Through the progression of analyzing and reflecting on experiences, feminist and participatory action approaches support the researcher to also voice personal responses and feelings, that increase awareness of stereotypical assumptions (Koch & Kralik, 2006).

The researcher must recognize personal biases based on culture, education, and experiences (Koch & Kralik, 2006). My role was to facilitate the discussion and contribute to the transformative process, not to provide answers. My greatest influence was working as a PHN on the downtown Eastside of Vancouver, one of the poorest and most marginalized areas in North America. Through critical examination of nursing, cultural, and equity issues in the course of graduate studies, I have formed opinions. I tried to avoid imposing my opinions on others, but rather to challenge the views of participants and stimulate discussion through use of communication techniques that included open-ended questions, probing, and reflection. I ensured

that participants had full ownership and that their voices were heard (Corbett et al., 2007; Williamson, 2012b). Relationships were based on respect; equality; and positive and productive interactions (Koster et al., 2012; Stringer, 2007). The researcher learns through mutual interaction, but relinquishes control to participants (Streubert & Carpenter, 2011a).

I have completed the Interagency Advisory Panel on Research Ethics online tutorial, which provided helpful direction. I was not in a true position of power over participants; however, I have a job based on a higher level of education, a different position classification, and higher pay which may contribute to perceptions of imbalance. In a few cases, relationships outside of work exist, based on history and personal interests. In recognizing my dual role as an insider and a researcher, I considered multiple influences to ensure the rigor of the research process and protection of participants. The development of a clear audit trail through the process of this dissertation will assist with transparency.

In participatory action research, it is common for the researcher to be an insider (Corbett et al., 2007). Participatory action research has proven extremely effective when the change agent was a clinical nurse specialist (Glasson et al., 2008). As an advanced practice clinical nurse specialist, I have responsibilities consisting of direct comprehensive care, education, research, support of systems, and publication and professional leadership (Winnipeg Regional Health Authority, 2011a). Clinical nurse specialists have supported front-line nurses in delivering evidence-based care through service re-design, assisting with problem-solving, increasing knowledge, and promoting empowerment (Gerrish, Guillaume, Kirshbaum, McDonnell, Nolan, Read, & Tod, 2007). Additionally, research undertaken by an insider may result in change and practice improvements not otherwise possible (Wainwright & Sambrook, 2010). Because of my

role, I understood the depth and complexity of the issue, operational processes and structures, as well as organizational functioning and politics.

Knowledge Translation

As this is the first professional practice model developed using a participatory action research approach that is specific to Canadian PHNs, it is important to disseminate the findings and recommendations in multiple venues. To date, several presentations to different audiences have already taken place. These include to nursing practice council, directors, medical officers of health, and managers in the WRHA; as well as at three provincial meetings to develop standards for prenatal, postpartum, and early childhood practice. I also presented at the Applied Health Sciences Research day on April 22, 2014 and in Ottawa at the national Community Health Nurses of Canada conference on June 2, 2014. The majority of presentations were done in partnership with RWG members, when they were able to attend. The full report has been printed and distributed within in the WRHA. The September 2014 staff development sessions focused on health equity. Following the health equity component, the director provided a one-hour presentation to PHNs to celebrate the development of the professional practice model. She also stated that changes to practice would follow, based on the professional practice model. Lastly, I plan to pursue publications through peer reviewed professional journals.

Summary

In this chapter, I have provided rationale for using a participatory action approach. Participatory action research has not previously been undertaken with nurses in Canada, but has proven effective with nurses in the United Kingdom. I described philosophical underpinnings, and outlined procedures for data generation. Based on the structure and functioning of the nursing practice council, participatory action research appears to be an innovative method to

address an outstanding PHN practice issue. After receiving ethical approvals and consent, data were gathered using interviews, field notes, and a reflective journal. Interviews were audio-taped and transcribed verbatim. The data were analyzed using qualitative methods and strategies to promote rigor were discussed. In the following chapter, I will present findings.

Chapter 4: The Findings

In this chapter, I present the findings from the study. I begin by providing an overview of the timeline (Table 1) and sample used to collect data. Themes are then presented. To reflect the action research progression, Stringer (2014) suggests organizing the findings chapter into three sections: participant stories, interpretation, and action.

The first RWG on November 21, 2012 was depicted as participant stories. I used a semi-structured questionnaire to elicit discussion regarding PHN practice. Participants shared perceptions regarding their situation, as well as discussing their ideal practice and what excited them about the PHN role. In the second section of the findings chapter, I describe the RWGs that took place from January 16, 2013 to May 15, 2013. Participants continued to reflect and share their 'stories,' but with the goal of developing a model for service delivery. This process was titled interpretation, because the RWG was challenged to not only reflect on their current practice but to reconstruct and create new meaning in developing a model. Through discussion and exploration of a wide variety of literature, the RWG came to understand their practice in a different way, and developed a plan for improvement based on their ideal practice. In the third section, I described the final RWG that took place on July 3rd, 2013, in which participants reflected on the process and outcome of the participatory action research project. In each section, I have outlined themes substantiated by direct quotations. The quotations are numbered based on the RWG in Table 1, to assist in understanding the working group reflection and growth. The final section of the chapter contains my personal reflections as a participatory action researcher, based on reflective journal entries.

Table 1: RWG Data Generation Timeline

Data generation (months)	Nov 21, 2012	Jan 16, 2013	Mar 20, 2013	Apr 4, 2013	Apr 25, 2013	May 15, 2013	Jul 3, 2013
Participant stories RWG 1							
Participant interpretation 1st research cycle -RWG 2							
Participant interpretation 2nd cycle -RWG 3							
Participant interpretation 3rd cycle - RWG 4a							
Participant interpretation 4th cycle - RWG 4b							
Participant interpretation 5th cycle -RWG 5							
Participant action Evaluation -RWG 6							

Description of the Sample

PHNs were invited to take part as primary, secondary, or tertiary participants. Data were generated during RWG meetings (primary), however, because there was potential for the data to be influenced by monthly discussions at the nursing practice council (secondary), and community team (tertiary) levels, all PHNs in the WRHA were invited to participate. For the primary (n=7) and secondary groups (n=9), 100% of the consents were returned from invited participants, dropping to 64% (82/128) for the invited tertiary sample.

Participants were coded (using pseudonyms) as ‘Kira,’ ‘Rachel,’ ‘Beth,’ ‘Sarah,’ and ‘Helena.’ Before the 2nd RWG on January 16, 2013, ‘Kira’ moved to another office and was replaced by ‘Danielle.’ ‘Helena’ was on vacation during the January 16th RWG, and sent a replacement who was coded as ‘Aryanna.’ After that time, the RWG members remained consistent, and there was 100% attendance at each meeting. All participants were female. The average age was 38 years, ranging from 27 – 53 years of age. The length of time working as a

PHN varied from 2.5 to 23 years, with an average of 8 years. The length of time on nursing practice council ranged from 0 to 4.5 years, with the average being 1.7 years. All but one worked full time and had obtained certification as either a lactation consultant or breastfeeding counsellor. Two of the participants held other undergraduate university degrees, in addition to the Bachelor of Science in Nursing. One participant had taken advanced online education in epidemiology provided by the Public Health Agency of Canada.

Section 1: RWG Number 1- Current State

1.0 Participant Perceptions and Stories regarding their Practice

As seen in Table 2, three themes and several subthemes emerged from the initial RWG. These categories are described using the 'Look-Think-Act' participatory action research cycle.

Table 2: RWG Number 1 Themes - Participant Stories and Perceptions

Participatory action research cycle/ theme	**Category and sub-categories** **1. Current Practice**
Look Current practice	1.1. Erosion of PHN role in population health promotion 1.11 Focus on individual level clinical care in the community 1.12 Organizational impact on PHN practice 1.13 Lack of understanding of PHN scope
Think Ideal PHN practice	1.2 Full scope promotes health equity 1.21 Practice based on PHN competencies and WRHA position description 1.22 Inter-professional collaboration to address the social determinants of health
Act Opportunities for improvement	1.3 The need for PHN role clarification 1.31 Defining PHN practice 1.32 Facilitators of upstream reorientation

1.1 Erosion of PHN role in population health promotion. Data from the initial RWG reflected observations of current practice. Participants spoke about the manner in which services were organized and delivered, and the extent to which organizational structures created barriers

to PHN practice. The RWG also reflected on important elements of their practice that had been lost, and activities they were involved with but felt they should not be.

1.11. Focus on individual level clinical care in the community. The RWG spoke repeatedly about the narrowing of their role. The PHN role had become heavily based on provision of clinical services, in particular providing postpartum care. The RWG commented on the negative impact associated with hospital early postpartum discharge. Around 1999-2000, significant health system changes had taken place. Restructuring under the auspices of regionalization resulted in the integration of two public health systems, with very different service delivery approaches, to become the WRHA. Simultaneously, birthing was centralized to the larger hospitals, and women were discharged home earlier. A system was developed for PHNs to respond to postpartum referrals within a 24-hour timeframe. Standards and a hospital postpartum care map for documentation were implemented. Since clinical care in the postnatal period was a new skill for PHNs, to promote uniformity, essential tasks were bolded on the caremap. The bolded tasks focused on acute care routines such as taking blood pressures, infant weights, and observing complete breastfeeding sessions. In the excerpt below, 'Rachel' described her memory of that time.

> What they were trying to do, was get us all together in terms of our practice being more consistent. I don't think there was ever an intention to lose that opportunity to work with groups and families and the community development. But it morphed into that, because once we had those standards, we became more of an extension of the hospital service (1-855).

The approach to the delivery of PHN services outlined by the standards and care map had not changed since implementation 15 years earlier; however, the early discharge of women and newborns within 24-48 hours of birth had become the norm rather than the exception.

Following the implementation of early postpartum discharge, a universal approach to postpartum care and increased client acuity created a shift in organizational culture. PHN practice became focused on weighing babies and promoting breastfeeding, or providing hospital-like services in the community. Post-partum care accounted for approximately 80% of the services delivered by PHNs. 'Sarah' questioned the value of this PHN approach:

> So much focus when you hear public health nurse(s) talking about weight losses and is there availability of formula in those first three to five days. How many babies die or have negative outcomes as a result of dehydration, versus the long-term stuff that we need more focus on as public health nurses, like the financial stuff, relationship stuff with moms and dads. I question those long-term consequences versus how many babies die from dehydration. We're so fixed on, "oh my god, eight percent weight loss, nine percent weight loss, supplementation." In the time that I've been in public health the focus on breastfeeding is ginormous, which is absolutely important, but in my opinion we've lost some of the other stuff (1-653).

The RWG acknowledged the importance of supporting women to breastfeed; however, their job had become in-home individual clinical care and health education in the post-partum period.

A variety of other workload pressures affected PHN practice, in addition to the increased clinical demands associated with postpartum discharge. 'Rachel' summarized the workload pressures associated with PHN practice:

> That is the challenge, because our standards do require us to make those contacts, do the home visits within a certain amount of time. When you have so many families on your caseload, plus prenatal, plus immunizations, plus Youth Health Survey, and 'Heads Up,' and everything is happening at once. So sometimes we fall back on empowering the client to call us, and if they have the capacity you can leave it to them. Hopefully they will come to Healthy Baby group and you can connect with them there. That's what I always encourage for people... sometimes I think we have to, to cope, because we just can't go back and do the total amount of follow-ups (1-737).

The RWG did not feel good about this approach for the most vulnerable clients. The vulnerable clients were most at risk, yet least likely to reach out to access PHN services.

Historically, PHNs had strong connections and linkages within their communities. Traditional PHN practice components included a role in the school, community development,

and long-term relationships with vulnerable clients. Prior to the introduction of the postpartum standards, experienced PHNs recalled spending approximately half of their time in schools and the broader community. During the discussion, 'Beth' posed the following question for consideration:

> So how did that come about then? I'm asking as food for thought I guess. How did that come about that we were busy doing traditional public health work, and I remember that too, and then all of a sudden there was that shift to supporting moms coming home from hospital, and getting in and doing more hands-on task work and away from public health, so how did that happen to us (1-824)?

As a result, PHN relationships with community partners were severed. The majority of client charts were closed once physical indicators for health in the postnatal period were met. The individual level clinical focus came at the expense of the broader community and population health focus of PHN practice.

1.12 Organizational impact on PHN practice. Organization drivers of PHN workload were centralized programs that included immunization, communicable disease, injury prevention, Families First, smoking cessation, and physical activity. Medical officers of health and/or program specialists, with decision-making authority that influenced PHN practice, led these programs. The RWG discussed the role the organization played in influencing current practice directions. 'Rachel' described her perception of the practice below:

> We have so many different players in our practice. There's the grassroots level, there's the clinical nurse specialists, there's our program specialists, there's managers of all these different programs....We'll get a direction from the manager for immunization, "okay we want to increase immunization rates, so we're going to do this pilot where if you have less than seventy percent you're going to be doing this...." Well we're just told that and same thing here we're rolling out with communicable diseases, the ideal is we want you to do a home visit, that you're not just making phone contact..... Or Youth Health Survey, we've got somebody whose hired specifically for that area, that's their focus. This isn't a criticism, the person needs to do a good job of what they're doing, so they're really focused on that, but they have their one way of doing it and they're rolling it out to us... (1-2198).

Each individual leading, believed their program was a priority and wanted to promote PHN consistency.

One participant described the organization as a "dictatorship," based on her perception that PHNs were constantly navigating competing workload priorities, but not included in decision-making processes. In the excerpt below, the RWG reflected on a previous initiative developed by one these individuals, based on the idea that hot water scalds were preventable injuries that PHNs could address since they now had universal access to postpartum homes:

> PHN: …and they think they're public health. I think back to when I was in [a low socio-economic urban Canadian suburb] and there was that hot water tap scald initiative. Do you remember that one?....We were told by the injury prevention person, they developed a way we were going to address this....we're going to be doing this intervention with all families. We were told... "you're going to use the card to test their hot water, and if it's too high you can assist your families and go down into their cellar and turn down the hot water tank (group laughter)." This is in [a low socio-economic urban Canadian suburb] where the homes are so old that people have those cellars that open up out of the floor..... (laughter)…I don't like going into my own basement, I'm not going to be comfortable going into somebody else's basement... talk about safety. These are the kinds of things that are sometimes rolled out, without seeking feedback from us at the grassroots level. I appreciate why, because it's probably time-consuming, they're probably going to get a negative reaction.
> PHN: That's why they roll them out five minutes before we have to implement them (chuckle) (1-2239).

As the above example illustrates, decisions that influenced PHN practice did not always seem logical. Rather than meaningful consultation, PHNs were expected to carry out officious directions, without an understanding of the implications for them or their practice.

The RWG expressed frustration because the organizational focus and program direction was incongruent with their PHN practice philosophy. Participants considered numerous PHN roles that were no longer possible. Examples cited included community development activities such as working with coalitions, parenting groups, schools, or community partners. There was no longer a PHN focus on health promotion, in particular a focus on health promotion/

prevention targeted to youth/ teens. Participants discussed inadequate time for policy level work, such as writing grants. Lastly, there was inadequate PHN focus on inequities, outreach, and meeting the needs of vulnerable individuals, families, and populations unable to access traditional health services.

Evidenced based practice was a foundational tenet of the current organizational approach. Yet decisions about what PHNs should be doing were not always congruent with what the RWG believed their role should be. At times, attending to their organizational requirements created tension. The RWG described how PHNs felt obligated to follow organizational procedures and standards, even though they believed they may be sacrificing client needs. Additionally, the competing workload demands impeded PHN ability to target services where they were most needed. Current equity work was limited to Families First clients, accounting for a relatively small proportion of PHN time in most offices. Below, 'Beth' described the impact of this task-based approach on equity:

> In terms of equity, my experience with families that aren't accessing service, or don't have the same resources, those are people that really need a long time. And I don't always have that because I'm rushing off to the next visit or I've got two post-partums or I'm doing a clinic. Those families that really need that help, you could be in that home many many times, and over a period of months [to] develop a relationship where you can really make a difference. How my job is structured is difficult to do that, so we're missing the boat in terms of an equity strategy in that way (1-1578).

In managing competing workload priorities, in conjunction with intensive clinical management of postpartum clients, PHNs had lost the health promotion and autonomy that they valued in their role.

PHN work had become task based, and the depth and value of their role in promoting equity and population health had been eroded. This was especially prevalent as it pertained to the promotion of healthy early childhood development, which the group identified as a huge gap.

The RWG cited the delivery of prenatal classes as one example. Each community area was responsible to deliver a certain number of classes each year, using a standardized format and curriculum. High functioning clients who were well prepared for their pregnancies quickly filled the small numbers of available classes. While the PHNs did not believe that this was a good use of their time or public health resources, they were told what to do. The PHNs questioned whether their practice and the constant changes were evidenced-based, or a reflection of organizational hierarchies.

Lastly, the RWG spoke of the PHN role promoted by the organization, as evidenced by the orientation for new staff and statistical measures. Statistics submitted by PHNs did not reflect the scope or depth of the role. The organization kept quantitative measures of tasks such as the numbers of home visits, immunizations, and communicable diseases. Participants did not feel these statistics accurately reflected their priorities or the complexity of their work. 'Beth' stated: "if we need to keep stats let's revamp how we do that so it accurately reflects the work that we do and places value on the work that we do" (1-2472). Work that was measured seemed to equate with valued activities within the organization. In the case of immunizations, funding was based on doses of vaccine administered, so PHNs felt organizational pressure to increase uptake based on the premise that immunization was a public health priority. In terms of equity, there were no measures that reflected the complexity of working with the most vulnerable populations.

Since the implementation of the postpartum standards, the majority of the orientation for new staff focused on skills associated with clinical health assessment and breastfeeding. 'Kira,' one of the newer and younger PHNs recalled her experience entering public health, in that broader PHN practice elements such as community development were allocated an hour or two in the orientation schedule. She commented "... and so how can we expect our workforce to be

community-based or work on capacity-building and community development when we're not giving them the skills at the beginning" (1-1052). Conversely, a two-day breastfeeding orientation was only the introduction to developing that skill. The organization also provided advanced breastfeeding education by offering a 12-week course. After that, many PHNs continued their education and became internationally certified lactation consultants. Below, the RWG reflected on these organizational influences:

> Beth: We're sending everybody through Douglas College and what has happened in the last few years is that people are becoming certified as lactation consultants. So that should have been a positive thing, but that's not what I'm hearing.
> Helena: But the standards haven't changed, so we all feel that we have certain tasks that still to be completed each visit....
> Sarah: Is it this focus that we as a program keep feeding? That breastfeeding, post-partum visits is our role? I'd be curious to ask a lot of public health nurses to describe their role, and see what their response is.
> Beth: One of the first things they'll say is post-partum visits.
> Sarah: Breastfeeding, post-partum. If you gave them enough time maybe they'd get onto to school health and some of the other things but I think as an organization maybe we're unconsciously feeding (1-1028)....

Any broader PHN practice components were left to individuals and the teams to implement based on their personal knowledge or previous experiences.

1.13 Lack of understanding of the PHN role. The theme that the PHN role lacked clarity was dominant. The RWG expressed concern that the current standardized approach to PHN practice limited the ability of the PHNs to use critical thinking and practice autonomously. 'Rachel' stated that typical language to describe the PHN role was "I do post-partum visits, I go into the schools and immunize, I follow-up with communicable diseases" (1-1673). The RWG debated whether the inability to articulate the depth of their role contributed to lack of understanding.

Role clarity within public health, as well as the broader health care systems, was identified as a priority. The PHN role in promoting health equity by addressing the social determinants of

health was a foundational component of PHN practice. In the excerpt below, 'Beth' discussed why it might be difficult to understand this PHN function.

> And as public health nurses we'll look at that example and understand completely how important that was to that woman...because it addressed one of the determinants of health, it empowered her, it gave her some self-confidence but from somebody outside public health looking in, I don't think they would have understood that at all. They would have watched you talking to somebody about her finances and thought you're a nurse, I don't get it (1-199).

The RWG believed that hospital staff saw the PHN role as following-up on postpartum discharges, since the public health system had restructured to accommodate this practice. 'Sarah' challenged the group to consider how PHNs may have inadvertently contributed to their narrowed scope, by also not having a clear understanding of the full scope of PHN practice:

> You hear that between offices.... you hear some people in a specific office saying, "I feel like I'm more of a social worker than a nurse." And maybe that's not a really great understanding there. That is our role, we are talking about relationships and finances and so if you want to label it as social work, but that's the generalist model of public health (1-216).

The RWG agreed that tasks were easier to articulate and understand. Terminology to describe broader components of PHN practice included community development, facilitating equity, capacity building, advocacy, health promotion, and addressing the social determinants of health. Because of the complexity of these concepts, PHNs did not have a consistent understanding, and describing it to others was problematic. 'Helena' commented " it's easy for you to articulate to somebody by saying those tasks...their eyes glaze over if you start going into this broad…. " 'Rachel' finished her sentence saying "community development, working with families" (1-1693). Plain language was inadequate to capture the depth and complexity of the work. The RWG also reflected on how PHNs and public health leaders also now lacked clarity and had not done a good job describing or advocating for the broader PHN role within and outside of public health.

While the PHN role had grown very clinical and detailed in certain areas, there was lack of consistency and confusion in other areas of practice. A main area that PHNs were unsure about was their role in working in the schools. Since the implementation of the postpartum discharge standards, the PHN role had been eroded to the point where PHNs' interactions were limited to school-based immunization programs. In recent years, the Youth Health Survey provided a concrete opportunity for involvement in the schools. The Youth Health Survey was a provincial initiative undertaken through the collaboration of a variety of community partners. The surveys produced detailed health assessment information about school-based populations.

> Sarah: I've heard so much negativity about the Youth Health Survey, and to me that's public health.
> Rachel: All we're doing is giving it to the school to do. It is important work but the way it's being rolled out, the research team can do that work. There's other valuable work we could be doing, maybe in helping the school identify the priority area..."How are we going to address that health need, how are we going to implement that here in our school? The students have told us smoking is the concern, how are we going to do a health promotion program intervention to address that." That's what I see our role as in public health, not "okay here's the health survey and this is what you need to do" (1-767).

Although the Youth Health Survey provided an opportunity for community involvement, PHNs had not had meaningful involvement in the process.

With difficulty understanding and articulating the role, in addition to the multitude of individuals providing direction, sorting out workload priorities was challenging. The RWG felt as though their work was continually being added to, and they were asked to do it all, without a true appreciation for their role and what their focus should be.

> Rachel: ...It's decisions that are made beyond us. The hospital has the bulk of the healthcare dollars given to it and they a lot of times drive our practice, like look at us.
> Beth: It's being responsive. Where has there been somebody in public health that said "whoa, wait a minute."
> Rachel: "This isn't our role."
> Beth: "Does what you're asking us to do fit with what public health nursing is all about?" I don't know that that happened.

> Rachel: It's that bigger leadership piece. Our leaders also need to appreciate and understand what our role is so that we don't lose it. And that's not a criticism, I'm talking about all of us needing to appreciate it, so grassroots, our managers, our higher level leaders as well, our clinical nurse specialists, everybody. We all need to understand what our role is in public health, because then we're not just this extension of the hospital. Because that's what we've become and we are responsive. So the moms and babies are being discharged sooner, we still have these standards that are ten years old and we're trying to follow and meet those, and then we're not addressing what we should be in public health (1-2144).

The RWG were frustrated that their practice was not holistic, and that there did not seem to be anyone advocating for the PHN role as health decisions were being made.

'Kira,' the most recent graduate spoke of how little community content there was in her undergraduate program, and suggested schools of nursing as a logical place to increase awareness of the role. However as discussed in the conversation below, nursing schools did not seem to be advocating for PHN practice either.

> Rachel: And the faculty will say to students considering public health as a practicum, they'll discourage it, because they'll say you really should get some experience first in a hospital setting. So they're even encouraging experience that is task focused, before you go on to public health (1-1317).

The RWG believed that nurses outside of public health did not understand the PHN scope and role. The perception was that nurses choose this specialty because of the ability to work regular hours, rather than based on a passion for the work. The RWG wondered how lack of role clarity contributed to lack of value for PHN practice.

1.2. Full scope promotes health equity. Under this theme, I grouped components the RWG identified as valued and foundational aspects of PHN practice. The PHNs discussed their ideal practice and times when they experienced the greatest levels of satisfaction with their role.

1.21. Practice based on PHN competencies and WRHA position description. Participants shared a variety of stories and perspectives that highlighted their excitement and enthusiasm for the full scope of the PHN role. In the WRHA, PHN roles were Nurse IV jobs based on the

Manitoba Nurses Union classification system. To the RWG, the Nurse IV role highlighted the advanced nature, complexity, and critical thinking necessary for PHN practice. Within this role, working to address the social determinants of health and promote health equity was foundational, and an extremely satisfying component of their practice. 'Rachel' described her belief regarding the value of the PHN practice:

> An important piece for me is addressing inequities in health, through the broad determinants that we address, and going into the home, that's a huge factor for me. I feel we can move our citizens forward in terms of their health and where they're at, through public health more so than any other area of healthcare practice (1-53).

The generalist model created multiple access points for PHNs to reach clients, to assist in promoting and improving their health. In the past, the PHN role had a strong equity focus. PHNs were known within the community and worked actively to address the social determinants of health. 'Beth' described how skilled PHNs routinely built capacity in their interactions with clients, based on their understanding of the client context and broader community in which they lived.

> Those are things we do every day but might not even realize it. You get a post-partum referral and you're thinking about all the tasks that you're doing in that home, but at the same time you're doing lots of teaching and you're not always stopping to think, "okay this is what I've done, I've taught her this, I've connected her with that." You roll through the tasks of the visit, but maybe they don't have a family doctor, "and by the way here's somebody that might be accepting or did you know the library down the road has a tot program," or all those sorts of things that happen in the course of that one hour or two hour visit that is part of health promotion that we don't always think about (1-295).

Complex clients often did not trust health providers, and took more time to establish relationships. However, through establishment of trusting relationships and understanding the context of their lived experience, PHNs were able to assist clients with broad and multiple needs. 'Rachel' described being client centred, and the satisfaction associated in applying those PHN skills and knowledge:

> ...every interaction with every client, you determine what the priorities are in that visit, for that family. Our work is not the same for every family, its client-centred, we determine the needs, what's happening in this given situation... that's what makes our job so great, it makes it so interesting. Even though we do so much in terms of post-partum referrals, they're not the same, they're all different (1-636).

Often the initial purpose for the client interaction was less pressing than the need that emerged during the interaction. The following excerpt highlights the flexibility of the role:

> Sarah: …the things that family is struggling with the most, or that your school is struggling with, you're going in to immunize but the picture is much bigger and your role, it's morphed in front of your eyes (1-180)....

That variety in practice was exciting and created a role that was intellectually challenging and rewarding for PHNs.

The RWG discussed their disappointment regarding erosion of the PHN role. PHNs who had worked in schools described a sense of loss pertaining to the full scope of practice and working at a population level in the community. 'Kira,' as a new PHN, reported feeling cheated that she did not have the chance to experience the practice that PHNs spoke so passionately about. While acknowledging the impact of full scope for PHNs, 'Rachel' described the importance of reorienting PHN practice for the benefits of clients.

> We're the ones that can look holistically at their health needs and things that keep you healthy, so that you're not sick and having to access the system. What's going to help you down the road to have your children be successful in school, and maybe not end up on welfare like you did. That's what we can do and make a difference in public health (1-1763).

PHN practice should be prioritizing population health promotion and equity.

1.22. Inter-professional collaboration to address the social determinants of health.

Working with families over the long-term to foster early childhood development, PHNs had the chance to interrupt cycles of intergenerational trauma and poverty, and promote health equity. This mainly happened with Families First clients, where PHN involvement could span several

years. The RWG described their role in empowering clients, advocating, as well as assisting clients to break negative cycles and adopt more positive techniques for coping. 'Beth' spoke passionately about promoting the health of children and families and creating "remarkable" changes and ultimately population level improvements:

> ....our work is more than just the twenty minutes it takes to do a physical assessment. It's long-term, you might work with that client for three years if she's on the Family First Program before you see some really significant changing start to evolve. So it's not just in and do your tasks, and out, it's a starting point of something much bigger (1-409).

The goal of PHN practice was to address the social determinants of health. While fostering the parent child relationship, PHNs could improve the long-term health of clients by increasing their access to fundamental issues such as income, housing, and employment.

The RWG spoke about the importance of system integration, and the need to understand the PHN role in relationship to other sectors, agencies, and providers. Participants discussed the value of working in collaboration to promote client health, and the associated satisfaction. In the example below, 'Kira' described a PHN role in working with the client to address the social determinants of health:

> I am the most satisfied, when I'm in an area for a while, and I really get to know my community and I am able to provide the resources 'Rachel' was talking about....Know what Employment and Income Assistance is all about, and what resources in that community I can provide. You can actually see the client utilizing them and the positive outcome because of that (1-378).

The RWG discussed the importance of **i**nter-professional collaboration for vulnerable clients. 'Rachel' had recently initiated a case conference, where all providers met together in the client's home. She reported tremendous benefits for the client, as well as the health providers, associated with increased coordination and collaboration. While PHN leadership was important in promoting full scope of practice and inter-professional collaboration, the organization and broader system had to understand and support PHNs to practice in this manner.

1.3 The need for PHN role clarification. The RWG recognized that articulating their role was imperative in promoting full scope of practice, managing workload pressures, and defining their value within the broader health system. The main suggestion was reorienting PHN practice to be focused on upstream preventative activities, particularly the PHN role in equity and early childhood development.

1.31 Defining PHN practice. The RWG believed that the full scope of PHN practice should be optimized. Participants discussed the importance of the PHN role in focusing on equity and early childhood development, and opportunities to create population health improvements:

> Rachel: Thinking of prenatal contacts with families and the opportunity to connect families with Families First, and make a difference for families who are in that cycle of poverty. To support them in bonding relationships with their children, knowing how to promote the growth and development of their children. Those first five years are so crucial and that's going to make a huge difference for families, if we can give them that initial support so they know what they can be doing to support their children for those payoffs down the road....I look at that generation of people living in poverty and then going from one generation to the next. I think that our practice can really interrupt that and make a difference.
> Beth:...what you're talking about is empowering people through our educational pieces or supporting or advocating..... you're empowering people to make choices that lead them to breaking cycles and negative types of behaviours, and adopting more positive ones.
> Kira: I also think it's a matter of building confidence in individuals. So Families First, our connection to them, really helps to build confidence. I find working in a high poverty area, the more you can empower someone with confidence to make better decisions, the more success they're going to have. The more linkages you can provide with other people that feel the same way or have made those similar changes, the better outcome.

The PHN role required clarification however, to return to a focus on population health promotion. The RWG believed that PHNs should be involved in program decisions that influenced their practice. They understood the needs of the community because of their grassroots work and relationships. They also wanted autonomy and flexibility to incorporate their knowledge of public health and nursing sciences, to make practice decisions to meet the diverse needs of populations.

Participants wanted to work to the full scope of their competencies and adapt organizational programs to meet the needs of diverse clients. The following excerpt provides an example related to prenatal classes:

> Sarah: People feel the most satisfied when they have input on how something is delivered...
> Sarah: Anything we do, our flu clinics, and teaching prenatal classes. The more we have freedom to deliver service based on our client's needs, the more satisfying it is.... I'll use an example with prenatal classes, who we're delivering those to is a joke, and secondly we're told this is how you deliver them, the same across the board. That's the worst thing you can do. To deliver prenatal classes to clients in a [low socio-economic] versus [an advantaged suburb], its two totally different populations and for us to be told that this is the curriculum that you're going to use and everyone's going to do it the exact same way.
> Beth: And deliver "x" number during the year (1-2720).

The significance of organizational communication was raised repeatedly. 'Kira' had the following suggestion

> I know we have nursing practice council which is good, we review practice issues, but I'm just curious if there is another channel of communication that we could be utilizing to open up dialogue about what our role is and what the expectation is and why it's come to be the way it is. Maybe that would improve things a little bit and get people on the same page instead of having the roll out and the next day we're supposed to do it (1-2590)....

Opportunities to improve current practice included PHN participation in program leadership decisions, and allowing PHNs the flexibility to use critical thinking and problem-solving skills.

1.32. Facilitators of upstream reorientation. The goal of the RWG was to develop a model for service delivery, and participants wanted their practice to be consistent with the theoretical PHN role. To focus on upstream public health work, everyone in the organization, starting with PHNs, managers, directors, and program specialists, would need to collaborate. This would require a fundamental shift in the conceptualization of the PHN role, and reorganizing all components of practice, including orientation and staffing. As on participant stated:

> Management needs to be proactive and advocate for us, to listen to us and to fight for what we're saying needs to be done in terms of resources....What I've seen often in public health is the communicable disease piece telling us we have to do this, and the post-partum is telling us we have to do this, and somebody else is talking about prenatal, but there's nobody at the top sorting through that and saying "okay we've got these six things that have to be done on our plate, but this is number one".... It just doesn't seem like there's a strong voice for sorting out priorities, we have to do it all (1-2158).

The RWG discussed the importance of management support and communication.

The RWG believed that without an explicit purpose and concrete indicators of achievement, it would be difficult to describe the PHN role to others. In addition to measures that more accurately reflected the depth of their practice, the RWG spoke about the significance of organizational recognition. The PHNs believed that if their role was respected, there would be formal acknowledgement. The group described a regional initiative in which PHNs were not credited and the resulting negative feelings. Formal recognition also created opportunity for knowledge translation and the organization to learn and build on strengths and achievements. 'Kira' described her idea below:

> And then it's brought to light for the whole group, how it started, what was the middle piece and what was the outcome. And with nursing that's what we move through every day, but being able to review that and have the whole region learn from it is great, because the next time I come to a project [I'm] going to move through those things....That person is honoured and brought forward and recognized, but at the same time everybody learns from that (1-2690).

If the PHN role could be defined and reoriented to focus on upstream work, it could be used to advocate for redistribution of staff, resources and policy changes. Below, 'Kira' questioned practice in other countries, and whether more funding would be needed if practice were shifted to maximize the impact.

> Do we have the capacity in terms of our staff to actually do what we want to and if we don't then maybe requesting more funding from the government to look at more upstream thinking and how can we support that. Let's look at other countries, what are they doing and how come they have better health outcomes....a lot of times those outcomes are because they're more upstream thinkers (1-1980).

In summary, at the first RWG meeting, participants shared their views of current practice, gaps, and opportunities for improvement. Over the course of the next six months, using the participatory action research process, the RWG developed an action plan for a model to clarify the role of the PHN.

Section II: RWG Numbers 2-6 - Participant Interpretation

2.0. The Journey to Development of the Professional Practice Model

Five RWGs took place from January 16, 2013 to May 15, 2013. A brief summary follows and the detailed agendas and plans for each session are contained in Appendices R-W. On January 16th, participants reviewed summary documents from the November RWG, in addition, to documents intended to enrich the process. These included key Canadian documents pertinent to PHN practice (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b), as well as the WRHA PHN position description, and the Population & Public Health conceptual framework. The March 20th RWG integrated research articles describing service delivery and professional practice models. During the April 4rd meeting, the RWG summarized and incorporated feedback from the teams, using a process of grouping similar concepts under the Population & Public Health conceptual framework headings. Where additional information or definitions of concepts were required, Canadian PHN textbooks were consulted. On April 25th, the collated feedback from the previous session was reviewed, in addition to the draft action plan. During the May 15th meeting, the RWG reflected on feedback from two meetings with the director of public health, in addition to making revisions to the action plan that highlighted the PHN role, reflected diversity in PHN practice, and made the professional practice model applicable to broad audiences. I have framed this as the RWG's

interpretation, with themes identified in Table 3. Using the participatory action process, participants created meaning and began to visualize options to improve their situation.

As the researcher, I listened to the audio files, verified transcripts, and analyzed data. To facilitate the process I developed summary documents, agendas, and draft action plans based on the audio files and transcripts. I brought updated documents to each meeting for participant reflection, feedback, and to stimulate discussion to move forward.

Table 3: RWG Numbers 2-6 Themes - Participant Interpretation

Participatory action research cycle / theme	**Category and sub-categories** **2. The journey to the professional practice model**
Look: Expanding view	2.1 Successes associated with participatory action research 2.11 Cyclical nature, critical reflection, and discussion enriched the process 2.12 Awareness of organizational inefficiencies, inequities and power imbalance
Think: PHN solutions to practice issues	2.2 Fostering a shared vision 2.21 Adaptation to organizational structures and processes 2.22 PHN leadership for population health promotion
Act: Development of the professional practice model	2.3 A professional practice model describes and supports the full scope of PHN role 2.31 Delivery structures and processes articulate autonomous PHN practice 2.32. Essential organizational structures to support PHN practice 2.33 A necessary starting point

2.1 Successes associated with participatory action research. Under this theme, I included data that reflected participants' perception of the participatory action research process. To develop the final product, the RWG reviewed multiple sources of information. Through reflection on their current role, reviewing information and ongoing dialogue, awareness of the PHN role as well as increased understanding of the organizational impact on PHN practice became evident.

2.11 The cyclical nature, critical reflection, and discussion enriched the process. A key theme associated with the participatory action research was the importance of RWG immersion in the process. 'Rachel' made the following observation regarding the participatory action approach: " it was helpful in breaking it down, what was the piece that we assessed and themes related to that, then the critical thinking, and action strategy in terms of how you address that in PHN practice" (2-118). Initially, participants asked questions to clarify their role, and to ensure the process was meeting my needs. They were nervous about representing the views of their teams, and were careful to identify personal opinions. The group was not clear what the final product would be.

Participants became increasingly comfortable and confident, assuming ownership. They regularly described learning and positive impacts associated with the project. 'Rachel' stated: "...look at this process here....I feel so energized when we meet as a group, this is so positive...you get stagnant, this kind of stuff reenergizes us" (4a- 2705). At multiple points, RWG members commented that suddenly an issue had become clear to them. The excerpt below is one example:

> Rachel: I feel all of a sudden really excited that we made some progress.
> Beth: It's like a light bulb went on.
> Rachel: ...yeah and it's "let's use this," and we all agree what our vision is, it sounds like this makes so much sense (3-1923).

Through ongoing reflection and discussion, something resonated. Participants could understand a concept, the PHN role had become clearer, or members had developed a potential solution to one of the issues. 'Beth' described her learning: "It's taken us a lot of discussion to wrap our heads around the concepts, and that's taken time. It's good, it's all good stuff, it's been valuable, but personally I find it's taken some time" (4b- 82). Rachel' went on to describe how reflection and discussion contributed to her ability to process information and move forward. She said "....and

talking it through has really helped to get a better understanding of where we're going and what we need to try to accomplish here" (4b- 90).

The cyclical nature of the participatory action research process was also helpful in engaging others beyond the RWG. Enthusiasm and interest of the teams, and a desire to contribute to the process increased throughout the duration of the study. 'Danielle' described her experience of eliciting feedback from her team:

> I had a couple meetings with the team. I didn't think I had enough feedback but then once I wrote it down I was like "Hmm maybe I should leave them alone," I kept telling them they weren't giving me enough (laughing) (4a - 656).

Initially there was skepticism; however, as the project progressed, momentum grew within and outside the RWG.

2.12 Awareness of organizational inefficiencies, inequities and power imbalances. A theme that continued to emerge was PHN recognition regarding their current situation. Their current role was not consistent with the PHN role outlined in theory. As the RWG and the PHN teams engaged in discussion, the inconsistent understanding of the role became apparent. While reviewing and collating feedback from the community teams, 'Sarah' stated:

> Supporting the role, defining the role of the public health nurse...that was a lot of what I read too.....need to increase sharing of public health knowledge, public health theory and sciences. There is quite a few of them under here (4a - 1075).

As the RWG struggled to move forward in developing the model, the extent of organizational barriers affecting PHN practice was pervasive. PHNs were trying to stay on top of program demands and workload expectations, often with little time to question or reflect on the purpose. 'Sarah' commented "we didn't realize when they came and presented Early Developmental Instrument results that a good chunk of it came from our screening, yet we don't even realize it" (4b-2343). In response to a current initiative, 'Helena' commented that PHNs

were not included in organizational decisions, stating, “again that communication piece is taken away from us, like with scheduling of PHN visits, I feel like we’re not being consulted on that” (5-2319). While discussing PHN roles and activities early on, ‘Beth’ expressed the need “to promote, protect, and preserve PHN work, so that essential elements would not be taken away” (2-232).

The process of gathering feedback from the teams provided the clear message that PHNs did not feel valued or that they had a voice. Practice was disjointed and PHNs were feeling powerless to create change. A main reason was lack of prioritization of the work and silo’d program approaches that had become taken for granted within the organizational culture. Similar to stories shared at the initial RWG, ‘Aryanna’ described how PHN practice was dictated by those with more power, but who did not understand the full scope of their role:

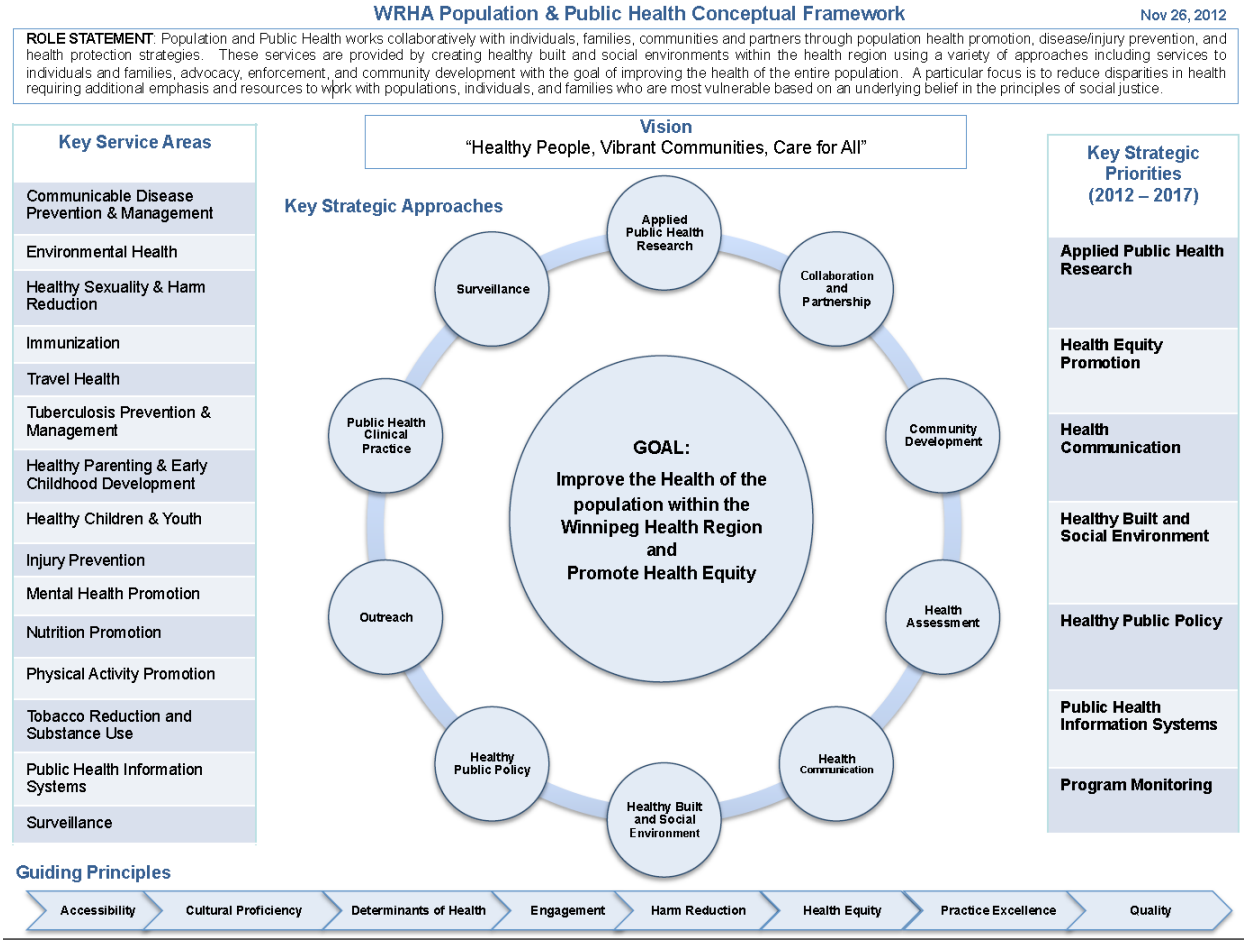
> What it comes down to is that we’re trying to be the service deliverers of all these different programs. So when you have the Communicable Disease focus, they’re the ones doing the pandemic planning, their focus is on one area and we’re the service delivery. They’re not looking at what else the public health nurses have to do, they just look at it from their end and deliver it to us. So I think that’s where a lot of our problem is, all these bigger people saying, okay we want you guys to do this now, because this is what works.
> Beth: The disconnect between program management and practice management.

A new Population and Public Health conceptual framework was introduced to PHNs for the first time at the December 2012 annual staff development sessions (see Figure 2). The RWG did not feel that the Population & Public Health conceptual framework reflected PHN practice, further contributing to feelings of staff disengagement. The following discussion ensued during the January 16, 2013 meeting regarding application of the conceptual framework to PHN practice.

> F: Do you see yourself in here?
> Beth: Yes (chuckle).and no. I see myself in pieces of this, I see places where we could be used more, but like you said ‘Rachel’ what’s missing, this is everything we should be doing but it’s the prioritization piece, or the how to piece given our resources.

Sarah: You see yourself heavily in one area, and then trying very hard
Rachel: to do other things (2-1732).

Figure 2: WRHA Population & Public Health Conceptual Framework



The RWG reported frustration among the teams regarding the framework. It was presented to them without their input, and depicted a vision that was not attainable within their current practice because of the extent the organization directed and contained PHN practice. The RWG discussed that dissatisfaction in a later meeting, while reviewing team comments:

Beth: I think we heard that over and over again in the feedback from the different community areas. That theme of being dissatisfied because we're doing something different than what we thought we should be doing....
Rachel: Yes, exactly.
Sarah: Well and the frustration that something like that is presented and you hear the same comments over and over. "Well we're not doing that anyway, we're referral driven, we're not in the schools, we're not in the...".it's all of the same.

> Beth: It's that other theme of our work being led by people other than ourselves so our work is being planned based on somebody else's agenda (3-1088).

The RWG spoke about the importance of evidence-based practice and the organizational role in staying current with best practice and trends across the province and country. Clinical practice guidelines were helpful when concise and applicable to the reality of their practice. Basing PHN practice on evidence added credibility to the role. Participants discussed this issue below:

> Sarah: ...one thing that I've noticed from a nursing practice council perspective, we have four things sitting waiting for approval at a management level that they never get to on the agenda. We do all the great work and we're waiting for these guidelines and they sit somewhere.
> Helena: Till they get forgotten about (chuckle).
> Sarah: That doesn't feel like support, that feels like a barrier. We're not even practicing with best practice currently because of that stall. So whatever they need to do to alleviate that (5-1890).

Timeliness of organizational documents to support PHN practice was an issue. Even when PHN input was asked for, often projects weren't completed. The RWG spoke of guidelines for prenatal, hypertension, and jaundice screening, that had been in draft form for several years. Similar to the clinical practice guideline for postpartum discharge, a new guideline for work with prenatal clients cited rigid timelines for contact and follow-up that were not realistic given current workload pressures. Completed guidelines often left very little room for the critical thinking or judgement that the RWG believed the Nurse IV role should allow. Optimizing PHN full scope however, would also mean clarifying others' roles, to increase overall organizational efficiency and effectiveness.

The RWG spoke of a prioritization document being developed at the senior management level. The following discussion was based on concerns that the prioritization document would contradict the action being developed by the RWG:

> Sarah: My concern would be that public health nurses have really taken this seriously and have given us great feedback. If there is a bunch of messages sent out in the meantime that aren't really consistent....we have given the message that [this project] is your opportunity to have impact on your role and your practice. I don't know what that messaging is going to say, the prioritization document, if that doesn't fit...I am afraid that messaging is going to be
> Helena: lost...
> Sarah: Or nurses are going to go "whatever, our voices aren't being heard again."
> Helena: I am struggling with getting feedback from people too. You hear "oh really, because is anything going to change in the long run."
> Danielle: I've heard that in comments too (4a- 809).

'Rachel' summarized disappointment associated with projects in the past, and feeling that PHN input was not valued.

> People on our team have commented "we have been through this before and we've done a lot of work, we have invested a lot of time and energy and then nothing comes of it." So just feeling like they are really hoping this will lead somewhere (4a - 843).

In some cases, the organizational approach to PHN practice had led to apathy and distrust. PHNs had not been successful in creating changes or influencing program direction in the past, and had given up. 'Sarah' described this below:

> I think that we've got an environment where public health nurses sit back and wait for the organization to make a decision about something, prenatal being a good example of that. Every community area probably has the exact same feelings about how we service prenatally and we're just sitting and waiting for a caremap and guidelines to come out. Are we going to be back in the same situation when we don't have that public health representation, where we're going to have these guidelines like our Healthy Beginnings guidelines that make us so clinically-based (2-1259).

In addition to a program management team, each community area had a separate management structure. As a result, program activities valued in one area may not be supported in another area. Teams therefore functioned independently and were often unaware of practices at other offices. This had potential to further contribute to inefficiencies and lack of coordination. 'Beth' commented:

> There is so much of each office making it up as they go along. And I know to some degree you want to meet the needs of your community, but there is so many things happening out there that we don't know what each other is doing **(**4a-2869).

Clients were not the same across community areas. The need for program consistency and standardization diminished the complexity of delivering services in areas with disproportionate inequities. 'Danielle' described this below:

> That's a common theme that's been coming forth from [lower socio-economic suburb]. The need for people in higher levels of public health to recognize that we do require more funding for capacity building to build that relationship to make a difference. If we're just trying to get in there and check off our epi-stats that we've done a visit and make no actual positive outcome that's fine, but if our goal is to have health behaviour change and make a difference in the community we need to actually recognize that we need more services to be allocated to be able to go into those homes and spend a few more visits with families that need it (3-1217).

In addition to the challenge of managing competing workload demands, the RWG spoke of the constant changes and addition to their jobs, without adequate resources or replacement for sick time or vacation. 'Rachel' commented:

> That's the thing that I find that sometimes gets in the way, it's the fact that we do have so much that comes to us and we don't replace staff. I know that people hear it a lot and it's felt like a negative and sometimes people tune us out but it really speaks to whether we value the work or not (4a - 2773).

PHNs seldom seemed to be respected as health professionals with content expertise important to include in decision-making processes. Organizational communication seemed to be either directive or nonexistent 'Danielle' commented:

> Just to highlight the need for communication, it troubles me that there's all these different things going on and we don't know what they are. For public health nurses to exhibit good leadership, it starts with awareness of what's going on, so that we can help facilitate a direction to go in that benefits the organization or the team. But if we don't have that knowledge we're just told what happens and it's a top down approach and its disempowering (5-2026).

PHNs required organizational support that was consistent with their scope and role. 'Beth' facetiously commented on the risks associated with lack of adequate program evaluation below:

> ... Isn't this how we ended up in this situation (group laughter)? Not having evidence to back the work that we're doing so we're being told what to do. The early post-partum discharge program for example which has gobbled up a lot of our time (4b-2451).

Participants spoke of the need for organizational measures that reflected the full scope of PHN practice and the depth of the role.

2.2 Fostering a shared vision. Under this theme, I grouped data that reflected participants' ideas for generating solutions to the issues affecting them. As the RWG reviewed the differing sources of information, they came to appreciate that the PHN voice was necessary in advocating for their practice and creating change. Participants recognized that to be successful however, the RWG action would have to be consistent with the WRHA organizational context.

2.21 Adaptation to organizational structures and processes. To create improvements, the RWG and the PHNs wanted to be working to the full scope of their job description. Although the Population & Public Health conceptual framework did not create language that resonated with PHNs, it could be a starting point. A developed framework made the task a bit less overwhelming, and built on elements significant to the organization. In developing the plan, 'Rachel' discussed alignment with the organization:

> And that first article I was referencing...they talked about the fact that we work to our competencies and there's greater job satisfaction when you work with the vision of the organization.…So this makes sense, if we do something different based on the strategic plan that the WRHA Population and Public Health has developed, we're not in line (3-1075).

Acknowledging the organizational impact on practice and moving forward in a collaborative direction was a political strategy to gain acceptance and begin to influence the more dominant culture. Beth stated: "We want to be collaborative and have partners, and these are going to be our partners" (4a- 1930). Fostering a shared vision with the organization was critical to having the PHN voice heard. Rachel stated:

> When people were looking at the 'Look, Think, Act,' there's a bit of frustration that comes through that we're not at the area that we could be at in terms of practice. But what I feel today is that this is bringing us together collaboratively with our leadership and management and we're going to all be on the same page (3-1950).

A shared vision would be especially important when it came to the broader health care system. 'Beth' considered the potential impact of a change in PHN practice for the director of public health:

> I appreciate that she is in a difficult position, where there's funding to consider and limited resources, and our connection to other programs like hospital for example. When you're discharged home there has to be something on the other end. It's a huge big machine, and if it's going to turn around it's going to be challenging and it's going to take time (5-2578).

'Rachel' described an "ah-ha moment," recognizing that everyone in the organization would have to buy-in. If there were to be a fundamental change, individuals in leadership positions would need to be on board and able to advocate for PHN practice as decisions were made within the healthcare system. 'Rachel' stated:

> We are going to need the support from our managers and leaders in terms of articulating this and informing other areas that look to us as picking up....for instance, we have heard lots about early discharge, there is more expectation "oh if breastfeeding didn't get initiated in hospital, don't worry your public health nurse will come out and support that." We need to help inform other people that we work [with]... to know this is what public health is, this is what we are going to be focusing on, we are changing the way that we're prioritizing our work (4a- 1944).

2.22 PHN leadership for population health promotion. The RWG recognized that if they wanted the organization to function differently, PHNs could assume a leadership role. The first step was for PHNs to clarify their role with a focus on population health. 'Beth' nicely articulated this below:

> One of the themes that we've heard from the feedback from offices and discussions we've had here, we want clearly to be based in community health...it's not community care, not that task oriented piece, but we want it to be based in true public health work, which is community health. Although what we're doing now really is quite different then what we see as part of that service delivery model for the future, two different directions (3-1025).

It became apparent however that a tension now existed between the role in providing clinical postpartum care and working to the PHN full scope. More than a decade after the implementation of early postpartum discharge, many PHNs had been hired because of previous hospital experience. With extensive organizational focus on clinical assessment and breastfeeding, many PHNs had developed considerable expertise.

Some PHNs understood and valued the full scope of the role, particularly those who had practiced prior to the implementation of early postpartum discharge and the standards. Yet the lack of consistent understanding contributed to confusion and controversy. 'Sarah' described a situation at her office:

> One of our nurses has taken the initiative on the battle against ...chewing tobacco within our community. She's gone out to schools that have hockey teams and has presented on the health risks of chewing tobacco. And that's been not well received on our team.
> Beth: By other team members?
> Sarah: Yup.
> Rachel: Because people feel that it impacts their workload or why?
> Sarah: Potentially.
> Beth: ...because it's all about...your number of referrals (4a-2169).

Managers and PHNs who did not understand the full scope of PHN practice may have reinforced an inaccurate and inconsistent approach to postpartum work, as the discussion below highlighted:

> Rachel: The comment that one team manager made, was some of the PHNs on the team really enjoy the postpartum work and don't see the broader part as something that they enjoy or value, or part of their role....That was from years ago and I wonder if that could be what we might be challenged with, although this is within our job description and we should all be working in that way and according to our competencies...
> Sarah: ...there is comments throughout, saying that's where we are champions (4a- 2591).

The RWG spoke of the need to clarify the intended goals of PHN practice. This involved acknowledging a PHN role beyond individual level clinical care, and embracing a population

based approach that framed PHN practice within public health theories and sciences. 'Danielle' described reorienting PHN practice:

> ...highlighting the importance of focusing on population public health as part of our role. We've gotten away from that with our task-based extension of the healthcare system, and that's been articulated by all the community areas. If we can look at the foundation of public health, looking at the Ottawa Charter, from the past what public health is and weave that into our role. If we can articulate population and public health and not just the one on one baby visits, that doesn't always line up with the broader perspective (5-763).

Participants recognized that PHNs as a group should contribute ideas and solutions within the organization, and be active partners in shaping their practice. PHNs could advocate for their practice and feel confident voicing their opinions. One participant commented:

> Not just to think about it but to say "hey wait a minute (chuckle)," to management or program people.... Something as simple as the flu clinic, we said no to these people because we do mass clinics, but... I think strongly that we should be in there...but we've been all towing the line because that's the direction that's come down... Or...we've all been grumbling about prenatal classes but nobody at our team anyways put their foot down and said, "no"....we're missing this piece over here as we're busy trying to decide whose doing the next series to all these well-educated people with lots of resources... (2-1259).

Leadership was a PHN competency. Beth articulated the need for PHNs to step up, to participate fully, and work to their full scope:

> ....better understanding of the PHN role by everyone, including public health nurses. Maybe recognizing that we do have a voice that we can exercise and we can challenge and speak up for what we think we should be doing and how we should be doing it and who we should be serving. I think you're right, that there is kind of this culture of sitting back and saying where is the caremap and tell us what to do with prenatal classes, rather than exercising an opinion or choosing to challenge that (2-1269).

Options for sharing the PHN opinion and being involved in organizational decisions affecting PHN practice were discussed. 'Sarah' suggested, "advocating for public health representation during decision-making processes" (2-1264). 'Rachel' commented on helping colleagues to move forward in their thinking:

> That's why we all need to be on the same page. We have the benefit of being here and hearing this conversation and giving input, so we're moving forward in this thinking. But

> our teams, we need to help people appreciate that there's differences in our practice but at some level we have to have some consistency in terms of what we value, how we want to practice so that we support one another to work as a team, we are not getting caught in that working as individuals (4a-2180).

In developing a plan to transform their practice to become more population based, the RWG reflected on personal attributes and strengths. Participants discussed PHN knowledge and experience, and how that may influence others. Helena' described PHN leadership potential:

> "... I think we do have a big influence as public health nurses....We would be influencing other(s) if we're speaking at a group, who we are and what our title is, I think we have a lot of influence. If we're talking about healthy nutrition, how we're communicating to that group, we have a big influence on maybe future practices and beliefs.....
> Beth: It's our knowledge base and our experience too that contributes to that influence... (4b-2260).

The RWG built upon the leadership skills they used in their PHN practice, to create opportunities and a plan for improvement. Rachel' stated:

> ...doing that brainstorming and suggestions for how we can move to the place that we want to be in our own practice. There's some things we can't control and we won't ever be able to, but there's certain things we can do that make a difference. It can bring us to the place that we feel valued and that we are doing good work and are working to the role (4a - 1120).

The RWG used a variety of their leadership skills to engage others. On a monthly basis, participants' facilitated communication and suggested documents to share with nursing practice council and the teams. The RWG kept the process moving forward, as evidenced by the interaction below:

> Beth: When that document goes out with the minutes, I'm thinking about communication and we maybe have to give a little blurb in your email about how we expect teams to use that document. To get feedback from their teams and next steps.
> Sarah: Yeah with some of these questions, what are the next steps, similar to how we did it before.
> Beth: Other initiatives that are happening in public health and our vision is to see this governs, or the lens.
> Sarah: Yeah, we'll do a little blurb like we did before.... I think we underestimate how much we're now immersed in it. To just simply say what is your feedback...

> Beth: It's a way of telling our members to pass on to the rest of our teams how important it is that we get feedback on this. I think that we really need to do that.
> Helena: It would be difficult for them to be presenting to teams (5-2466)....

The RWG considered how and when to communicate, varying levels of understanding among teams, and competing organizational priorities.

In addition to providing leadership at nursing practice council, the RWG met with the director of public health, to update and keep her informed. The RWG also hoped to be advised of other projects that could be complementary or contradictory. The following is an example of a conversation that took place prior to one of the meetings:

> Sarah: So our purpose of this meeting with [the Director], we've slightly kept her up to date on where things are going, but we need to summarize what we've done and where we're at.
> Helena: And where we're going, where our vision is.
> Beth: We also wanted to meet with her because she's working on some kind of a prioritization document (4b-3840).

Participants shared responsibility by taking turns drafting e-mails to the director on behalf of the group, by taking minutes at the meetings, and strategically advocating for the PHN role. The following excerpt is an example:

> Sarah: Well from an implementation, next steps perspective. First question, is there one of us that is willing to draft an email to [the Director].
> Beth: Oh right, so we're giving her feedback about how we want to see this used.
> Sarah: She asked for our input and I think if we don't send it, that's a missed opportunity.
> Beth: Yeah. Well if everybody wants to send me their thoughts, I can draft an email (5-2766).

'Sarah' described the importance of impressing upon decision-makers the level of buy-in and support that had come from teams regarding the process:

> The third point that we really need to get across with [the director]..., and why we asked for the meeting, is that if something doesn't come out of all of the work that the public health nurses have done on this. She really needs to hear how much feedback we've gotten, how consistent it's been, nurses have put a lot of work into it. We have, but so have everybody else... (4b-3946).

The RWG maintained an enthusiastic and strength-based approach, while taking every opportunity to increase project success. The RWG summarized the process used to develop the model and their hopes for the document:

> Danielle: ...we've been very respectful to line up the model we're using with what the region is using and I don't think there's any very crazy shifts in suggesting what we should be doing, I think they'll embrace it.
> Beth: And maybe that's something Rachel that we could incorporate into that email. To say this is where we are at this point in time, we've been successful in incorporating all the great feedback that's come...now we're asking you to critique it. But why not make a positive statement in the email too, acknowledging all the work that's gone into that from everybody (5-2610).

PHNs were important in contributing to a positive practice environment and should be included as decisions were made about their practice. The development of the action plan and model came to be recognized as opportunities for PHN input and influence.

2.3 A professional practice model describes and supports the PHN role. During the process, the RWG came to recognize that a professional practice model provided the framework necessary for PHN services to be contextualized and understood within the organization. The service delivery component could describe an autonomous PHN role in providing client care, however to be attained, the other components of the professional practice model had to be explicit. 'Beth' explained it as follows "…because if we're going to talk about a service delivery model, which is the how do you do your work, what precedes that, is what is the work you're doing" (3-1813). The full professional practice model assisted in prioritizing PHN work, based on the theoretical philosophy of public health nursing.

Members came to the conclusion that the outcome of the participatory action research project should be a comprehensive report composed of multiple segments. The RWG discussed this below:

Sarah: I think we're going to need something that goes along with a diagram...

> Helena: Of the service delivery model…
> Sarah: ...we have been keeping people up to date as we've gone on but there needs to be...
> Helena: a fairly substantial report that gives the background, that gives a little bit about the literature (4b-546).

The report would describe all components of a professional practice model. These were: delivery structure and process; values and principles; professional relationships and partnerships; management practices; and rewards and recognition. 'Beth' described the need for the professional practice model "because we're talking about a PHN role evolving in response to the changing needs of populations and going back to the core of what public health work is" (5-1769). The RWG wanted the professional practice model as a document that could be used now but comprehensive enough for the future. 'Helena' discussed this:

> I'm looking at this for the long-term too, not just what we want to change today. If we have this goal and we've made changes and everything's worked the way we want it to, we don't want this document to be null and void at that point. We want it to continue on with us, we don't want to keep having to make changes every six months....we're talking about a model that's going to be carrying us through our practice for years and years (4b-2802).

The document incorporated literature and documents defining the PHN role, feedback from peers, dialogue with the director, and pertinent organizational documents.

2.31 Delivery structures and processes that articulate autonomous PHN practice. In reflecting on their situation and trying to understand the concept of a service delivery model, participants reviewed literature on nursing care models. Terminology was not consistent and the majority of models were based on hospital rather than community practice. As evidenced below, participants struggled with applying the literature to their practice.

> Rachel: And when you look at the second article...about the models of care, it's all focused on hospital-based work.
> Beth: It is, that's our history.
> Rachel: It doesn't even consider how we practice in the community, so I had a hard time, how does this fit with what we're doing. I wanted to share Sarah, you had asked about "were they not the same, the care delivery model and professional practice model," and what this author says is although the terms care delivery model and professional practice

> model are often used interchangeably, they're not synonymous. It says care delivery models focus on how the care is structurally organized to facilitate the work that we do and the quality outcomes, but the professional practice model looks at how nurses are supported to deliver care, so things like aligning clinical practice with education, with administration and research. They need to go together but they're suggesting that you need to do the professional practice model first before you talk about getting into care delivery models and make decisions about that (3-795).

The RWG came to understand that a service delivery model was one component of the larger professional practice model structure. 'Sarah' later explained:

> And my understanding was that the care delivery model was only one component of the practice model, out of the five sub-systems....That's probably what nurses are going to be a little bit fixated on because it's what we do, but the other ones being values, relationships, management, the rewards... that came very clear to me. (3-826).

To collaborate with the organization and foster a shared vision, the RWG used the Population & Public Health conceptual framework in Figure 3, to depict the PHN service delivery model.

Figure 3: WRHA PHN Service Delivery Model

The Population & Public Health conceptual framework described organizational strategic approaches of clinical practice, outreach, healthy public policy, healthy built and social

environment, health communication, health assessment, community development, collaboration and partnership, applied public health research, and surveillance.

Participants observed that many PHNs weren't good at articulating their role. As an example, 'Beth' the most experienced of the RWG described her routine assessment of the social determinants of health and the associated difficulty in describing that to others:

> It's funny to hear us talk because the assessments that we do, from the minute we walk in the door, as you're approaching the door you're already assessing, it's such an integral part of the work that we do. I think sometimes we have a hard time articulating that, because it's just there, it just happens, it isn't always that you're thinking okay now I'm going to assess this, it's just always happening as you're interacting with clients (4b-1715).

Similarly, the RWG discussed that without clearly articulating each aspect of the service delivery model, inconsistency and confusion could continue. Each strategic approach in the Population & Public Health conceptual model therefore provided an opportunity to expand understanding, using language specific to PHN practice.

The RWG debated about the best structure to articulate the service delivery model. One way to help others understand the broader and more complex concepts of PHN practice was to include practice examples. 'Danielle,' one of the newer PHNs, suggested a quick glance document for those wanting a summary in addition to a longer document containing practice examples.

> Sarah: We either take them out completely and use no examples and just use the theory behind it or use some examples that maybe the community areas are doing, that people go "ohhh."
> Helena: I like the idea of putting a few examples of what we should be doing and what we are doing
> Danielle: I 100% agree, I think in some context people are at a loss, not able to think...some people can create that in their mind and have a vision of what to do, where they've done it in practice, new nurses might not be able to do that. So I think if there's a supplementary document that someone can go to if they want, that's not daunting and in this document, then they can see some really flushed out great examples.
> Helena: Like an appendix maybe (4b- 579).

'Helena' commented on the significance of the language for PHNs and the organization: "I think it's good because then it provides consistency. If you're reading outreach, we all generally know what it is, but to see it written down provides consistency and we know what we're talking about" (4b-227).

The RWG wanted the examples to highlight all aspects of the PHN role, and especially those that had been eroded, so the full scope of the PHN role was represented. 'Sarah' commented: "we put in a couple more outside of the obvious ones, because what we always hear is "it's all we do is healthy baby, it's all we do is breastfeed...." If we use those examples, people are going to go "well this is no different" (4b-557). One example that would challenge others was healthy public policy. Below participants discussed this, and the fact there were multiple levels and areas for PHN influence:

> Danielle: ...different sectors like school, government.
> Rachel: Because otherwise we're not appreciating that we do have an impact on healthy public policy, even if it's not legislation, we're making a difference (4b- 790).

The document needed to depict a PHN role that was attainable, but to challenge everyone to think differently.

The RWG believed that the examples would resonate because feedback had been framed within higher level theoretical language that articulated the PHN role and linked it to the Population & Public Health conceptual framework. The practice examples were also a way to recognize and acknowledge PHN work that had taken place. The importance of the examples was discussed:

> Rachel: I like the examples that have been incorporated; I think that's really valuable. It reflects the feedback. People....they're going to be able to see their comments reflected here and their examples.
> Sarah: And it gives nurses permission to be doing this kind of stuff, outside of what they think they're expected to do.

> Rachel: Because the information before was very based on theory, this is the actual feedback.
> Helena: Concrete, yeah.
> Rachel: Concrete, what we've received from our colleagues and we've incorporated in this document (5-1323).

Couching the practice examples within the broader theoretical components of the role made the complex concepts easier to understand and attainable. 'Sarah' stated:

> From a new person reading it, I really love the examples because it makes sense and it feels like home for me. This terminology feels like home to me and goes okay we are acknowledging all of the areas...they are the service delivery areas (5-482)....

The RWG recognized that the document could provide the foundation to build PHN and organizational understanding and capacity regarding the full scope of the PHN role. 'Rachel' said:

> It will support all of us, our colleagues included, when we get to a place where we're implementing this, if people can have a point of reference. When they're not sure, they can look back at the definitions. Because look at how much work we've put into trying to get our heads around this (4b-259).

The service delivery model defined components associated with the autonomous PHN role. To achieve the service delivery model however, other essential factors would have to be in place within the broader organization and healthcare system to enable PHN practice.

2.32 Essential organizational structures to support PHN practice. The full professional practice model articulated the structures and processes necessary to optimize the scope of PHN practice. Additional essential components consisted of values and principles, professional relationships and partnerships, management practices, and rewards and recognition.

Values and principles. Articulation of 'values and principles' provided the foundation of the professional practice model, or the philosophical basis for PHN practice. The necessity of having to state a PHN practice philosophy was an unexpected finding, but one that was important in creating shared understanding of the role across the organization. The RWG adapted the

Canadian Public Health Association definition of PHN (Canadian Public Health Association, 2010), stating that the objective of PHN practice was "promoting, protecting and preserving the health of populations, and facilitating equitable health outcomes by addressing the determinants of health." A key point was that PHN practice was population-based, with a goal to keep people healthy and alleviate pressure on the healthcare system by creating population health improvements. This distinguished PHN practice from other types of nursing practice that provided healthcare to the individual. The RWG discussed this below:

> Beth: Getting back to defining our role and trying to come up with a concept, a model....I'm still coming back to these guiding principles.... and equity is one of them, but if we are talking about the work that we do, there has to be some base in our document that we refer to. Is that not the guiding principles?
> Rachel: Um-hmm because that's our values, that's what [is] grounding all of our work (4a-1654).

A little later 'Rachel' stated "it's the values, the more we are talking about this, it's like...light bulb!" (4a 1845)

PHNs could prioritize how services were to be delivered, by basing decisions on the values and principles. Incorporating the social determinants of health and equity, as well as other pertinent pieces of information, was critical. Danielle' commented:

> In the synergy model article they were making reference to the fact that we need to look at client needs. I think that's so important. If we take an equities approach and start there, and think about if we want positive outcomes, what are our goals? I think we have to start there and then work backwards from that (3-1190).

The RWG discussed multiple examples of how their practice could change using this new framework. 'Rachel' described the application to postpartum home visiting:

> ... even though we each practice a little bit differently, these values can help us determine whether we would refer someone to a breastfeeding group or we would go back to do a home visit for instance. So if you are looking at accessibility....people in the suburbs...that might help you figure out should I be referring this client to come to our group...or should I be going back and doing a home visit? Same thing, health equity, single parent, mom with four kids, that would help you determine... (4a 1545).

Rachel' later described a potential PHN role with families who qualify for Families First but declined the program.

> If they've scored, that's a priority family, those are the people we should be prioritizing. The other people who can come out to groups, who can call us when they need, who go to our prenatal classes and are educated before they come to the six classes, those are our high functioning families and they are able to advocate for themselves. They seek support, so they should be the ones who call us, come to us. We should be going to out to the ones who don't (4a - 1811).

Helena discussed approaching prenatal classes from an equities perspective. She commented that the majority of people were capable of accessing information online and community resources. To achieve an equities approach she said, "we need to be targeting the population, targeting these classes to those people that aren't accessing them" (4a- 4187). Participants were suggesting that making decisions on PHN service delivery should be based on population level indicators and outcomes, rather than assuming everyone was equal and would access universal services in a consistent manner.

The example of immunization was discussed at several points during the development of the professional practice model. The RWG discussed potential shifts in the approach to immunizations, as well as working with others in the healthcare system:

> Beth: As you guys are talking it brings us back to those guiding principles and how important that is in rethinking how we value our work....
> Rachel: So health equity, we should be focusing on increasing the immunization rates perhaps with the inner city but the people who are in the suburbs who call us and "Oh, can I come in for the Tdap (immunization)," really they should be going to Quick Care or somewhere else like that. Not us one-on-one seeing them.... that's what we're doing and it's wasting time (4a 2849).

The task of administering the vaccine was one that could be completed by a wide variety of healthcare providers.

There were licenced practical nurses or Nurse II's hired into a casual pool that could staff the public health immunization clinics. Many PHNs used their colleagues however, because it was easier. 'Sarah' discussed that if the goal was to complete the clinic, then using PHNs was simpler because they were familiar with the process and vaccines. Conversely, if the goal was to consider immunization at a population level, then PHN resources could be used more effectively and efficiently.

> I think there's a preference to be immunizing with people you know, there's discomfort with only having one PHN at a community clinic...there's thinking that why should we pay a nurse for three hours, let's use half of our public health nurses, get in and out of there really quick. So it's different thinking, it's getting the task done as quickly and as efficiently as we can, and comfortably because we're working with people we know, versus the overall outlook like what is our role in immunization, is it poking or educating.
> F: So again identifying that Nurse IV role and how we can work within the system we have, and best utilize the resources, while working to the full scope of practice.
> Sarah: I think the point to begin with and when we got onto this [was] lack of resources, but using the resources that we have (2-1857).

'Danielle' suggested the PHN role should be taking a leadership role at the clinics, and working at the community level to reach vulnerable populations who would not routinely access immunizations. Consistent with 'Sarah,' 'Danielle' recommended utilizing available resources for the task-based work such as ensuring consents were completed and administering vaccines.

> Danielle: I may have opposition here, but to me, public health should be looking upstream and looking at immunization instead of making it task based, any nurse can,
> Sarah: get it done
> Danielle: take the immunization course and provide immunizations. We have casual nurses that can do that, but how do we best coordinate services to reach the population, do the outreach clinics in an appropriate way, keeping a pulse on what the need is that year because it's going to change....Taking the time from our workload to do community development and talk to the population to see where the need is. To me if we have time to better coordinate our services that's more public health nurse role, or should be, as opposed to spending all your time getting the consents back, doing admin work because you don't have enough admin staff, and then doing the clinics yourself. So if we could maybe get more support from level II nurses to do the actual immunizations...(2-1767).

Basing PHN service delivery decisions within the context of the 'Values and Principles' articulated in the professional practice model had potential to substantially change PHN practice. 'Sarah' asked "if you took these [values and principles] and applied it to decision making on a daily basis, with how many follow ups you need to make... how much more time would a public health nurse have to do some of the other stuff" (4a- 2231)? Basing practice decisions on population health and equity could increase the scope and effectiveness of the PHN role.

Professional relationships and partnerships. Another component of the professional practice model was professional relationships and partnerships. The RWG recognized that PHNs needed to better articulate their role, and to work collaboratively with others. Beth stated:

> We talk about how people don't know what we do, so what are we doing about that? We do a very poor job of promoting what kind of work we do and the services that we have available...And not just for clients but for other service delivery people (2-1444).

To practice to their full scope, PHNs had to successfully establish professional relationships and partnerships with clients, but they also had to do so with a wide variety of healthcare providers and agencies. In working with clients, whether at the individual, community or population level, PHNs endeavoured to develop therapeutic relationships that promoted population health.

There was recognition that establishing trusting relationships with an equity focus necessitated the incorporation of multiple sources of information and knowledge. 'Beth' made the following comment regarding effective communication: "when you're communicating with people there's a language component, but there's a cultural component…"(4b – 1479). PHNs geared their communication skillfully, valuing client diversity, and with the goal of establishing trusting relationships. The RWG recognized that developing those relationships took time, which also had to be recognized and valued within the organization. During the following discussion,

participants expressed frustration with the current lack of importance attached to the establishment of relationships with community partners:

> Sarah: And we have that smoking cessation book that was suggested by our smoking cessation person... "go to one of your elementary schools during 'I Love to Read' month." That creates a relationship with your school, increases knowledge of the role of a public health nurse, it's health promotion.
> Rachel: Get there early when you can make a difference.
> Sarah: Well we don't want to do that because what if we get referrals
> Beth: How do [we] attach value to that, so people are okay with supporting each other doing that kind of work? It's messed up (4a-2212).

'Rachel' discussed how the PHN role in schools had been eroded. She also shared a story of a PHN in her office who had recently taken the initiative to further develop the relationship with her school, and the positive benefits. The RWG discussed the role of the PHN in schools, highlighting outreach, being relationship-based, and developing trust:

> Helena: So connecting with schools then maybe for an example.
> Rachel: With schools and you take it from what their questions are, you let them guide, it's client-centred then, we're going with what their need is, what their focus is. You might come in with an idea of a presentation but then you go with what they're asking. Outreach needs to be done in a way that it's not lecturing, it's relationship-based. You're doing different things that engage and allow them to interact with you, and so it builds that relationship and that trust. The school as a result is connecting more with "B," she's recognizing.
> Beth: You're talking about the school as a whole.
> Rachel: As a whole and the students as well. That's the work that I found I was able to do in [low socio-economic suburb], but since our practice has evolved and we've come to the place where we are much more task-based and responding to referrals, that's what's been eroded from our work. I'm talking about when I first started in [low socio-economic suburb] in 2000 (4b-421).

PHNs worked in collaboration and partnership with other providers, agencies, and sectors. The professional practice model legitimized the variety of skills and relationships important in PHN practice. Inter-professional collaboration could be improved if there was a better understanding of the PHN role. 'Rachel' stated "And people within Population and Public Health, so perhaps the medical officers of health would find this helpful, and they'd appreciate our role a little bit

better" (5-1241). Greater understanding of the PHN role could increase effectiveness and efficiency across the health system, so that all providers worked to their full scope.

Management practices. The professional practice model provided the opportunity to work collaboratively with management to clarify roles and responsibilities. There needed to be much clearer understanding of manager and PHN roles, especially when it came to practice decisions. Managers may not be nurses and often did not understand the scope of the PHN role. 'Rachel' described confusion related to roles at flu clinics:

> Since H1N1 we have fallen into where our mass clinics are organized with our managers...they're much more involved than what they probably need to be. They need to be involved when it's a pandemic situation but when it's our basic annual flu clinics, we are nurse IVs, we've always been able to organize them, staff them, run them. We are often overstaffed at these clinics, you have more staff than you have people coming in...(4a - 1151).

Managers should understand and support but not interfere or direct PHN practice. The RWG discussed that managers were expected to be responsible for staff, and this created role confusion. At a later meeting, One participant elaborated on this point:

> I think it's tough for managers as well because they're put into that position where they feel like... "this is expected of me, so I'll go and I'll try and manage and support with the running of the flu clinic," but then it's almost like they're underfoot a little bit. Our manager has tried to the best of his ability to be effective there, but he's going around asking if we need coffee... (5-1971).

The RWG described the need to improve organizational communication, to increase effectiveness and efficiency. 'Beth' recognized "So once again we're talking about communication. Why not have a communication beforehand about that, whose role is it and clearly defined?" (5-1980) 'Beth' commented:

> What we were hearing from teams was that communication between all levels within our organization is not strong, that it presents challenges in communicating what our role is, what's happening with other teams, communicating some of the health issues that come up within the organization, we don't hear about them. At every level, even communicating

> about changes in orientation or practice, lots of challenges around that, the nurses have to take responsibility for that, but so does management (5-1805).

In particular, PHNs should be included in decisions affecting their practice. Participants discussed this below:

> Beth: Changes, trends, standards...what we heard from the teams was communication about anything could be strengthened.
> Helena: And just having that conversation with the nurses as opposed to that whole top down approach, like looking at the Youth Health Survey, where a lot of that could have been alleviated with some conversation and communication (5-1807).

The RWG recognized the opportunity to work collaboratively with management, and the importance of developing the management section of the professional practice model in partnership. Helena cautioned, "We shouldn't have to change our thoughts in how we should be, based on what management wants..." (5-2568). However, managers could better understand and be responsive to changes in public health and the PHN role. They had to appreciate the nature of autonomous PHN practice, and consider how to best support the PHNs. The RWG wanted to stress the extent of feedback and evidence that had gone into the development of the professional practice model, so that management could use it as a foundation:

> Sarah: And again I think the importance of this work and how much has been put into it from all of the nurses perspectives and the fact that we feel that this document should be considered before anything else gets rolled out.
> Rachel: Guide their work in term of prioritizing, because it's based on our standards and our competencies and the way we should be practicing (5-2791).

Prior to the development of the professional practice model, the RWG did not feel as though there was opportunity to successfully influence the organization. Although there was more work to do on the management practices section, this was a good starting point.

> Rachel: ...this is a huge success that we're giving our feedback to our management. They might not be able to incorporate absolutely everything in the way that we would ideally like, but at least they're utilizing it and mapping out this plan and going forward. That's a huge success.

> Helena: And even putting consideration into thinking about what the document is saying (5-2600).

Rewards and recognition. The final section of the professional practice model was the rewards and recognition section. The literature reviewed on professional practice models came from the United States, and had a category titled 'Rewards and Compensation.' The Community Health Nurses of Canada professional practice model did not include this category. However, the RWG felt strongly that a section be included, to acknowledge the value of PHN practice within the organization. In having discussions about if and where to include this category, 'Beth' made the following comment about having a stand-alone section: "…I don't see it as part of management. I mean you could make an argument for that, but I'd prefer to see it left the way it is" (5-230). Participants wanted their role to be understood and respected as an autonomous profession within the organization.

The organization could be better at valuing the PHN role. Adding recognition as an explicit expectation of the professional practice model would raise awareness.

> Rachel: That was another interesting point in that first article that I referenced. They were talking about how managers value our work but they're not articulating it, so the grassroots don't appreciate that they're valued. Managers need to articulate that more....
> Sarah: Well and maybe if we're out there we can articulate it more.
> Rachel: We could, yeah that team approach....
> Beth: We should be doing that with the support of our management. So our management needs to be well-grounded in the principles of community care (3-1127).

The RWG discussed the importance of developing the language to clarify their role. To address some of the deeply rooted organizational power imbalances, participants spoke of articulating the value associated with the PHN role. 'Beth' commented:

> We don't have the language that adequately reflects the work we are doing in community health nursing and because we don't have that language it decreases our credibility, it decreases our confidence. It's because it doesn't jive with the traditional medical models that are being used in healthcare. So it's like we're invisible because we're talking about

> things that other people in healthcare don't even recognize, they don't understand... (3-784).

It was vital to challenge organizational bureaucracies and take action, if there was to be change.

The professional practice model was intended to be a document that could meet the needs of numerous audiences. This included PHNs, managers working with PHNs, medical officers of health, community area directors, as well as partners working within and outside of public health. The group wanted a product that was readable, but comprehensive enough that information was easily accessible within the final document. A number of supporting documents were included as appendices, to serve as companion documents that legitimized the PHN role and the professional practice model. One appendix was a summary of the literature that had been reviewed during the course of the project. I compiled the literature summary, because the RWG thought it would be beneficial:

> Rachel: I think the literature summary can be helpful to people who read this who might not appreciate the full extent of our work. So our managers who haven't worked as public health nurses themselves, this can help to define our work a little bit better. Even for ourselves as nurses, if we need a refresher. It can be overwhelming to just have links and have the time to go to them. So what I like, if you need that extra review you have it right here and handy and you're not having to search for it on websites or trying to negotiate time within your team, you have it right here...and go to the sections that you feel are relevant. So I like the idea of having it attached and having that shorter version that someone can go to....
> Beth: I like it, it supports and adds credibility to the process, so I think it's important (5-1211).

The RWG was conscious of the process they had undergone that had increased their knowledge and awareness. They hoped that by making the professional practice model comprehensive, information reviewed by the RWG would be easily accessible for those who were interested.

In addition to the literature summary, the RWG opted to include a number of key documents as appendices. The other documents were: the Community Health Nurses of Canada practice model, the WRHA position statement on health equity, and the Population & Public

Health conceptual framework. Links to the PHN standards, competencies, and roles and activities were also included. A final companion document the RWG identified as important was the PHN position description. It was clear from team feedback that the RWG and other PHNs in the WRHA valued their Nurse IV title. All registered nurses practiced under the legislation of the Registered Nurses Act, which enabled them to deliver a wide variety of healthcare services. The majority of registered nurses had a lower classification than Nurse IV, but because the governing legislation and many activities were the same, there was role blurring and overlap. Pay increased with the classification, so it was important to identify the unique aspects associated with the PHN Nurse IV designation. The conversation below highlighted this complexity:

> Beth: That's a union thing, there's other Nurse IV's that work in healthcare, whose job is quite different from ours...
> Sarah: I hear what you're saying but I think that nurses will recognize what we mean by the Nurse IV, because everyone refers to themselves as the Nurse IV role.
> F: The nurses in public health.
> Helena: What does that mean to a Nurse II?
> Sarah: I'm hearing what you're saying, although when our nurses read this...
> Beth: We'll know, yeah (5-315).

The Nurse IV role was intended to be highly autonomous nursing classification, where PHNs displayed leadership and were accountable for their practice decisions. 'Sarah' argued that PHN practice could be shifted by refocusing on the professional practice model values and principles, and by optimizing the Nurse IV role. "I say take out numbers, take out timelines and let nurse IVs have the autonomy to use their values and principles to guide their practice" (4a-2266).

The professional practice model document articulated an autonomous PHN practice, as well as the organizational supports, structures, and processes to attain the full scope of PHN practice. 'Beth' outlined the risks and benefits nicely:

> I think when we started on this project you made that pretty clear "F," that we can go through this process and it should feed information to management and those program specialists that make those decisions about the directions, but they can choose to adopt all,

> or some, or none of it. But at least we've done the exercise and we've had our voice, we've had our say, this is what we want, this is our vision for public health nursing work and I think we should feel good about that (5-2331).

The RWG hoped that the professional practice model would be embraced by the organization, but was pleased with document and the work completed.

2.23 A necessary starting point. The original issue paper referenced variation in PHN practice, with offices using either a neighbourhood or intake model. An unexpected finding was that the RWG couldn't reach agreement regarding a recommendation on this issue. At present, 'Helena' and 'Rachel' worked in the only two offices using a neighbourhood model; the rest had switched to a referral system. 'Sarah' discussed the multiple access points offered: "It's part of being visible, and when I did work in those areas you were known as the nurse in there. You're in those schools; you're seeing the people that you saw as babies, in those daycares." The approach to PHN practice needed to change, but there were varying levels of support for recommending a neighbourhood model, and little clarification in the literature reviewed. The RWG discussed the opportunity to achieve the professional practice model using the neighborhood approach:

> Sarah: ...if we just stick with intake I don't think I'm going to get this (4b – 3425).
> Helena: And if you think about consistency among all of the areas, everybody wants to do more community development, that was a big thing...but how are you going to achieve that in such a large area where you don't quite know the entire community.
> Sarah: When you've got ten cooks in the kitchen.
> Helena: Yeah, and if you had that one pocket and you get to know that one area really well, and build those relationships, you can see what community development needs to be done and it's going to be a lot easier to coordinate (4b- 3451).

There was a need to develop the broader PHN role and help others understand beyond the tasks. In the neighborhood model, the PHN became known within their community. The group also discussed the risks of burnout associated with high-risk neighborhoods. 'Beth' raised the

example of being the neighborhood PHN in an advantaged suburb, as an argument against the neighborhood model. She said:

> I'd have to poke my eyes out to tell you the truth, can you imagine visiting in [advantaged suburb], that's the only place you visit. No offence to anybody but that's the other end of working with a high risk group, not that there isn't high risk people there, but how could you be a nurse day in and day out for [advantaged suburb (4b -3541)]?

The RWG discussed that the neighborhood model would need to be considered in the context of the full professional practice model and equity, and practice would be quite different than it currently was. 'Rachel' countered with the following suggestion:

> When you give the example of [advantaged suburb], if you had one nurse for that community area, those are often high functioning, high capacity people who often are very very focused on themselves, and have a lot of capacity to find the answers to their questions or get the supports that they need. Should you be the one going in there regularly and doing weight checks? They should be coming to us, right. We should be focusing on the high risk people, that's where we need to invest our time and our energy. So I think it's a shift in terms of our thinking, in terms of okay what is the capacity of this family and empowering individuals to seek us out or other services and resources, versus our going and investing the time and energy and visits with certain families (4b 3561).

The RWG later discussed that there needed to be opportunities to explore a variety of options. 'Beth' stated, "that's what excited me about your comment, we should challenge ourselves to think outside the box of neighbourhood versus intake nursing, what a thought!" The group agreed those discussions needed to continue, but were beyond the scope of this project.

Section III: RWG Number 7 - Participant Action

In this section, I grouped data generated during the final RWG that took place on July 3, 2013. In this RWG meeting participants' reflected on the outcome of professional practice model report, as well as the participatory action research method. Though the professional practice model document would continue to be a work in progress as it was discussed throughout the organization, the RWG was pleased to complete this portion of the journey. The group wanted to finalize the document, as 'Rachel' stated "because then we say this is the finished product, this is

our vision, based on all the feedback that we've received" (6-2649). Participants felt proud of the accomplishment in a relatively short period, and wanted the professional practice model to be an example of a large project completed through the nursing practice council. The RWG also wanted the professional practice model to provide the voice of PHNs and their practice, and be a tool for the organization moving forward. Themes are summarized in Table 4 and discussed in more detail below.

Table 4: RWG Number 7 Themes - Participant Action

Participatory action research cycle/ theme	**Category and sub-categories** **3. A professional practice model for PHNs in the WRHA**
Look: Perceived accomplishments	3.1 A key organizational tool 3.11 A professional practice model creates common language 3.12 A professional practice model clarifies the PHN role and creates a shared organizational vision
Think: Facilitators of success	3.2 Participatory action is an important research method 3.21 An effective process to develop a professional practice model 3.22.Factors contributing to success
Act: Shifts in practice and next steps	3.3 The framework to link PHN practice and theory 3.31 Assists PHNs to shift their practice and influence systems 3.32 The concept of health equity requires clarification

3.0 **A Professional Practice Model for PHNs in the WRHA**

3.1 A key organizational tool. Under this theme, I grouped data that the RWG identified as successes associated with the project. A main accomplishment and the action, was the development of the professional practice model report. The professional practice model was important for two reasons. The first was to articulate PHN practice based on a common language that highlighted an autonomous PHN practice based on specific knowledge, skill, and expertise. The second reason was that the framework created a shared organizational vision for PHN

practice. Creating common language depicting the full scope of PHN practice with a focus on population health and equity could assist PHNs and the organization with decision-making.

3.11 A professional practice model creates common language. The RWG recognized that lack of role clarity had been a fundamental issue among PHNs and the organization. Individuals had personal values, beliefs, and assumptions, which fostered differing approaches and understanding of PHN practice. Inconsistent understanding contributed to erosion of the role, as PHNs were continuously drawn into providing individual level clinically based community services. During the final evaluation, 'Sarah' shared an example of her team attending a recent school division meeting about the Youth Health Survey, and the inability of PHNs to describe their role.

> Sarah: We stood at the back of the room as they did their presentation on the Youth Health Survey and the outcomes they saw from that. The questions [from] the principals were "... what can our public health nurse offer?"
> F: And what did you say?
> Sarah: ' [The manager]' answered. We didn't say much, because it was like, I don't know (6-1487).

PHNs were unable to articulate the their value in working with the school community, and lacked confidence in interacting with these partners. Interestingly, the team manager who was not a nurse, answered on the team's behalf. The RWG identified the professional practice model as a starting point for developing common understanding of the PHN role.

The RWG believed that the professional practice model could increase clarity, consistency, and understanding of the full scope of the PHN role. Participants excitedly spoke of reprioritizing their role with an equity focus, using the professional practice model as their framework. They described deliberate use of targeted outreach strategies, founded on the professional practice model values and principles. 'Danielle' talked about application and use of the professional practice model within the organization:

> It's a common framework, it's a lens that we can ALL look through and by putting the words on paper and articulating our role in such a beautiful way that it connects the standards of practice and our job description and everything, it's unified. It's a place for public health nurses from all community areas to come together, for the community area directors, for everyone, the managers, to look through the same lens of how we should be practicing. We can have that common language and conversation, instead of just trying to explain (6-903).

The professional practice model described the full role, with opportunities for PHNs to utilize their Nurse IV critical thinking and problem-solving skills. As 'Helena' stated: "It provides consistent goals and how we achieve those goals might differ from community area to community area." Using the professional practice model as a lens, PHNs could structure and prioritize their work so it was based on their competencies and job description. 'Sarah' talked about increasing understanding of the role by being more visible in activities that extended beyond individual clinical care. Articulating the impact and effectiveness of the role would be important in advocating for the practice, as well as for developing arguments for potential funding increases.

3.12 A professional practice model clarifies the PHN role and creates a common organizational vision. The RWG discussed the importance of all stakeholders in the organization utilizing the professional practice model as their lens to plan, articulate, and evaluate PHN services. Participants spoke repeatedly about the contrast between the theoretical PHN role, and the operationalization of this role at the organizational level. Frustration existed among PHNs because their position description was not achievable in practice. To support PHNs to enact that practice however required that others within the organization such as managers, community area directors, and medical officers of health, be oriented to the professional practice model. Below, 'Beth' articulated the value of the professional practice model, and its potential impact:

> I think it grounds us, it's the roots and our practice grows from there. People hope the organization will also use this as orientation so that new people coming into the program,

> this is one of the first things they should be looking at, this is the work you're going to be expected to do, and this is a document you need to be using in your practice (6-965).

The RWG had purposively aligned the professional practice model based on organizational direction and key documents. 'Rachel' nicely summarized the RWG approach below:

> That's what you need for this to work, it's not just us at the grassroots level having a vision, we need to work in partnership with the managers and with [the program director] and the medical officers health and everyone else. And even with "F" as well and her involvement with the inequities piece, it just seems like it's all coming together (6-420).

Participants were conscious that structuring the professional practice model in alignment with the organization was more likely to contribute to its success. The RWG hoped that the professional practice model provided the structure to understand the PHN role, as well as how PHNs complemented and collaborated with existing health and social services. Other factors influencing PHN practice were under development simultaneously, and the RWG wanted the director and organization to include the professional practice model, as these various pieces of work moved forward.

The professional practice model provided a unifying framework, so that all stakeholders could have a shared understanding and common language to articulate the PHN role. Helena summed up the aspirations associated with the professional practice model moving forward in the organization as follows: "I see the hope. People are hoping that we will change, not the fear that we're not going to change, it's that hope. Yes, I'm hoping we're going to change" (3077)! Ultimately, the group hoped that articulation of the value associated with the PHN role could be used to advocate for PHN resources and funding. The RWG hoped the final document would be used with clients, governments, and others in health and social services. 'Beth' described her vision below:

> I think we heard over and over again that what nurses hope is the organization can use this document to advocate for public health nursing within the larger health care system, so that

> that document is used when we're planning new initiatives or revising old ones, that this is the go to document that should guide those changes (6-903).

Participants recognized that more information was needed to provide evidence of the effectiveness of health promotion and associated health system savings, however defining the PHN role was a first step.

3.2 Participatory action is an important research method. In this section, I grouped data that represented the RWG's perceptions related to the participatory action research process and the professional practice model outcome. The PHNs spoke about two main components that contributed to the success of the project. The first was the participatory action research process, and the second was process facilitators.

3.21 Participatory action research is an effective process to develop a professional practice model. The RWG believed development of the professional practice model using participatory action research was a success to be celebrated. The organization had never had a professional practice model before, and now one existed that brought all components of the PHN role together in a comprehensive document. Participants thought the model and process contributed to an empowering practice environment, and hoped the organization would highlight this achievement using the 'Rewards and Recognition' section of the professional practice model. The outcome was the development of a credible, evidence-based and actionable product. The RWG saw this project as a learning opportunity for the organization. The RWG discussed the participatory action research process below:

> Danielle: I think this participatory action research approach is so important for people to embrace change because it is hard. If they're involved, they're more likely to embrace it.
> Helena: Well and they get excited for it, they're hoping for change whereas with the weekend services..people, their backs are up.
> Beth: There's an accountability built into the nursing practice council structure too, we're forcing things to move forward that can't be left.

> Rachel: It's a good lesson for our management as well and our organization in terms of lessons learned that may inform future efforts. This helps to show [the director]... and our managers how something that looks like a really big process that could be really hard to implement, how you CAN move it forward, how you can make it work (6-3251).

The ongoing integration of materials contributed to the depth of conversations and the richness of the final product. The RWG found it exciting to increase knowledge of resources and evidence pertinent to their practice. The different sources of information guided the dialogue and assisted in sorting through complex issues. The RWG found it reassuring that concerns in the WRHA were also PHN challenges across Canada and internationally. Considering this evidence within the local context also challenged the group. 'Rachel' stated "...what I love is that this whole process is getting us all to be really creative and think outside the box..... and think of new ways to make this work" (6-1580). 'Danielle' described the impact of the participatory action research process below:

> It was empowering. Empowering for the teams to hear their voices. I liked the fact that you used the nursing practice council as a venue for doing your PhD. To get all the voices of the team members and that communication, but at the same time being able to have the working group spend a little bit extra time going [over] the theories of how to develop a model and things that team members wouldn't have the time to go through in that much detail, I think that was a good structure. The end product is pretty amazing for the amount of time, it was pretty quick that we were able to get to that point (6-384).

The RWG members reported that their personal involvement in the research was a rewarding experience. Participants valued the opportunity to broaden their horizons and be involved with the bigger picture. Helena described the RWG learning as an evolution, from the beginning stages, to where they had come by the end. Initially there was trepidation, as participants did not know how the process would unfold, or what the outcome would be. Reflecting back, participants found this to be critical, because they had stayed true to the data and developed the professional practice model based on the feedback from PHNs. The RWG reflected on their participation in the discussion below:

> Beth: And even if we come to realize a lot of our work is outside of our control, because we are mandated to do certain things and there are limitations on our resources, at least we've got that philosophy and that practice model to think about and incorporate it in ways that we can, even if it's small.
> Helena: It incorporates all the documents and brings them together. They're all out there but they didn't have the same meaning when there's the conceptual framework over here, and there's the competencies and our job description, but it's all over the place. This document brought them together...and made it all make sense for us (6-3137).

The process had been huge and daunting, but participants recognized personal growth in leadership skills and knowledge as a result. Participants also valued the extent of system feedback that had been sought.

PHNs across the WRHA had come to embrace the participatory action research process. The 'Look, Think, Act' cycles provided opportunity for PHNs to be engaged throughout the course of the project. Keeping the topic on the nursing practice council agenda contributed to the transparency of the project, and kept it moving forward. The RWG believed including PHNs throughout the process assisted in their engagement and valuing of the professional practice model. The ongoing dialogue provided the opportunity to become immersed, while staying focused on the purpose and action. The RWG compared this process, to other projects under development at nursing practice council:

> Rachel: My team, I feel that they've developed a respect for this process because it has been moving forward, we haven't been lagging, we've been keeping it current, and making sure it's been on the agenda every month, and meeting regularly and doing these extra meetings as well.
> Sarah: That's a good point for nursing practice, this is off to the side, but you're absolutely right, it doesn't give much value to our work when you see guidelines that sit there,
> Rachel: for years.
> Sarah: for years that we've put a lot of work into.
> Helena: And then they have to be redone before we can even approve them. (6-2496)

Trust developed as PHNs saw their voice reflected.

Initially as trust was being developed, participants had to actively follow up with their colleagues. By the end, participants found people were coming to them, offering feedback,

wanting to be involved. They commented that their colleagues were now citing the professional practice model when organization direction was not consistent. 'Danielle' stated:

> It's important to empower teams, to have a structure in place to provide their feedback and even though nursing practice council has always been that process, this has made it salient for the team. It's everyone's individual voices that can make a difference. That is empowering to everybody ... I think that when a team sees that you've actually written down everyone's feedback, that makes them realize "okay what I have to say is important, it's anonymous, I can share it, it may not make a difference, but we're going to factor it in." That is an important process to continue, and that excitement, that sharing the feedback, makes a difference (6- 3190).

The participatory action research process provided a structure for the teams to voice their opinions and offer feedback. The nursing practice council discussions further stimulated team discussions. The RWG discussed the benefits of participatory action research and the process that had been undertaken:

> Beth: I think the participatory action research approach has given us a structure to have those conversations. Our team had loose conversations about what does it mean to be a public health nurse in the past, but it was more of an informal discussion. This has really given us a structure to put those thoughts and ideas into, and so it's been a constructive conversation that we've had instead of that informal type of sharing of ideas, so I think that was a real bonus (6-449).

> Danielle: I think it was important that it was participatory action research and not top down in any way because it gives the nurses empowerment in creating their role... if the nurses can be a part of that process...if you can help create it, then you're going to be more motivated to do a good job....The participatory action research model is good for any important topic in nursing practice council. I think that we should continue using it (6-2135).

The success of this project highlighted the importance of nursing practice council and provided evidence that PHNs had the capacity and structure to resolve complex organizational issues. Nursing practice council was more legitimate and credible, and seemed to have been strengthened as a result. Representatives were reminded they represented the perspective of their teams, and the important role nursing practice council played in resolving PHN practice issues

within the organization was solidified. ‘Beth’ articulated the value of using the nursing practice council structure below:

> It wasn’t obvious to me when we started, that we could do a project like this through the structure of the nursing practice council, but it became obvious pretty quickly that was the right way to go. I think we proved that there is value in the nursing practice council...it’s maybe to some extent raised the profile of the nursing practice council (6-3204).

The RWG wanted the final product to be a written report that could be disseminated widely. Communication being an ongoing issue, the RWG wanted it clearly specified that this was a final version, which contained the vision of all PHNs in the region. There was also respect associated with a formal report, which the RWG hoped would improve organizational valuing of the PHN role and nursing practice council. The RWG believed the final product was a usable document that every PHN in the WRHA would see themselves in, that reflected the PHN voice and advocated for their practice.

Although the research had ended, there was a great deal of ongoing work to do. The RWG spoke of the importance of ongoing dialogue, so others would have the opportunity to reflect and grow, similar to the experience of participants. ‘Beth’ stated:

> It’s not just presenting it or people having access to it online. What would be most helpful is for people to have an opportunity to sit and have a discussion about it so it can be digested, that’s how I think it work well for people (6-191).

To actualize the model and create system changes required collaboration within and outside of the organization. The RWG felt strongly that the project should continue to be led by nursing practice council. ‘Sarah’ argued for continuing the project with the existing structures and processes, versus returning to previous methods:

> How we’re going to implement this,... stay within nursing practice council.... Continue to get the feedback exactly the way we’ve been doing, because we’ve had the buy-in, nurses have been having the ongoing discussions monthly, so they’re on top of it.... Let them have some input into the decisions going forward (6-1682).

In reflecting back, the RWG identified that being more deliberate with the participatory action research would be a recommendation. The RWG wanted to continue to provide the voice of PHNs, and keep them involved in a similar manner going forward. Two participants had extended their nursing practice council terms to continue with the professional practice model, so this also seemed like a natural time to renew the working group membership, but not to change the process. Participants wanted to maintain momentum by continuing to keep the professional practice model on the nursing practice council agenda, as well as on the radar of the director.

3.22 Factors contributing to success. The participatory action research process and nursing practice council were critical; however, there were additional facilitators that contributed to achievement of the final product and ultimate success of the project. Table 5 provides a summary of facilitators to the participatory action research process at the individual, organizational, and facilitator levels.

Table 5: Facilitators of Participatory Action Research

Participant facilitators	Researcher facilitators	Organizational facilitators
Trust- voices were important and could share views openly	Content expertise – research, theory on PHN practice, knowledge of resources and literature	Complex organizational issue requiring change
Commitment to the process - time, prepared, enthusiasm	Process management - planning, implementation, system navigation	Senior management support – staff time and resources, engagement
Ownership - Leaders, champions, change agents,	Enthusiasm, passion, commitment	Facilitate communication and creates a safe environment
Collaborative	Supportive/shared leadership	Open to learning and change

PHNs had to develop trust in the process, that their voices were important and that they could share their views openly. Some PHNs who had been with the organization for an extended length of time were jaded. As 'Helena' stated, there was the perception: "we've been wanting to do this for so long, but nothing's happened, why is it going to change now" (6-1097). PHNs had tried to advocate for their practice in the past, and were never successful in influencing the organization. In this case, the situation was not only complicated by organizational history but also because this was a research project for my PhD. The RWG discussed this issue:

> Sarah: I think that's a really important piece that we should still communicate again, because yes it was supported by your work, but it is our voice.
> Beth: We've all been excited about it and we've all been very dedicated. We learnt in our discussions, people are on the same page, they needed to get their heads wrapped around it and then take it to their teams. From the start, I think all of us, I didn't know how it would work.
> Helena: I didn't realize though at the beginning, that this great document is what we were going to get out of it at the end. So I think it was hard to know (6-2352).

There had to be trust that PHNs could have influence into their practice before the PHNs could feel ownership. The RWG spoke of having several "a-ha moments" during the course of the project. 'Rachel' described one of those moments:

> .... It's the same for us, it's a parallel process. We need to build that trust with grassroots and with our organization, that we're being heard, that we have a voice, that we have something to say that's valued. And it might not end up... that the practice is going to be exactly as this document has been rolled out, but at least its moving us forward to practice toward our competencies, and so its baby steps. It's all that parallel process and the conceptual framework, the guiding principles, that's our values (6-3118).

'Rachel' described the professional practice model values and guiding principles as the foundation, just as PHNs utilized the core foundations of the Families First program to engage the families.

The RWG acknowledged their role in the success of the project. They acted as leaders at nursing practice council and within their teams, enthusiastically engaging others, and responding

to negativity and skepticism at times. As 'Rachel' noted, "I think that we have more control than we realize a lot of times." In the excerpts below, participants described their role:

> Danielle: ... being the leader and trying to get everyone excited about this and redirect people as to the whole purpose, that we're all part of this. Trying to empower the team, I think that helped to put out the negativity and get them more onboard (6-3010).

> Beth: I have friends that work in other sectors that use this idea of champions. People seem to like that word or really hate it, but the concept is that you become a bit more focused or develop expertise in one area and then you're the little spark plug in your group. That would be your champion, to get people excited about it and create some enthusiasm, and I think that's what we've done with our teams. It hasn't always been easy, there have been some challenges but like you "Rachel" I come away recharged and ready to talk about it around the coffee table (6-3004).

The RWG facilitated communication and championed the project, which was critical in engaging their colleagues. 'Helena' stated: "from the beginning to where we are now, I felt like I had a lot of explaining and justifying what we're doing." They acted as change agents in moving forward, which was not straightforward or easy. They had to get people excited, and help them to see the value. The RWG participants recognized that they did have influence and the power to contribute to change, and it was up to them to make the effort to engage their teams and support the project.

The RWG co-chairs and myself as the project lead provided additional leadership that contributed to the project's success. Consistent with nursing practice council processes, two RWG members assumed additional responsibilities by acting as co-chairs. The co-chairs took the lead in speaking at nursing practice council, as well as with the director. They also drafted e-mail messages to the director, and to nursing practice council representatives to facilitate communication with teams.

The development of the professional practice model was a complex project with multiple components that had to be viewed holistically. Participants spoke about the importance of leadership and my role:

> Beth: …yeah and I guess a different level of leadership for five of us sitting around the table. You've been able to provide that because of your level of expertise, so that's lent a really important piece to the group as well.
> F: In terms of that academic component.
> Beth: Yes and the facilitation and the resources that you've been able to give us to feed our knowledge and help us to build on the concepts so that we could contribute.
> Sarah: It was overwhelming as it was, let alone if we didn't have that support for sure.
> Beth: Because we're not immersed in that academic piece like you are, so that's been important.
> Rachel: The literature (6-3330).

The RWG spoke of contributing factors that included my passion, enthusiasm, as well as knowledge of literature and PHN practice that fostered their learning. The RWG discussed my role as the facilitator:

> Beth: What we've also learned is that strong leadership is really important, for this process that's been you F...
> F: And you, the group, and as co-chairs definitely (6-3345).

A partnership developed in which each of us contributed to the success of the professional practice model in a different way. 'Sarah' offered the following observation:

> From the start...I didn't know how it would work. There was always, well this is F's work, but where's our role and how is that not going to be a conflict. There was a comment from one of the nurses on our team saying, for lack of a better word, "Is this F's agenda?" No. I saw this completely as supportive. If we didn't have you doing this work I don't know how we could have ever done this, but I don't feel that your agenda drove this at all. I think the outcome is exactly the nurses' voices not your objective or what you wanted to see come out of it (6-2244).

The RWG saw my role as supporting them and the success of the project, using an approach of shared leadership and collaboration. This approach established trust critical in engaging others. 'Rachel' described this below:

> And I think that's what our team has come to embrace too, they see that this is their opinion, that you have been guiding us to get us to the point where the nurses are sharing their point of view and their opinion, it's not what you want our practice to be, it's what we want our practice to be, and so there's that trust (6-2250).

Lastly, the RWG recognized the role of their teams and the organization in facilitating project success. RWG members were supported to attend within their workday, which meant they were not available to assist with day-to-day work. As momentum grew, the RWG added three, three-hour meetings. Participants believed they were supported to attend because their teams valued the work and they were seeing as the project moved forward.

3.3 The framework to link PHN practice and theory. In the 'Act' section, I grouped data the RWG identified regarding the impact of the professional practice model on their practice and the organization. While the professional practice model provided a theoretical framework, there were outstanding issues and gaps requiring further action. A key area identified was the concept of health equity, which the RWG recognized was not understood consistently. Application and understanding of equity would be instrumental in shifting practice.

3.31 A professional practice model can assist PHNs to shift their practice and influence systems. During the final evaluation, the RWG reflected on the impact of this project and the extent to which the professional practice model had become entrenched in their practice. 'Beth' said it had become her "frame of reference." 'Helena' commented the professional practice model is "always in the back of my mind" as she makes decisions. 'Sarah' described having "an ah-ha today again, when we talked about what we thought we were getting when we came into public health, is not what we do" (6-1317). The RWG had a much clearer vision for PHN practice and saw opportunities for change. 'Rachel' summed up this message and the RWG role nicely:

> It's up to us to look at things differently. Like we've been talking about, this process has helped us all to look at our practice differently and make decisions about who we're targeting. That's a really powerful message to get through to nurses as well (6-3540).

There was recognition that larger structural and system changes were needed to fully enact the professional practice model, however at the individual and team levels PHNs could influence change. With enthusiasm, RWG members described how they found themselves working more to the competencies, and making changes to be more consistent with this professional practice model. As 'Sarah' stated: "we're not adding," which was the concern that many PHNs had. Rather, the RWG recognized changes to existing PHN services were possible. In the conversation below, 'Sarah' and 'Beth' discussed opportunities to refocus PHN priorities:

> Sarah: I use this lens. I've absolutely changed my post-partum follow-ups. Before I thought it was just an expected thing, I was doing what everybody else was doing; continuing to see a baby until they're starting to gain weight in the community. I don't need to do that. I had a mom yesterday, exactly that, she was seen once, there was a bit of weight loss on day four, nothing concerning, you talk to her on the phone, everything is going brilliantly. I said come to the group, she's going to the group. She knows the weight, it's her responsibility as well if that weight is down. Call me...
> Beth: That's what it's about, it's empowering the client.
> Sarah: Absolutely. Not us constantly phoning and phoning…

Clients with capacity were invited to access community based services, even when medical risk factors in the postpartum period such as weight loss or breastfeeding were identified. Conversely, PHNs had more time to refocus on population level priorities and health promotion.

The RWG discussed how they valued components of their work differently. They focused more on the full scope of the PHN role, in particular health promotion and work at the community level. One participant described how she has a different approach with her school work, and felt validated in doing so:

> I've changed, I think of it as a bigger view too, similar to what you said 'Danielle' I have a school in [advantaged suburb] that has high need, I could spend every day there, but in a broader picture, working on this committee has given me ideas about what to do with that school and it's also given me permission to take time at my desk to develop those ideas. So it's validating that work that we do that's not actually in a client's home or at a school, but its work that you need to do yourself in developing plans and initiatives and community development. It feels legitimate when I do that, and I can explain that better to other people too (6-769).

The RWG spoke with enthusiasm as they described changes that extended to the team level. The culture had started to shift. They saw colleagues more engaged and excited about the broader scope of work, and greater support for that work within teams. Rachel described how her team had reprioritized the "important work," and had a greater equities focus. Teams were more attentive to the Families First program, and ensuring it was implemented with fidelity. As a result, more visits were being completed, and the teams were noticing the benefits for their families. All participants agreed that their teams had refocused on Families First work, as well as clients who declined the program but were eligible. In the past, those were the first elements let go, mainly to accommodate the follow-up of postpartum families in their homes. Participants described personal and team shifts in practice:

> Beth: At our team we had discussion around we may not see a lot of big opportunities to change practice but we can find opportunities in our day to day work.... you don't follow your post-partum's in quite the same way but maybe you follow your prenatal clients in a different way, or you do something with your schools. Within the resources that we have there are opportunities, maybe on a smaller scale to find some of those pieces and work (6-1176).

> Rachel: Even though we've always immersed in the inequities model, I see that people are trying to work to their competencies a lot more. It's really neat to see how even these little, little things can make subtle changes, and that all makes a difference (6-3569).

> Danielle: I've actually changed my practice a little bit too, even in [low socio-economic suburb] where I find my caseload is very heavy all the time and high needs all around. I've changed in preparation for what's coming in the sense that I'm trying to give a little bit of the onus to the client. We can't necessarily see a client three times for every family, so I'm trying to free up time to spend with families that do need it more and I'm hoping to free up some time for community development initiatives which we don't have time for at the moment (6-712).

The teams had come to recognize the imperative role PHNs could play in promoting health equity, social justice, and early childhood development.

During the final evaluation, the RWG continued to offer stories about their practice, but with solutions that were population-focused. Examples included using targeted outreach

strategies to access vulnerable populations and increase awareness of immunizations among at risk groups, rather than being the nurse at the clinics giving needles. Beth described an option her team was considering for prenatal classes. Rather than continuing to offer a series of six classes to high functioning groups, they were planning to offer one regular monthly drop-in class to accommodate the "rite of passage." In the drop-in format, they discussed focusing on topics such as comfort techniques, breastfeeding promotion, and community/ web-based resources. The RWG members and their teams had shifted their practice to have a greater focus on population health and equity. They were more aware of the concept of population health, and the need to focus beyond individual level healthcare. By reprioritizing, the RWG participants found themselves able to spend more time with those more at risk and to focus on addressing the social determinants.

The professional practice model framed the full scope of PHN practice holistically, based on values and principles that formed the collective belief system of PHNs. The practice examples were particularly important component of the service delivery model. The examples linked the organization's work and strategic priorities, to the theoretical language that described the PHN role. 'Helena' described the theory as conceptual: "a bunch of words on paper." Conversely, the RWG discussed the impact of the examples as follows: 'Sarah': Those examples are critical in that document. I think that's what put the life, turned the light on for a lot of nurses as they were reading it. Helena: Well it grounded it, right" (6-1783). Articulating PHN responsibilities within the context of the professional practice model assisted with workload prioritization. Foundational elements of the model were based on population health, the social determinants, and equity. 'Beth' described the opportunity created by the development of a formal report on the professional practice model:

> Yeah, kind of floated along and many of us felt that our practice was dictated by forces outside of public health. It makes a difference when you have something in writing. It's in writing, its formal, it gives some respect attached to the role (6-999).

For PHNs, the abstract nature of public health concepts had not translated into a vision that was attainable in their practice. Framing concepts within the professional practice model highlighted components that had been eroded and assisted in refocusing on PHN priorities.

3.32 The concept of health equity requires clarification. While the RWG was pleased to mark the end of the work on the professional practice model, the group recognized it was the starting place for additional activities.

One of the unexpected findings associated with the project, and an area where additional discussion would be essential, was pertaining to the concept of equity. In discussions at nursing practice council, there was concern and lack of clarity regarding the concept of health equity, and the impact on PHN practice. The topic was discussed at the June 2013 nursing practice council meeting and concerns were raised regarding the impact to community areas that were wealthier. Discussions based on use of the Families First screen as a tool to recognize postpartum client strengths and challenges generated a heated discussion:

> Danielle: …no one in [low socio-economic suburb] suggested that we only see people that score. Nobody suggested that, but just some way of identifying who needs more services. The next community area of feedback was instantly, "well maybe we shouldn't look at equities at all...."
> Helena: Yeah, we absolutely do not agree with the equities approach.
> Danielle: Yeah I think it was fear-based, possibly that would suggest there would be no services at all for some community areas, and that's not what equities is.
> Sarah: Some of the comments, which shows that they're not really understanding, like what about our mom in our community area, she was a professional and has issues with control and has a terrible post-partum depression. Well if you use an equity lens…
> Helena: It's going to capture those people (6-118).

The RWG members were surprised at the extent of opposition expressed by some of the nursing practice council PHNs. In the discussion below, RWG participants highlighted the

organizational role in continuing to develop an understanding of the concept of equity and engaging staff in developing a shared vision consistent with the professional practice model.

> Beth:... we have that work that's already done, it fits in VERY well with the work that we're doing, but there needs to be more work done around using that equity definitions and strategy that we already have within the WRHA... there needs to be some work done at the field level in helping people to understand.... That's what we're seeing, is that people are not on the same page with what an equities lens, strategy, approach is, and how it applies. Sarah: I'm trying to remove myself from our spot, and the general public health nurses, the only exposure they would have to equities was H's equities presentation however many years ago at staff development, and I don't recall getting this message (6- 166).

The RWG was concerned that lack of consistent understanding could potentially undermine the professional practice model, by creating fear that practice changes may result in a loss of resources in some offices.

In other conversations, the RWG recognized that an equities approach would necessitate a reallocation of existing resources. In particular, for community areas with greater proportions of inequities, it would be more difficult to shift their practice within existing resources. 'Danielle' described this issue:

> I do understand that we have to work within a means of trying to reallocate resources or work within the system of funding that we have without asking for more money, that's not an effective approach. But if we do want to work from an equities perspective you still have to look at the capacity we have right now, what we can actually do for our families. If we did have an opportunity to advocate for more funding, Families First resources would be probably one of the top priorities, because if we could offer that for every family that was eligible that would be great.... As far as community development is concerned I don't think we have a lot of capacity, even if we practice a little bit differently, I think we need a little bit more…(6-1342).

The current way that services were structured did not provide all community areas with adequate capacity to promote health and address inequities in the same way. This controversy pertaining to equity had been somewhat apparent throughout the process, which was a key factor in including the WRHA position statement on health equity within the professional practice model

document. However, more work at the organizational level would be important in moving forward.

Section IV: Researcher Reflections

In this section, I describe the process and journey that I experienced as a participatory action research researcher. I learned far more than anticipated during this experience, and was impacted on a personal level more than I expected. While increased awareness among participants is a common outcome associated with action research, in this case I became far more conscious of the constraints and hierarchies that affect nursing practice. I describe my experience below, depicting my role as a facilitator, researcher, and an organizational insider.

Consistent with Bradbury-Jones' recommendation, I maintained a reflexive journal (Appendix Z) composed of journal entries, analysis, and reflection(Bradbury-Jones, 2007). I documented my feelings, to examine my subjectivity and potential impacts. As an insider, it was important to consider the potential impacts that I brought to the process and participants. This was modeled after Peshkin, an anthropologist who recognized that researcher feelings of subjectivity could influence data, and should be acknowledged using "I'' statements (Bradbury-Jones et al., 2009). To provide a format for the reflections, I used the three-stage model of reflection for leadership development. The first stage described objective experiences. The second stage depicted personal growth and the application of professional knowledge. The final stage aimed to articulate learning and future action (Sherwood & Horton-Deutsch, 2008). These topics will be discussed in more detail below.

As noted in the 'Objective Description' journal entries, I ensured that the physical environment for each RWG was comfortable. I set up the recording devices and circulated advance materials to guide the session. I tried to facilitate participant engagement by creating a

friendly and safe environment. I welcomed participants, provided food and coffee, and reassured the group when they expressed anxiety and trepidation. I tried to act as a role model, resource person, and collaborator, keeping my own anxieties hidden from the group to invoke their confidence. I tried to stay neutral in terms of individual suggestions and activities, to elicit participation by using communication and group facilitation skills, and to build capacity of the group to promote ownership. I also tried to respect individual learning styles and comfort levels, recognizing that some adults learn and formulate ideas as they speak, while others are more reflective.

The journal entries in the Engagement' section, described the confidence and engagement I saw emerge in RWG participants. As the project progressed, participant apprehension was channelled into excitement and enthusiasm. The RWG functioned effectively as a group; they were well-prepared, respectful and active contributors. Those who were initially quiet became more fully engaged throughout the process. Initially the RWG wasn't clear or confident in the process, but we learned together and worked in collaboration to complete the project.

The journal entries depicted my personal and professional learning through the process. I immersed myself in the data, and developed agendas and documents based on participants' discussion and ideas. At each subsequent RWG, I brought summarized data back to participants for reflection and validation. Meeting documents included new information to expand participant views and to aid in developing the action plan, based on the direction provided. Finding a balance between researcher and facilitator included: being comfortable with silences and pauses; not providing answers but helping the group to answer questions and reach their own solutions; providing adequate information for each group without overwhelming participants; raising

awareness without imposing my views; staying on track with the agendas and time line while being inclusive and respectful of divergent views and ideas.

It was challenging to maintain the balance between resource person, writer, and researcher. As a researcher, there was a need to maintain absolute objectivity and not influence participant opinions. I needed to maintain the rigor of the research process, while being sensitive to participant needs and the emergent and participatory nature of the process. I was transparent regarding the research process at all times, and adhered to the ethical principles outlined earlier. However I was always conscious of the research project, and I became invested in supporting the success of participants and the process. As a resource person, I wanted to provide the best sources of information. I appreciated the complexity in discerning the plethora of information available, having spent close to a decade familiarizing myself with it at the graduate and doctoral levels. To mediate this issue, I provided explanations of the documents, with associated strengths and limitations, and encouraged participants to critically evaluate the information. It was equally challenging to maintain the balance between keeping the project moving forward in a timely fashion, while allowing for adequate participant engagement. Lastly, as the writer, I was concerned the document would be perceived as my work rather than participants, and that the PHN voice was not adequately reflected.

While there is literature supporting participatory action research as an effective process for obtaining degrees of higher learning, I believe this project was especially complicated. In some ways, the research objectives were dichotomous – the first to develop a service delivery model using participatory action research, and the second to evaluate the process. However, I think the area that created the most complexity and tension for me, was my role as an organizational insider. I spent more than one year exploring the feasibility and desire of nursing practice council

members and the organization to embark upon this project. During the actual research process, there was constant navigation, awareness of system and organizational issues, and balancing multiple roles. As an insider in a leadership role, I had greater understanding of organizational activities than the PHNs. I definitely used my skills and position as a clinical nurse specialist role to facilitate the likelihood of project success at the organizational level.

This project was constantly in my mind, and I facilitated connections across the organization. I aligned myself with appropriate organizational initiatives, for instance I volunteered to be the clinical nurse specialist representative on a committee to move forward the concept of equity in the region. I bridged communication between the RWG with organizational leaders, as well as nursing practice council. I organized RWG meetings with the director, so that she was hearing the voice of participants. I coached and mentored participants to take ownership of the process by assisting with agendas, documents, and discussion ideas. I did not take meeting minutes, but ensure minutes were taken and reviewed them for accuracy and to ensure key points were captured. I was there for support and guidance and to facilitate the process, but purposively did not lead. I encouraged communication with the director and nursing practice council to come directly from the participants, and supported them to chair and lead discussions while planning ahead.

I acted as a liaison and facilitator within the organization by raising awareness of the professional practice model at multiple levels. I kept the director up to date, and I provided updates to the team managers, as well as at clinical nurse specialist meetings. I shared literature on healthy work environments for nurses, PHN practice, inter-professional collaboration, and transformational leadership; in an effort to raise awareness of inconsistencies in the WRHA compared to those articulated in the literature. There was some apprehension and defensiveness

that I had not anticipated. Yet many issues associated with current PHN practice, such as the focus on breastfeeding and the care map, are directly attributable to organizational leadership. Challenging organizational leaders' personal values, beliefs, and assumptions, especially pertaining to health equity and the need to shift current PHN practice was perhaps one of the greatest challenges of this project for me. I do not believe the successes associated with this project would have been possible, had I not been an insider with awareness of deep-rooted system and organization issues and hierarchies, and the ability to navigate within the organization. The fact that this project had remained unresolved, despite previous attempts and approaches, speaks to its complexity.

As my journal entries mentioned, at times I felt caught in the middle, which created personal and professional tension. The overt oppression of PHNs and power imbalances within the organization became increasingly evident to me. I often tried to advocate for PHNs, or even the clinical nurse specialist role, without success. The lack of awareness of these deeply entrenched traditions by those around me, and the continued negative impact on PHN practice created extreme frustration and disappointment for me. The system that I have been part of in differing capacities within and outside of Manitoba for close to two decades suddenly appeared deeply flawed to me. I had not anticipated the extent that I would be affected by the daily activities of my role in the organization, that had nothing but everything to do with this research project. I am still extremely happy for taking this approach, it was the right thing to do, but a traditional method would have been far simpler.

Summary

In this chapter, findings were presented. Seven RWGs took place from November 2012 to July 2013, which elicited rich and meaningful data. The data from the RWGs were categorized

into three separate sections to depict participant stories, their interpretation and journey, and lastly the evaluation and action that was developed. Within each section, three themes were developed using the 'Look, Think, Act' framework, and associated categories and sub-categories. A separate section was devoted to my reflections, as a participatory action researcher.

Participant stories were elicited during the initial RWG November 2012, and reflected participants' observation of their current situation. While passionate about PHN practice, the RWG spoke about disappointment with their current practice, the erosion of their role in population health promotion, and their inability to influence system change. From January 2013 to May 2013, the RWG continued to reflect on their practice, but within the context of current literature. With the incorporation of multiple sources of information, the RWG developed a professional practice model to provide a consistent organizational vision for their practice. The final RWG took place July 3rd, 2013. The RWG described positive impacts associated with the professional practice model, as well as the participatory action research process. In the next chapter, I will discuss these research findings in the context of current literature, as well as make recommendations for PHN practice, research, education, administration, and policy.

Chapter 5: Discussion

The purpose of participatory action research is to ensure that the voice and experiences of the research participants remains as the primary focus (Stringer, 2014). Therefore, the final chapter is written in two sections. Part I situates study findings within the current literature. Part II describes implications for public health nursing and conclusions are drawn.

Part I: PHN Practice Findings situated within Current Literature

The objectives of this study were two-fold. The first was to develop a service delivery model to support PHNs in an urban Canadian health region to practice to their full scope, especially in relation to promoting healthy early childhood development and health equity. The second was to explore the utility of participatory action research in developing a model of practice to clarify the role of PHNs. Consistent with participatory action research, findings were described as participant stories (look), interpretation (think), and actions (act) (Stringer, 2014). Findings were important in three main areas: 1)The need for current PHN practice to be reoriented to focus upstream with equity as a guiding principle; 2)The significance of the professional practice model in providing a structural framework to articulate PHN practice; 3)The effectiveness of participatory action research methodology in working with PHNs. Findings are discussed below, using the Community Health Nurses of Canada professional practice model in Figure 1 on page 28 as a guiding framework. Although this model pertains to all community health nurses, I refer to the subset of PHNs. The WRHA professional practice model was an adaptation of the Community Health Nurses of Canada professional practice model, and therefore findings have been situated within this broader framework.

PHN practice. Several findings emerged from this study specific to PHN practice. To begin with, the study findings support the health equity framework proposed by Reutter and Kushner (2010), used in the literature review. The authors suggested the mandate of nursing was to ensure access to health and healthcare by providing sensitive empowering care; understanding and tackling inequities; and working to address underlying issues. The RWG spoke repeatedly about the importance of promoting equity and reorienting PHN practice to more upstream approaches that promoted health, as opposed to providing healthcare. The RWG also spoke passionately about the importance of PHNs developing meaningful relationships and working with clients using a collaborative and strength-based approach to tackle inequities, particularly in the early childhood period. These findings will be discussed in more detail below.

While the RWG clearly described a significant role in the promotion of equity and early childhood development, their stories depicted tremendous challenges in articulating and understanding the PHN role, making attainment of this practice difficult. Their work had become task-based and driven by organizational standards and policies. The tasks were easier to describe, compared to the broader concepts that were the foundation of public health nursing. Tasks, such as the numbers of post-partum visits, communicable diseases, and immunizations, had become measures of PHN workload. The tasks, primarily clinical work at the individual level, had eroded the broader tenets of the PHN role. The traditional PHN role felt devalued. As a result, PHNs were not working to full-scope, and practice was inconsistent with PHN standards and competencies. Despite a well articulated job description, the RWG spoke of the tensions caused by the inability to work to their competencies. Participants depicted PHN feelings of frustration, apathy, and powerlessness. They also reported difficulties influencing and changing their practice, within complex organizational hierarchies and bureaucracies.

These finding are consistent with a plethora of Canadian literature depicting a looming crisis in public health nursing. Inconsistent terminology has contributed to lack of role clarity and underutilization of the PHN workforce in Canada (Schofield et al., 2011).Other studies have documented that PHN practice has become focused on individual clinical care and health education, there is a pervasive lack of role understanding, and PHNs are feeling devalued and powerless to promote change (Beaudet et al., 2011; Cohen & McKay, 2010; Cusack et al., 2008; Dunne, 2011; Poulton, 2009; Schofield et al., 2011). The experience of PHNs is consistent with other areas of nursing practice. Nurses have routinely been challenged to express how their practice contributes to health and societal improvements, or to describe the supports necessary to improve their practice (Litchfield & Jonsdottir, 2013). Additionally, unless nurses take time to consciously reflect on what they are doing, they are unaware that their actions are based on a complex integration of knowledge, tradition, culture, practice norms, work environments, and experience (Gottlieb, 2013). In failing to articulate the qualities of good care however, nurses' performance often remains unnoticed (Donohue-Porter, 2012).

Barriers and facilitators to PHN practice have been well documented in the Canadian literature (Cohen & McKay, 2010; Falk-Rafael & Betker, 2012b; Meagher-Stewart et al., 2010; Reutter & Kushner, 2010). MacDonald (2013) argues that the PHN definition contributes to personal conflict; due to the duty to care for populations as well as individuals. Other Canadian authors explain "moral distress" as "the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment" (Varcoe, Pauly, Webster, & Storch, 2012). Factors

leading to nurses' moral distress include organizational constraints, and lack of appreciation for nursing knowledge within organizational hierarchies (Austin, 2012).

The RWG developed the first Canadian professional practice model specific to PHN practice. Components of ideal Canadian PHN practice were consistent with cornerstones described in two recent publications from the United States and Norway (Glavin et al., 2014; Keller et al., 2011). Similar aspects included a population focus, responsiveness to community needs, a broad definition of the client, and PHN approaches incorporating collaboration, as well as autonomy. The RWG also described new cornerstones, unique to the WRHA and potentially Canadian PHN practice.

A common cornerstone to United States and Norway PHN practice was a holistic approach that incorporated, which the RWG also described. Consistent with the Community Health Nurses of Canada professional practice model however, they spoke of the influence of reports such as *The Ottawa Charter for Health Promotion* (World Health Organization, 1986), that have been foundational in influencing public health approaches in Canada. The RWG repeatedly described the impact of the social determinants on health, and the value of the PHN role in equity promotion. Another common United States/Norwegian cornerstone pertained to social justice and diversity, with attention to those who are vulnerable. The RWG extended this cornerstone to articulate the importance of the PHN role in advancing health equity, and in particular the promotion of healthy early childhood development. These elements seem to illustrate a particular RWG recognition and value for social justice and the need to address root causes of inequity through PHN action. These attributes support the theory of critical caring (Falk-Rafael, 2005) and the framework to promote health equity (Reutter & Kushner, 2010) developed by Canadian scholars.

A Norwegian cornerstone discussed the role of the PHN in promoting equality through universal approaches. The RWG described PHN practices that integrated both universal and targeted approaches to promote equity as well as equality, appreciating differences in these concepts and recognizing that equity may require more intensive approaches. The United States cornerstone described PHN use of epidemiological evidence, while the Norwegian document referenced evidence-based practice. The WRHA PHN professional practice model incorporated evidence-based practice, surveillance, and applied public health research, to promote and evaluate health outcomes. Interestingly, one of the themes raised by the RWG was the onerous process of collecting organizational statistics, and the belief statistics did not adequately represent PHN activities. The RWG was also unaware of the use of collected statistics in research and published reports. PHNs in other studies have reported not using statistics to inform their practice, and the collection of statistics as a barrier to innovative PHN practice (Poulton, 2009).

The final difference in the United States / Norwegian cornerstones pertained to PHN practice authority. The authority in the United States appears to come from state legislation, while Norwegian authority for PHN practice is national. Canadian PHN practice and independent authority seems to meld these factors, being derived from a combination of organizational, provincial, and national structures. PHN practice in Manitoba is founded on professional regulatory standards set out by the College of Registered Nurses of Manitoba and the Canadian Nurses Association Code of Ethics. Other national documents describe PHN standards, competencies, and roles and activities (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b). Public health is a specialized nursing role in Canada, representing the fusion of public health sciences with nursing theory and practice

(Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009; Keller et al., 2011). Table 6 was adapted Glavin et al (2014, p.163) to provide a comparison of PHN practice in Canada, to that described in the United States and Norway.

Table 6: Comparison of Cornerstones for PHN practice

United States Cornerstones	**Norwegian Cornerstones**	**RWG Cornerstones**
"Focuses on the health of entire populations,"	same	same
"Reflects community priorities and needs"	same	same
"Establishes caring relationships with communities, systems, individuals, and families"	same	same
"Grounded in social justice, compassion, sensitivity to diversity, and respect for worth of all people, especially the vulnerable."	same	Different- Incorporates concepts of health equity action and critical caring to promote social justice
"Encompasses mental, physical, emotional, social, spiritual, and environmental aspects of health."	same	Different –Holistic definition of health influenced by theory and context
"Promotes health through strategies driven by epidemiological evidence"	Different - "Use evidence-based practice to promote health in the community"	Different – Uses evidence-based practice, surveillance, and applied public health research, to promote and evaluate health outcomes
"Collaborates with community resources to achieve those strategies but can and will work alone if necessary"	same	same
"Derives its authority for independent action from the Nurse Practice Act"	Different – "Derives its authority for independent action from national laws"	Different – Derives authority for independent practice from organization, provincial, and national structures
	New - "Promotes equality for all through offering universal health care"	Different- Promotes population health and equity using universal and targeted approaches

A vital finding identified by the RWG was the importance of framing the WRHA professional practice model using PHN values and principles. Values and principles are described in the Community Health Nurses of Canada (2011) professional practice model as the integration of theories that form the basis for community nursing practice. Values and beliefs guide practice, by focusing on the most significant components of the role (Glavin et al., 2014). Hoffart (1996) states that without defining values and principles, other components of a professional practice model lack focus. While documents defining PHN practice provide this guidance, the lack of role clarity and inconsistent practice in the WRHA necessitated more detail. Defining the purpose of the PHN role as population based with a focus on equity, the RWG described examples of shifting their approaches to service delivery, based on competencies and their job description. Professional practice models are intended to assist nurses with practice decisions and change (Ives Erickson & Ditomassi, 2011). In addition, the RWG used the examples in the WRHA professional practice model to illustrate PHN professional practice. The examples assisted in bridging the gap between the theory and PHN practice. The RWG spoke of how the concepts were difficult to understand, but the real-life examples portrayed application of the theory in practice. Incongruence between theory and actual PHN practice has represented a significant gap (Cohen & Reutter, 2007; Lind & Smith, 2008).

This study extends current literature, by articulating the importance of nursing practice councils in supporting Canadian PHN practice. Nursing practice councils have been reported to promote professional exchange and address practice issues for some Canadian PHNs. However, in this study the RWG spoke of the value of the nursing practice council structure in developing the PHN professional practice model. Using standard nursing practice council structures, the RWG communicated with nursing practice council representatives, who disseminated

information to their teams. Likewise, the representatives returned to nursing practice council and provided the feedback from their teams, which led to deeper reflection and discussion. Developing a structure for shared governance, where nurses have accountability for decision-making, has been cited as the most critical aspect in development of a professional practice model and the transformation of nursing practice environments (George & Lovering, 2013). Using shared governance a practice model can be developed that reflects organizational strategic priorities and staff values (Kear, Duncan, Fansler, & Hunt, 2012).The goal of the RWG was to develop a document that reflected PHN practice, but was readable and could be used by others to assist in their understanding. A key component was a summary document, containing a visual. Developing a visual model that staff relates to is vital for the success and utilization of a professional practice model (Tinkham, 2014). The RWG hoped that articulating the impact and effectiveness of the role through the WRHA professional practice model could assist in advocating for their practice, as well as for developing arguments for potential funding increases.

Community organizations. Under the heading of 'Community Organizations' the Community Health Nurses of Canada professional practice model includes the topics of delivery structure and process; professional relationships and partnerships; and management practices. At the outset of the project, the intention was to develop a service delivery model. According to Hedges et al. (2012) articulating a delivery model provides the structure to create organizational transformation by defining core principles that guide nursing practice, outcomes, and the roles of nurses. After reviewing literature on professional practice models and service delivery models, the RWG quickly recognized that articulating PHN practice in isolation would not be sufficient. In addition to the role, the WRHA professional practice model established the professional practice environment necessary to support PHN practice. A professional practice model depicts

relationships between the nurse and clients, the organization, and other providers (George & Lovering, 2013; Ives Erickson & Ditomassi, 2011; Schlotfeldt, 1989). Professional practice models and professional nursing practice environments can improve client outcomes, staffing, as well as enhance nurse and client satisfaction (Mensik, 2013).

Management practices can act as both barriers and facilitators to the attainment of ideal PHN practice (Poulton, 2009).This study extends current literature by identifying PHN perceptions regarding the need for role clarity in management practices. Managers in public health play a key role in facilitating effective PHN practice (Meagher-Stewart et al., 2010). While the purpose of a professional practice model is to move all staff to achieve professional practice, to do so, all organizational leaders must understand and support a professional practice environment (Mensik, 2013). The RWG recognized organizational power imbalances, system inefficiencies and the need for role clarity between PHN leadership activities and managers. Many managers were not nurses themselves, and/ or did not have advanced education. In the literature, PHNs have reported feeling disempowered as a result of organizational influences (Cawley & McNamara, 2011). However, development of a common framework and language has assisted managers in understanding PHN practice (McDonald, Frazer, & Cowley, 2013).

The RWG identified barriers in their current practice, but using the professional practice model suggested organizational and management solutions to support PHN practice. Tinkham (2014) reported that use of a professional practice model and shared governance nursing environment promotes the “three A’s of nursing care: authority, autonomy, and accountability” Although nursing practice council uses a shared governance approach, this term was not specifically mentioned by the RWG. Participants described shared power and decision-making, and the value associated with autonomy in the PHN Nurse IV practice. Other essential

components identified by the RWG and reported in the literature were a shared vision that was responsive to community needs and evidence based (Meagher-Stewart et al., 2010; Poulton, 2009). The RWG proposed the development of a working group, to continue to clarify organizational roles and responsibilities and build a shared vision.

The RWG spoke of the importance of professional relationships and partnerships and working in collaboration. However, the RWG repeatedly described top-down and silo'd approaches to decisions that had an impact on PHN practice. Program decisions were made without understanding implications for PHNs or the communities, which resulted in task-based approaches. While nursing tasks are easier to measure, a workplace based on technical practice is in direct opposition to a professional practice environment (Mensik, 2013). Top-down hierarchal approaches diminish PHN control and negatively influence organizational culture (Poulton, 2009). The RWG identified the professional practice model as the framework to articulate and clarify the PHN role within the organization. Participants hoped that the professional practice model would help managers, directors, medical officers of health, and outside organizations understand the PHN role, and promote collaborative professional relationships that valued PHN knowledge and skill.

The RWG spoke of the value of inter-professional collaboration in their practice. Working collaboratively within the organization to have a consistent vision, as well as working with partners outside of the program. For complex families, the RWG spoke of efficiencies and effectiveness of coordinated services. This is consistent with literature citing that coordinated action and shared responsibility are essential in promoting health equity and creating population level improvements (Fawcett et al., 2010; Hernandez et al., 2010; Horwath & Morrison, 2011;

McFadyen et al., 2010; Moore & McArthur, 2007; Standing Senate Committee on Social Affairs Science and Technology, 2009; World Health Organization, 2010).

A unique finding in this study was the importance attached to the final component of the professional practice model, titled "Rewards and Recognition." This was a new category developed specifically by the RWG. Hoffart (1996) included "Compensation and Rewards," in recognition of the American healthcare system where nurses are not unionized, and pay and working conditions vary. The Community Health Nurses of Canada professional practice model excluded this final category. The RWG felt strongly this be included and suggested both formal and informal organizational activities to identify nursing attributes and promote PHN motivation. In the literature, informal methods to engage staff may include reinforcement through public recognition (Fawcett et al., 2010). Conversely, formal structures include development of a theoretical perspective to link organizational goals, scope, and the outcomes of nursing practice (McEwen, 2011). Organizational policies and staff education have been identified as central components to support PHN practice (Poulton, 2009), and could also be examples of formal structures. Perhaps this is an example of empowerment developed among the RWG, in advocating for structures that recognize and value PHN practice. The WRHA professional practice model can also serve as the framework to link these activities.

System. The third area illustrated in the Community Health Nurses of Canada professional practice model relates to system factors, which identifies the categories of government support and determinants of health. As with other nursing positions, the provincial government provides funding to the WRHA, to deliver PHN services. The RWG repeatedly spoke of competing workload demands and the need for adequate funding to support PHN practice. Multiple government departments are relevant to PHN practice. These include the departments of Public

Health, Healthy Child Manitoba, Healthy Living and Seniors, Housing and Community Development. Each has large bureaucratic structures, reporting to separate Ministers. Some departments, such as Public Health and Healthy Child Manitoba, provide direct funding to the WRHA for delivery of PHN services. Others provide funding to community groups or activities that PHNs are involved, or may not provide funding but have consistent philosophies.

Manitoba's Provincial Public Health unit falls under the Department of Health. This government department directly affects many PHN activities, often in a manner that is unpredictable, for instance in the case of disasters and communicable disease outbreaks. The Manitoba Public Health Act stipulates that "the minister has the authority to protect and promote the health and well-being of Manitobans" ("The Public Health Act,"). In contrast to other areas of healthcare, public health is legally mandated to provide population based services (Honoré, Wright, Berwick, Clancy, Lee, Nowinski, & Koh, 2011). Roles for regional health authorities related to community health protection, disease control, immunization, public health emergencies, information gathering and health surveillance are described within the legislation. PHNs and medical officers of health are provided special authority within this legislation to enable these functions.

PHNs promote healthy child development through a number of activities. PHN roles in home visiting and community based groups is supported through Healthy Child Manitoba (Government of Manitoba, n.d.-c). Healthy Child Manitoba falls under the department of Children and Youth. Other PHN population health promotion activities fall under the department of Healthy Living and Healthy Populations (Government of Manitoba, n.d.-a). This includes chronic disease prevention, injury prevention, healthy sexuality, healthy eating, injury prevention and mental health promotion. Lastly, Manitoba has a multi-pronged poverty reduction strategy,

which falls under the department of Housing and Community Development (Government of Manitoba, n.d.-b). PHN practice and the associated government support is clearly very complicated. The structuring of these government departments explains some of the workload pressures and lack of role clarity described in this study.

PHNs represent the largest group of public health practitioners and action on the social determinants of health is foundational (Community Health Nurses of Canada, 2009, 2011b; Reutter & Kushner, 2010). The RWG described their passion for a PHN role in health promotion and specifically in addressing the determinants of health. Multiple workload demands, a task-based approach to practice, lack of role clarity, and their practice being dictated by others, resulted in an inability to achieve this in practice. Based on documents articulating their role, PHNs should be working upstream to promote health equity, prevent chronic diseases, and improve population outcomes (Community Health Nurses of Canada, 2011b; National Expert Commission, 2012; Reutter & Kushner, 2010).

Canadian experts have cited a looming crisis due to the growing disconnect between the desired PHN practice and their daily activities, which is threatening the sustainability of the PHN role (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b). Current biomedical approaches continue to value illness care over health promotion (Schofield et al., 2011). Though PHNs are perfectly positioned (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b), their skills and knowledge remain under-utilized and invisible to the governments, the public, professionals, and employers (Beaudet et al., 2011; Cohen & McKay, 2010; Cohen & Reutter, 2007; Dunne, 2011; Meagher-Stewart et al., 2010).

A key aspect to support PHN practice within the WRHA professional practice model was the promotion of health equity. The RWG spoke about their actual PHN role being very different from what they expected, based on the interview process and job description. Both the PHN position description and interview process had been updated to reflect the Community Health Nurses of Canada competencies and standards (Winnipeg Regional Health Authority, 2011b). The WRHA board position statement and Population & Public Health mission and vision also explicitly depicted a strong commitment to health equity. Despite organizational support in the form of numerous processes and documents, the RWG reported inability to practice in this manner. Canadian authors have commented on the need of organizations to create conditions that allow PHNs to practice to full scope and maintain their competencies (Meagher-Stewart et al., 2010). Additional organizational components to promote capacity for equity action include adequate resources, infrastructure, and staff skill development (Cohen, Schultz, McGibbon, VanderPlaat, Bassett, GermAnn et al., 2013).

One of the interesting findings from this study was the RWG perception that the concept of health equity was not consistently understood by all PHNs. The RWG described how their knowledge had grown as a result of involvement in the participatory action research process, but reported that some colleagues expressed concern about changing their current PHN practice using an equity lens. A recent Ontario study reported that the assumption of public health staff maintaining a social justice and equity lens is not necessarily accurate (Raphael, Brassolotto, & Baldeo, 2014). Other Canadian studies have also found that PHN practice is mainly focused on individual level health behaviour change, and the concept of population health promotion is not consistently understood (Beaudet et al., 2011; Cohen, 2006a). Previous Manitoba studies have reported that PHNs did not have organizational support for population health promotion, and

managers often did not have the background to support this practice (Cohen, 2006a). Structural approaches such as health impact assessments can assist staff in reflecting on concepts and implications for their practice (Raphael et al., 2014). Essential system factors include adequate government funding, legislation, as well as supportive policies and leadership (Cohen et al., 2013).

The RWG hoped that articulation of the PHN role using the professional practice model would assist in developing greater understanding and awareness of the PHN role at the system level. Ultimately, the RWG hoped that the professional practice model could be used to advocate for the PHN role and the allocation of resources. Public health programs must move beyond epidemiology to create equity indicators and strategies that address the determinants of health, to promote social change (Cohen, 2006b). PHNs in international studies have also commented on the relevance of governments prioritizing health and supporting PHN practice (Glavin et al., 2014). A more clearly articulated PHN role in addressing health equity through establishment of a professional practice model is a first step to assist governments making that health human resource investment.

Participatory Action Research Findings situated within Current Literature

This study extends current knowledge by using participatory action research with urban Canadian PHNs to develop a professional practice model. Koch & Kralik (2006) describe five key features that separate participatory action research from other action research approaches. The first feature is the extent of participant engagement. Second, the lived experience of participants is central. Third, through exploration of inequities, empowerment may be an outcome. The fourth feature is consciousness-raising. Lastly, the outcome of participatory action research is to create individual and/or system change, which aims to address power inequities.

Two studies specific to PHNs were located that used similar approaches. Researchers in Ireland used participatory action research with PHNs to develop a population based caseload management system (McDonald et al., 2013). The authors highlighted the significance of participatory action as a research method, however PHNs in Ireland work with clients across the lifespan, so their practice is not applicable to the Canadian context. The second was a large Canadian study that utilized appreciative inquiry, which is a type of action research. The study included PHNs, managers, and policymakers, to identify attributes to support PHN practice. The research was reported in three separate publications (Ganann, Underwood, Matthews, Goodyear, Leeseberg Stamler. L., Meagher-Stewart, & Munroe, 2010; Knibbs, Underwood, MacDonald, Schoenfeld, Lavoie-Tremblay, Crea-Arsenio et al., 2010; Meagher-Stewart, Underwood, Schoenfeld, Lavoie-Tremblay, Blythe, MacDonald et al., 2009).

Participant engagement. A unique of feature of participatory action when compared to other action research approaches is the extent of participant engagement in the process. The topic of interest originates with participants, who are involved in an ongoing basis (Koch & Kralik, 2006). The issue of developing a service delivery model originated at nursing practice council and had been outstanding for close to a decade. Although nursing practice council representatives had changed, the RWG participants agreed this issue remained important and wanted to embark on a participatory action research study, to attempt to resolve it. Using action research, nurses are able to be involved in research pertinent to their practice (Holloway & Wheeler, 2010). In Ireland, authors reported the importance of having PHNs define the concepts relevant to their practice, in creating the common language for their framework (McDonald et al., 2013).

The development of WRHA PHN professional practice model was possible because of the extent of engagement of the RWG. This approach builds on the appreciative inquiry approach previously reported, where PHNs were included in data generation and initial analysis (Knibbs et al., 2010). Consistent with literature on participatory action research, I worked in partnership with the RWG to define the problem, methods for data generation, analysis, communication of research findings, and ultimately to create change (Bellman, 2012a; Corbett et al., 2007; Koch & Kralik, 2006; Polit & Beck, 2012). The RWG used leadership skills and acted as change agents in working with their PHN and nursing practice council colleagues, to elicit and incorporate their views. The success of participatory action research project is often related to the extent of participant engagement in the process (Corbett et al., 2007).

Lived experience. The second feature of participatory action research pertains to lived experience, and the significance of participant direct knowledge of their situation (Kemmis, 2008). Different ways of understanding and opportunities for change evolve through the critical examination of lived experience (Koch & Kralik, 2006). Throughout the process, the RWG continually reflected on their practice, and considered multiple sources of information and opportunities for action. When reflecting back, if there was anything that could have been done differently, the RWG suggested more deliberate use of the participatory action research process. The RWG described how using the participatory action framework, reflection, and discussion facilitated their learning. The RWG shared their stories, explored solutions and varying perspective, and then developed an action plan. The Ireland study with PHNs used a similar approach. Through five participatory action research cycles, a common framework and language was developed to assist in resource management and increasing the visibility of PHN practice (McDonald et al., 2013).

Action research approaches are consistent with nursing philosophies. The intention of participatory action research is to develop local actions that benefit participants (Braye & McDonnell, 2013). Compared to traditional bio-medical deficit based approaches, appreciative inquiry generated enthusiasm among Canadian PHN's and recommendations for improvement due to the strength-based approach (Knibbs et al., 2010). The RWG described their excitement and enthusiasm with the process as well as the final product. The professional practice model illustrated PHN practice, and created meaning, within the WRHA organizational context.

The RWG spoke of the value of the participatory action process, and having their voice heard. They developed an approach that was collaborative and created a shared vision, within a system they described as a "dictatorship." Rather than sitting back and waiting, they proactively identified solutions to improve their situation. Consistent with these perceptions, participatory action research discussions assisted PHNs in Ireland in understanding the scope and complexities associated with their practice, leading to development of their model (McDonald et al., 2013).

Empowerment. Participatory action research acknowledges relationships of power and inequity, and focuses on the development of participant empowerment (Koch & Kralik, 2006). The RWG initially described feelings of nervousness, and lacked confidence that the project would be completed. Participants also spoke of frustration with their current practice. They felt it was not well understood or valued within or outside of the system in which they worked, but did not feel that previous PHN efforts had been successful in creating change.

The RWG acted as leaders in developing the professional practice model, as well as change agents or champions in working with colleagues. Participants were excited to be named as co-researchers, and worked together cohesively. They assumed ownership. The process of engagement creates a sense of belonging and empowerment among participants (Corbett et al.,

2007). Upon reflection, participants expressed pride, excitement and disbelief regarding the outcome of the project. According to Corbett et al., empowerment is created as the researcher and participants work in partnership to expose power imbalances and bring forward the voice of those who have been oppressed (Corbett et al., 2007). Involvement in the participatory action research increases participants' awareness regarding their skills and knowledge, and promotes their capacity (Koch & Kralik, 2006). The RWG repeatedly commented on their feelings of empowerment, as they developed attainable solutions to issues affecting their practice.

Consciousness-raising. Consciousness-raising is a central element of participatory action research that consists of assisting participants to view their situation differently, as a result of new knowledge (Koch & Kralik, 2006). The RWG spoke enthusiastically regarding the learning associated with the project. They also spoke passionately about no longer being scared of change, but wanting and needing to change their practice. The integration of new information challenged and stimulated participants. The RWG discussions were invigorating, and the process was creative. Participants spoke of the value of information, and appreciation that other Canadian PHNs were experiencing similar issues.

Participatory action research has been successful in generating clinical improvements, and is the preferred methodology for nurses to critically examine concerns regarding service delivery (Corbett et al., 2007). Improved learning is a criteria that should be assessed (McNiff, 2013). Incorporating literature during the process requires participants to identify key characteristics of complex articles, highlight and deconstruct main concepts, and then apply the information during reflection and analysis (Stringer & Dwyer, 2005). Practice improvements become apparent as participants' gain awareness through the cycles of reflection (Corbett et al., 2007; Hughes, 2008). Action research has been reported to also raise awareness of system imposed policies and

procedures, and to help participants make sense of their nursing practice (Holloway & Wheeler, 2010). Canadian authors have touted the promise of these research methodologies in addressing power imbalances that generate negative cultures in nursing practice environments (Rodney, Buckley, Street, Serrano, & Martin, 2013).

Participatory action research discloses knowledge that would otherwise remain invisible and highlights conditions of inequity and oppression (Elliott, 2011). Participants recognized PHN apathy, as well as the importance of PHNs assuming a leadership role to create a sustainable solution to address their practice challenges. Through reflection and analysis, participants come to recognize that their practice and views have been influenced by history, tradition, and wider local contexts (Kemmis, 2008). Previously held personal assumptions and prejudices are challenged, as new understanding is developed (Kemmis, 2008). Through expanded awareness, local solutions are created (Genat, 2009). During the process of inquiry and discussion, co-researchers gain knowledge and often establish learning that is transformative (Stringer & Dwyer, 2005). The cyclical process is educational for participants as well as the researcher (Braye & McDonnell, 2013; Koch & Kralik, 2006).

Individual and/or system change. The final element of participatory action research is to develop an outcome that creates change. The intention is to benefit the lives of participants and to create more equal distributions of power (Koch & Kralik, 2006). Three main changes were associated with this participatory action research project, two specific to RWG members, and one pertinent to the larger system.

In the final evaluation, participants each described personal shifts in their practice, using the professional practice model as their lens. The RWG illustrated the depth of their learning and the positive practice impacts, by being much more deliberate in their interventions and

approaches. They described making planned decisions by applying the values, principles and theory articulated in the professional practice model. In shifting their practice, they spoke about how they were able to free up time, and focus more on equity and foundational elements of practice that had been eroded.

The second individual shift that the RWG noted was the development of leadership skills. The RWG described the ability to use the professional practice model in advocating for their practice, and hoped it could be used at multiple junctures to argue for resources and funding. The RWG spoke of their excitement and enthusiasm, and their role in working as change agents or champions with other PHNs. Though participatory action research has not previously been studied among PHNs, a recent Canadian study found an association between local and trusted opinion leaders in public health departments supporting knowledge translation among colleagues (Yousefi-Nooraie, Dobbins, & Marin, 2014).

In the literature, participatory action approaches have led to sustained and meaningful change in work environments. Among nurses, participatory action research has been found to raise awareness, shift practice, and develop leadership skills (Mackoff, Glassman, & Budin, 2013; Minthorn & Lunney, 2012; Onnela, Vuokila-Oikkonen, Hurtig, & Ebeling, 2014). Consistent with findings from my study, a participatory action doctoral study with hospital nurses in Barcelona reported a narrowing in the theory-practice gap, and nurses transforming their practice to be more evidence-based (Abad-Corpa, Delgado-Hito, Cabrero-García, Meseguer-Liza, Zárate-Riscal, Carrillo-Alcaraz et al., 2013). Munten et al. (2010) reported action research as a promising method to promote evidence-based practice in nursing, following a review of 21 research studies.

The last potential shift is at the system level. The RWG recommended that the community area PHN teams work through many of the same processes that they had. At the evaluation, the RWG gave examples of how nursing practice council and team members had shifted their practice, because of the learning associated with the project. The RWG also commented on health equity and promoting early childhood development. Many staff were excited at the prospect of returning to the foundation of PHN practice. However, the RWG recognized that not everyone had the same understanding of equity. The RWG outlined an action plan for a professional practice model going forward; but full implementation and system transformation will require ongoing work. Although the research component of this project has ended, many next steps continue to move forward at nursing practice council and in the WRHA.

Role of participatory action researcher. The RWG spoke of my role as the researcher in facilitating project success. A partnership developed in which I facilitated the process, acted as a resource person, and assisted in navigating organizational bureaucracy. An identifying feature of action research is collaboration with participants as equal partners (Streubert & Carpenter, 2011b). As a subset of action research, participatory action research extends this method. The relationship between the researcher and participants is mutual, and participants are fully and actively engaged throughout the course of the study (Braye & McDonnell, 2013; Hughes, 2008).

Empowerment can only result from the researcher assisting participants in articulating their voice, and ensuring that the research process does not impose power and control (Streubert & Carpenter, 2011b). I continually asked the RWG for feedback and direction. I tried to be sensitive to individual comfort levels, but also to elicit feedback through prompting and questions. As the process evolved, the participants assumed greater control and volunteered feedback and suggestions. Participatory action research leads to power shifting, as the researcher

collaborates with participants (Braye & McDonnell, 2013). The researcher facilitates communication, and acts as a resource or catalyst as opposed to an expert, to generate common meaning and action (Corbett et al., 2007; McDonald et al., 2013; Stringer, 2014). The RWG described my role in facilitating the process as crucial to project success. As participants create meaning about their experiences, the facilitation provided by the researcher is vital to the outcome of the research (Genat, 2009).

The goal of an action research critical paradigm is social justice, aiming to advance the situation of participants (Koshy et al., 2011). Koshy et al adapted features from Guba and Lincoln specific to action research. Based on a critical paradigm, participants' realities are shaped over time by aspects such as gender, culture, social, political, and economic values. From the epistemological perspective, findings are assessed from both subjective and objective views and values are central in determining the action plan. Knowledge is historically positioned and accumulated over time. Participatory action research necessitates "a broad view of epistemology," recognizing that research can generate different types of knowing (Braye & McDonnell, 2013). The researcher must collaboratively create an action that benefits participants, privileges their knowledge, develops participant learning and capacity, and ensures credibility (Genat, 2009).

Action research contributes to scholarship because it offers insight, opportunities, and new knowledge that are not be possible using traditional approaches (Elliott, 2011). The creation of knowledge specific to local context has been neglected in academic settings (Coghlan, 2011). The cycles of action and reflection generate "shared experiential knowledge" regarding participants' situation that leads to construction of local theory (Genat, 2009). Participatory

action research appreciates alternate ways of knowing that can produce both local knowledge and theory (Koch & Kralik, 2006).

Recognizing the opportunity to embark on this project was a direct result of my knowledge of the organization. In working as a clinical nurse specialist, I had observed the nursing practice council structure successes in resolving issues. Action research is often undertaken by organizational insiders pursuing doctoral degrees, because the process promotes reflection and problem solving (Herr & Anderson, 2005). Researchers should be knowledgeable regarding the approach, applicable sources of evidence and information, and prospective benefits (Hughes, 2008). The action researcher's integrity is critical in addressing the practical and political activities necessary to create the change (Levin, 2012).

In writing for a dissertation, researchers should reflect on their role, power, and beliefs, as well as learning outcomes resulting from reflection and participant evaluation (Bellman, Webster, & Williamson, 2012; Genat, 2009). Reflexivity is particularly important for participatory action research studies in healthcare when the researcher is a practitioner, and the potential influence of bias and interpretations could impact the research process (Koshy et al., 2011). Following each meeting with the RWG, I reflected on the process, using the 'Three stage model for leadership development.' I critically examined the situation, my assumptions, group functioning, and articulation of learning. I also reflected on pertinent theories and resources.

My dual role as a PhD student and an organizational insider contributed to the success of the project. Understanding organizational functioning, and reflecting on PHN challenges within the context of graduate education, created the recognition that a different approach was needed. I became more aware of the privileging of traditional knowledge and organization hierarchies. I also noticed the inability to apply research finding in practice contexts. Insider action research is

the term used when an organizational member conducts the research (Coghlan, 2011). Eikeland uses the term "praxis-research" to refer to transformational action research in which researchers with context expertise incorporate theory during the process (Eikeland, 2012). My role as an organizational insider and PhD student provided the opportunity to bridge these complexities.

The activities of participatory action researchers include facilitation, interpretation, and navigation (Onnela et al., 2014). As a clinical nurse specialist, I had the necessary knowledge of the organizational context to assist the RWG in navigating organizational processes. I was also knowledgeable of theory that supports PHN practice, and assisted the RWG in navigating the plethora of information available. There is growing evidence regarding the importance of clinical leadership in nursing to support knowledge development and evidence-based practice (Abad-Corpa et al., 2013; MacNeil & MacKinnon, 2011). I remained aware of my role as a participatory action researcher and tried to stimulate discussion and awareness among the RWG, and avoid imposing my own views and judgements. The process of action research has great potential for clinical nurse specialists and the populations of the nurses they work with. The clinical nurse specialist role creates a bridge between theory and practice, using advanced education and knowledge to provide leadership and make nursing clinical expertise visible (MacNeil & MacKinnon, 2011).

A distinction of action research is the emergence of ethical dilemmas. Participants share their personal experience of the problem, and the researcher provides theoretical information and acts as a liaison by increasing awareness of those with greater power (Streubert & Carpenter, 2011b). These authors describe tensions pertaining to group cooperation and shared decision-making, as well as pressure the oppressed group may experience from the dominant group. In this study, the RWG functioned phenomenally and became more excited and energized through

the project. They appeared to be empowered by developing a document they could use to describe and advocate for their practice.

As an action researcher and organizational insider who is a clinical nurse specialist, I experienced ethical challenges. Domains of clinical nurse specialist practice include leadership, role development, clinical expertise, and autonomy (Dowling, Beauchesne, Farrelly, & Murphy, 2013). The domains of role development and clinical expertise are simultaneously depicting nursing and clinical nurse specialist practice. The clinical nurse specialist role within healthcare organizations is therefore plagued by a similar lack of role clarity and dichotomy as that faced by PHNs in providing population and individual care. However, the advanced education and knowledge associated with doctoral studies increased my consciousness of organizational hierarchies and the oppression of nurses within health systems. It also raised awareness of evidence-based practice and research processes, and current gaps that exist in practice. Witnessing these factors on a daily basis, while working to advance nursing as a profession within organizations and structures that are unknowingly repressive based on deeply entrenched histories, may contribute to ethical dilemmas for action researchers.

Part II: Implications and Conclusions

The findings of this research study have implications for public health nursing practice, research, education, policy, and administration. These implications are discussed below.

Implications for PHN practice. Findings of this study have several important implications for PHN practice. Schlotfeldt (1989) advised that occupational groups claiming professional status must fulfill two criteria. The first is a social mission or goal, and the second is a distinct body of knowledge (Schlotfeldt, 1989). The purpose of PHN practice in the WRHA has been articulated in the professional practice model, based on a distinct body of knowledge.

The function of a professional discipline is to develop, disseminate, and use knowledge (Fawcett, 2013), in attainment of their social goal. The value of developing a professional practice model was to organize professional PHN knowledge in a manner that was meaningful in the WRHA. The ability to conceptualize nursing tasks within a broader framework that incorporates standards, values, and ethics, is the hallmark of professional practice (Mensik, 2013). PHNs in the WRHA should continue to articulate their professional role based on the professional practice model.

The application of nursing knowledge to practice is called praxis (Swearingen, 2009). Praxis is important for the profession because, as theory is incorporated into daily functions, PHN practice will become more transparent and visible to the public and healthcare providers (Phillips, 2013). The language used to depict and describe nursing practice to others is extremely pertinent (Mitchell, Ferguson-Pare, & Richards, 2013). Nurses actions are based on a complex integration of knowledge, tradition, culture, practice norms, work environments, and experience (Gottlieb, 2013). To be equivalent to other scholarly disciplines, nursing practice must be guided by nursing specific theory (Cody, 2013a; Swearingen, 2009). It is critical that PHNs fully understand, and be able to articulate the autonomous nature of their practice, and the theories upon which it is founded. This is especially significant for PHN practice, which is a complicated and unique specialty within the nursing field.

This study extends knowledge regarding current Canadian PHN practice through development of a WRHA PHN professional practice model. A professional practice model identifies activities over which nurses have control and direct responsibility (MacPhee et al., 2011), by articulating a nursing philosophy based on specific knowledge, skills, and competencies for autonomous practice (George & Lovering, 2013; Ives Erickson & Ditomassi,

2011; Schlotfeldt, 1989). Professional practice models aim to promote nursing excellence, innovation, and quality patient care (American Nurses Credentialing Center, 2014). The RWG integrated all components of PHN practice within the WRHA professional practice model; creating the common language to describe their ideal practice.

Other models have been developed for community practice (Barry, Gordon, & Lange, 2007; Bigbee & Issel, 2012; Smith & Bazini-Barakat, 2003), with a recent Canadian example (Vancouver Coastal Health, 2010). Professional practice models are more holistic than these nursing models because in addition to articulating nursing practice, they incorporate organizational, community, and system elements. The professional practice model therefore may hold promise in reducing some of the barriers to PHN practice, through clarification of roles and responsibilities at the organization level.

Findings from this study indicate that PHNs found it difficult to articulate their practice. The reasons nurses may find it difficult to describe their practice, and the theory behind it, may be linked to historical factors. Fawcett (2013) postulated that the clinical focus in nursing may be a desire to emulate medicine, with the perspective that nursing practice would be more highly valued. Alternately she suggested that "many nurses feel so oppressed by physicians that they, like virtually all oppressed persons, have a disdain for the science of their own discipline and identify with the science of the perceived oppressor" (Fawcett, 2013, p. 39). Another Canadian nursing scholar stated that nurses have been silenced by the "individualistic orientation of the healthcare system underpinned by a biomedical model and physician dominance, and a corporate model of healthcare focused on minimizing costs and protecting corporate interests" (Canam, 2012, p. 65). Canam postulates that relational knowledge has been routinely discounted or ignored in health care decisions, decreasing legitimacy and confidence in nursing practice.

Creating improvements in nursing practice environments is fundamental to advancing the profession as well as the science of nursing practice (Ives Erickson, 2011). The professional practice model has the potential to improve the nursing environment in the WRHA by clarifying the PHN role, scope and function. PHNs should continue to value and advocate for their practice, using the professional practice model. Lack of understanding regarding a holistic client centred perspective by the dominant organizational structures, has contributed to nurses' perceptions that their role is less important (Canam, 2012). Nursing practice has to value the caring processes and interventions over tasks, if client care is to be holistic and the professional is to remain satisfying and future oriented (Drenkard, 2008). Canadian authors have commented on the power that medical officers of health hold in influencing PHN scope and practice (Falk-Rafael & Betker, 2012a). Nurses must consider alternate perspectives in providing care that are not based on bio-medical approaches or dominant world views (Arnold & Bruce, 2013). It is critical that PHNs in the WRHA understand the history and influence that bio-medical and organizational approaches have had on their practice. This involves increased awareness of gender and social issues that continue to be relevant to PHN practice.

It is essential that PHNs in the WRHA continue to highlight the importance of equity and early childhood development. The lack of clarity regarding their practice, and perhaps lack of voice, essentially resulted in the erosion of a population-based PHN approach. A key consideration is awareness of other health and social service providers, and how the full scope of PHN practice complements and works in collaboration with others. The inquest into the death of Phoenix Sinclair recommends that there be universal and targeted services to support families and reduce the likelihood for child maltreatment and removal (Hughes, 2013). PHNs play important roles in the provision of both universal and targeted programs, and working in

collaboration to foster healthy early childhood development. PHNs in the WRHA can be deliberate in the approaches to healthy child development, by basing their practice on epidemiological and research evidence.

Findings from this study indicate that the PHN role in addressing the social determinants of health requires further education and development to promote a more consistent and evidence-based approach. In addition, the concept of health promotion continues to be misunderstood by PHNs, and impacted by dominant biomedical approaches (Coscrato & Bueno, 2013). For PHNs to address the determinants of health, they require knowledge and skills, and a supportive organizational culture that places value on collaborative and intersectoral approaches (Community Health Nurses of Canada, 2013b). The development of PHN leadership skills for policy development and advocacy are critical in promoting professional practice and ultimately improving community health outcomes (Jones & Smith, 2014). PHNs in the WRHA can utilize the professional practice model as the framework for a population based PHN practice, with a focus on health equity and early childhood development. PHNs can continue to reflect, discuss, and question their practice, striving for PHN and organizational approaches that are more consistent and evidence-based.

The professional practice model could serve as a framework to begin to develop PHN-sensitive indicators. Indicators that reflect the complexity of PHN practice should be implemented in the WRHA. Increased understanding of factors which define nursing services is useful in beginning to understand the contribution that nurses make to health outcomes (Dubois, D'Amour, Tchouaket, Rivard, Clarke, & Blais, 2012). Nursing interventions have to be explicit and measurable (Meyer & O'Brien-Pallas, 2010). A practice that is based on and measures PHN competencies, promotes effectiveness (Poulton, 2009). Given the invisibility and lack of

understanding regarding the PHN role, it must be better defined and measurable. PHNs must be prepared to change their practice, and must feel that methods of evaluating nursing practice are relevant (Poulton, 2009).

Canadian PHNs have described the relevance of being included in how their role and practice is being shaped (Schofield et al., 2011). PHNs in the WRHA can use the professional practice model to continue to define processes for communication and decision-making in the organization. In addition to creating efficiencies, the clear articulation of nurses roles and responsibilities optimizes collaboration and coordination of care, and assists in communicating one's role to clients and other providers (Cody, 2013b; Hedges, Nichols, & Filoteo, 2012). Donohue-Porter (2012) argues that to strengthen professional practice models, nurses must display confidence, understanding, and scholarly skills regarding their role in shared leadership (Donohue-Porter, 2012). The author suggests nurses can incorporate curiosity, reflection, evaluation, and creativity to their practice. Critical analysis through reflection contributes to personal growth, enhanced emotional intelligence, and ultimately transformation (Sherwood & Horton-Deutsch, 2008). PHNs can continue to use the leadership skills developed, as they move forward creating improvements and actualizing their practice based on the professional practice model.

Given the positive associations with professional practice models in the literature, it is relevant to mention that one study reported a statistically significant negative relationship between hospital nurses' satisfaction and their practice environment, 10 months after the introduction of a professional practice model (McGlynn, Griffin, Donahue, & Fitzpatrick, 2012). The authors postulated the nurses had increased awareness of factors associated with dissatisfaction after the introduction of the model, citing the complexity associated with

workplace satisfaction. The model was developed using a shared governance approach, however the authors described 8-hour programs of study to explain the model, how to sustain it, and the rationale. Based on the implementation process described, one wonders if the model was perceived as a top-down initiative, and buy-in was not developed among the nurses studied. Professional practice models may require assessment of nursing capacity, and scholarly skills may benefit from development (Donohue-Porter, 2012).

Implications for research. Action research methods are innovative approaches that challenge the status quo (Elliott, 2011). In nursing, action research extends beyond the production of knowledge, to creating interventions with potential to improve clinical practice and create change (Holloway & Wheeler, 2010; Streubert & Carpenter, 2011b). The depth of research is enhanced as professionals draw on their education and experience to develop solutions to difficult and ongoing issues (Stringer & Dwyer, 2005). There is opportunity to build capacity, develop trust, and foster engagement that assists in identifying and articulating local knowledge that may otherwise remain buried (Elliott, 2011). For these reasons, participatory and other action research methods should be recognized as important modalities in nursing research, and continue to be explored.

There are multiple research implications and unanswered questions stemming from the findings of this study. The data were collected using qualitative methods with the RWG. It would be interesting to undertake research with the secondary and tertiary participants, to understand their perceptions of the professional practice model and the participatory action research process, particularly the extent they felt included. The RWG provided rich data, however it is possible that secondary and tertiary participants may have provided additional or varied information. Interviews with leaders regarding their perception of the professional

practice model would also be useful. This could involve managers and directors, nursing leaders such as clinical nurse specialists, and inter-disciplinary staff such as medical officers of health. The professional practice model could also be used as a framework to explore how clients and other health professionals understand the PHN role. Additional research would be amenable to both qualitative and quantitative approaches.

The primary aim of this study was to develop a service delivery model. Findings indicated that both the participatory action research process and the development of the professional practice model were positive. The interactive and reflective group process that generated the professional practice model consisted of open dialogue, refinement, and co-construction of the data (Genat, 2009). Other research could explore the tenets of collaboration and group process leading to a successful outcome. The RWG was pleased with the length of time to develop the professional practice model, and did not want to extend the process. The time is likely dependent on multiple issues, but it would be interesting to know if there are minimum and maximum periods that influence outcomes.

One of the outstanding issues in this study was a recommendation for a consistent PHN approach to practice, for example neighborhood or referral systems. Different approaches exist across Canada. However a paucity of models and theories to guide PHN practice has contributed to lack of PHN role clarity (Bigbee & Issel, 2012). There is a need to quantify PHN work in the WRHA, as well as to define workload. One aspect is equality among PHNs, but the more important issue is to determine adequate staffing and numbers of PHNs. Given the lack of role clarity and purpose, understanding and determining workforce capacity is clearly a research priority. The professional practice model and service delivery components of the model could be used as a framework to begin this analysis. An optimal delivery model is client centred, cost

effective, and the outcomes associated with each component can be replicated (Ives Erickson & Ditomassi, 2011). A similar definition describes care models as a configuration of resources, processes, and organizational attributes necessary for the delivery of nursing care (Dubois et al., 2012). The professional practice model provided an overall framework to define the expectation for PHN practice activities, and methods for allocation of resources could be developed. A priority to advance nursing knowledge must be identification of activities and structures, that serve as the basis for practice (Schlotfeldt, 1989).

It would be interesting to evaluate the implementation process associated with the professional practice model in the WRHA. Next steps include operationalization and a critical examination of all PHN program activities using the professional practice model lens, including a recommendation on the neighborhood model. It would be helpful to learn about the effectiveness of the professional practice model in supporting PHNs to work their full scope, as outlined in their position description. A professional practice model articulates the functions of PHN practice, based on multiple nursing theories (Mensik, 2013). The WRHA PHN professional practice model is based on Canadian documents articulating the PHN role. It would therefore be interesting to understand the extent that the professional practice model promotes evidence based practice. Measures of PHN activity is an obvious gap, yet indicators have to capture the depth of the PHN role. Is there a way to assess the PHN role in population health promotion? It would be interesting to explore the issue of moral distress among PHNs, building on the tension created from individual/population focus, as well as the organizational context. It would be interesting to explore the professional practice model outside of the WRHA to determine is applicability in other Canadian contexts, and the extent it explains and predicts PHN practice.

While the outcome of action research studies may not be generalizable, there may be opportunity for theory development (Streubert & Carpenter, 2011b). A theoretical perspective links the goals, scope, and outcomes of nursing practice; creating actions that are purposeful rather than random or based on intuition (McEwen, 2011). Theory provides a framework and language to communicate the unique contributions of nurses to healthcare systems, articulating the rationale for the nurse-client relationship (Gottlieb, 2013; Mitchell et al., 2013). Findings from this study support the value of relationships in PHN practice. PHNs have in-depth knowledge of clients' lives and the multitude of factors that contribute to their health and well-being (Hemingway, Aarts, Koskinen, Campbell, & Chasse, 2013). Scientific knowledge in nursing practice values client wholeness, describing how nurses assists clients to thrive in a healthcare environment entrenched in hostility, hierarchies, and history (Mitchell et al., 2013; Phillips, 2013).

Implications for administration. The findings of this study have a number of implications for nursing leaders in the WRHA and other public health programs. The RWG expressed frustration with their PHN role, which has potential to lead to unsatisfactory work environments. The workplace is essential in not only meeting economic needs, but also in promoting nurses' social, mental, and physical health (Tomey, 2009). Leaders play a significant role in creating the context for nursing work, and promoting a culture that recognizes and communicates the value and autonomy of nursing practice, ultimately contributing to a healthy, productive and satisfied workforce (Sherwood & Horton-Deutsch, 2008). First steps have been taken in the WRHA with the structure for the nursing practice council and the development of a professional practice model. These are two of the necessary components for high quality nursing

practice environments outlined in the literature (Tinkham, 2013). However, there is considerable work left to do.

Administrators can initiate and support operationalization of the professional practice model. The creation of a common vision, clearly identified goals and responsibilities promotes understanding of the nursing role and enhances organizational efficiency (Underwood, Mowat, Meagher-Stewart, Deber, Baumann, MacDonald et al., 2009). Findings from this study indicate that PHNs are passionate about the role, but want to reorient their practice to function to their full scope. The professional practice model is consistent with a range of organizational documents, but PHNs require support for the professional practice model to be fully actualized. PHNs in the WRHA must be supported to work to full scope of competencies, and PHN practice must evolve to meet public needs and emerging demands (Community Health Nurses of Canada, 2011a; Schofield et al., 2011). Dangers have been associated with reflection in nursing, when nurses do not have the ability to foster change (Bulman & Schutz, 2013). Organizational structures must be established that support innovative nursing practice, and respect nursing knowledge and skills (Mitchell et al., 2013). Nursing leaders in the WRHA could utilize principles of shared governance, transformational leadership, and inter-professional collaboration, in supporting the professional practice model implementation.

Nursing leaders in the WRHA could be educated regarding principles of transformational leadership. Transformational leaders are skilled in professional practice and clinical expertise, as well as communication. They are able to influence others, and assume a leadership role as the need arises (Messmer & Turkel, 2011). In hiring new leaders, the WRHA could aim to hire individuals with this background, or alternately support leaders in skill development. Leaders

should be knowledgeable role models who advocate for a coherent vision in delivering nursing services, displaying transformational leadership competencies (Messmer & Turkel, 2011).

The WRHA can develop structures that provide greater PHN input. A strong organization promotes a professional practice environment in which nursing input flourishes, creating improved relationships and organizational processes as a result (Tinkham, 2013). The responsibility of management is to foster nursing excellence by creating links and partnerships through the facilitation of "connections both horizontally and vertically in the organizational hierarchy" (George & Lovering, 2013, p. 54). Based on the significant role that management approaches have on PHN practice, their engagement, awareness of leadership competencies, and inclusion in the attainment of full scope of PHN practice is significant and should be examined from the organizational level. Particularly, the concept of PHN and nursing practice council decision-making should be clarified.

Nursing leaders in the WRHA should foster shared governance and decision-making at all organizational levels. Healthcare structures reported as excellent "were perceived to be flat with decentralized nursing departments that had strong nursing representation in the organization" (Tomey, 2009). The nursing practice council is one structure that provides a venue for PHN input and attempts to flatten organizational hierarchies. This approach and the functioning of nursing practice council should continue to be supported. Perhaps the organization could consult with PHN's to determine the extent that staff believes nursing practice council is effective. WRHA administrators could revisit terms of reference for nursing practice council, and ensure their clarity. Shared governance must be founded on principles of accountability and collaboration that are clearly articulated (Marshall, 2011).

Findings from this study indicate that PHNs want to be more involved in decisions that affect their practice. Work that is led by staff using a collaborative strength based approach to practice decisions is more likely to reduce system costs, increase efficiency, and improve nurse satisfaction (Shendell-Falik, Ide, Mohr, Laliberte, & De Guerre, 2012). The WRHA should seek to engage PHN input at all organizational levels, and include PHNs as equal partners with professional content expertise. Governance structures must embody shared decision-making between direct care staff and management, and challenge organizational hierarchies by acknowledging, respecting, and trusting the unique content expertise of nurses (George & Lovering, 2013; Leclerc & Lavoie-Tremblay, 2007).

The WRHA could continue to promote inter-professional collaboration and education among PHNs, as well as others working within public health programs. There is evidence that collaboration and satisfaction among providers improves with education and training (Fleet et al., 2008). The WRHA has developed a toolkit to promote collaboration. The Population & Public Health Program could explore staff knowledge and understanding, as well as develop program specific policies and recommendations. Inter-professional collaboration benefits from organizational policies and structures that are in line with overarching program goals (Banks et al., 2008; D'Amour et al., 2005; Fawcett et al., 2010; Fleet et al., 2008; Hicks et al., 2008; Moran, Jacobs, Bunn, & Bifulco, 2007; Young, 2009). Clearly outlined roles and responsibilities; regular reviews of protocols; and formal mechanisms for documentation of communication and assessments, optimize collaboration and coordination of care (Cody, 2013b; Hedges et al., 2012; Murphy, Shardlow, Davis, Race, Johnson, & Long, 2006).

Developing competencies for inter-professional collaboration among WRHA PHN managers is key. Leaders can promote inter-professional collaboration through team building and

service coordination, but require education to develop competencies that include fostering skills in staff (Feng et al., 2010; Umble, Steffen, Porter, Miller, Hummer-McLaughlin, Lowman, & Zelt, 2005; Whiting, Scammell, & Bifulco, 2008). Managers also benefit from skills in team dynamics and facilitating communication in teams, across departments and organizations (Claiborne & Lawson, 2005; Reeves et al., 2010). There is no single approach; team-building activities must be specific to those involved (Andreatta, 2010). The WRHA could identify competencies, and seek out leaders with specific skills. Leaders must value innovation and risk-taking; possess a high degree of credibility and influence; and possess interpersonal skills that allows them to negotiate ambiguity, tension, and turf issues (Horwath & Morrison, 2007).

Role clarity is essential in high functioning collaborative teams. The WRHA would benefit from clarifying roles and responsibilities as it pertains to PHN practice, accountability, and decision-making. There are a variety of leadership models in Canadian healthcare. A recent Canadian study reported that managers were key individuals in promoting evidence based practice (Yousefi-Nooraie et al., 2014). Findings from this study indicated that managers in the WRHA lacked understanding of the PHN role. Managers in the WRHA should be clear regarding their responsibility for evidence based practice. Public health managers should utilize the professional with the formal position description in the organization best suited to this role (Yousefi-Nooraie et al., 2014). Clinical nurse specialists have been utilized in transforming work environments through support and mentorship, knowledge of evidence and quality, and enhancing inter-professional collaboration (Walker, Urden, & Moody, 2009).

Organizations must expect professional practice by PHNs, but also develop environments to support professional practice (Mensik, 2013). A clearly articulated organizational structure outlining opportunities for formal and informal recognition and rewards can promote employee

motivation. The WRHA should develop a transparent structure to highlight formal and informal PHN practices, consistent with the professional practice model recommendations. The formal structure could include development of a theoretical perspective that links organizational goals, scope, and the outcomes of nursing practice (McEwen, 2011). For instance a plan for assessing, analyzing, and improving clinical and operational outcomes sensitive to PHN influence could be developed (Messmer & Turkel, 2011). The WRHA could also use the professional practice model as a framework to develop orientation and professional development opportunities.

Successful organizations support nurses ongoing personal and professional growth by creating learning environments that offer and value ongoing education, certification, and career development (Messmer & Turkel, 2011; Tomey, 2009). A strength-based approach to professional practice optimizes the nursing role, and builds on what is important to individuals, teams, and systems (Gottlieb, Gottlieb, & Shamian, 2012). Informal opportunities can also be created. Findings from this study highlight the importance that these PHNs placed on recognition. As a female dominated profession, nurses typically feel uncomfortable with recognition and fail to highlight their accomplishments, which can result in feeling undervalued (Daggett, 2014). Informal methods to engage staff may include reinforcement through public recognition (Fawcett et al., 2010). This could include recognition at team levels, as well as at annual staff development sessions. Leaders should acknowledge PHN contributions, and provide support for the PHN role within the organization (Meagher-Stewart et al., 2010). These expectations could be made explicit within the Population & Public Health Program.

Lastly, the issue of workload has to be addressed for PHNs in the WRHA. Administrators are accountable to maintain nursing practice environments through provision of adequate resources and supports (Messmer & Turkel, 2011). One suggestion is to utilize the professional

practice model and to collaborate with PHNs in developing a tool to estimate PHN workload. PHNs do not feel that current measures are valid or represent the complexity of their work. In Ireland, estimating the acuity of clients on PHN caseloads assisted in the more equitable distribution of PHN resources (McDonald et al., 2013). In estimates of workload, the PHN role in promoting health equity has to be considered. Equity must be an explicit goal, with standards to serve as benchmarks for service expectations for public health action (National Collaborating Centre for Determinants of Health, 2011).

Organizational capacity to promote equity can be developed by increasing training opportunities in areas of advocacy, intersectoral partnerships, and program evaluation (Gore & Kothari, 2013). Leaders knowledgeable regarding public health are necessary to act as champions to move forward the agenda required in addressing the social determinants of health and implementing actions to create equity (National Collaborating Centre for Determinants of Health, 2011). Findings from this study indicated that PHNs spoke of value, time, measures, and adequate resources to engage in equity work. Clear and consistent messaging and support will be required to attain this goal. This requires building leadership skills among staff in working collaboratively with governments and other sectors and agencies (National Collaborating Centre for Determinants of Health, 2011).

Implications for policy. There are a number of policy implications related to this study. The first policies that have to be considered are within the WRHA. While the WRHA has a number of policy documents supporting full PHN scope of practice, findings from this study indicate this has not been possible in practice. Policies should be amended to support the professional practice model, and allow for greater PHN autonomy and consistency with the Nurse IV role. Programs and standards must build on professional regulations and allow PHNs to

practice to their full scope (Poulton, 2009). All WRHA PHN programs and policies require review, using the professional practice model lens. Stringent policies will continue to promote a task-based approach where PHNs practice in silos. It is critical to involve PHNs in policy decisions affecting their practice.

A key area for policy development is greater clarity of the PHN in early postpartum discharge. Current PHN practice is driven by postpartum discharges; however, universal postpartum and breastfeeding care is not the most appropriate use of the PHN role. What should the PHN role be in providing individual level clinical care and education? Policies could be established for inter-professional collaboration and communication, to assist providers in the WRHA in working more efficiently and effectively. Given government election promises to increase the number of primary care providers in Manitoba, how should PHNs be working collaboratively within this system? Focusing data generation on client and population level indicators rather than PHN tasks/ activities has been reported to optimize the PHN role and to provide infrastructure that supports management in guiding practice (McDonald et al., 2013).

Findings from this study challenge PHNs and the organization to consider how the information obtained from the Families First screen is utilized in PHN practice. Building on existing policies, PHNs could utilize the Families First screen and parent survey information collected for Healthy Child Manitoba to assist in decisions regarding PHN interventions. An extremely simplistic approach could be for PHNs to build individual capacity among families who screen negative, by providing information about group and community level interventions. For these low-risk families, the PHN could work in collaboration with other health services, referring the family back to their primary care provider and/or to breastfeeding clinics based on

need. For families screening positive, completion of the parent survey process would provide greater depth of information to determine ongoing PHN strategies.

PHNs can assist organizations and governments to consider policies that promote social justice (Ivanov & Oden, 2013). Nurses must recognize and assume a leadership role in challenging the social structures that contribute to inequities in both policy and practice (Pauly, 2013). When finite resources are challenged by competing demands and complex needs, theories of social justice and ethics should guide PHN decision-making processes (Ivanov & Oden, 2013). This is particularly relevant for policies directing PHN practice with individual clients in the WRHA. While health promotion is identified as a solution to the current healthcare crisis, a biomedical perspective continues to prevail, with a disproportionate focus on illness and healthcare (Schofield et al., 2011). PHNs must advocate for policies, health system reform, and collaborative efforts that will improve the health of Canadians (Community Health Nurses of Canada, 2011a). Policy analysis and advocacy to create improvements in areas such as education, child development, and nutrition, will contribute to population health improvements (Honoré et al., 2011). PHNs are ideally positioned, and can continue to bring forward social injustices they observe in practice and advocate for change.

Canada would benefit from policies that promote healthy early childhood development, particularly those that create strong relationships and environments to support children to grow (Williams et al., 2013). The inclusion of equity and equity indicators in public health work has been a growing trend in Canada, with the recognition that this is the priority of public health work (National Collaborating Centre for Determinants of Health, 2011). Policies and programs in the WRHA must continue to build on the professional practice model and equity initiatives to establish indicators. Gaps will continue to widen by the unequal distribution of power, resources,

and public health interventions (National Collaborating Centre for Determinants of Health, 2011). PHNs require a greater understanding of their role in advocating for policy changes that promote equity (Cohen & McKay, 2010). It is critical that PHNs are aware of the importance of equity and early childhood development to intervene with families directly, but they must also be active in advocating for policy changes at all levels of government based on their direct knowledge of the communities.

Implications for education. The findings of this study raise considerations regarding nursing education. To begin with, PHNs value the full scope of their generalist practice and Nurse IV role. Students should be exposed to the passion and enthusiasm associated with the PHN role, as well as the complexity and depth. Students should understand the principles of a population-based practice, and the competing demands that individual clinical care creates. Students would benefit from a detailed understanding of community concepts, particularly health promotion and health equity, since findings from this and other Canadian studies indicate that experienced PHNs are not clear on these meanings and implications for practice. This requires that students are able to understand and apply the competencies, which define PHN practice as a unique nursing specialty (Schoneman, Simandl, Hansen, & Garrett, 2013).

Students require education regarding health equity and early childhood development. Promoting equity and addressing the social determinants of health are complex concepts, but in my opinion, a distinguishing feature of the PHN role. Authors of a recent study highly recommend students develop an understanding of population health and social determinants, as well as skills in advocacy and facilitating community change (Jones & Smith, 2014) Understanding these concepts is important for all areas of nursing, since failing to address root

causes of illness will continue to perpetuate inequities. Nurses have the largest numbers of the health professionals, and must leverage the associated power and benefits that should imply.

Students would benefit from awareness of concepts of inter-professional collaboration in PHN practice settings. The trend towards teamwork has promoted models of inter-disciplinary education. The basis of well-functioning collaborative teams however, is a strong foundation in one's own discipline and the ability to articulate discipline specific knowledge. Findings from this study indicated that PHNs had difficulty articulating their role and were not always clear about their function in working collaboratively with community partners. For PHNs to be active participants, they must graduate from baccalaureate programs with a strong theoretical foundation in public health nursing. This requires understanding of similarities and differences between different types and models of nursing care.

Public health practice is extremely complex. For this reason in many countries, with the exception of Canada and Finland, entry level requirements for PHN practice includes additional specialist education (Hemingway et al., 2013). Nursing curricula could place greater emphasis on PHN practice in baccalaureate programs, and in creating graduate level leaders (Community Health Nurses of Canada, 2011a). The creation of public health as nursing specialization within regulatory bodies has been suggested (Poulton, 2009). Another option is specialized education programs in Canada for public health/community health nurses. This could include specialized streams within existing undergraduate curriculum, post-baccalaureate certificate programs, or graduate education programs specific to community health. There is a lack of consistency in education programs to prepare nurses to work in the field of public health (Hemingway et al., 2013). Currently the Canadian Nurses Association offers certification in community health nursing. Nursing education programs could build on the program of certification, as well as

support/ entice staff to obtain certification. For students, case-based scenarios that portray the complexity of PHN practice may be helpful, especially promoting understanding of contrasts pertaining to clinical/bio-medical issues encountered in acute care settings (Sarsfield, 2013).

Findings from this study highlight the impact that organizations have on PHN practice. Students can be educated to understand organizational and government structures, and their impact on nurses and nursing practice. Greater understanding of workforce issues and professional practice environments may assist nurses in recognizing and addressing negative organizational and bio-medical influences. Students can learn to be politically active, and to identify methods by which nurses can have greater influence as a profession. Nurses not only have to advocate for the clients, but have to be strong advocates for the profession.

Conclusion

This study had two main research objectives. The first was to develop a model to support PHNs in an urban Canadian health region to practice to full scope, especially promoting early childhood development and equity. Despite being a wealthy country, substantial health inequities exist in Canada. Compared to other provinces, Manitoba has tremendous work to do to optimize the health of its citizens, particularly for individuals of Indigenous culture. Pregnancy and the early childhood are critical times to address these inequities and to create positive health trajectories, contributing to population health improvements. While ideally situated, multiple barriers prevented PHNs in the WRHA from maximizing this potential.

The outcome of this study was development of a professional practice model. The model was theoretically based and provided a common framework and language to articulate the full scope of the PHN role with a greater focus on population health and equity. Using this new lens, study participants described shifts in their practice from an individual clinical perspective to one

that was population based and focused on equity. Development of the professional practice model is the first step in reorienting PHN practice in the WRHA to be consistent with the role depicted in theory.

The second study objective was to explore the utility of participatory action research in developing the model. This was the first participatory action research study with PHNs in Canada. The participatory action process enabled a long-standing and complex organizational initiative to be resolved. It contributed to PHN leadership, empowerment, and consciousness-raising. Ultimately, the RWG hopes that the professional practice model will shape PHN practice at all levels of the organization, contributing to practice improvements and enhanced client outcomes. While the approach was non-traditional, it was effective and should continue to be explored. Research that bridges the gap between theory and practice, appreciating the context of nursing within complex bureaucracies, will articulate the unique value of the profession.

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Appendices

Appendix A: Chronological overview of action research process and methods

The table below is a chronological summary of events and relevant documents. It describes the main issue, associated documents, and communication within the organization. History prior to ethics approval is included to increase awareness of the action research progression.

Date	Event	Summary	Relevant Document/s	To teams	Comments
2006	Original issue brought to nursing practice council	PHN request for clarification on service delivery model	Issue paper	Yes	Identified that PHN teams functioned differently; some were geographically based while others used a referral system.
Aug-07	Staff survey	Following an electronic survey, a summary document was developed that contained recommendations.	Summary document	Yes	A recurrent theme was the need to better articulate the PHN role and to determine PHN priorities. There was a dominant theme that more resources were needed, which wasn't realistic in the fiscal environment.
2008	Explored research options	Some working group meetings took place, but the issue failed to move forward	DVD on appreciative inquiry was circulated	Yes	Explored option of using an appreciative inquiry approach, supported by WRHA research and evaluation unit
2010-2011	Ongoing teleconferences	The service delivery model was the only outstanding issue at nursing practice council. The co-chairs continued to raise this in meetings with the director. The director felt unable to move forward since the 2007 survey had elicited feedback from PHNs that more resources were needed.		N/A	During these discussions, I began to explore how this issue could be addressed as a component of my PhD dissertation. My course work on program evaluation and knowledge translation, in addition to my lead clinical nurse specialist responsibilities with nursing practice council, assisted me in recognizing that for plausible solutions and effective change, the end users should be involved at the outset. I reviewed options in the literature, as well as explored the idea within the WRHA and with my PhD advisor.

Date	Event	Summary	Relevant Document/s	To teams	Comments
February 2012	teleconference	At the monthly planning meeting, the nursing practice council co-chairs asked if a working group could be re-established to explore the feasibility of addressing the service delivery model within the context of my PhD research study.		N/A	The director was open to discussion at nursing practice council to determine if the original issue paper was still a concern for PHNs.
February 15, 2012	Bi-monthly working group meeting	Five members agreed to be involved in a working group to discuss the relevance and associated options for a service delivery working group.	nursing practice council minutes	Yes	The group had many questions, but expressed interest in participating in a PhD study, using the standard nursing practice council processes. The group was also interested in learning more about the idea of being co-researchers. Consistent with the nursing practice council structure, two of the PHNs agreed to be co-leads, and to work in collaboration with me as the facilitator.
Apr-12	Bi-monthly working group meeting	Draft action research planning sheet formed the basis for discussions.	Draft action research planning sheet	Yes	I drafted a planning sheet, to outline a potential approach. The group made recommendations that were incorporated and shared with the full nursing practice council at the June meeting.
Jun-12	Bi-monthly working group meeting	A presentation that contained a summary of literature highlighting inequities, the role of PHN, and participatory action research was reviewed	Powerpoint presentation	Yes	RWG asked for presentation to be shared with full nursing practice council and teams.
23-Jul-12	ENREB submission	The first research proposal outline was submitted to University of Manitoba Research Ethics and Compliance Board	U of M Ethics Protocol Submission Form; Fort Garry Campus Research Ethics Board Submission Form	No	

Date	Event	Summary	Relevant Document/s	To teams	Comments
20-Aug-12	ENREB submission	Letter received from Ethics board indicating that reviewers had identified "a number of serious issues," but invited resubmission of the proposal with revisions.	Revised forms above, including a detailed response to address reviewer comments	No	The biggest concerns pertained to the study being conducted in the workplace, and participants not being able to opt out and anonymous, and being potentially vulnerable to the employer. Revisions to the proposal were resubmitted.
19-Sep-12	Bi-monthly working group meeting	It was decided that the group should develop a draft "presentation" that would be presented to nursing practice council reps in October, summarizing the group's work, time line, consent process	Action research planning sheet, summary Sept working group minutes, updated PP presentation.	Yes	The group felt it was necessary to provide each rep with a presentation to take to their teams so that the process was explained consistently. The research project spoke to the importance of this work to PHN practice. (meeting minutes)
25-Sep-12	ENREB updated submission	U of M approval for study to proceed was received	Letter of approval from Uof M REB	N/A	U of M process completed, next step was to gain permission from the WRHA Research Review Unit
04-Sep-12	WRHA request for expedited review	A request for expedited review and approval was submitted	WRHA Research Application Form, Updated ENREB application forms, Director Letter of Support	N/A	
19-Oct-12	WRHA Research Review	WRHA approval for study to proceed was received	Letter of approval from WRHA Research Access	N/A	WRHA requested the Agreement for the protection of personal information and personal health information for research purposes be signed and submitted.

DATA COLLECTION BEGINS					
Date	**Event**	**Summary**	**Relevant Document/s**	**To teams**	**Comments**
22-Oct-12	E-mail to nursing practice council reps	Consent forms were e-mailed to the reps by the administrative assistant to nursing practice council	Primary, secondary, tertiary consents, letter of invitation, demographic form	Yes	To promote anonymity, PHNs were advised that they could leave the consent blank or sign indicating their agreement, and return the consents to the researcher in a closed envelope via IDM
21-Nov 12	1st RWG - 3401 Roblin	**Goal:** To understand the perspective of PHNs regarding their current practice and opportunities for improvement. All participants consented to recording meetings for purpose of collecting data.	RWG discussion guide, Action research planning sheet, Sept working group minutes, Updated participatory action research PowerPoint presentation	Yes	The RWG wanted the teams to engage in the same discussions they had, regarding the organization of current services, what was important and moving forward.
Jan-13	2nd RWG - 3401 Roblin	**Goal:** To agree to project goals and identify concepts for a PHN service model. The RWG reviewed summaries of the Nov meeting, as well as other documents to begin brainstorming options for a service delivery model.	RWG Agenda; WRHA Position Statement on Health Equity; PHN position statement; Population & Public Health conceptual model; Community Health Nurses of Canada standards and competencies; Canadian Public Health Association roles and activities; RNAO PHN sensitive quality indicators; Summaries of Nov RWG	Yes	The agenda identified goals to keep the RWG moving forward and to stimulate discussion regarding potential options for a service delivery model. Since the process was emergent ,the group did not have an idea of what the outcome would be. I wanted to assist the group to expand their thinking as well as meet the project goals and timelines that were set out. It is during this component of the process that documents intended to enrich the process were added.

Date	Event	Summary	Relevant Document/s	To teams	Comments
20-Mar-13	3rd RWG - 3401 Roblin	**Goal:** To develop a PHN practice model; 1. Review and agree to goals, objectives, and priorities for the project; increase understanding of concepts, begin to develop an action plan	Draft Action Plan for RWG; Feedback from PHN teams on participatory action research summary; March Agenda; Thirteen readings to assist discussion	No	The readings were divided so that the full group had 3 documents, and each person had 2 additional articles – one related to theory of practice models and one specific to PHN practice. The group started with a round table for each person to report key features of their assigned articles. After contributing as individuals, the discussion was opened up for the group. The RWG shared observations about how assigned readings fit with the readings for the full group and identified unresolved questions regarding the overall working group process.
04-Apr-13	4th RWG 755 Portage	**Goal:** Participants used feedback from teams that was categorized using the Population & Public Health conceptual framework headings.	Compiled feedback from 12 CA teams, Population & Public Health Conceptual framework; Canadian PHN Text Stamler & Yiu, 2012	No	The intent was to keep exact wording as much as possible, and to categorize the information using the Population & Public Health conceptual headings. Once all the information was accounted for, as a group we started to collapse the data and to develop common themes/ language.
25-Apr-13	5th RWG 755 Portage	**Goal:** To continue to develop the plan for a PHN practice model. Review and agree to goals, objectives, and priorities;-	Compiled work from April 4; Draft action plan incorporating feedback from Apr 4 session and beginning to outline a professional practice model; agenda	No	Reflected on the draft report and if team feedback was incorporated. Started to develop an action plan, starting with the highest priority and to identify actions to resolve the issue. Discussed need to meet with director of PH.
15-May-13	6th RWG - 3401 Roblin	**Goal:** To get group feedback on the model and prepare for the meeting with the director	Action Plan; Community Health Nurses of Canada professional practice model graphic; agenda continued from previous RWG; draft agenda for meeting with director	Yes	A meeting was scheduled with the director of the public health. The PHNs want to highlight the energy this project has created.

Date	Event	Summary	Relevant Document/s	To teams	Comments
May 6 and June 24	Meetings with program director	The RWG had 2 - one hour meetings with the director to advise of status of the professional practice model	draft agenda	Yes	RWG meeting May 6, 2013 with program director. The RWG took the lead in coordinating a message for the director in preparation for the meeting, doing an agenda, chairing and recording minutes from the meeting.
19-Jun-13	Monthly meeting	The RWG facilitated discussion about the professional practice model	Draft professional practice model	Yes	Draft was distributed and discussed at the June nursing practice council meeting. The RWG led the discussion, and while there was positive feedback there was also some apprehension expressed by some members regarding the impact on current services. In particular, there was inconsistent understanding of equity and implications for current practice.
03-Jul-13	7th RWG - 2735 Pembina	Final RWG to debrief the research process and the professional practice model	Process/outcome evaluation questionnaire	No	This was the final wrap up for the research component. Completing this aspect of the work and finalizing the professional practice model document is a success associated with the nursing practice council s. The next component of the project involves implementation and continuing to build and move forward what has been outlined.
DATA COLLECTION COMPLETE					

Appendix B: April Working Group - Draft Action Research Planning Sheet

Adapted from Koshy et al. (2011)

This action research planning sheet provided the initial basis for discussions with the working group, nursing practice council, and teams. It was updated to incorporate RWG feedback, and distributed to elicit discussion and interest in proceeding with the project.

---

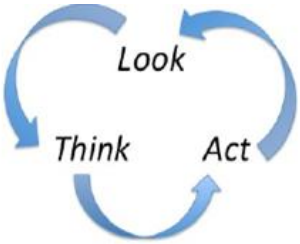
1. **The topic is:** The Public Health Nurse (PHN) service delivery model

2. **Why do we want to do research on this topic?** An issue paper was submitted to nursing practice council in 2006 identifying that teams functioned differently; some were geographically based while others used a referral system. In 2007, recommendations were provided by PHNs. A recurrent theme was the need to articulate the PHN role within the generalist model, and to establish PHN priorities based on existing programs and funding. An appreciative inquiry approach was initiated in 2008, but to date the issue paper has remained unresolved. The nursing practice council agreed this issue remains important and a working group was reconvened in February2012.

3. **The working title of the project will be**: PHN service delivery: Development of a new model using participatory action research

4. **The study will focus on:** The theory and science that informs public health, to guide the development of a PHN model with a focus on healthy early childhood development and equity.

5. **The study will be based on the following principles:**
   - Utilize a participatory action research approach. Action research is a systematic method of investigation that assists groups to develop meaningful solutions to concerns that most affect them(Stringer, 2007). In health care, action research has become increasingly popular as a strategy to improve organizations, practice, and client care (Bellman, 2012a; Koshy et al., 2011; Williamson, 2012a). In the UK, governments are promoting its' use, based on successes in creating system change and implementing evidence based practice (Bellman, 2012a; Sharp, 2005). This project will utilize the participatory action research approach outlined by Koch & Kralik (Koch & Kralik, 2006), who are community based researchers, using the cycle below.



- Project leadership will be based on the existing nursing practice council structure. Using this process, working group co-chairs, the researcher and participants, will work in partnership to define the issue, collect and analyze data, and to develop an action plan. This group will be known as the research working group (RWG). As per routine nursing practice council functioning, the RWG will incorporate feedback from nursing practice council and teams (Appendix I). The topic will be a monthly nursing practice council and team agenda item for discussion. Participants reflect and increase awareness of practice through a reciprocal and collaborative process.
- Consistent with WRHA mission/vision and Population & Public Health program direction.
- Promote innovative and creative solutions that are achievable within existing resources. The process of increasing awareness and contemplating actions generates alternative practice options.
- Evidence informed – incorporating research and theory from public and nursing sciences; as well as local and regional health data. The literature recommends an approach which is:
    - Client centred
    - Recognizes the importance of healthy early childhood development
    - Promotes equity across social gradients
    - Fosters inter-professional collaboration
    - Encourages PHN practice that is competency based and full scope

6. **What kind of data should be collected? Why?** Qualitative data will be gathered during five RWG sessions, which will take place during the latter portion of every 2nd nursing practice council meeting. The sessions will take approximately 2 hours and are tentatively planned according to the schedule below:
    a. November – **Problem Identification (Look):** Facilitated working group
    b. January - **Review Data (Think):** Review of themes and concepts identified
    c. March - **Develop Plan (Think):** Develop draft model/ action plan
    d. May – **Evaluation (Act)**: Present draft report and action plan at nursing practice council . Debrief and discuss recommendations for revisions
    e. July - **Debrief:** Working group process/outcome debrief

7. **Possible outcomes of the research include:**
    - Development of a report submitted to the WRHA senior management
    - Development of new strategies for delivering services based on the theory and science of public health nursing and the full scope of PHN practice
    - Identification of actions PHNs could take to promote population health across income gradients
    - Opportunity for PHNs to have input into proposed practice changes
    - Identification of opportunities for PHNs to work more collaboratively within and outside the health sector to impact population level outcomes
    - Greater understanding and integration of research evidence into PHN practice

Appendix C: June Working Group – Development of Objectives

This agenda was used as a guide during the June Working Group meeting. I provided a presentation to assist the discussion.

Agenda

1. PowerPoint Presentation

2. Draft Ground Rules

3. Problem Identification

Draft Ground Rules for discussion

Non-judgemental
Respectful of differing opinions
Not interrupting
Maintaining confidentiality of personal shared information
All questions/comments are important
Accountable for own learning and behavior
Every person has equal opportunity to talk

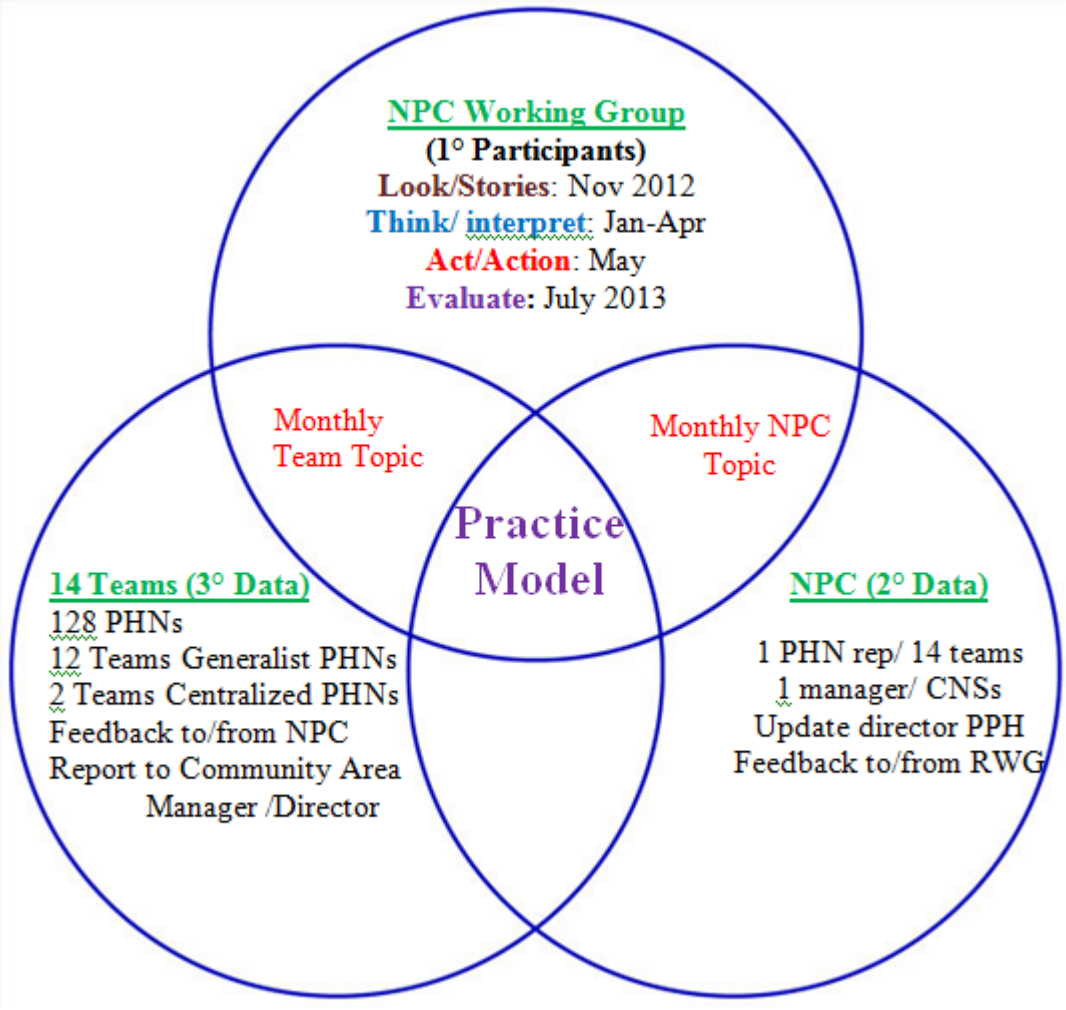
Problem Identification:

Identify 3 or 4 main ideas for the questions below:

1. For myself individually, I hope this project will achieve the following:
2. The team that I represent hopes this project will achieve the following:
3. For the clients and community/population, I hope this project will achieve the following:
4. For the clients and community/population, the team that I represent hopes this project will achieve the following:

Appendix D: Process Overview for Participatory Action Research

The study consisted of primary, secondary, and tertiary participants. The primary participants were PHNs on the nursing practice council who agreed to participate in the RWG. Using the standard structure for working groups, the topic of the practice model was a standing agenda item at monthly nursing practice council and community area team meetings. Although the data for the study was collected at RWG meetings, it may have been influenced by discussions at the nursing practice council and team levels. Therefore, all PHNs were asked if they wished to be included as secondary and tertiary participants in the study. The nursing practice council representatives not participating in the RWG were secondary participants (contributing their team's feedback during nursing practice council discussions, and informing their team of the nursing practice council discussion and perspectives of the other teams), while the non- nursing practice council PHNs from the community teams and centralized teams were tertiary participants (providing feedback to working group documents).



Appendix E: Letter of Invitation

A letter of invitation was sent to tertiary participants.

UNIVERSITY OF MANITOBA

Applied Health Sciences Ph.D. Program

HLHP Research Institute
307 Max Bell
Winnipeg, MB
Canada R3T 2N2
Phone: (204) 474-7493
Fax: (204) 261-4802

You are invited to participate in a research study titled "Public Health Nurse (PHN) service delivery: Development of a new model using participatory action research (PAR)." The Principal Investigator of the study is Cheryl Cusack and her Research Supervisor is Dr. Benita Cohen, RN, PhD from the Faculty of Nursing, University of Manitoba.

This research study is being conducted as part of a doctoral program in Applied Health Sciences at the University of Manitoba. The primary objective is to develop a service delivery model that will support PHNs to practice to their full scope, especially in relation to promoting healthy early childhood development and health equity. The second objective is to explore the effectiveness of a PAR approach in developing a model of practice to clarify the role of PHNs. The risks of participating would be minimal. The benefits of participating may be an opportunity to share ideas about effective PHN practice, as well as to learn more about research processes that could be applicable to PHN practice.

Your participation in this study will be within your PHN staff role, contributing to discussions that may be shared at Nursing Practice Council (NPC) meetings and the NPC Research Working Group (RWG). There will be no compensation given for participation in the study. Using the standard structure for NPC working groups, the topic of the practice model has been and will continue to be a standing agenda item at monthly NPC and community area team meetings. Data will only be collected at the RWG and all names and identifying information (or any individuals' referred to during the interview) will be removed and replaced with pseudonyms to maintain confidentiality. Although the data for the study will only be collected during the RWG, it may be influenced by discussions at the NPC and team levels. Therefore, PHN NPC representatives are invited to be included as secondary participants, and all other PHNs are invited to be tertiary participants in the study. Your decision to take part in this study is fully voluntary, and you can withdraw at any point without impacting your employment status or performance evaluation. Your signed consent if you choose to participate will only be seen by the researcher. If you would like additional information about the study, please contact Cheryl Cusack at ccusack@wrha.mb.ca or 940-1660. Thank-you for considering this invitation.
Sincerely,

Cheryl Cusack, RN., MSN., PhD (C)

Appendix F: Consent Form for Primary Participants

The following consent was used for primary participants.

UNIVERSITY OF MANITOBA

Applied Health Sciences Ph.D. Program

HLHP Research Institute
307 Max Bell
Winnipeg, MB
Canada R3T 2N2
Phone: (204) 474-7493
Fax: (204) 261-4802

Research Project Title: Public Health Nurse (PHN) **s**ervice delivery: Development of a new model using participatory action research (PAR)

Principal Investigator Cheryl Cusack, RN, PhD (C)
2-496 Hargrave Street, Winnipeg MB
ccusack@wrha.mb.ca
(204) 940-1660

Research Supervisor: Benita Cohen, RN, PhD
Faculty of Nursing, University of Manitoba
Winnipeg, MB
Benita.Cohen@ad.umanitoba.ca
(204) 474-9936

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose: This research study is being conducted as part of a doctoral program in Applied Health Sciences at the University of Manitoba. The primary objective is to develop a service delivery model that will support Public Health Nurses (PHNs) to practice to their full scope, especially in relation to promoting healthy early childhood development and health equity. The second objective is to explore the effectiveness of a Participatory Action Research approach in developing a model of practice to clarify the role of PHNs.

My Understanding of the Study Procedures: I understand that if I agree to participate, I will be a primary participant in this research project. I understand that if I agree, as a primary participant, I will be a member of the Research Working Group (RWG). Five RWG interviews 1.5 to 2 hours long will take place every other month following the Nursing Practice Council (NPC) meetings. These RWG meetings are tentatively planned for September, November,

January, March, and May. The RWGs will be consistent with the NPC processes and structure for working groups. As such there may be additional communication required between the scheduled meetings that may take place in person, by phone or e-mail. I understand that the RWGs will use open-ended interview guides, and be facilitated by Cheryl Cusack, principal investigator of this study. I understand that the RWGs will be audiotape recorded for data analysis purposes, transcribed verbatim, and that the facilitator may take written notes. I also understand that the topic will be a standing agenda item at monthly NPC and team meetings, and that I will receive any applicable documents via e-mail with other NPC documents. I understand that I could call or e-mail the researcher at ccusack@wrha.mb.ca or (204) 940-1660 if I wish to receive a written copy of the report.

Risks and Benefits:

The risks to me would be minimal if I participate in this study, or no greater than those encountered in my daily PHN practice. Information gathered during the RWGs will be held in the strictest confidence and only directly shared with the Research Supervisor. There will be no way to identify participants (or individuals referred to during interviews) in any documentation or presentations related to this study. I understand my decision to take part in this study is fully voluntary, and I can withdraw at any point without impacting my employment status or performance evaluation.

The benefits of participating may be an opportunity to share ideas about effective PHN practice, as well as to learn more about the research processes that could be applicable to PHN practice. As a member of the RWG, if I choose, I could be named as a co-researcher. The study has the potential to provide important information that could benefit future PHN practice, as well as inform managers and decision-makers about PHNs' views of effective practice. I understand that the researcher may benefit through completing her PhD, and disseminating study findings via published papers or conference presentations.

Protecting Confidentiality:

The information I provide will be strictly confidential. The names of the participants will be known by the researcher and potentially the advisor. I understand that anonymity cannot be guaranteed due to the format of the study, but the following precautions will be taken to protect confidentiality:

1. Participants will be reminded they have taken PHIA and signed a pledge of confidentiality, and discussions that could breech confidentiality will be discouraged.
2. Interviews and questionnaires will be identifiable by a numerical code only (no names will be attached). Electronic files will be password-protected.
3. As soon as data are collected names and identifying information will be removed and replaced with pseudonyms.
4. Records will be stored in a locked filing cabinet and/or password secured computer files in the researcher's home office. All files (digital, hard copies) and recordings will be destroyed confidentially after seven years.

5. Only the researchers and the transcriptionist will have any access to records (interview participants will not be asked to identify their names once the recording begins, so the transcriptionist will not know the names of participants).
6. The transcriptionist will be asked to sign a pledge of confidentiality.

Compensation:

I understand that I will be participating within my job as a PHN, and I will receive my regular rate of pay. I will not receive additional compensation for participation in this study.

Voluntary Consent

I understand that my decision to take part in this study is voluntary, and that I can withdraw at any point without impacting my employment status or performance evaluation. Individuals may withdraw by advising the principal investigator verbally or in written format such as e-mail. I agree to maintain the confidentiality of participants by not naming individuals during discussions about this project, or disclosing any personal information that may be shared by participants.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Education/Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

I would like to be named as a co-researcher on any reports or publications: Yes_____ No_____

Note: If an individual waives anonymity by indicating they would like to be named as a co-researcher, but other participants object because identification may potentially be harmful to the group, the researcher must maintain anonymity for all group members.

Appendix G: Consent Form for Secondary Participants

The following consent was used for secondary participants.

UNIVERSITY OF MANITOBA

Applied Health Sciences Ph.D. Program

HLHP Research Institute
307 Max Bell
Winnipeg, MB
Canada R3T 2N2
Phone: (204) 474-7493
Fax: (204) 261-4802

Research Project Title: Public Health Nurse (PHN) **s**ervice delivery: Development of a new model using participatory action research (PAR)

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Purpose: This research study is being conducted as part of a doctoral program in Applied Health Sciences at the University of Manitoba. The primary objective is to develop a service delivery model that will support Public Health Nurses (PHNs) to practice to their full scope, especially in relation to promoting healthy early childhood development and health equity. The second objective is to explore the effectiveness of a Participatory Action Research approach in developing a model of practice to clarify the role of PHNs.

My Understanding of the Study Procedures: I understand that if I agree I will be a secondary participant in this research project. I understand that as a secondary participant, I will be acting within my PHN staff role at Nursing Practice Council (NPC). I understand that data for the study will only be collected during the NPC Research Working Group (RWG) but that the topic of the practice model will be a standing agenda item at monthly NPC and team meetings. I will receive

any applicable documents via e-mail with other NPC documents. I understand that the process for the research study will be consistent with the routine NPC processes and structure, and there may be additional communication between the scheduled meetings in person, by phone or e-mail. If I agree to participate, I understand that as the liaison to my team, I may distribute information about the study, collect team consent forms, and assist my team in better understanding the study. I understand that I could call or e-mail the researcher at ccusack@wrha.mb.ca or (204) 940-1660 if I wish to receive a written copy of the report.

Risks and Benefits:

The risks to me would be minimal if I participate in this study, or no greater than those encountered in my daily PHN practice. Information gathered will be held in the strictest confidence and only directly shared with the Research Supervisor. There will be no way to identify participants (or individuals referred to during interviews) in any documentation or presentations related to this study. I understand my decision to take part in this study is fully voluntary, and I can withdraw at any point without impacting my employment status or performance evaluation.

The benefits of participating may be an opportunity to share ideas about effective PHN practice, as well as to learn more about research processes that could be used in PHN practice. The study has the potential to provide important information that could benefit future PHN practice, as well as inform managers and decision-makers about PHNs' views of effective practice. The researcher may benefit through completing her PhD, and disseminating study findings via published papers or conference presentations.

Protecting Confidentiality:

The information I provide will be strictly confidential. The names of the participants will be known by the researcher and potentially the advisor. I understand that anonymity cannot be guaranteed due to the format of the study, but the following precautions will be taken to protect confidentiality:

1. Participants will be reminded they have taken PHIA and signed a pledge of confidentiality, and discussions that could breech confidentiality will be discouraged.
2. Interviews and questionnaires will be identifiable by a numerical code only (no names will be attached). Electronic files will be password-protected.
3. As soon as data are collected names and identifying information will be removed and replaced with pseudonyms.
4. Records will be stored in a locked filing cabinet and/or password secured computer files in the researcher's home office. All files (digital, hard copies) and recordings will be destroyed confidentially after seven years.
5. Only the researchers and the transcriptionist will have any access to records (interview participants will not be asked to identify their names once the recording begins, so the transcriptionist will not know the names of participants).
6. The transcriptionist will be asked to sign a pledge of confidentiality.

Compensation:
I understand that I will be participating within my job as a PHN, and I will receive my regular rate of pay. I will not receive additional compensation for participation in this study.

Voluntary Consent
I understand that my decision to take part in this study is voluntary, and that I can withdraw at any point without impacting my employment status or performance evaluation. Individuals may withdraw by advising the principal investigator verbally or in written format such as e-mail. I agree to maintain the confidentiality of participants by not naming individuals during discussions about this project, or disclosing any personal information that may be shared by participants.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Education/Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

Appendix H: Consent Form for Tertiary Participants

The following consent was used for tertiary participants.

UNIVERSITY OF MANITOBA

Applied Health Sciences Ph.D. Program

HLHP Research Institute
307 Max Bell
Winnipeg, MB
Canada R3T 2N2
Phone: (204) 474-7493
Fax: (204) 261-4802

Research Project Title: Public Health Nurse (PHN) **s**ervice delivery: Development of a new model using participatory action research (PAR)

Principal Investigator Cheryl Cusack, RN, PhD (C)
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ccusack@wrha.mb.ca
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Research Supervisor: Benita Cohen, RN, PhD
Faculty of Nursing, University of Manitoba
Winnipeg, MB
Benita.Cohen@ad.umanitoba.ca
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This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose: This research study is being conducted as part of a doctoral program in Applied Health Sciences at the University of Manitoba. The primary objective is to develop a service delivery model that will support Public Health Nurses (PHNs) to practice to their full scope, especially in relation to promoting healthy early childhood development and health equity. The second objective is to explore the effectiveness of a Participatory Action Research approach in developing a model of practice to clarify the role of PHNs.

My Understanding of the Study Procedures: I understand that if I agree I will be a tertiary participant in this research project. I understand that as a tertiary participant I will be acting within my PHN staff role and contributing to team discussions that may shared at Nursing Practice Council (NPC) meetings. I understand that data for the study will only be collected during the NPC Research Working Group (RWG) but that the topic of the practice model will be

a standing agenda item at monthly NPC and team meetings. I will receive any applicable documents via e-mail with other NPC documents. I understand that the process for the research study will be consistent with the routine NPC processes and structure, and there may be additional communication between the scheduled meetings in person, by phone or e-mail. I understand that I could call or e-mail the researcher at ccusack@wrha.mb.ca or (204) 940-1660 if I wish to receive a written copy of the report.

Risks and Benefits:

The risks to me would be minimal if I participate in this study, or no greater than those encountered in my daily PHN practice. Information gathered will be held in the strictest confidence and only directly shared with the Research Supervisor. There will be no way to identify participants (or individuals referred to during interviews) in any documentation or presentations related to this study. I understand my decision to take part in this study is fully voluntary, and I can withdraw at any point without impacting my employment status or performance evaluation.

The benefits of participating may be an opportunity to share ideas about effective PHN practice, as well as to learn more about research processes that could be used in PHN practice. The study has the potential to provide important information that could benefit future PHN practice, as well as inform managers and decision-makers about PHNs' views of effective practice. The researcher may benefit through completing her PhD, and disseminating study findings via published papers or conference presentations.

Protecting Confidentiality:

The information I provide will be strictly confidential. The names of the participants will be known by the researcher and potentially the advisor. I understand that anonymity cannot be guaranteed due to the format of the study, but the following precautions will be taken to protect confidentiality:

1. Participants will be reminded they have taken PHIA and signed a pledge of confidentiality, and discussions that could breech confidentiality will be discouraged.
2. Interviews and questionnaires will be identifiable by a numerical code only (no names will be attached). Electronic files will be password-protected.
3. As soon as data are collected names and identifying information will be removed and replaced with pseudonyms.
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5. Only the researchers and the transcriptionist will have any access to records (interview participants will not be asked to identify their names once the recording begins, so the transcriptionist will not know the names of participants).
6. The transcriptionist will be asked to sign a pledge of confidentiality.

Compensation:
I understand that I will be participating within my job as a PHN, and I will receive my regular rate of pay. I will not receive additional compensation for participation in this study.

Voluntary Consent
I understand that my decision to take part in this study is voluntary, and that I can withdraw at any point without impacting my employment status or performance evaluation. Individuals may withdraw by advising the principal investigator verbally or in written format such as e-mail. I agree to maintain the confidentiality of participants by not naming individuals during discussions about this project, or disclosing any personal information that may be shared by participants.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

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Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

Appendix I: Demographic Information

The following demographic questionnaire was used to better understand the PHNs who agreed to participate in the RWG.

The following information will assist in understanding more about the PHNs participating in this study.

1. How long have you been on the Nursing Practice Council?
2. What is your current age in years?
3. How many years have you worked as a public health nurse?
4. Are you employed full or part-time?
5. Please check all that apply as far as your education

_____Bachelor's degree in nursing

_____Graduate degree in nursing

_____Canadian Nurses Association Community Health certification

_____Douglas College or lactation consultant certification

_____Other degree or certification. If yes, please state

6. Is there any other information you would like to add?

Thank-you for taking the time to complete!

Appendix J: November 21, 2012 RWG Semi-structured Discussion Guide

(Adapted from Stringer, 2007)

The following interview guide formed the basis for the first RWG, which focused on the RWG's perception of their practice, gaps, and opportunities for improvement.

---

1. What are the goals or purpose of the PHN role?

- What do you hope to achieve? What is valued?
- What should be done to improve the practice?
  - To promote equity? Early childhood development? Population health?
- What would make good indicators for observing whether PHN priorities are being met?

2. Who is mainly affected by the way PHN services are currently delivered?

- Who are the individuals, groups, communities, populations that benefit from the current way PHN services are delivered?
  - Who is else is important to consider? Why?

3. How did we get here?

- What is the history of PHN practice?
  - What structures contributed to the current practice?
  - How have decisions regarding PHN practice been made?
- How has your view of PHN practice and your role developed?
  - How should you work to the full scope of your competencies?
  - How should whole systems working be fostered?

4. Where are there gaps in PHN practice?

- Where are the barriers? What contributes to and what hinders PHN practice?
  - What is not taking place that should be?
  - What is taking place that shouldn't be?
  - What other information is needed?

5. When are you most satisfied with the PHN role?

- When are you most dissatisfied?
- When do problems occur?
  - What is the extent?
  - What are solutions?

Appendix K: November RWG Organized under Discussion Questions

Below, interview data from the November 21, 2012 RWG were organized using the discussion questions as a guide

---

1. Goals of PHN practice

Passion for a PHN scope of practice based on the new position description was articulated. PHNs valued building relationships and capacity, promoting and protecting health, facilitating access and equity for the clients they worked with. The PHNs described situations that incorporated critical thinking based on assessment and analysis of the situation, and application of public health and nursing sciences. PHNs described situations where they worked in collaboration with clients and other health profession to address the social determinants of health.

The scenarios are consistent with the Community Health Nurses of Canada standards and competencies, and WRHA position description. The dialogue expressed value in working to full scope of PHN competencies, addressing inequities and social determinants of health, promoting health and early childhood development. PHN expressed the desire to work with complex families over the longer term to promote their health, often requiring inter-professional collaboration, and reported tremendous feelings of satisfaction when these endeavours were successful. Concern was expressed that these roles and concepts were difficult for others to understand and to measure.

Indicators of PHN practice

Short –term
Postpartum referrals
Immunization rates
Teaching and health promotion education
Breastfeeding initiation
CDs
Epi-stats
Discussion that these are task based and in many situations represent a number but are not good measures of the complexity associated with the situation

Longer – term
school success – attendance/drop-out rates
Developing trusting relationships
Facilitating access to community resources and equity
Chronic disease prevention
Employment rates
Attendance in ER/ physician's offices
Community development
Working inter-professionally
Need to develop indicators that address the complexity of PHN work

Obesity
Finances and social determinants of health
Promoting healthy families
Smoking reduction rates
Successful happy children that grow to be productive citizens
The RWG agreed that these are more valuable indicators of the PHN role, but much more difficult to measure. Also takes more PHN time, that isn't always available.

2. Who is mainly affected by current services?

Current practice is focused on postpartum moms and babies, and mandated services such as CDs. The organization has supported staff to improve skill in this area by sending everyone through Douglas College, and development of the care map. These shifts as well as earlier discharges have resulted in PHN practice becoming an extension of the hospital. Work has become focused on clinical care in the immediate post-partum period, and the nature of the work has become that PHNs are visiting pp families multiple times.

Who else should be considered?

- Clients – PHNs do not have opportunities to promote health across the lifespan –care has become episodic and task based
- Community areas are not all the same, though a consistent approach is promoted
- Mom/baby beyond PP – to address social determinants of health
- Schools
- Community groups and agencies
- Equities – complex families require lots of time that PHNs don't always have. They often fall off, although it is recognized that establishing relationships can take time and these families are less likely to access PHN services on their own
- PHNs – a great deal of satisfaction described with the PHN role was based on functioning to the full scope of practice. PHNs who have experienced that role feel a sense of loss, and some of those who haven't feel cheated.

3. How did we get here? What is the history of PHN practice? What structures contributed to the current practice?

- Provincial and organizational restructuring
- Lack of funding for health promotion/ community
- Devaluing and lack of understanding of the PHN role/ invisibility
- Driven by demands of acute care
- Organizational culture
- Focus on PP standards/ care map
- Desire to promote consistency
- Matrix structure creates competing priorities
- Lack of PHN involvement in decisions that affect their practice
- Orientation focus heavily on breastfeeding/PP – broader components of practice have minimal information, if at all

- Lack of value for community development, partnerships, school work
- Postpartum/breastfeeding – strong organizational focus

4. How has your view of PHN practice and your role developed?

There was discussion about the value of the traditional PHN role, with the broader full scope of practice. The importance of working long-term with complex clients to promote health and equity. The RWG identified variation in practice that exists between PHNs and community areas. The importance of allowing practice to meet the needs of the diverse community areas was raised, yet there was still acknowledgement of variation. Two extremes were discussed:

1. Some PHNs have become very task based and focused on breastfeeding/ weight loss and clinical care. Often files get closed once the baby is gaining weight.
2. Some PHNs value a broader scope of practice – many were PHNs who practiced prior to the PP standards being in place

The discussions articulated the difficulty in describing and understanding the PHN role based on the position description. This lack of understanding creates tensions, where post-partum and CD referrals are seen as valid measures of PHN work, but working at the broader scope is not. For example coordinating inter-professional case conferences for complex clients, which address the social determinants of health and promote equity, are not recognized or valued in the same way. The organization has promoted a similar message with a focus for orientation on post-partum work.

Appendix L: November RWG Organized into Action Framework

Below, interview data from the November 21, 2012 RWG were organized using the participatory action research cycle of 'Look, Think, Act,' with suggested themes.

Look

Who is mainly affected by current services?

- Postpartum moms and babies
- Clients who fall under mandated services such as CDs.

How did we get here? What is the history of PHN practice? What structures contributed to the current practice?

- Provincial and organizational restructuring
- Earlier discharge from hospital/shift to more community care
- Lack of funding for health promotion/ community
- Devaluing and lack of understanding of the PHN role/ invisibility
- Driven by demands of acute care
- Organizational culture
- Focus on postpartum standards/ care map – may diminish critical thinking
- Desire to promote consistency
- Matrix structure creates competing priorities
- Lack of PHN involvement in decisions that affect their practice
- Orientation focus heavily on breastfeeding/postpartum – broader components of practice have minimal information
- Lack of value for community development, partnerships, school work
- Postpartum/breastfeeding – strong organizational focus – all staff taking Douglas College

How has your view of PHN practice and your role developed?

Concept of role develops over time – impacted by community area, team, and experiences
At 1st practice may be more task-based Eg. focus on PP visits– the orientation promotes this approach with a significant focus on BF and PP

Two extremes in the general program were discussed:

1. Some PHNs have become more task based and focused on breastfeeding/ weight loss and clinical care. Files may be closed once the baby is gaining weight.
2. Some PHNs value a broader scope of practice - where long-term relationships are developed and PHNs are active within their communities

Differences in understanding and implementation of the role create tensions between and within teams, where post-partum and CD referrals are seen as valid measures of PHN work, but working at the broader scope is not. For example coordinating inter-professional case

conferences for complex clients, which address the social determinants of health and promotes equity, are not recognized or valued in the same way.

Themes

1. Narrowing PHN role – focus on clinical care in postnatal period
2. Role of Organization in supporting PHN practice

Think

Goals of PHN practice – Valued components

- Broad and long-term role, looking holistically at client
- Developing trusting relationships, supporting clients, making a difference, empowering
- Building capacity and confidence, interrupting cycles of poverty
- Promoting population health
- Health promotion and disease prevention
- Addressing the Social Determinant of Health / inequities
- Community development
- Promoting healthy Early Childhood Development
- Linking to resources
- Working with other providers – FFHV, EIA, CFS etc to coordinate care and improve outcomes for clients

Who else should be considered in PHN practice?

- All other clients – PHNs do not have opportunities to promote health across the lifespan – care has become episodic and task based
- Community areas are not all the same, though a consistent approach is promoted, variation in practice is significant
- Mom/baby beyond PP needs – to address social determinants of health and promote early childhood development/equity
- Schools
- Community groups and agencies
- Equities – complex families require lots of time that PHNs don't always have. They often fall off, although it is recognized that establishing relationships can take time and these clients are less likely to access PHN services on their own
- PHNs – satisfaction described with the PHN role was based on functioning to the full scope of practice. PHNs who have experienced that role feel a sense of loss, and some of those who haven't feel cheated.

Where are gaps/barriers in PHN practice? What contributes to and hinders PHN practice?
Equity focus and client/community needs may be prohibited by:

- focus on tasks (BF, PP, weight, CD, immunizations) and
- organizational requirements (care map, FF screen/survey, standards)

What is not taking place that should be?

- Community development – coalitions, parenting groups
- Outreach – for those who don't access services
- Working with partners within the community
- Equity focus – vulnerable individuals, families, communities
- Writing grants (policy level work?)
- Health promotion
- Work with schools/ health promotion for teens
- Practice must meet the needs of the diverse community areas, yet variation still exists

What is taking place that shouldn't be?

- Medical management of postpartum moms/babes - Multiple visits for weight checks , breastfeeding is the main PHN health promotion activity fixated on numbers
- Task based - referrals drive work and are considered to be measures of workload – everything else is extra
- Program directing community activities – immunization, CD, Youth health survey

What other information is needed?

- How is PHN practice structured in other jurisdictions? Rural Manitoba as well as in other provinces.
- What is the best timing for a PP contact, does it need to be within 24 hours? Are weight checks helpful or harmful? How could we be working more effectively with other providers? (Eg referral back to FPs)
- How do you measure success of the PHN role?
- What practices are evidence based?

When are you most satisfied with the PHN role?

- Practice autonomously – use critical thinking (Nurse IV)
- Working with individuals, families, communities over the long-term and seeing success (client-centred)
- Supported by the organization and the team manager
- Working as a partner within the community
- Collaborating with other providers/clients to improve health- long-term and holistic approach
- Working as a team towards a common goal
- Recognition for achievements and learning from others successes – supported and empowered
- Having input to decisions that affect PHN practice

Versus dissatisfied

- Focus on tasks and numbers
- Focus on consistency – standardized approach does not work across community areas
- Focus on postpartum clinical care – PP, BF, care map
- Not accessing those who need services the most – equities approach
- Lack of understanding of PHN role and public health concepts

- Difficulty in articulating the PHN role – to clients and others (sometimes even other PHNs may not fully understand)
- Lack of value for PHN role
- Top down approach – without understanding of community context

Themes:

3. Passion for PHN role, full scope of practice, working to position description and competencies
4. Lack of understanding regarding PHN role - Erosion of health promotion/prevention/community development

Act

How should you work to the full scope of your competencies? How should whole systems working be fostered?

- Focus on the PP work often prohibits working to full scope (workload)
- Task based approach to PP home visits/ BF, often working in isolation (silo – PHN providing primary care) –Could be letting go of work with clients who have other system supports and encouraging them to contact and access available PHN services- whole systems approach
- Mentors play an important role, often it is mentors who assist in developing a broader approach to practice
- Managers understanding of practice and support for a broader practice is essential
- Opportunities to practice to broader scope must be valued, and included in measures of workload Ie community work, coalitions

What could be good Indicators of PHN Practice?

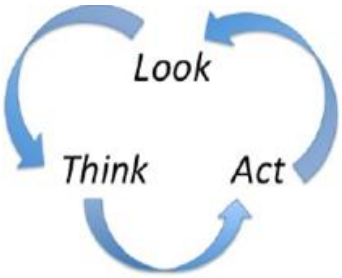
- Naming of important routine PHN activities that may not be recognized
- Developing trusting relationships
- school success – attendance/drop-out rates, teen pregnancy, eating disorder, mental health
- Facilitating access to community resources and equity
- Chronic disease prevention
- Employment rates
- Attendance in ER/ physician's offices
- Community development
- Working inter-professionally
- Indicators that address the complexity of PHN work
- Obesity
- Impact on finances and social determinants of health
- Promoting healthy families -PHN referrals (speech, nutrition, ped/FP, child health)
- Smoking reduction rates
- Successful happy children that grow to be productive citizens

What are solutions to improve PHN practice and satisfaction?

- Articulating the PHN role in a way that is easier to understand
- PHN active participation and inclusion in practice decisions
- Working more efficiently within the whole health system – inter-professional collaboration
- Working upstream - getting in prenatally, using an equity focus, going beyond the 1st days of life
- Organizational agreement and support
- Review of standards and PP role
- Determining practices that are evidence-based
- Review of staffing
- Examining practices outside of the WRHA
- Reviewing orientation – focus on purpose of public health, more broad, less focus on tasks
- Communicating with partners
- Developing stats or measures that accurately reflect PHN priorities and goals
- Developing forums to have discussions with PHNs
- Management understanding and supporting PHN practice

Themes:

5. Desire to work to full scope of PHN competencies and position description
6. Value of Inter-professional collaboration in addressing social determinants of health
7. Upstream reorientation of PHN Practice is essential – particularly promotion of equity and healthy early childhood development
8. Need to develop PHN sensitive indicators



Appendix M: January 16, 2013 RWG Semi-structured Discussion Guide/Agenda

At the January RWG, participants reviewed summary documents from the November RWG, in addition, to documents below intended to enrich the process.

Goal: To review project goals and begin to identify concepts for a PHN service model

The goals of the RWG project are to (Draft):

- Resolve Service Delivery Issue Paper
- Use participatory action research to recommend a service delivery model for PHN practice in the WRHA
- Suggest strategies that allow PHNs to work to full scope of practice, especially in relationship to promoting equity and early childhood development that optimize the Nurse IV role and PHN competencies

Process:

1. Review and agree on central themes that outline what the group thinks, has reflected on, and potential actions. This will be accomplished by reviewing the following:
    a. Summary of November RWG (Draft) – The discussion from November RWG was summarized into headings under the questions discussed
    b. Participatory action research Framework (Draft) – The November RWG summary was then organized into the participatory action research framework with themes developed for discussion

2. Identification of documents that could enrich the process. Consider your practice and the November discussion. Please review and bring the following:
    a. Winnipeg Regional Health Authority. (2011). Position description. Public health nurse. Population and Public Health. Winnipeg Regional Health Authority. Winnipeg.
    b. Population & Public Health conceptual model
    c. Community Health Nurses of Canada. (2009). Public health nursing discipline specific competencies. (version 1.0 ed.). Toronto: Community Health Nurses of Canada.
    d. Community Health Nurses of Canada. (2011). Canadian community health nursing professional practice model & standards of practice. Toronto: Community Health Nurses of Canada.
    e. Canadian Public Health Association. (2010). Public health ~ community health nursing practice in Canada: Roles and activities. (4th ed.). Ottawa: Canadian Public Health Association. (Available at http://www.cpha.ca/uploads/pubs/3-1bk04214.pdf

3. Co-construction of new themes may occur
    a. Consider the relevance/ accuracy of the suggested themes. What themes should be added / deleted to better articulate your views?

4. Brainstorm ideas for development of a PHN service model and action plan.
    a. Considering what has been discussed and what is most valued in PHN practice, how should we move forward in developing a model and plan that would best fit practice in the WRHA?

Appendix N: March 20, 2103 RWG Semi-structured Discussion Guide/Agenda

The March 20th RWG discussion was based on research articles describing service delivery and professional practice models, as well as an outline for an action plan.

Goal: To develop a PHN practice model

1. Review and agree to goals, objectives, and priorities for the project

Purpose of readings:

- Increase understanding of terminology – model, theory, conceptual framework
- Raise awareness of the theory practice gap in PHN practice
- Stimulate thinking and discussion about the process of socialization into the PHN role and the influence of organizational/medical/system influences on perceptions
- Generate discussion regarding aspects of the role that are the responsibilities of PHNs and define the fundamental characteristics of the job

Readings to assist Discussion:

Everyone to review:

Betker, C. (2010). Practice models in community health nursing. Literature Review. Community Health Nurses of Canada. Ottawa. Retrieved from http://www.chnc.ca/members/documents/CHNC_practice_model_literature_review_FINAL_2_.pdf

Community Health Nurses of Canada. (2011). Canadian community health nursing professional practice model & standards of practice. Toronto: Community Health Nurses of Canada. (p. 3-6 describe components of a professional practice model)

Vancouver Community. (2010). Vancouver Community Public Health Nursing Service Delivery Model. Vancouver: Vancouver Community.

Beth:

Canam, C. J. (2012). The link between nursing silence discourses and nurses' silence. In Pamela G. Reed & Nelma B. Crawford Shearer (Eds.), Perspectives on Nursing Theory (pp. 64-72). Philadelphia: Wolters Kluwer/ Lippencott Williams & Wilkins.

Schofield, R., Ganann, R., Brooks, S., McGugan, J., Dalla Bona, K., Betker, K., . . . Watson, C. (2011). Community health nursing vision for 2020: Shaping the future. Western Journal of Nursing Research, 33(8), 1047-1068. doi: 10.1177/0193945910375819

Sarah:

Wolf, G. A., & Helenahouse, P. K. (2007). Rachelprint for design: Creating models that direct change. Journal of Nursing Administration, 37(9), 381-387.

Bigbee, J. L., & Issel, L. M. (2012). Conceptual models for population-focused public health nursing interventions and outcomes: the state of the art. [Review]. Public Health Nurs, 29(4), 370-379. doi: 10.1111/j.1525-1446.2011.01006.x

Rachel:
Shirey, M. R. (2008). Nursing practice models for acute and critical care: Overview of care delivery models. Critical Care Nursing Clinics of North America, 20, 365-373. doi: 10.1016/j.ccell.2008.08.014

Underwood, J. M., Mowat, D. L., Meagher-Stewart, D. M., Deber, R. B., Baumann, A. O., MacDonald, M. B., . . . Munroe, V. J. (2009). Building community and public health nursing capacity: A synthesis report of the national community health nursing study. [Special Insert]. Canadian Journal of Public Health, 100(5), I 1-I 11.

Helena:
Hoffart, N. (1996). Elements of a nursing professional practice model. Journal of Professional Nursing, 12(6), 354-364.

Smith, K., & Bazini-Barakat, N. (2003). A public health nursing practice model: melding public health principles with the nursing process. Public Health Nursing, 20(1), 42-48.

Danielle:
MacPhee, M., Wardrop, A., Campbell, C., & Wejr, P. (2011). The synergy professional practice model and its patient characteristics tool: a staff empowerment strategy. Nursing leadership (Toronto, Ont.), 24(3), 42-56.

Keller, L. O., Strohschein, S., & Schaffer, M. A. (2011). Cornerstones of public health nursing. Public Health Nursing. doi: 10.1111/j.1525-1446.2010.00923.x

When reading, Fawcett suggests these 4 steps in selecting a conceptual framework:

- Compare several nursing models
- Examine the content of the models compared to the organizational mission statement
- Evaluate if the philosophy of the models is consistent with the nursing philosophy
- Select the model that most closely matches the mission of the organization and the philosophy of the nursing program

2. Develop an action plan, starting with the highest priority (Draft Action Plan Appendix T):

    a. Identify the actions needed to resolve the issue and to meet project goals
    b. Specify activities within each action
    c. Design the sequence of tasks to address each activity
    d. Assign a responsible individual or group, timeframe, and resources

Appendix O: March 20, 2013 RWG Draft Action Plan for Discussion

The following was a summary of RWG discussion, applied to theory from readings. This document formed the basis for the action plan and professional practice model.

Schlotfeldt (1989) advises that professions must have a social mission or goal and be based on a distinct body of knowledge. A philosophy of nursing generally articulates beliefs related to person, health, environment, and nursing.

Key concepts to consider in nursing models include:

a. Person/client – recipient of care – Eg - who/how is client defined
b. Health – Prevention – primary, secondary, tertiary
c. Environment - social determinants of health
d. Nursing – defines the role of the nurse in relationship to client health – case manager, leader, inter-professional - consider most efficient/effective use of resources

Goal/Philosophy: *Consider: What is the overarching goal of PHN practice?*

Example - PHNs promote, protect and preserve the health of populations, and reduce inequities by addressing the determinants of health and promoting equitable health outcomes

Conceptual Models or Frameworks – depict interrelated phenomena to increase understanding, often are visual or include a schematic.

Consider the distinct body of nursing knowledge that forms the basis for the PHN role and a professional practice model. Hoffart describes the following components:

Professional Practice Model Components Definitions:

1. Values – Values in professional nursing models have been described as a collective belief system that forms the basis for developing education and the foundation of practice. Without defining values, the other 4 components of the model lack focus

2. Relationships – Describe nurses beliefs and attitudes, relational skills and interactions within the health system and to promote client care

3. Care model or delivery system – how client care is coordinated and distributed as well as who is responsible for client decisions (professional nursing models typically use a primary nursing or case management delivery system)

4. Management approach – structure and processes for decision-making related to organization decisions (shared governance, decentralized decision-making)

5. Compensation and rewards (maybe recognition and rewards instead of compensation) – system recognition of nursing attributes – management understanding of employee motivation

Consider*:* Do these components make sense to consider in developing a model?

Components of a Professional Practice Model

1. **Values – What collective beliefs are foundational to PHN practice? (could be used to determine daily work)**
   Previously we discussed:
   - Working upstream to promote equity and address the social determinants of health, to interrupt cycles of
   - poverty
   - Focusing on population level health promotion (versus individual and tasks)
   - Working to full scope of PHN role – autonomous, based on position description and PHN discipline specific competencies
   - Developing therapeutic relationships based on client strengths and capabilities
   - Focusing on the value and complementary nature of the PHN role within a complex healthcare system
   - Collaborating with communities, agencies, and other providers to holistically promote health

2. **Relationships – What relationship attributes should be articulated in this section?**
   - Working in partnership with clients (individuals, families, communities, populations) where they are at to promote, protect, and preserve health
   - Developing therapeutic and strength-based relationships
   - Incorporating key principles that include cultural proficiency, harm reduction, evidence-informed practice, community engagement, inter-professional collaboration
   - Working with other providers – FFHV, EIA, CFS etc to coordinate care and improve outcomes for clients
   - Mentors/mentorship

3. **Care model or delivery system -** Wolf (2007) suggests that in developing a care model the following trends should be considered:
   a. Changes in clients - (increasing inequities, consumerism, client choice of providers)
   b. Changes in providers – (primary healthcare, more choice, increased scope of practice)
   c. Medical advances - (earlier discharge, access to and client use)
   d. Information technology – (access to and client use, complementary/alternative care)
   e. Reimbursement – (system effectiveness and efficiency, continuum of care)

Putting model together ***(Determine structure, process, outcome)***
Aligns with organization – position description, equity statement, Population & Public Health conceptual model

Outcomes – What outcomes do we want to see?
- How can those outcomes be achieved (processes)? Equity focus, population health, early childhood development
- What does the PHN role do?
- What difference will the PHN role make?

- What outcomes should be measured? How? When?
- How will the results be used to improve services?

Structure - What structure is needed to support achievement of identified outcomes?

- What is the most effective and efficient use of the PHN role?
- How can client needs be quantified?
- What skill mix will be used for different populations?
- How will we promote consistency and seamlessness across the continuum of healthcare? Who should do what?
- How can staffing decisions be made?

Process – How will client care delivered across the healthcare continuum?

- Is there a nursing theory we want to use?
- What standards will be used and how will they be developed to be current and evidence based?
- How will we work with others healthcare providers and disciplines in coordinating and providing care?
- How will client preferences and priorities be considered?

4. Management Approach

- Shared governance/ Nursing Practice Council
- PHN active participation and inclusion in practice decisions
- Working as a team towards a common goal
- Supported to work to full scope
- Review of staffing

5. Recognition and Rewards

- PHNs are valued for their expertise
- Recognition for achievements and learning from others successes valued
- Supported by the organization and the team manager
- Developing forums to have discussions with PHNs

Definitions

- Equity/inequity
- Social Justice
- Social determinants of health
- Harm reduction
- Prevention – primary, secondary, tertiary
- Shared governance: Shared decision-making and leadership using NPC
- Evidence-informed
- Cultural proficiency
- Health Behaviour change
- Client centred
- Community engagement and participation

Appendix P: April 4, 2013 RWG Semi-structured Discussion Guide/Agenda

During the April 4rd meeting, the RWG summarized and incorporated feedback from the teams, using a process of grouping similar concepts under the Population & Public Health conceptual framework headings.

Goal: Categorize team feedback into Population & Public Health Conceptual Framework

1. Each participant take feedback from their team and categorize what was said using the Population & Public Health conceptual framework as headings – keep exact wording. If something doesn't fit add it to the parking lot.

2. When done, start categorizing feedback from the teams that are left.

3. Once all the information is accounted for and categorized under the headings, as a group we will start to collapse it and find common themes/ language.

Headings from Population & Public Health Conceptual Framework

Public Health clinical practice

Outreach

Healthy public policy

Healthy build environment

Health communication

Health assessment

Community development

Collaboration and partnership

Applied public health research

Surveillance

Appendix Q: April 25, 2013 RWG Semi-structured Discussion Guide/Agenda

On April 25th, the collated feedback from the April4, 2013 session was reviewed, in addition to the draft action plan.

Goal: To continue to develop the plan for a PHN practice model

1. Review and agree to goals, objectives, and priorities:
    a. How does the draft report meet this objective?
    b. Is team feedback incorporated?

2. Develop an action plan, starting with the highest priority.
    a. Identify the actions needed to resolve the issue and to meet project goals
    b. RWG will develop the 1st three sections of the professional practice model
    c. RWG will make recommendation for model of PHN practice – case management, team/neighborhood
    d. Meet with director? Who else should be involved?
    e. Postpartum guidelines based on approach outlined
    f. Management approach - agreement and further development to clarify roles and responsibilities - organizational approach
    g. Recognition and rewards – organizational approach
    h. Development of PHN sensitive indicators
    i. Specify activities within each action
    j. What makes sense to structure the sections
    k. Design the sequence of tasks to address each activity
    l. Assign a responsible individual or group, timeframe, and resources

Appendix R: May 15, 2013 RWG Semi-structured Discussion Guide/Agenda

During the May 15th meeting, the RWG reflected on feedback from two meetings with the director of public health, in addition to making revisions to the action plan.

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1. Debrief the meeting the with Director

2. Integrate feedback into updated action plan

    Reflection on:

    - How is the document coming together for you?
    - What needs to be added/deleted/ revised?
    - What are the next steps?

3. Continue discussing unfinished agenda items from April 25th

Appendix S: July 3, 2013 RWG Semi-structured Discussion Guide/Agenda

The following interview guide formed the basis for the final RWG, which was a process/outcome evaluation.

Outcome – Development of the Professional Practice Model

1. What successes have been achieved as an outcome of this work?
   - personally/for teams/ the organization
   - What has changed from when the project was initiated?
2. What impact is there for PHN practice as a result of the professional practice model?
   - Do you see opportunities where PHNs can practice to the full scope of their competencies?
   - How could this contribute to program/policy improvements?
3. What issues remain unresolved?
   - Are there areas where revisions may be needed?
   - What might next steps be?

Process – Participatory Action Research

4. How effective has the participatory action research process been?
   - What did you like? What did your team like?
   - If we were to do this again, what could be improved?
   - How could participation in this process impact future practice?
5. How has this process worked for you/ your team?
   - What has been the impact and learning?
   - What lessons have been learned that might inform similar future efforts here and elsewhere?

Appendix T: PHN Professional Practice Model

The following document is the professional practice model developed by the RWG.

Winnipeg Regional Health Authority, Population & Public Health

Public Health Nurse Professional Practice Model

December 2013 – Final

Acknowledgements

The development of this Professional Practice Model was possible as the result of the efforts of the working group, the nursing practice council, and Public Health Nurses (PHNs) in the Winnipeg Regional Health Authority (WRHA). The response from PHNs was exceptional, with the consistent message that PHNs want to function to the full scope of their PHN Nurse IV role and position description.

Preliminary work began in the winter of 2012, to explore interest in reconvening a nursing practice council working group to address the outstanding issue of PHN service delivery. A Participatory action research study was completed as a component of my PhD dissertation. Data were collected during 7 working group meetings that took place from November 2012 to July 2013, which were audio taped and transcribed verbatim. The audio tapes and transcriptions were summarized and the working group reviewed, discussed, and provided feedback. The working group strived to capture the feedback of the nursing practice council, as well as input from teams of PHNs working in community areas and centralized programs, leading to the development of the professional practice model and this document.

The working group deserves special recognition and thanks for their professionalism, commitment, collaboration, and passion. Preparation for the meetings involved not only collating PHN and team feedback, but also reviewing literature and other documents. The group was always prepared, provided leadership, and contributed with vigour and enthusiasm. The working group and co-authors of the document are:

- Anne Sikora
- Leanne O'Keefe
- Lenore Finnson (co-chair of working group)
- Lori Ann Laramee (co-chair of working group)
- Vicki Charski
- Special thanks to Cathie Pickerl; Hedy Heppenstal; Kristi Hutchinson; and Shireen Eastman for their feedback and contributions

This project was successful due to support from Lynda Tjaden, Population & Public Health Program Director, and Dr. Benita Cohen from the University of Manitoba. Lynda recognized development of a PHN model as a complex organizational issue and allocated staff time and resources. She met with the working group to offer leadership, promoted an organizational culture that was safe and open to learning, and facilitated communication. As my PhD program advisor, Benita provided ongoing guidance and direction throughout the project. Lastly, I would like to acknowledge the Foundation of Registered Nurses of Manitoba, and the Faculties of Applied Health Sciences; Nursing; and Graduate Studies for contributions of funding.

Sincerely,

Cheryl Cusack, RN PhD (C)

Table of Contents

Background:

This document outlines a Professional Practice Model for Public Health Nurses (PHNs) in the Winnipeg Regional Health Authority (WRHA). Professional practice models have been identified as key organizational tools to support nursing practice (Betker, 2010; Community Health Nurses of Canada, 2011b; MacPhee et al., 2011), by identifying activities that nurses have direct control and responsibility for (MacPhee et al., 2011), and articulating a nursing philosophy based on specific knowledge, skills, and competencies for autonomous practice (George & Lovering, 2013; Ives Erickson & Ditomassi, 2011; Schlotfeldt, 1989). Professional practice models assist nurses with practice decisions and change (Ives Erickson & Ditomassi, 2011), as well as promote nursing excellence, innovation, and quality client care (American Nurses Credentialing Center, 2014).

A professional practice model has been conceptualized as a rope, which is strongest when the individual strands are woven together (Hoffart, 1996).

The following essential components have been identified (Community Health Nurses of Canada, 2011b; Hoffart, 1996):

1. **Values and Principles** – Form the collective belief system and foundation for PHN practice and professional development. The values and principles create focus for the other four components of the model, and assist with prioritization.

2. **Professional Relationships and Partnerships** – Describe PHN beliefs and attitudes, relational skills, and interactions that promote client care within the health system.

3. **Delivery Structure and Processes** – Articulate PHN service delivery to optimize client care and population outcomes.

4. **Management Practices** – Outline the organizational structures and processes for decision-making and supporting autonomous PHN practice.

5. **Rewards and Recognition**– Describe formal and informal organizational structures and acknowledgements based on nursing attributes and employee motivation.*

The rope cannot do its job well when any of these components fail to be included.

Professional practice models and professional nursing practice environments can improve client outcomes, staffing, as well as enhance nurse and client satisfaction (Mensik, 2013). In comparison to other nursing models, professional practice models are more holistic. In addition to articulating nursing practice, professional practice models incorporate organizational, community, and system elements. PHNs in the WRHA and across Canada have identified that lack of clarity regarding the PHN role in conjunction with multiple competing workload demands, has created inconsistency and difficulty in working to the full scope. Professional practice models hold promise in optimizing PHN practice by providing a framework and the common language to articulate the PHN role, while clarifying roles and responsibilities at organization and system levels.

Professional practice models require adaptation and customization into existing organizational systems and infrastructure (Hedges et al., 2012). In developing the WRHA PHN professional Practice Model a wide variety of literature and key WRHA and Canadian documents were reviewed and integrated. This included literature on public health and nursing practice, service delivery models, nursing leadership, and key Canadian research articles and policy documents.

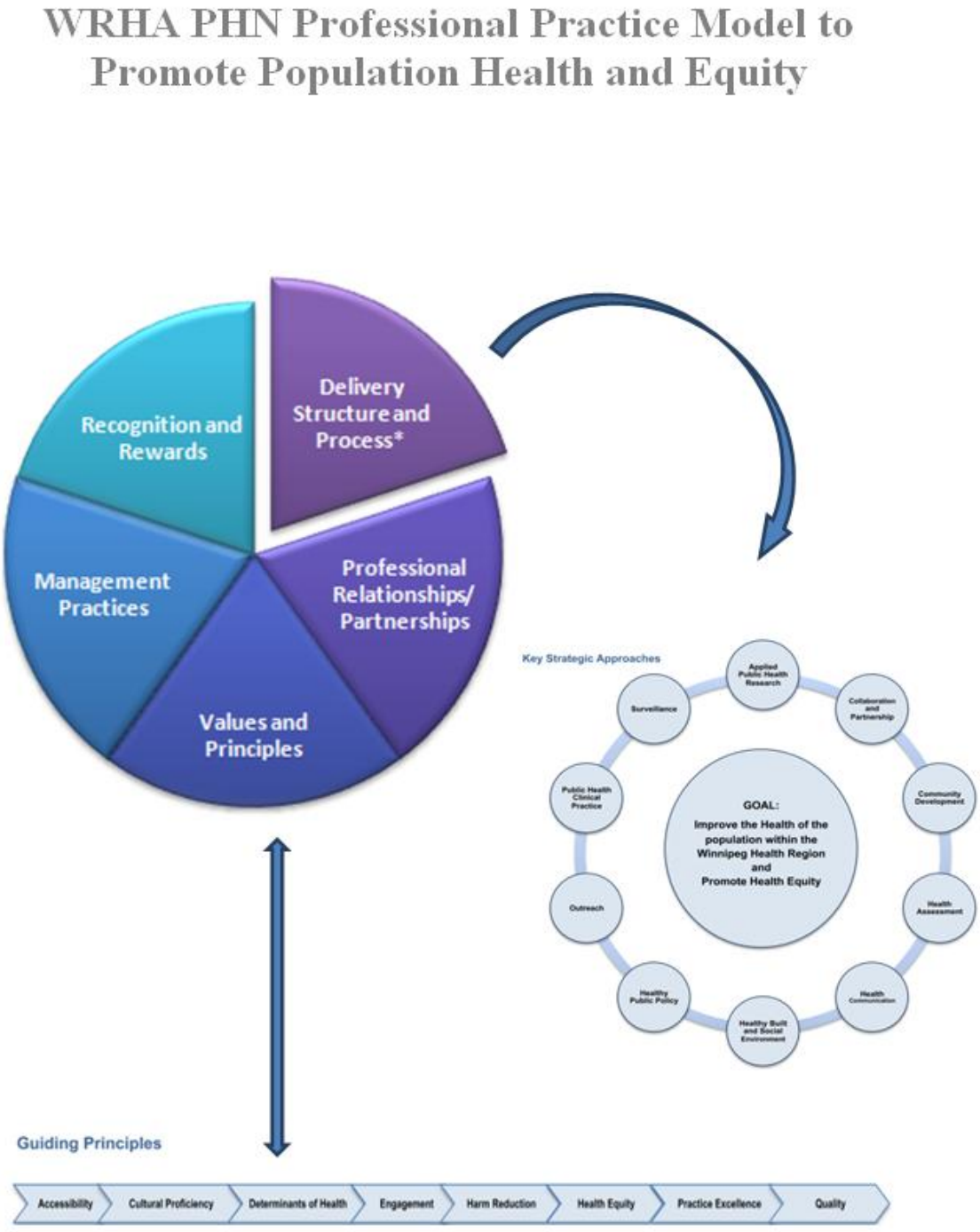
The professional practice model incorporates the following, which are included in the Appendix for additional information:

- ❖ Community Health Nurses of Canada Professional Practice Model - provides the guiding structure and components of the Professional Practice Model
- ❖ Literature Summary - provides the background
- ❖ WRHA Public Health Nursing Position Description - based on the Community Health Nurses of Canada PHN discipline specific competencies, and depicts a PHN leadership role in promoting population health and health equity
- ❖ WRHA Population & Public Health Conceptual Framework - provides the framework to articulate the PHN service delivery model
- ❖ WRHA Position Statement on Health Equity

A shared governance approach and participant engagement has been identified as critical in developing a practice model that reflects organizational strategic priorities and staff values (Kear et al., 2012). The intention is to articulate the unique aspects of the PHN role within the broader Population & Public Health program structure; so that a consistent and more evidence based approach to public health nursing work is attainable in the WRHA. The professional practice model creates a framework and common language to clarify the PHN role.

*The Community Health Nurses of Canada Professional Practice Model does not contain a 5th category. Hoffart titled this category Compensation and Rewards. In the WRHA professional Practice Model, this category was adapted to be applicable within the Manitoba/ Canadian context.

WRHA PHN Professional Practice Model Summary



WRHA PHN Professional Practice Model Components

PPM Component	Description
Delivery Structure and Process	PHN practice is delivered based on structures and processes consistent with PPH key strategic approaches
Professional Relationships and Partnerships	PHNs develop professional relationships that are client centered, respectful, strength-based, and therapeutic. Relationships are based on PHN assessments and interventions that incorporate cultural proficiency and harm reduction, aiming to increase client engagement and access to services and resources. To advance client health, PHNs have professional relationships and partnerships with a wide variety of providers and agencies.
Values and Principles	PHN values and principles form the collective belief system and foundation for PHN practice and professional development. The basis of PHN practice is promoting, protecting and preserving the health of populations, and facilitating equitable health outcomes by addressing the determinants of health.
Management Practices	PHN practice is supported by management approaches that promote PHN input, utilizing a collaborative, strength based approach. The role of management is to support and foster nursing excellence and practice model implementation by creating successful organizational structures and facilitating connections both horizontally and vertically in the organizational hierarchy.
Recognition and Rewards	PHN practice and attributes are acknowledged by formal and informal organizational structures that create an empowering practice environment.

PHN Service Delivery Model Summary

WRHA PHN Delivery Structures and Processess:

PHN Practice Definitions and Potential PHN Interventions

PPH Key Strategic Approach	PHN Practice Definition	Potential PHN Interventions/ Roles
Public Health Clinical Practice	PHN clinical practice is broad. It includes health promotion, disease and injury prevention, health protection, health assessment, as well as emergency response and preparedness. Practice is responsive to client needs and utilizes a case management approach to coordinate care and promote equitable access to services and resources for long-term clients with identified risk factors for poor health outcomes.	Health threat response; Case management; Promoting health; Team building and collaboration; Resource management, planning, coordination
Outreach	PHNs use strategies such as outreach, targeted home visiting, and case finding, to promote equity and facilitate access to resources and health services for vulnerable populations. PHN outreach strategies are relationship based and built on trust.	Outreach, Targeted home visiting; Case finding; Increasing access
Healthy Public Policy	PHNs identify opportunities for policy and program development, participating in the development of policies with measurable outcomes based on clear philosophies, objectives, and standards. PHNs influence policy at multiple levels, including schools, daycares, community, and across sectors that affect health determinants.	Policy and program development and implementation; Advocacy; Leadership
Healthy Built and Social Environment	PHNs incorporate the built and social environment into program planning activities. The built environment refers to physical structures developed by humans. It consists of buildings; roads and transportation systems; as well as access to healthy housing, food, water, physical spaces, schools, and recreation facilities.	Collaborating; Advocacy; Building coalitions and networks

PPH Key Strategic Approach	PHN Practice Definition	Potential PHN Interventions/ Roles
Health Communication	PHNs use the most appropriate media, current technology, and communication strategies to support their practice and to mobilize individuals, families, groups, and populations.	Counselling; Health education; Referrals; Facilitating change
Health Assessment	PHN practice priorities are based on analysis of health status within populations. Health assessment incorporates the nursing process components of assessment, planning, intervention, and evaluation.	Advocacy; Communicable disease prevention; Referral and follow-up
Community Development	PHNs utilize knowledge, assessment, and a strength based approach to empower and build capacity of the community to meet its needs.	Capacity building; Empowering; Partnering; Building coalitions and networks
Collaboration and Partnership	PHNs share resources, responsibility, and influence while recognizing the strengths of others and working towards common goals that promote health. Collaboration and partnership is based on effective PHN communication and consultation with clients, team members, and other agencies and organizations.	Consultation; Advocacy; Service /care coordination; Leadership; Facilitation
Applied Public Health Research	PHNs appraise and apply research evidence from public health and nursing sciences. PHN practice is current, accountable and evidence informed.	Applying public health and nursing theory; Appraising; Synthesizing; Research and evaluation
Surveillance	PHNs collect and interpret surveillance data, as well as apply surveillance information to guide their practice. PHNs monitor community based trends and health assessment data to understand the population they work with and to plan PHN interventions.	Monitoring; Immunizing; Screening; Referral and follow-up; Leadership; Resource management, planning, coordination

WRHA PHN Professional Practice Model

Values and Principles

The basis of PHN practice is promoting, protecting and preserving the health of populations, and facilitating equitable health outcomes by addressing the determinants of health. In contrast to health care which mainly focuses on the individual, the purpose of public health is to keep people healthy and alleviate pressure on the healthcare system by creating population level health improvements (Public Health Agency of Canada, 2008). A distinguishing feature of the PHN role is the prominence of primary prevention activities, to promote equitable health outcomes and prevent future problems by addressing root causes, focusing beyond health risks and/or disease (Canadian Public Health Association, 2010; Keller et al., 2011). A population based approach is premised on understanding and influencing complex interacting factors that contribute to individual-level health outcomes (Macdonald, Newburn-Cook, Allen, & Reutter, 2013). The Ottawa Charter for Health Promotion identifies prerequisites for health that include food, income, shelter, peace, a stable eco-system, education, social justice and sustainable resources. PHNs mediate, enable, and advocate for health by actions identified in the charter that include building healthy public policy; creating supportive environments; developing personal skills; reorienting health services; and strengthening community action (World Health Organization, 1986).

Practice excellence and quality PHN delivery structures and processes will be achieved by recognizing the Population & Public Health key strategic approaches of health equity and population health improvement. According to the WRHA equity statement, equity is an ethical principle that recognizes health services must be allocated proportionately based on need, supporting all citizens to reach their full potential and to not be advantaged or disadvantaged by "social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance." Health inequities are socially produced and amenable to intervention. PHNs will base practice decisions and priorities on the Population & Public Health guiding principles of: health equity, accessibility, cultural proficiency, determinants of health, engagement, harm reduction, practice excellence and quality. Basing PHN practice on these guiding principles and goals articulates the unique focus and value added component that PHNs contribute within an integrated system of healthcare.

Professional Relationships and Partnerships

PHNs develop professional relationships that are client centered, respectful, strength-based, and therapeutic. Relationships are based on PHN assessments and interventions that incorporate cultural proficiency and harm reduction, aiming to increase client engagement and access to services and resources. In establishing relationships, PHNs respect different levels of education, literacy, and language, utilizing interpreter services as appropriate. PHNs tailor their communication skills to meet complex clients where they are at, with the plan of establishing and maintaining long-term relationships to promote health.

To advance client health, PHNs have professional relationships and partnerships with a wide variety of providers and agencies. The new public health movement highlights the importance of moving beyond individual level education and health promotion, to tackle the structural determinants of inequities through collaboration among sectors and agencies (Koch & Kralik, 2006). PHNs work within multiple dynamic teams composed of varied health and social service providers. The teams and level of PHN intervention vary depending upon client need, capacity, and other services involved. For example, PHNs may collaborate with staff from Child & Family Services, Housing, Employment & Income Assistance and schools. PHNs are ideally situated to address the determinants of health and promote equity through action at multiple levels that include the individual, community, and government (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b).

Delivery Structure and Process

PHN delivery structure and processes are based on the following components outlined in the Population & Public Health conceptual framework:

Public health clinical practice. PHN clinical practice consists of health promotion, disease and injury prevention, health protection, health assessment, as well as emergency response and preparedness (Canadian Public Health Association, 2010). PHN practice is responsive to various client needs. A case management approach is used to coordinate care and promote equitable access to services and resources for long-term clients with identified risk factors for poor health outcomes.

PHN practice is broad, incorporating the components outlined in the Population & Public Health conceptual framework below within the Population & Public Health key service areas of communicable disease prevention; environmental health; healthy sexuality & harm reduction; immunization; travel health; tuberculosis prevention & management; healthy parenting & early childhood development; healthy children & youth; injury prevention; mental health promotion; nutrition promotion; physical activity promotion; tobacco reduction and substance use, public health information systems, and surveillance.

Examples.

- A PHN links a mother of an obese 10 year old to a program that focuses both parent and child on healthy eating and regular exercise;
- A PHN facilitates a truth or myth session on Human Papillomavirus with a group of Grade 6 girls for whom unprotected sex, multiple partners and sexually transmitted infections have become a cultural norm.

Outreach. PHNs use strategies such as outreach, targeted home visiting, and case finding, to promote equity and facilitate access to resources and health services for vulnerable populations (Community Health Nurses of Canada, 2011b). Vulnerable populations may include but are not limited to teen mothers, Aboriginal people, refugees or new immigrants; people living in poverty or with mental illness; and those who are isolated or experience communication barriers. PHN outreach strategies are relationship based and built on trust.

Examples.

- A PHN accesses prenatal clients by working in collaboration with community Employment and Income Assistance workers;
- A PHN raises immunization consent return rates by attending organized school-based family events;
- A PHN increases immunization rates by coordinating an inner-city health fair with community partners and providing youth immunizations;
- A PHN works with target populations attending community based groups such as Healthy Baby/Healthy Start.

Healthy public policy. PHNs identify opportunities for policy and program development, participating in the development of policies with measurable outcomes based on clear philosophies, objectives, and standards (Canadian Public Health Association, 2010). This may include PHN advocacy for social, health, environmental or income policies to promote health, resources, and equity (Cohen, 2012). PHNs influence policy at multiple levels, including schools, daycares, community, and across sectors that influence health determinants.

Examples:

- PHNs raise awareness of the importance of bike helmet legislation within their community and advocate for individuals to lobby the government;
- A PHN identifies a trend of increasing chewing tobacco use among youth hockey teams in the community. The PHN works in collaboration with the school division and sports teams to increase awareness of the health risks of chewing tobacco and to influence policies to limit youth access.
- PHNs lead the implementation of Baby Friendly policies across WRHA community programs. A related activity to increase awareness is organizing a "latch on" day at the legislative building in recognition of World Breastfeeding Day.

Healthy built and social environment. The built environment refers to physical structures developed by humans (Stanhope & Lancaster, 2010). It consists of buildings; roads and transportation systems; as well as access to healthy housing, food, water, physical spaces, schools, and recreation facilities (National Collaborating Centre for Healthy Public Policy, 2010). Based on PHN knowledge of the community and to promote equity, PHNs incorporate the built and social environment into program planning activities to promote equity.

***Examples*:**

- A PHN collaborates with a Healthy Child coalition and recreation centre to develop community based programs;
- PHNs works in collaboration with the community and advocate for flu and breastfeeding clinic sites that are welcoming and accessible based on community structure, function, and transportation systems;
- A PHN collaborates with the community facilitator and public health dietician to identify healthy food options and to increase awareness within the community;
- A PHN works with a client, their landlord, and an environmental health officer to address a rodent infestation in an apartment building;

- A PHN identifies a possible restaurant link in the course of a CD investigation and works with the health inspector;
- A low income housing complex is closed and a PHN works in collaboration with Manitoba Housing, the community facilitator and others to advocate for healthy housing options within the same neighborhood.

Health communication – PHNs use the most appropriate media, current technology, and communication strategies to support their practice; to coordinate care and social services for complex clients; and to mobilize individuals, families, groups, and populations (Community Health Nurses of Canada, 2009, 2011b). Communication involves the exchange of information, ideas, and opinions (Community Health Nurses of Canada, 2009); it is not just one way, but an interactive process to determine client preferences for learning and to evaluate effectiveness. Communication may be verbal, non-verbal, face-to-face, telephone, group, electronic, or written (Community Health Nurses of Canada, 2011b). PHNs assess client needs, the social media they use, and gear communication to the audience. PHNs are strength based and sensitive to nonverbal communication cues, as well as assessing timing and client readiness. PHNs recognize the influence of culture on communication, and appreciate that culture extends beyond ethnicity. Examples include but are not limited to deaf; homeless; or lesbian, gay, trans, bisexual, and intersex (LGTBI) communities. PHNs advocate for current information technology to support their practice, such as the use of evidence based websites, e-mail, and texting. Health communication takes place between team members, between PHN's and primary care practitioners; as well as during referrals to other health services etc.

Examples:

- A PHN is presenting to a group of newcomers and adapts the communication medium and her own approach to be relevant for that target population;
- A PHN is working with a high functioning new mom who has many questions and is requesting information. The PHN refers her to evidence based websites where she can find her own answers;
- A PHN is working with a client with numerous identified risk factors. The client is isolated and doesn't read or have computer access, so the PHN uses visual, hands on and client-centered discussion during home, office and/or community visits;
- A PHN is hoping to complete a parent survey during her home visit. During discussion of abuse and family history, a change in the client's verbal and non-verbal communication indicates she is shutting down. To continue to engage and develop trust, the PHN acknowledges what she has noticed, and explores whether the client wishes to continue or would prefer to discuss more at a subsequent visit and move to a different topic now.

Health assessment – Health assessment is integral and ongoing in every aspect of PHN work with families, schools, and the community. Health assessment incorporates the nursing process components of assessment, planning, intervention, and evaluation. PHN practice priorities are based on analysis of health status within populations (Canadian Public Health Association, 2010).

PHNs collect apply, and analyze information from multiple sources (Community Health Nurses of Canada, 2009). Based on their health assessment, PHNs facilitate and advocate for equitable access to services and resources. This may include screening, referrals, and/or coordination of services within and outside the health system (Community Health Nurses of Canada, 2011b). Experienced PHNs often integrate assessment and nursing process into their daily work with such proficiency and skill, that the theory upon which the practice is grounded may be difficult to recognize. PHN assessment is holistic, assessing not only health and/or disease status but the broader social determinants that impact health outcomes. Equity is considered within all components of one's health assessment.

Examples:

- While completing a health assessment for surveillance purposes in a client who has been diagnosed with pneumococcal infection, the PHN refers the client to housing and other resources identified as needs by the client
- Using a client-centered approach, PHNs assess health and social needs to plan PHN interventions. The Families First screen and parent survey, care map, communicable disease follow-up, and immunization consent forms are assessment tools that can be used to plan PHN interventions, referrals, and priorities;
- PHNs make referrals to a range of community partners based on health assessment. Examples may include speech and language pathologists, mental health providers, addictions counsellors, and food banks.

Community development. PHNs utilize knowledge, assessment, and a strength based approach to empower and build capacity of the community to meet its needs (Canadian Public Health Association, 2010). Community development may include work with neighborhoods, schools, families, and a variety of communities including cultural groups or groups with a common belief.

Examples:

- A PHN works with the nutritionist, community centre, and community members to implement a Community Kitchen where families cook and take home healthy meals made from items available at the local food bank;
- A PHN works with a parent child coalition to develop drop-in programs to meet the needs identified by parents with children age 1-5;
- A PHN works with students and community members to develop a peer led parenting group in an inner city neighborhood;
- A PHN supports the school community to implement actions that promote health based on needs identified by the school population through the Youth Health Survey.

Collaboration and partnership. PHNs share resources, responsibility, and influence while recognizing the strengths of others and working towards common goals that promote health (Community Health Nurses of Canada, 2009). Collaboration and partnership is based on effective PHN communication and consultation with clients, team members, and other agencies and organizations (Community Health Nurses of Canada, 2011b).

Examples:

- PHNs work in partnership and collaboration with a variety of agencies to promote population health and equity. Examples include Healthy Baby/Healthy Start and other community support groups such as the group for newcomers held at Knox United Church in Central Park and The Network of Organizations Working for War Affected Newcomers (NOWAN);
- A PHN works in collaboration with a community group to influence health by introducing an evidence based program to promote nutrition;
- A PHN advocates for a client requiring medication and works in collaboration with an Employment & Income Assistance worker to navigate system barriers that would have delayed treatment initiation.

Applied public health research. Focuses on public health program and policy research interventions. Currently the Manitoba Centre for Health Policy holds a research chair with the Canadian Institutes of Health Research and is examining population health improvements of national relevance (Canadian Institute of Health Information, 2012). PHNs participate in these and other research initiatives on an ongoing basis.

PHNs appraise and apply research evidence from public health and nursing sciences(Community Health Nurses of Canada, 2009). PHN practice is current, accountable and evidence informed. Tools to incorporate current research evidence in PHN practice may include raising issues at NPC to develop a consistent system approach, working with team leads (i.e. smoking cessation champions); or collaborating with the Clinical Nurse Specialists (CNS).

Examples:

- Data elements collected by PHNs are used in a variety of population level reports and research studies that include the Families First Program evaluation, Towards Flourishing, Early Development Instrument, Youth Health Survey, and Child Health Atlas;
- PHNs assist a University of Manitoba graduate student researcher to access a vulnerable population;
- A PHN uses current safe sleep evidence and anticipatory guidance while working with a vulnerable young mother.

Surveillance. Surveillance involves monitoring disease patterns and trends, to identify events that do not fit expected norms. PHNs collect and interpret surveillance data, as well as apply surveillance information to guide their practice (Canadian Public Health Association, 2010). For infectious diseases surveillance may consist of assessing individuals with a reportable disease and their contacts (Stamler, 2012). PHNs also monitor community based trends and health assessment data to understand the population they work with and to plan PHN interventions. PHNs utilize surveillance data obtained from formal information systems such as the Manitoba Immunization Monitoring System, Panorama, Integrated public health information system (iphis), the Healthy Parenting and Early Childhood database, as well as the Community Health Assessment and Manitoba Centre for Health policy reports. PHNs also identify trends through their expertise and ability to integrate surveillance principles and other pertinent sources of information to recognize emerging issues. PHNs recognize that while quantitative data is important, qualitative data obtained from the community may also assist in identifying

significant issues for PHN action. Trends not captured by quantitative or formal surveillance methods are often based on PHN knowledge of the community and relationships with key stakeholders.

Examples:

- Formal surveillance data include: Rates of sexually transmitted and blood borne infections, tuberculosis, injury, immunization, teen pregnancy and breastfeeding as well as flu outreach clinic statistics; immunization consent return rates; Families First Program reports and statistics;
- Informal surveillance data may consist of recognizing patterns of newcomer families functioning within the Canadian health and social system, For instance, while African newcomer families may live in a variety of areas across the city, they access downtown community groups and resources;
- A PHN recognizes a trend that inaccurate information is being disseminated in newspaper articles and advertising on infant sleep training, and that mothers attending a breastfeeding group are being misled. The PHN develops an issue paper for NPC, and discussion indicates this is a new and concerning trend across the city.

Management Practices. The management approach pertains to the process and structures for decision-making within an organization (Community Health Nurses of Canada, 2011b). Successful healthcare organizations promote professional practice environments in which nursing input flourishes, contributing to improved organizational relationships and processes (Tinkham, 2013). Work that is led by nurses using a collaborative strength based approach to practice decisions is more likely to reduce system costs, increase efficiency, and improve nurse satisfaction and client outcomes (Gottlieb et al., 2012; Shendell-Falik et al., 2012). The role of management is to support and foster nursing excellence and practice model implementation by creating successful organizational structures and facilitating "connections both horizontally and vertically in the organizational hierarchy" (George & Lovering, 2013). Decision-makers have to share power, to foster staff commitment and organizational transformation (Leclerc & Lavoie-Tremblay, 2007).

Accreditation Canada suggest the following organizational responsibilities (Accreditation Canada, 2012):

- Ensuring staff are educated, trained, qualified and competent
- Conducting workforce assessments
- Ensuring each team member has the necessary credentials
- Evaluating and documenting team member performance in an objective, interactive, and positive way on a regular basis
- Basing performance assessments on demonstration of core competencies for public health that are specific to the work setting
- Ensuring the workforce is participating in ongoing professional development activities and training
- Evaluating staffing effectiveness and making improvements on an ongoing basis
- Including staff in work and job design, including defining roles and responsibilities and case assignments

Additional feedback provided by the PHN teams/working group include:

- Active PHN leadership, participation, and inclusion in all practice decisions
- Support for PHNs to work to their full scope and to address equity
- Adequate staffing
- Trust and value for PHN Nurse IV role
- Clarify manager versus PHN roles and responsibilities in practice. Eg. Prior to H1N1 PHNs organized, staffed, and ran annual mass flu clinics
- Work as a team to achieve common goals. Individual PHNs assume professional responsibility to provide input to their teams and nursing practice council rep
- Develop an effective organizational structure and process for communication that can be used to disseminate organization changes and future directions

Recognition and Rewards. Rewards and recognition describe formal and informal organizational structures for acknowledging nursing attributes and employee motivation. A strength based professional nursing leadership model aims to determine what is significant and motivating to individuals, teams, and systems and to create a professional practice environment that is empowering (Gottlieb et al., 2012).

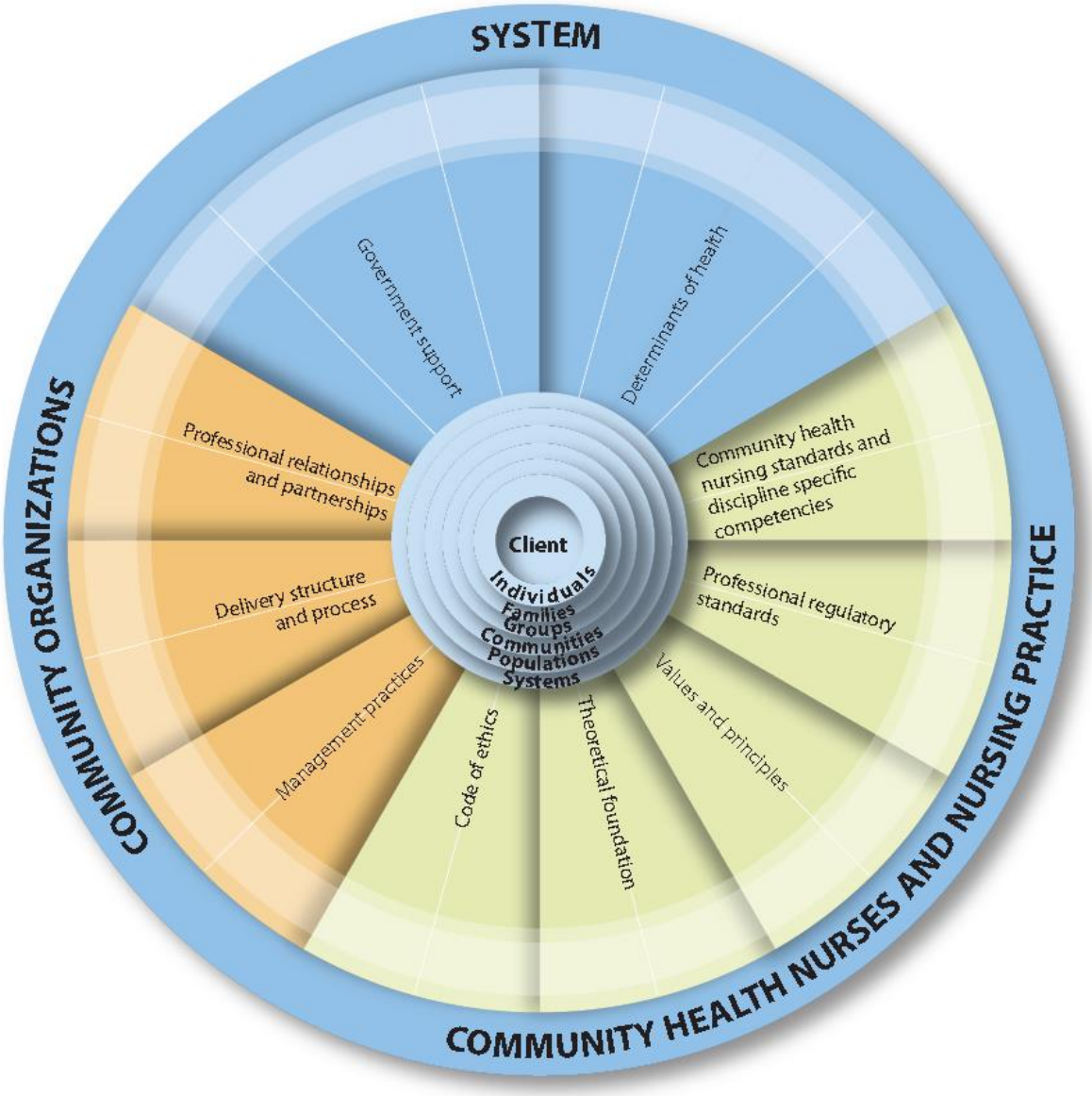
Accreditation Canada suggests (Accreditation Canada, 2012):

- Organizational incentives for participation in education and training – ie career advancement, time off for course work or conferences, tuition reimbursement, supervisor recognition
- Recognition of team member contributions

Team and working group suggestions include:

- PHNs expertise valued
- Case studies that cultivate shared learning
- Celebration of successes
- Organization and team manager support
- Staff recognition for certification / education at staff development sessions
- Orientation scheduled over time – focusing on the full scope of PHN practice
- Sharing best practices at NPC
- Building on models of best practice teams
- Mentorship program

Appendix I – Community Health Nurses of Canada Professional Practice Model
Community Health Nurses of Canada, 2013



Professional Practice Model Components

Code of Ethics: The Canadian Nurses Association's *Code of Ethics for Registered Nurses* is a statement of the ethical values of nurses and of nurses' commitments to persons with health-care needs and persons receiving care. It is intended for nurses in all contexts and domains of nursing practice and at all levels of decision-making. It is developed by nurses for nurses and can assist nurses in practising ethically and working through ethical challenges that arise in their practice with individuals, families, groups, communities, populations and systems.

Professional Regulatory Standards: Professional regulatory standards demonstrate to the public, government and other stakeholders that a profession is dedicated to maintaining public trust and upholding the criteria of its professional practice.

Community Health Nurse: Community health nurses:

- View health as a resource for everyday living.
- Promote, protect and preserve the health of individuals, families, groups, communities, and populations in the settings where they live, work, learn, worship and play in an ongoing and/ or episodic process.1
- Consider and address the impact of the social determinants of health within the political, cultural and environmental context on health.
- Support capacity building focused on client strengths and client participation.
- Protect and enhance human dignity respecting social, cultural, and personal beliefs and circumstances of their clients.
- Advocate and engage in political action and healthy public policy options to facilitate healthy living.
- Incorporate the concepts of inclusiveness, equity and social justice as well as the principles of community development
- Participate in knowledge generation and knowledge translation, and integrate knowledge and multiple ways of knowing.
- Engage in evidence informed decision making.
- Work at a high level of autonomy.
- Have a personal commitment and accountability to professional practice with an emphasis on teamwork, collaboration, consultation and professional relationships.

Values and Principles: Values are part of a collective belief system that underpins professional practice, informs the development of educational programs and guides administration. Community health nursing is rooted in caring3 and social justice as reflected in public policies such as the Canada Health Act4, the declaration of Alma Ata5, the Ottawa Charter for Health Promotion6, the Jakarta Declaration7, the Bangkok Charter for Health Promotion8 and the "Nairobi Call to Action"9 which are consistent with the Community Health Nurses of Canada Vision Statement.10 The community health nursing is accountable, committed to quality care and competency through continuous professional development.

Theoretical Foundation: The practice of community health nursing combines nursing theory and knowledge, social sciences and public health science with home health and primary health care principles. The nursing metaparadigm includes: person (individuals, families, community,

group, and populations), health, nursing, environment [culture] and social justice as central to the practice of community health nursing.

Discipline Specific Competencies: Competencies are the integrated knowledge, skills, judgment and attributes required of a registered nurse to practice safely and ethically. Attributes include, but are not limited to attitudes, values and beliefs.

Professional Relationships & Partnerships: Professional relationships in community health nursing have an impact on communication, consultation, collaboration and forming effective partnerships with clients, team members other professionals as well as other sectors and organizations.15 Community health nurses:

- Recognize assets and capacity of people/partners in building collaborative partnerships based on the principles of primary health care, caring, social justice and empowerment.
- Establish respectful, trusting relationships / partnerships with individuals, families, groups, communities, populations, and systems.
- Ensure individuals, families, groups, communities, populations and systems are active partners in defining their health issues and in making decisions that affect their health and well being
- Build professional relationships and partnerships with colleagues, other disciplines, communities and sectors that support inter-professional collaboration.
- Recognize socio-political and cultural influences that may impact relationship and partnership building.

Management Practices: Management practices refer to the structure and processes for decision-making within community organizations and agencies. An approach consistent with professional nursing values such as autonomy and accountability will support community health nurses to practice their full scope of skills and knowledge. Effective management practices promote realization of the full potential of community health nursing resources with a goal of excellence in community health/public health nursing practice. Formal communication and decision making mechanisms are essential for effective community health nursing professional practice. This involves having direct authority relating to "creating an environment that supports clinicians to incorporate evidence-based practice, maintain their competency and/or create systems and processes to enhance practice and professional development." Community health nurses take personal and professional satisfaction from their contribution in promoting the health and well-being of individuals, families, groups, communities, populations and systems. Community health nurses value a management approach that recognizes their contribution both informally and formally. Examples of rewards include but are not limited to: celebration of successes; certification; promotion and professional advancement or remuneration.

Delivery Structure and Process: A variety of service delivery models that integrate Community Health Nursing Process into practice are used in community health nursing including, but not limited to: generalist practice based on geographic location (e.g. neighbourhood nursing), focused practice (based on developmental stage or health issue (e.g. sexual health, post partum, wound care, shift nursing, palliative care), or care process (e.g. team nursing, primary health care, case management or perhaps family centered care). Community health nursing practice roles and activities are continually evolving to meet the health needs of the different population

groups. Service delivery is focused on preventive/curative/social aspects of care and is responsive to community needs and takes into consideration stewardship of resources as an appropriate means of making services less costly, and more efficient and effective.

Community Health Nursing Standards: A key characteristic of a self-regulating profession like nursing is the development of standards of practice based on the values of the profession. Practice standards describe the knowledge, skills, judgment and attitudes needed to practice nursing safely. They represent the desirable and achievable levels of performance expected of nurses in their practice and provide criteria for measuring actual performance.

Government Support: Provision of community health nursing in Canada requires government resources and supportive policies. Decisions about funded services, resources, performance standards and policies that affect community well-being as well as the nursing profession all have an impact on the ability of community health nurses to deliver care consistent with their professional standards. Consultation with the nursing community will assist government to make decisions that optimize health in the community.

Social Determinants of Health: The social determinants of health, are the individual and collective factors and conditions affecting health status. The social determinants of health extend beyond the community health nurses practice environment and scope of influence but impact on CHN practice because of their profound influence on the health of their clients (individuals, families, groups, communities, populations and systems). Community health nurses support their clients by recognizing and identifying these factors as major influences on health status and in advocating for positive means to address these issues.

Health of Client (Individuals, Families, Groups, Communities, Populations, Systems): Community health nurses practice in health centres, homes, schools and other community-based settings. Using a capacity building and strength-based approach, they provide, coordinate or facilitate direct care and link people to community resources. Community health nurses view health as a dynamic process of physical, mental, spiritual and social well-being. Health includes self-determination and a sense of connection to the community. The practice of community health nursing community health nurses support the health and well-being of individuals, families, groups , communities , populations and systems.

Appendix II - Literature Summary to Support Professional Practice Model

by Cheryl Cusack

Background

The final report of the World Health Organization's Commission on Social Determinants of Health described growing and avoidable health inequities and posed the challenge to improve the conditions that perpetuate inequities within one generation (Commission on Social Determinants of Health, 2008). Specific actions highlighted as solutions within the report present an opportunity for PHNs to contribute to this important global movement. In Manitoba, PHNs work with all new families and have access to others who may be experiencing inequities through mandated communicable disease work and community relationships. These multiple access points, combined with PHN knowledge and expertise, make PHNs ideally situated to reduce inequities and to contribute to population-level health improvements.

Professional Practice Model

A professional practice model is an organizational tool to provide the framework and common language to articulate the PHN role. A common vision for community health nursing based on the Community Health Nurses of Canada discipline specific competencies and full scope of practice has been identified as a priority by Canadian experts (Schofield et al., 2011). A paucity of models and theories to guide PHN practice has contributed to lack of PHN role clarity. A recent review of the literature found 12 PHN conceptual models, most had not been tested or used in practice (Bigbee & Issel, 2012). As nurses incorporate PHN specific theory and knowledge into daily practice, it will become more transparent and visible to the public and other providers (Phillips, 2013). The intention of this professional practice model is to clearly define the PHN Nurse IV role, so that a consistent and evidence based approach to public health nursing work is attainable in the WRHA.

A wide variety of literature was reviewed to articulate the PHN role, as well as to define a structure and process for this project. This included literature on public health and nursing practice, service delivery models, nursing leadership, and key Canadian research articles and policy documents. Though the initial task of the group was development of a service delivery model, after reviewing the literature it became evident that a professional practice model was essential, if the service delivery model was to effectively guide and support PHN practice. Components of a professional practice model include values and principles; professional relationships and partnerships; delivery structure and process; management practices; and rewards and recognition. Each component will be addressed briefly in the following sections, using a summary of current evidence.

Values and principles. Values and principles provide the foundation for a professional practice model. Values and principles are defined as the collective belief systems that guide nursing practice and nurses' decisions (Hoffart, 1996). Registered Nurses are autonomous, self-regulated professionals governed by the College of Registered Nurses of Manitoba, the entity that ensures nurses are qualified and competent. Public health nursing is a specialized Registered Nursing role, representing the fusion of public health sciences with nursing theory and practice (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009; Keller et al., 2011). Similar to other areas of Registered Nursing practice, PHN practice is founded on professional regulatory standards set out by the College of Registered Nurses of Manitoba and

the Canadian Nurses Association Code of Ethics (College of Registered Nurses of Manitoba, 2013a, 2013b). (Schlotfeldt, 1989).

Several other documents are relevant to PHN practice. The purpose of a professional discipline such as nursing is to develop, disseminate, and use knowledge (Fawcett, 2013). Groups claiming professional status must have a social mission or goal, which is based on a distinct body of knowledge. In Canada, the knowledge that articulates the unique PHN scope and function is described within four key documents. These are the Public Health Agency of Canada Core Competencies, Canadian Public Health Associations' Roles and Activities, and the Community Health Nurses of Canada Standards of Practice, and PHN Discipline Specific Competencies (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b). These documents will be discussed in more detail in a subsequent section.

PHNs represent the largest group of public health practitioners. Based on documents articulating their role, PHNs should be working upstream to promote health equity, prevent chronic diseases, and improve population outcomes (Community Health Nurses of Canada, 2011b; National Expert Commission, 2012; Reutter & Kushner, 2010). Action on the social determinants of health is foundational (Community Health Nurses of Canada, 2009, 2011b; Reutter & Kushner, 2010). Reutter and Kushner (2010) argue that nurses promote equity by facilitating access to health as well as health care, using skills of sensitive and empowering care that appreciates the context of equities and addresses underlying conditions and root causes (Wilson & Neville, 2008).

Professional relationships and partnerships. The second component of a professional practice model is professional relationships and partnerships. This category describes nurses beliefs, attitudes, relational skills, and interactions with clients and others within the healthcare system (Hoffart, 1996). PHNs utilize a variety of skills to develop professional relationships with clients. Based on the voluntary nature of the PHN role, the ability to foster therapeutic relationships with complex clients is essential (Falk-Rafael, 2001; Heaman et al., 2007; Jack et al., 2005b; Oliveira & Marcon, 2007). Adeline Falk-Rafael proposed a mid-range theory of empowered or critical caring, based on the development of a trusting and reciprocal relationship between the nurse and client (Falk-Rafael, 2001, 2005). Empowerment resulted from the clients' active participation. Aspects included establishing a mutual and trusting relationship; education; developing personal skills; advocacy; and increasing client capacity. A reciprocal relationship developed in which the PHN shared her clinical expertise, and incorporated theoretical and empirical evidence into practice. The theory was rooted in equity, social justice, and feminism. PHN professional relationships with clients are based on understanding the personal, interpersonal, and socio-environmental contexts that impact and promote health (Macdonald et al., 2013). Successful relationships meet client needs, attend to anxiety, and avoid imposing the PHN's agenda (McNaughton, 2005). Disconnected relationships may occur when clients feel they are being lectured, treated paternalistically, or agency needs are prioritized (Jack et al., 2005b). Communication skills, adequate time, and an individualized holistic approach build trust (Heaman et al., 2007; Wilson & Neville, 2008). Nurses have knowledge about health, but the client is the expert regarding their life circumstances (Wilson & Neville, 2008). Organizational support for "critical caring" and PHN advocacy for social justice is essential (Falk-Rafael & Betker, 2012b).

In addition to developing relationships with clients, PHNs must have skills to work in partnership and collaboration with colleagues, other disciplines, and across sectors (Pelaseyed &

Jakubowski, 2007). The importance of interprofessional collaboration to address the social determinants of health has been a global priority since the early 1990's (Reeves et al., 2010; World Health Organization, 2010). The needs of complex clients are beyond the scope of any one professional, and there is increasing appreciation that interprofessional collaboration is vital in fostering equity (Hernandez et al., 2010; Horwath & Morrison, 2011; McFadyen et al., 2010; Moore & McArthur, 2007; World Health Organization, 2010). The complexities associated with poverty highlight the advantages of interprofessional collaboration in promoting and protecting health, particularly for children (Feng et al., 2010; Halfon, 2009; Marcellus, 2005; Watkin et al., 2009). In Canada, appreciating the history of First Nations people and working collaboratively to reorient policy and practice through a process of decolonialism and revitalization of Aboriginal communities and culture is an essential component (Hackett, 2005; National Collaborating Centre for Aboriginal Health, 2009-10d; Ten Fingers, 2005).

Delivery structure and process. The delivery structure and process in a professional practice model articulates how client care is coordinated and distributed, as well as who is responsible for client decisions. In developing a model, Wolf (2007) suggests current trends be considered that include changes in clients, changes in providers, medical advances, information technology and overall system effectiveness and efficiency (Wolf & Greenhouse, 2007). Each of these areas will be discussed briefly in the sections below.

Changes in clients. Health inequities in Manitoba are growing in areas of teen pregnancy, chronic diseases such as diabetes and heart disease, dental caries, childhood mortality, premature mortality and potential years of life lost, hospitalizations for tuberculosis, mental health and suicide (Martens et al., 2010). These changes represent the growing gap between individuals, families, and communities living in poverty and others, which has resulted in disproportionate population health outcomes. Barriers are created for people in poverty, by placing the onus on the individual to navigate across complex programs and systems (Lynam et al., 2010). Simultaneously, poverty is characterized by constant stress, greater exposure to environmental toxins (Standing Senate Committee on Social Affairs Science and Technology, 2009), and inadequate nutrition (Conroy et al., 2010; Leiss & Kotch, 2010). Living situations tend to be overcrowded and unsanitary, which in conjunction with lower rates of immunization enhances the spread of communicable diseases, contributing to increased morbidity and mortality (UNICEF., 2012). Exposure to urban crime and violence may interfere with development and contribute to anxiety, depression, aggression, and poorer academic abilities (UNICEF., 2012). Lastly deficiencies in education programs that promote early childhood learning perpetuate inequities for children living in poverty (UNICEF., 2012).

The Commission on Social Determinants of Health advocates for "equity from the start," recognizing the potent effect that early childhood development has on future lifelong success. Children are more susceptible to environmental toxins and experiences than adults, particularly prenatally (Moore & Oberklaid, 2010). By age five there are significant differences in physical, social/emotional, and language/cognitive development based on level of income, education, and parenting (Hertzman & Boyce, 2010). Readiness for kindergarten is one method of assessing the adequacy of early childhood experiences (Hertzman & Power, 2004; Public Health Agency of Canada, 2009). The Early Development Instrument assesses key indicators of development that include physical, social cognitive, emotional and language skills (Hertzman, 2009). Research using the Early Development Instrument in Manitoba and British Columbia found that close to

30% of the kindergarten population was delayed in at least one area (Kershaw & Anderson, 2009). While approximately 5% of infants had detectable developmental limitations at birth, Early Development Instrument scores ranged from 5-70% based on neighbourhood diversity. Failure to adequately support early childhood development in Canada has increased inequities and resulted in considerable numbers of children with substantive but preventable learning disabilities, mental health issues, emotional, and social disabilities (Halfon, 2009).

Outcomes are particularly troubling for Canadian Aboriginal people; countless numbers experience poor health for their entire life, contributing to a reduced life expectancy rate that is comparable to third world countries (Standing Senate Committee on Social Affairs Science and Technology, 2009). Core areas of Canadian cities are disproportionately populated by homeless and marginalized Aboriginal people with crowded housing, low literacy, and unemployment (Lemchuk-Favel & Jock, 2004). Funding to Aboriginal people has not kept up with population growth, further increasing the gap between Aboriginal and non-Aboriginal people (National Collaborating Centre for Aboriginal Health, 2009-10b). The population is young and growing, with 50% of Aboriginal people being less than 25 years old (Standing Senate Committee on Social Affairs Science and Technology, 2009).

Rates of Aboriginal children living in poverty are particularly high (Public Health Agency of Canada, 2008; Raphael et al., 2008; Reading & Wien, 2009; UNICEF, 2009). Manitoba has a higher proportion of Aboriginal people than other provinces (Manitoba Health, 2011) and has been named the "child poverty capital of Canada" with estimates of 43,000 affected children (Manitoba Campaign 2000 Network, 2010). Poverty has been strongly correlated with low birth weight, and disproportionate infant morbidity and mortality (Brownell et al., 2008; Jutte, Brownell, et al., 2010; Public Health Agency of Canada, 2008; Raphael, 2010a).Although Aboriginal infant mortality has declined, rates remain significantly higher than for non-Aboriginal people (Public Health Agency of Canada, 2008; Simonet et al., 2010). There are also more Aboriginal children in government care today than during peak times of the residential school system (UNICEF, 2009).

The greatest concentrations of teens giving birth were in the poorest neighborhoods. Teen pregnancy is an equity issue, universal interventions have widened the gap between higher and lower socioeconomic areas. For instance teen pregnancy rates dropped 17.6% in the areas of lowest socio-economic status, compared to a decline of 48.4% in the richest areas, accounting for a nine-fold difference. The numbers of teen mothers in Downtown, Point Douglas and Inkster with Grade 12 education was also far below the Winnipeg average (Winnipeg Regional Health Authority, 2010). Teens were up to 3 times more likely to be on antipsychotic medications. Rates of suicide and hospitalization for injury in children under age 19 were also far above WRHA averages (Brownell et al., 2008).

In the WRHA, vastly different health outcomes exist in the lowest income areas of Downtown, Point Douglas, and Inkster (Brownell et al., 2008). The poorest neighbourhoods had rates of breastfeeding and immunization below average, but rates of dental surgery up to 11 times higher. Newborns were significantly more likely to be readmitted to hospital for respiratory illness, jaundice, and infectious/parasitic diseases. Rates of children taken into care by Child & Family Services, as well as those receiving protective or supportive services, were also highest.

More can be done to support the health of women and children in the early childhood period in this province. Many women do not access prenatal care, and one out of every seven reports drinking during pregnancy; the highest rates of alcohol and tobacco use are among

Aboriginal women (Manitoba Health, 2011). Manitoba has the highest provincial rates of fetal and neonatal deaths (Huang, Allen, & Liston, 2008), as well as infant deaths in the 1st year of life (Lindsay, Dzakpasu, & Allen, 2008). Rates of infant mortality are almost double national rates at 6 per 1000, compared to the national average of 3.7 (Public Health Agency of Canada, 2013). Each year there are about 100 deaths in infants under 1 year of age, and 100 deaths in children ages 1 to 5 years, largely from preventable causes (Manitoba Health, 2011). In children less than 5 years of age, 24% of deaths are in the lowest income quintiles (Martens et al., 2010). Universal injury promotion programs and policies have reduced hospitalizations in higher SES groups, but rates have increased for children most at risk (Brownell, Derksen, et al., 2010).

Advances in medical/health care. In the WRHA, PHNs have reported a systemic trend towards earlier postpartum discharge has contributed to a more narrowed PHN role with greater focus on postpartum community based clinical care (Cusack et al., 2008). Based on WRHA postpartum standards, all mothers discharged within 48 hours of a vaginal delivery and 72 hours of a caesarean are contacted within 24 hours and offered a home visit (Winnipeg Regional Health Authority, 2003). Approximately 80% of PHN time is dedicated to postpartum work, and considerable resources have been invested to develop PHN skills and breastfeeding knowledge.

PHNs support breastfeeding and transition to parenthood through ongoing client contact. In 2007, an audit of 302 charts found an average of 6.6 PHN contacts in the initial postpartum period. Breastfeeding is a well documented health promoting strategy with numerous benefits for maternal and infant health (Winnipeg Regional Health Authority, 2010). Martens and colleagues reported that in urban Manitoba breastfeeding initiation rates in lower socio-economic areas had improved, and rates were narrowing between socio-economic groups (Martens et al., 2010). However, in the areas of Downtown, Inkster, and Point Douglas, as well as among Aboriginal women, breastfeeding rates remain lower than provincial averages and in comparison to higher socio-economic and older mothers (Brownell et al., 2008; Manitoba Health, 2011; Martens et al., 2010). Breastfeeding rates may be positively impacted by PHNs, however it has not been documented that individual level PHN breastfeeding interventions correlates to population level improvements, and that this an effective utilization of public health human resources. In the literature, Whitehead cites examples of nurses confusing the concept of individual focused health education with health promotion (Whitehead, 2006, 2009, 2011). Given the intensity and short time frame of PHN involvement with clients identified from the chart audit, it is more likely PHNs are providing individualized clinical care and education, rather than working upstream to change underlying conditions. There is increasing evidence that downstream interventions such as individual education will continue to increase inequities, and more upstream interventions such as resource provision and policy advocacy would be more effective (Lorenc, Petticrew, Welch, & Tugwell, 2012; Reutter & Kushner, 2010).

Women and children living in poverty are at risk for inequities in the postpartum period (Kurtz Landy et al., 2008; Shonkoff, 2010). Four studies were located that considered the issue of poverty immediately following the birth of a newborn (Britton, Baker, Spino, & Bernstein, 2002; Kurtz Landy et al., 2008; Weiss & Lokken, 2009) (Weiss, Ryan, Lokken, & Nelson, 2004). An Ontario study reported women of lower socio-economic were more likely to be discharged from hospital earlier compared to socio-economically advantaged women, often within 24 hours of birth; in addition they had poorer health status and were less likely to receive recommended levels of community-based follow-up (Kurtz Landy et al., 2008). These women reported feeling overwhelmed and having difficulties adjusting to parenting (Kurtz Landy et al.,

2008). Mothers in poverty have been reported to experience the greatest effects of depression (Black & Oberlander, 2011); and mental health issues such as postpartum depression have been strongly linked to later childhood problems (Leve et al., 2010). Literature advocates the importance of the nursing role in promoting health equity for vulnerable groups (Pacquiao, 2008; Pauly et al., 2009).

A main government and WRHA intervention to improve family health and address inequities was implementation of the Families First Home Visiting Program. Since 1999, a component of the PHN home visiting role has been screening all women prenatally or postpartum, and offering the Families First Program for those who qualify. Families First is a targeted home visiting program aimed at reducing child maltreatment and improving outcomes for families based on identifiable risk factors (Brownell et al., 2007). Families First home visitors are paraprofessionals trained to deliver a curriculum that promotes positive parenting and a nurturing environment (Ek & Frankel, 2006). The program is intended to reduce the risk of child maltreatment by building on parent's strengths, reducing stress, increasing support, and being nonjudgmental (Ek & Frankel, 2006).

A 3 year program outcome evaluation by Healthy Child Manitoba indicated that Families First was associated with improvements in health and well-being for participating children and families (Healthy Child Manitoba, 2010). Regardless of whether the Families First Program is accepted, the screen and survey provide PHNs with important information regarding health and social risk factors. The screen was proven effective in identifying risk factors in 77% of children who ended up in the care of Child & Family Services , while 83% without identified risks did not end up in the custody of Child & Family Services (Brownell, Chartier, et al., 2010). Families not screened, accounting for about 20% of the sample, were twice as likely to be linked with child services (Brownell et al., 2011). Mothers with risk factors that included low education, lack of supports, financial difficulties, and previous involvement with Child & Family Services were 3-6 times more likely to have their infant taken into care (Brownell et al., 2007). Financial issues, low levels of education, previous involvement with Child & Family Services, alcohol use during pregnancy, and lack of prenatal care were strongly associated with apprehensions (Brownell et al., 2011). Mothers with risk factors that included teen pregnancy, financial difficulties, inadequate supports, smoking, low education attainment, and an existing Child & Family Services file were 1.5 to 20 times more likely to receive Child & Family Services assistance. Interestingly, mothers reporting depression and parents with substance abuse issues were not linked with Child & Family Services (Brownell et al., 2011). Additional research can assist in understanding reasons that families decline the Families First Program, as well as PHN interventions with these vulnerable families (Heaman et al., 2007). Through a qualitative research project in Inkster Community Health Area, 35 parents who declined or quit the program were interviewed to understand their experiences (Marchessault, 2011). A key finding pertained to the important role of the PHN in client acceptance of the program. It is equally important to understand the work of PHNs with families with risk factors that aren't involved with the Families First Program, as there is limited guidance to support PHN practice.

In the literature, PHNs have been found to play a critical role in identifying family risk factors and ensuring services that promote health (Sharp & Filmer-Shankey, 2010; Tinker et al., 2011). Advocating and supporting clients to access services and resources are PHN actions that can change underlying conditions and foster health equity for vulnerable clients (Cawley & McNamara, 2011; Cohen & Reutter, 2007; Hazard et al., 2009; Johns, 2010; Young, 2009). Social justice involves redistribution of resources to improve health outcomes for disadvantaged

populations (Bell & Hulbert, 2008; Boutain, 2005). Nurses have a role in advocating for, monitoring, and giving voice to those who are vulnerable (Reutter & Kushner, 2010). A framework by the Canadian Nurses Association identifies "ten defining attributes." Nurses can promote equity and access to health care and other human rights; build capacity, work to reduce poverty, promote enabling environments, advocate for human rights, and develop partnerships to create change (Canadian Nurses Association, 2010). Promoting equity and social justice are key components of effective and culturally appropriate care (Cohen & Reutter, 2007; Pacquiao, 2008; Starr & Wallace, 2009).

Changes in providers. PHNs work in complex and bureaucratic health systems, which influence PHN services and programs (Baldwin et al., 2011). In Canada, public health responsibilities are shared between federal, provincial, and regional governments, as well as Aboriginal organizations (Canadian Public Health Association, 2010). Public health services are often delivered by diverse professionals with on the job training and limited education specific to the field, resulting in varied perspectives when complex program decisions are required (Brownson et al., 2009). Following the global outbreak of Severe Acute Respiratory Syndrome (SARS), a plan to strengthen and coordinate the public health workforce was deemed necessary to prepare for future pandemics and public health emergencies, as well as to influence chronic disease prevention and health disparities (The Joint Task Group on Public Health Human Resources, 2005). In 2005, a pan-Canadian framework for public health human resources planning was released by the Public Health Agency of Canada, to support the regions in delivering population based services.

Through a number of Public Health Agency of Canada funded projects to strengthen the workforce, the Community Health Nurses of Canada has played a central role in articulating the scope of PHN practice. The Community Health Nurses of Canada is a voluntary organization that represents the voice of PHNs (Community Health Nurses of Canada, n.d.). Based on reviews of the literature and Delphi methodology with expert community health nurses, the Community Health Nurses of Canada has developed several key documents. Standards of practice were originally released in 2003; in 2011, the standards were revised for the third time and published with elements of a professional practice model. The standards exemplify "a vision for excellence" to guide all aspects of PHN practice, research, education, and management. The most recent publication describes standards in the areas of: health promotion, prevention, and maintenance; building capacity and promoting access and equity; professional relationships, accountability and responsibility (Community Health Nurses of Canada, 2011b). The standards are broad in scope; intended for PHNs and other classifications of nurses working in community-based settings. To further define PHN practice, the Community Health Nurses of Canada released discipline specific competencies in 2009 (Community Health Nurses of Canada, 2009). Eight main PHN competencies were identified: public health and nursing sciences, assessment, program planning, collaboration, diversity, communication, leadership, and professional accountability. Lastly, in conjunction with the Community Health Nurses of Canada, in 2010 the Canadian Public Health Association released a document defining the roles and activities of PHN practice. All of the documents are complementary and intended to guide PHN practice.

Despite support by Canadian literature substantiating a social justice approach and being perfectly positioned (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b), PHN skill and knowledge are under-utilized and invisible to the public, professionals, and employers (Beaudet et al., 2011; Cohen & McKay, 2010; Cohen & Reutter,

2007; Dunne, 2011; Meagher-Stewart et al., 2010). In fact, experts have cited a looming crisis due to the growing disconnect between the desired PHN practice and their daily activities, threatening the sustainability of the PHN role (Canadian Public Health Association, 2010; Community Health Nurses of Canada, 2009, 2011b). Practice is narrowing to a focus on clinical care and health education; there is an inability to practice to full scope; lack of understanding regarding the role; and PHNs are feeling devalued and powerless to promote change (Beaudet et al., 2011; Cohen & McKay, 2010; Cusack et al., 2008; Dunne, 2011) (Schofield et al., 2011). Incongruence in practice represents a significant theory-practice gap (Cohen & Reutter, 2007; Lind & Smith, 2008). The Community Health Nurses of Canada and Canadian Nurses Association convened experts to establish priorities for community health nursing in Canada (Schofield et al., 2011). Public need and population health were identified as levers for health system transformation based on the well-being of individuals, families, and communities. The first priority was development of a common vision for community health nursing, based on the Community Health Nurses of Canada discipline competencies and full scope of practice (Schofield et al., 2011).

System effectiveness and efficiency. The Canadian Health Human Resource Strategy is based on effective and efficient use of all providers, as well as optimizing skill mix and scopes of practice (Health Canada, 2011). Enhancing preventative interventions and service coordination for vulnerable clients has been suggested by creating changes in funding structures and organizational culture (Smith et al., 2009). Reports in the United Kingdom have repeatedly highlighted the importance of targeted and integrated preventative services for children in poverty (Sharp & Filmer-Shankey, 2010). Professionals may differ in approach, but each can play a role in strengthening client capacity and reducing the likelihood of harm (Darlington et al., 2010; Feng et al., 2010). A theme in the literature is utilization of a case manager, who could be from any number of fields. Case management is an effective model in ensuring one person oversees and coordinates client care when there are multiple providers involved (Schmied et al., 2010).

PHNs working to full scope and within inter-professional teams can improve health outcomes and contribute to system effectiveness and efficiency (Community Health Nurses of Canada, 2011a). Inter-professional collaboration is an efficient approach when multiple providers are involved with the same client (Banks et al., 2008; Claiborne & Lawson, 2005; Freeth, 2001). Due to the specialization among disciplines, collective decision-making produces more holistic and client-centered care (Axelsson & Axelsson, 2006; Bowen et al., 2009; Soklaridis et al., 2007). The most tragic situations are preventable childhood deaths; yet inquests into childhood fatalities typically cite inter-professional and inter-agency collaboration as system failures (Corby et al., 2009; Gillespie et al., 2010; Watkin et al., 2009). Current structures have rigid funding and eligibility criteria; creating gaps, service duplication, and system fragmentation that are not responsive to the needs of children and families with complex health and social needs (Halfon, 2009; May-Chahal & Broadhurst, 2006; Schmied et al., 2010). There tends to be a reactive focus on crises which results in episodic treatment; as opposed to services that are preventative, comprehensive, and family-centred (Halfon, 2009). Coordinated action and shared responsibility are believed to be essential in promoting health equity and creating population level improvements (Fawcett et al., 2010; Hernandez et al., 2010; Horwath & Morrison, 2011; McFadyen et al., 2010; Moore & McArthur, 2007; Standing Senate Committee on Social Affairs Science and Technology, 2009; World Health Organization, 2010).

Consistent with other Canadian literature, PHNs in the WRHA reported a lack of system coordination and responsiveness to the needs of complex families (Cohen & McKay, 2010). PHNs reported an emphasis on promoting individual health, largely using strategies of education and health behaviour change (Cohen & McKay, 2010). The importance of inter-professional collaboration in addressing the social determinants of health was recognized, but PHNs reported organizational conflicts which undermined their role, created barriers to being proactive, and reinforced "the persistence of functional silos"' (Cohen & McKay, 2010, p. 66). In earlier qualitative studies, PHNs in Manitoba reported the desire to foster population level improvements through activities such as health promotion and community development, but again cited organizational barriers to these activities (Cohen, 2006a). In particular, early postpartum discharge polices and the need to respond to immediate medical and breastfeeding needs were identified as a new role for PHNs, and a main factor contributing to the erosion of health promotion and community development activities (Cusack et al., 2008). PHNs reported feeling powerless to change their practice, and felt that other providers did not understand their role (Cusack et al., 2008).

PHNs have supported a healthcare shift to a model of primary health care, where resources are equitably distributed and clients are supported to increase control over their own health (Schofield et al., 2011). Within an integrated healthcare system, the unique goals and purpose of public health must be valued. Scutchfield & Howard (2011) argue that public health is the only agency with the "statutory and fiduciary responsibility" to create healthier communities and must be working upstream to address the social determinants of health (Scutchfield & Howard, 2011). In comparison to other healthcare services, public health is legally mandated to provide population based services (Honoré et al., 2011). The Manitoba Public Health Act states, "the minister has the authority to protect and promote the health and well-being of Manitobans." Roles for regional health authorities are described within the legislation that include health, public health emergencies, as well as information gathering and health surveillance ("The Public Health Act,").

According to Accreditation Canada, public health protection, disease control, immunization organizations are accountable to deliver community based services that empower and build capacity for healthy living (Accreditation Canada, 2012). This consists of services and activities that address root causes of health and integrate evidence-based community health promotion interventions into public health services. Organizations must be engaged in community development activities tailored to target populations, which assist in skill development and enabling people to take control over and improve their own health status. Core population health promotion strategies include reorienting health services, developing personal skills, promoting healthy public policy, fostering supportive environments, and strengthening community action.

Freiden (2010) postulates that the greatest population level impacts result from reorienting services to incorporate poverty reduction strategies that address socioeconomic factors and reach large segments of the population. Frieden developed the health pyramid to depict public health approaches and the corresponding population impact. Clinical interventions and education are situated at the top, depicting the smallest population effects. In areas of communicable diseases, preventative approaches may focus on housing, nutrition, and sanitation. For non-communicable diseases, approaches may focus on access to healthy nutrition and building capacity to prevent chronic diseases. Poverty reduction approaches may reduce injury by decreasing drug use and violence, as well as exposure to extreme weather. Freiden's approach is consistent with the

Commission on Social Determinants of Health recommendations to promote equity, that suggests daily living conditions could be improved by tackling the inequitable distribution of power, money, and resources (Commission on Social Determinants of Health, 2008).

Information technology: The final area to consider in delivery structures is Information technology, which is central to modern healthcare (Edwards, Hallet, & Sawbridge, 2008). Information technology is a broad category consisting of systems for communication, as well as tools for collecting data, monitoring, and maintaining clinical information (Marshall, 2011). Information technology influences communication with clients, providers, and the public. In public health, social media is becoming an important tool for health promotion (Korda & Itani, 2013). Awareness of positive and negative aspects of communication is critical.

Current client complexity reinforces the importance of regular and ongoing communication between professionals and agencies. Development of formal mechanisms for communication, such as referral systems and case conferences create routines as well as promotes collegiality and trust (Freund & Drach-Zahavy, 2007; Katz & Hetherington, 2006; Schmied et al., 2010). Information technology may be a barrier based on staff skill and comfort level (Gannon-Leary, Baines, & Wilson, 2006). Electronic information can reduce personal dialogue between team members and influence the quality of communication. For instance, an inquest into a death found that communication included messages and letters rather than discussion, and multiple providers had pieces of a larger puzzle. The belief was that had providers communicated directly and information been viewed in its entirety, the death may have been prevented (Corby et al., 2009). Providers may also be reluctant to record information accessible by others (Cameron, 2011). Achieving team outcomes requires getting to know one another, defining common goals, and building trust (Axelsson & Axelsson, 2006). There needs to be time for reflection and shared problem-solving to move towards mutual ownership (Horwath & Morrison, 2011). Leadership and time are essential as staff address concerns such as sharing of information, and learn to understand client issues from the perspective of differing professions, while optimizing available Information technology (Banks et al., 2008; Charles & Horwath, 2009; Frost & Robinson, 2007; Watkin et al., 2009).

There is an abundance of technology available to guide and support PHN practice. Tenets of evidence-based public health include use of peer-reviewed sources; systematically collecting data with information systems; using program planning frameworks founded on theory; community engagement; evaluation; and knowledge translation (Brownson et al., 2009). Community health assessment data should also inform PHN practice (Canadian Public Health Association, 2010). A main benefit of Information technology is program monitoring and improvement. Population based nursing necessitates that evidence-based interventions improve health outcomes for target populations (Cupp Curley, 2012). However, currently no data set exists to describe PHN practice and there are no tools that measure PHNs' unique contributions to population health (Issel et al., 2012). There is also limited research linking PHN sensitive indicators to client health outcomes (Bigbee & Issel, 2012). Public health services must be founded on program activities that have been demonstrated to be effective, and based on data that is reliable and valid (Baisch, 2012; Issel et al., 2012).

Management practices. Management practices are integral to the success of a professional practice model. Management practices refer to the structure and processes for decision-making within an organization. A recent study outlined characteristics necessary to

support PHN practice in Canada (Meagher-Stewart et al., 2010). Attributes in the areas of government, organization, and systems were identified. Frontline management support and organizational culture were critical in promoting and sustaining effective PHN practice. Essential components were a shared vision that was responsive to community needs and evidence based. Working to full scope was also imperative to PHNs, who highlighted the importance of fostering partnerships; community development; flexibility; and role development (Meagher-Stewart et al., 2010).

To achieve professional practice, all organizational leaders must understand and support a professional practice environment (Mensik, 2013). PHNs have reported feeling disempowered as a result of organizational influences (Cawley & McNamara, 2011). However, development of a common framework and language has assisted managers in understanding PHN practice in countries outside of Canada (McDonald et al., 2013). Professional practice models are therefore important organization tools for managers to clarify professional role expectations (Mensik, 2013). While nursing tasks are easier to measure, a workplace based on technical practice is in direct opposition to a professional practice environment (Mensik, 2013). Poulton reported that top-down hierarchal approaches diminish PHN control and negatively influence organizational culture (Poulton, 2009).

Professional practice models depend upon development of formal and informal organizational structures to support nursing practice and incorporate nurse's contributions. A positive professional practice environment promotes independent nursing assessment and care planning, scope of practice, and authority for decision-making (Arford & Zone-Smith, 2005). Autonomous care is the ability to implement nursing interventions in accordance with professional standards that improve client care based on knowledge, competence, and professional expertise (Messmer & Turkel, 2011).

Formal structures include the adoption of participatory or transformational leadership styles, shared governance and practice councils, continuous quality improvement, action research, and reflective practice (Community Health Nurses of Canada, 2011b). These types of governance structures embody shared decision-making between direct care staff and management; acknowledging, respecting, and trusting the unique content expertise of nurses (George & Lovering, 2013). Tinkham reported that use of a professional practice model and shared governance nursing environment promotes the "three A's of nursing care: authority, autonomy, and accountability" (Tinkham, 2014)." Shared governance and other leadership styles must be founded on principles of accountability and collaboration that are clearly articulated (Marshall, 2011).

Managers play the most important role in promoting quality PHN practice environments. The development of a healthy work environment promotes improved client outcomes and organizational performance (Marshall, 2011). According to the College of Registered Nurses of Manitoba, nurses are responsible for the delivery of safe and competent nursing care, and "no agency policy or professional statement can relieve individual registered nurses of the accountability for their own actions." The employer is responsible to ensure that there are policies and procedures in place to support nurses to practice autonomously. The employer is also accountable to provide orientation and professional development that assists nurses in developing and maintaining their competencies. Nursing practice must be supported to be innovative within an organizational structure that is respectful of nursing knowledge and skills (Mitchell et al., 2013). While the College of Registered Nurses of Manitoba's mandate is to protect the public, the mission of the Manitoba Nurses Union is to care for nurses and promote a

positive nursing culture (Manitoba Nurses Union, 2012). The manager plays an essential role in creating a safe environment, and meeting conditions of employment. The position statement on workplace safety states: "MNU takes a strong position with employers and government regarding the employers' responsibility to provide respectful workplace environments free from physical and verbal abuse, easy access to personal protective equipment, assistive devices to protect from musculoskeletal injury and appropriate policies and procedures with respect to dealing with chemicals and/or carcinogenic agents in the workplace" (Manitoba Nurses Union, n.d.-b).

Managers can support PHNs to accomplish health equity work. Action on the social determinants necessitates organizational approaches that prioritize populations based on the distribution of disease and positive characteristics (Baum, 2008; National Collaborating Centre for Determinants of Health, 2011). If the organization does not assume leadership in promoting equity, it is difficult for PHNs to enact change even if they have the knowledge and skill (Reutter & Kushner, 2010). Beaudet and colleagues interviewed 69 PHNs and managers and reported PHNs were focused on clinical services and individual level behaviour modification at the detriment of population level health promotion. The population level practice was constrained by under-resourced organizational structures that prioritized clinical and curative services. PHNs were worn out by the extent of changes in health delivery and "critical of their lack of involvement in the planning and implementation of the reforms" (p.E9), resulting in few practice changes. A study in the WRHA documented the role of PHNs working with families and children living in poverty (Cohen & McKay, 2010). PHNs reported a "grim picture" of the effects of poverty, and expressed frustration that families experienced social exclusion due to barriers such as stigma, language, culture, and trust. These PHNs believed that the region should provide leadership in addressing poverty and suggested actions of increasing awareness, advocating for policy change, and lobbying for funding to expand programs. This suggests a need to challenge PHNs to work to the full scope of their competencies.

Managers provide support for the PHN role within the organization, as well as acknowledge PHN contributions (Meagher-Stewart et al., 2010). A strength-based approach to professional practice optimizes the nurse-client relationship, and builds on what is important to individuals, teams, and systems (Gottlieb et al., 2012). Leadership is essential in strengthening inter-professional relationships, fostering respect, and promoting teams to function effectively. There is evidence that collaboration and satisfaction among providers improves with education and training (Fleet et al., 2008). Inter-professional collaboration benefits from organizational policies and structures that are in line with overarching program goals (Banks et al., 2008; D'Amour et al., 2005; Fawcett et al., 2010; Fleet et al., 2008; Hicks et al., 2008; Moran et al., 2007; Young, 2009). Clearly outlined roles and responsibilities; regular reviews of protocols; and formal mechanisms for documentation of communication and assessments are important (Murphy et al., 2006).

The creation of a common vision, clearly identified goals and responsibilities promotes understanding of the nursing role and enhances organizational efficiency (Underwood et al., 2009). In addition to creating efficiencies, the clear articulation of nurses roles and responsibilities optimizes collaboration and coordination of care, and assists in communicating one's role to clients and other providers (Cody, 2013b; Hedges et al., 2012). Managers require skill in team dynamics and facilitating communication within teams as well as across departments and organizations.(Claiborne & Lawson, 2005; Reeves et al., 2010). Leaders can promote inter-professional collaboration through team building and service coordination, but

require education to develop competencies that include fostering skills in staff (Feng et al., 2010; Umble et al., 2005; Whiting et al., 2008). Unfortunately, there is no single approach to meet the needs of all teams, and team-building activities must be specific to those involved (Andreatta, 2010). For these reasons, leaders must value innovation and risk-taking; possess a high degree of credibility and influence; as well as possess interpersonal skills that allows them to negotiate ambiguity, tension, and turf issues (Horwath & Morrison, 2007). Lastly, managers and the organization are accountable to maintain nursing practice through provision of adequate resources and supports (Messmer & Turkel, 2011).

Rewards and recognition. The final component of a professional practice model is rewards and recognition. To attract and retain PHNs, agencies must develop conditions which promote and sustain their competencies (Meagher-Stewart et al., 2010). The PHN role is complex, and advanced preparation has been deemed essential if PHNs are to positively influence current global and societal changes (Levin et al., 2008). Understanding the context of inequities is necessary to measure, monitor and to promote equity at individual and population levels. Organizational capacity can be developed by increasing training opportunities in areas of advocacy, intersectoral partnerships, and program evaluation from an equity perspective (Gore & Kothari, 2013).

An integrated and coordinated healthcare system based on population based needs and health promotion has been suggested as solution to sustain Canada's healthcare system (Suter, Oelke, Adair, & Armitagem G.D., 2009). However system transformation requires a transformation of nursing practice (Gottlieb et al., 2012). Clinical nurse specialists have been utilized in transforming work environments through support and mentorship, knowledge of evidence and quality, and enhancing inter-professional collaboration (Walker et al., 2009). A clearly articulated organizational structure outlining opportunities for formal and informal recognition and rewards can promote employee motivation. Informal methods to engage staff may include reinforcement through public recognition (Fawcett et al., 2010). A formal structure would be development of a theoretical perspective to link organizational goals, scope, and the outcomes of nursing practice (McEwen, 2011). Nurses have routinely been challenged to articulate how their practice contributes to health and societal improvements, or the healthcare contexts needed to support the work that they do (Litchfield & Jonsdottir, 2013). Nurses are often unaware that their actions are based on a complex integration of knowledge, tradition, culture, practice norms, work environments, and experience (Gottlieb, 2013). The organization can develop a comprehensive plan for assessing, analyzing, and improving clinical and operational outcomes that are sensitive to nursing influence (Messmer & Turkel, 2011). The identification of nursing indicators and outcomes creates nursing actions that are purposeful rather than random or based on intuition (McEwen, 2011). Successful organizations support nurses ongoing personal and professional growth by creating learning environments that offer and value ongoing education, certification, and career development (Messmer & Turkel, 2011).

Next Steps

In the literature, when implementing a PPM to create system improvements and change, organizational outcomes, structures, and processes, should be assessed (Marshall, 2011; Wolf & Greenhouse, 2007). The following points may be considered:

Outcomes. As a result of PHN intervention, what outcomes do we want to see?

- How can those outcomes be achieved (processes)?
- What does the PHN role do (process indicators)?
- What difference will the PHN role make (outcome)?
- What outcomes should be measured? How? When?
- How will the results be used to improve services?

Structure. What structure is needed to support achievement of identified outcomes?

- What is the most effective and efficient use of the PHN role?
- How can client needs be quantified?
- What skill mix will be used for different populations?
- How will we promote consistency and seamlessness across the continuum of healthcare?
- Who should do what?
- How can staffing decisions be made?

Process. How will client care be delivered across the healthcare continuum?

- What standards will be used and how will they be developed to be current and evidence based?
- How will we work with others healthcare providers and disciplines in coordinating and providing care?
- How will client preferences and priorities be considered?

Some PPH program initiatives under development where the PPM could be incorporated include:

- Standards for PHN practice in the key service areas
- PHN home visiting
- PPH prioritization document
- PHN orientation
- Healthy parenting early childhood database – developing indicators for PHN practice
- Organizational communication –including internal program communication as well as communication with other programs

A vision for a PHN professional practice model in the WRHA has been proposed. In the literature, a shared governance approach and participant engagement has been identified as critical in developing a practice model that reflects organizational strategic priorities and staff values (Kear et al., 2012). The vision for this professional practice model is based on current Canadian PHN literature and has been adapted to be consistent with WRHA PPH program strategic plan and other organizational documents. The intention was to articulate the unique aspects of the PHN role within the broader Population & Public Health program structure; so that a consistent and more evidence based approach to public health nursing work is attainable in the WRHA. The process has been iterative to include feedback from all PHNs, utilizing the structure established by the nursing practice council. PHN feedback has been incorporated throughout,

providing a voice for PHN input to practice. The professional practice model creates a framework and common language to clarify the PHN role.

Ideally, a professional practice model serves as an organizational foundation and tool for "assessment, planning, organizing, job description, a reward and recognition system, recruitment, staff development and research." While components are already in place or planned, multiple considerations and next steps exist to move forward. A roadmap to implement and achieve the professional practice model is necessary. It is the hope that this document will provide the basis and lens to coordinate and guide future Population & Public Health program directions and decisions that impact PHN practice.

Appendix III – Public Health Nurse Position Description

WINNIPEG REGIONAL HEALTH AUTHORITY
POSITION DESCRIPTION (Non-Management)

INCUMBENT: DATE: June 1, 2011

POSITION TITLE: PUBLIC HEALTH NURSE (PHN) **CLASS:** Nurse IV

UNION: MNU
DEPARTMENT: POPULATION AND PUBLIC HEALTH

SUPERVISOR'S TITLE: Team Manager

SUPERVISORY RESPONSIBILITIES: May provide day to day guidance to staff (e.g., Families First Home Visitors, Immunization Nurses) students and volunteers.

EDUCATION:

- Baccalaureate Nursing Degree is required.
- In addition, at least one of the following is preferred:
- Successful completion of a Public Health Agency of Canada's Skills Enhancement for Public Health Program content module certificate
- Canadian Community Health Nurses certification - CCHN(C)
- Successful completion of a related course at a master level (e.g., epidemiology, community development, community nursing)

EXPERIENCE

- Four years of recent, relevant experience in public health, primary care / primary health care, population-level health promotion or community development is required. Relevant experience may include:
  - Applying principles of health promotion, primary prevention, population health, primary health care, harm reduction, and community development in public health, primary care / primary health care, northern health (that includes primary care / primary health care or public health) or infection prevention and control settings
  - Family and child health
  - Promoting equity at a population level and community development with populations who experience lower health status (e.g., street-involved persons, lower income, vulnerable families)
  - Communicable disease control

OTHER:

- Demonstrated ability to assume a leadership role.
- Demonstrated ability to work independently and within a professional team.
- Demonstrated knowledge, skill, and interest in working with diverse people with a variety of backgrounds, lifestyles, abilities, health status, choices and other attributes.

- Demonstrated competency in working with community residents, community partners and agencies.
- Demonstrated competence in the areas of conflict management, problem solving, teaching and counseling and organization of activities and workload.
- Excellent interpersonal skills.
- Demonstrated ability to facilitate groups and to apply the principles of adult education.
- Excellent English oral and written communication skills.
- Proficiency in computer software applications.

For designated bilingual positions:

- Must be able to communicate in French at a predetermined linguistic level.

PHYSICAL DEMANDS AND WORKING CONDITIONS:

- Physically capable of carrying out clinical skills such as immunizations, intra-dermal injection, phlebotomy, newborn and maternal physical assessments
- Physically able to lift and carry equipment weighing up to 15 lb or 6.8 kg
- Physically capable of providing service in a wide variety of community settings under varying weather and environmental conditions
- Access to a reliable motor vehicle suitable for all environmental conditions
- Acceptable Child Abuse Registry check and Criminal Record check
- Subject to immunizations and tuberculin testing as per WRHA Policy

LICENCES, REGISTRATIONS, CERTIFICATION:

- Current College of Registered Nurses of Manitoba Registration (CRNM) required
- Possession of a valid Manitoba Class 5 Driver's License required
- Current CPR certification at the basic life support level required
- International Board Certified Lactation Consultant (IBCLC) or successful completion of Douglas College Breastfeeding Counsellor Certificate Program for Community Area positions preferred
- International Society for Travel Medicine (ISTM) Certification for Travel Health positions preferred

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MAIN FUNCTION:

The role of the PHN is to apply public health science and nursing theory to promote, protect and preserve the health of populations. Services may be directed to individuals, families, groups or communities across the life span. PHNs apply appropriate strategies to prevent injuries, chronic and communicable diseases (e.g., immunization); address environmental issues; promote reproductive and sexual health; and promote the health of perinatal women, their partners, infants and families. PHNs strive to improve the health of all people and reduce inequities among populations by addressing determinants of health and promote equitable health outcomes. PHNs provide services in communities, across communities and across the region. PHNs work collaboratively within the Population Public Health team and with colleagues in other programs, sectors and organizations. Population Public Health participates in Winnipeg Integrated

Services, supporting integration across WRHA and Family Services and Consumer Affairs (FSCA).

Under the direction of a team manager PHNs respectfully work in and with diversity including sexual and gender minorities, and across all ethnicities and all cultural, spiritual, political, age, ability, family and economic circumstances. PHNs support self-determination through activities such as pregnancy counselling and by respecting client decisions such as those affecting infant feeding, male circumcision, sexual and reproductive behaviour, and immunization status. PHNs work respectfully with those who are involved in drug using, sexual and other behaviour that may be harmful to them or to others. PHNs promote empowerment and community engagement. These values are consistent with a population health approach that is rooted in an understanding of the broad determinants of health and the principles of primary health care, community development, and harm reduction. Practice is strength-based, client-centered and incorporates the strategies of motivating, enabling, advocating, co-operating and collaborating when working with individuals, communities, and colleagues both within the health system and with other sectors.

PHNs may be required to work in locations other than her/his unit/worksite/office within the Population Public Health Program site.

POSITION DUTIES AND RESPONSIBILITIES:

Major Responsibilities:
In the context of working with individuals, families, groups and communities,

1. **Public Health and Nursing Sciences: Applies key knowledge and critical thinking skills related to the public health sciences:**

    1.1. Applies knowledge about the health status of populations, inequities in health, the determinants of health and illness, principles of primary health care, strategies for health promotion, disease and injury prevention and health protection, as well as factors that influence delivery and use of health services.
    1.2. Applies knowledge about the history, structure and interaction of health care services at local, provincial/territorial, national, and international level; in particular as it relates to the Public Health Act and the role of public health staff in the context of communicable disease outbreaks and disaster situations.
    1.3. Applies public health and nursing sciences to practice by synthesizing knowledge from a broad range of theories, models and frameworks.
    1.4. Uses evidence and research to inform health policies, programs and practice by maintaining and applying evidence-informed nursing and public health theory.
    1.5. Pursues lifelong learning opportunities in the field of public health as it relates to current public health nursing practice, new and emerging issues and the changing needs of the population.

2. Assessment & Analysis: Applies skills to assess and analyze information:

2.1. Recognizes when a health concern or issue exists by applying epidemiological principles, knowledge, and management/prevention skills especially with respect to injuries, chronic and communicable diseases, and environmental issues.
2.2. Identifies relevant and appropriate sources of information, including community assets and resources.
2.3. Collects, stores, retrieves and uses accurate and appropriate information about public health issues
2.4. Assesses the health status and functional competence of individuals, families, groups, communities or populations within the context of their environmental and social supports across the lifespan.
2.5. Analyzes information to determine appropriate implications, issues, gaps and limitations.
2.6. Determines the meaning of information, considering the current ethical, political, scientific, socio-cultural and economic contexts.
2.7. Recommends specific actions based on the analysis of information. This includes encouraging and supporting communities, families and individuals to balance choices with social responsibility to create a healthier future.

3. Policy & Program Planning, Implementation and Evaluation: Plans, implements and evaluates policies, programs and/or practice in public health:

3.1. Describes selected policy and program options to address a specific public health issue as well as the roles and responsibilities of the PHN and Medical Officer of Health as it relates to the Public Health Act.
3.2. Describes the implications of each option, especially as they apply to the determinants of health and recommends or decides on a course of action.
3.3. Develops a plan to implement a course of action taking into account relevant evidence, legislation, emergency planning procedures, regulations and policies.
3.4. Implements a policy or program and/or takes appropriate action to address specific public health issues in communities, across communities and across the region.
3.5. Provides care with all client levels using the nursing process: assessment, planning, implementation and evaluation, based on evidence-informed decision making, including available service delivery standards and practice guidelines.
3.6. Collaborates with and refers to other service providers and experts as needed. Accepts and responds to referrals from service providers and community members and groups who require Public Health support and expertise.
3.7. Conducts individual physical assessments and family assessments.
3.8. Obtains clinical samples (e.g., phlebotomy, urine, bacterial and viral swabbing) in accordance with standards, clinical practice guidelines and/or delegation of function agreements as appropriate.
3.9. Immunizes, tests (e.g., TST) and provides treatments and medications in accordance with standards, and clinical practice guidelines and requirements as appropriate.
3.10. Develops therapeutic relationships with clients.

3.11. Evaluates an action, policy or program.
3.12. Sets and follows priorities, and maximizes outcomes based on available resources.
3.13. Develops a plan, implements and evaluates responses to a public health emergency or disaster.

4. Partnership, Collaboration and Advocacy: Works with others to improve the health and well being of the public through the pursuit of common goals:

4.1. Identifies and collaborates with partners in addressing public health issues.
4.2. Engages in inter-professional practice.
4.3. Builds partnerships, coalitions and networks by using community development approaches and skills such as team building, negotiation, conflict management and group facilitation.
4.4. Mediates between differing interests in the pursuit of health and well-being, and facilitates equitable access to resources.
4.5. Advocates for healthy public policies and services that promote and protect the health and well-being of individuals and communities.
4.6. Involves individuals, families, groups and communities as active partners to identify assets, strengths, and available resources and to take action to address health inequities, needs, deficits and gaps.

5. Diversity and Inclusiveness: Interacts effectively with diverse individuals, groups and communities:

5.1. Addresses population diversity when planning, implementing, adapting and evaluating public health services and policies.
5.2. Applies culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, sexual minorities, and persons of all ages, genders, health status and abilities.
5.3. Uses harm reduction approaches when appropriate.

6. Communication: Communicates effectively with individuals, families, groups, communities and colleagues:

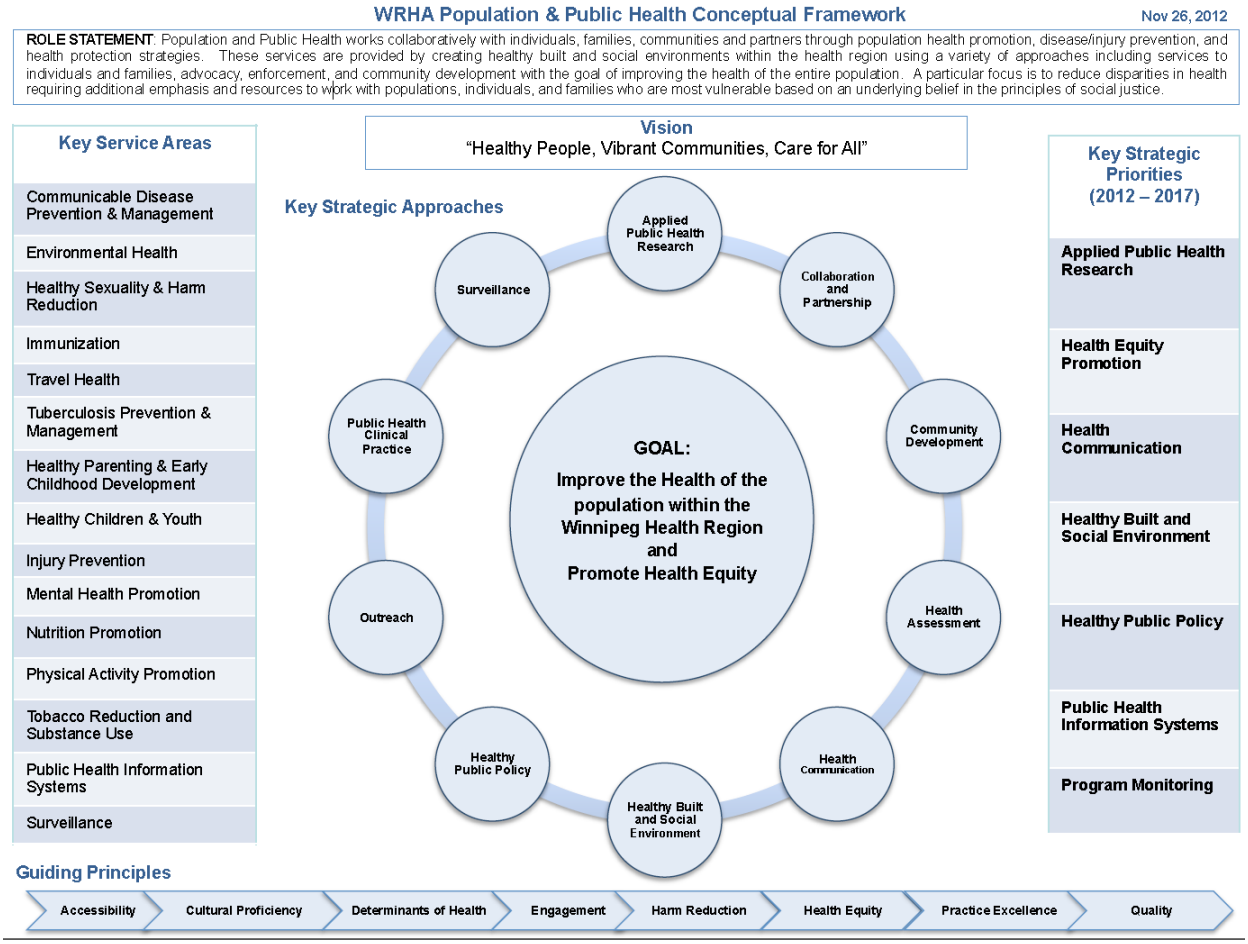
6.1. Interprets information for professional, non-professional and community audiences.
6.2. Connects with individuals and communities by using professional and respectful communication skills, appropriate media, community resources, Health Behaviour Change concepts and contributes to social marketing projects.
6.3. Facilitates groups, makes presentations and applies the principles of adult learning in education.
6.4. Uses current technology to communicate effectively.

7. **Leadership: Provides leadership mainly in primary and secondary prevention health services in a variety of settings:**

    7.1 Contributes to developing key values and a shared vision in planning and implementing public health programs and policies in the community.
    7.2 Contributes proactively to the quality of the work environment by identifying needs, issues and solutions; mobilizes colleagues and actively participates in team and organizational structures and mechanisms.
    7.3 Advocates for societal change in support of health for all.
    7.4 Systematically evaluates the availability, acceptability, quality, efficiency, and effectiveness of public health practice.

8. **Professional Responsibility and Accountability: Builds capacity, improves performance and enhances the quality of the working environment:**
    8.1 Applies the mission, vision, values and priorities of the WRHA in practice.
    8.2 Uses public health ethics to manage self, others, information and resources and practice in accordance with all relevant standards, legislation and codes of ethics.
    8.3 Contributes to maintaining organizational performance standards and a healthy and responsive workplace and organization.
    8.4 Builds capacity by sharing knowledge, through participation in professional development and practice development activities, mentoring students, orienting new staff, providing constructive feedback to colleagues, and participating in research and quality assurance initiatives.
    8.5 Completes documentation as per regional and professional standards.
    8.6 Completes and submits statistical information, reports and forms according to regional policy.
    8.7 Coordinates and facilitates activities of staff (e.g. Families First Home Visitors, Immunization Nurses) and volunteers.
    8.8 Adheres to established policies and procedures.
    8.9 Takes preventive, as well as corrective action individually or in partnership with others to protect individuals from unsafe, incompetent, or unethical circumstances.
    8.10 Responsibly uses and maintains equipment and supplies.

Appendix IV - WRHA Population & Public Health Conceptual Framework



Appendix V - WRHA Position Statement on Health Equity

Health Equity Description:
Health equity asserts that all people have the opportunity to reach their full health potential and should not be disadvantaged from attaining it because of their social and economic status, social class, racism, ethnicity, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance.

The Winnipeg Regional Health Authority (WRHA) recognizes that:

- Large health gaps exist in Winnipeg due to unfair, unjust and modifiable social circumstances
- Winnipeg's health gaps are larger than many other Canadian cities
- Some health differences or "inequalities" are not modifiable such as those due to genetic or biological factors, whereas "inequitable" health gaps can be significantly reduced or eliminated
- Remediable gaps in health due to modifiable social circumstances should not be tolerated
- Health is affected by the influences of social and economic advantage and disadvantage
- Colonization has had an ongoing negative and tragic impact on all aspect of Indigenous peoples' health and wellbeing
- Culture is a determinant of health and is related to health behaviours, perceptions of illness, social supports and the extent to which people use health care services. However, culture or ethnicity alone do not cause health inequalities; rather, ethnic groups and others who experience current or historical marginalization or oppression are disproportionately affected by economic and social disadvantage which leads to health gaps
- A more equal society is healthier for everyone across the social and economic gradient including those at the top
- Since everyone's health is affected, we are all in this together

The WRHA Commitment

The WRHA is committed to changing health equity outcomes through an increased health equity focus in the services we provide, the way we conduct our planning and operations, in providing knowledge and decision-making support to others, and in real partnerships and committed relationships outside the health care sector. Specifically, we commit to:

1. **Ensure health equity considerations and actions are embedded in the provision of all health care services**
   - Health care planning and service delivery designed to eliminate inequities in health outcomes and create opportunities for individuals to reach their health potential
   - Dignity in all health care service encounters
   - Cultural proficiency and diversity
   - Collaborative practice and inter-professional education
   - Create, implement and evaluate a WRHA health equity action plan that includes clear health outcome targets
2. **Produce and translate health equity knowledge**
   - Describe, translate and communicate health equity status in the WRHA
   - Use and promote the use of best and promising practices
   - Develop and disseminate research to inform action promoting health equity
   - Set health equity targets, monitor progress towards targets and evaluate efforts

3. **Promote health equity in decision-making (governance)**
   - At the WRHA, health equity is a required consideration at the leadership level and in all WRHA organizational decision making (e.g., planning, resource allocation, human resources practices, procurement)
   - The WRHA engages with all levels of government on policies, funding and practices to influence health equity
   - The WRHA advocates with decision makers in key sectors to influence health equity
4. **Facilitate participation and partnerships to amplify health equity action within and beyond the health sector**
   - Engage with partners having similar goals to improve health equity and reduce poverty
   - Support and facilitate coordinated or complementary action
   - Amplify and support successful and promising community initiatives
   - Support community development activities and facilitate authentic public engagement
   - Listen to and involve those with lived experience

Background:

WRHA Health Equity Mission:
- To coordinate and provide equitable health services that promote optimum health and well-being for everyone, recognizing that achieving the provision of universal health care requires proportionally more effort and resources to reach out to those in most need
- To portray and call attention to the impact of social disadvantage on health
- To facilitate sustainable contributions and collaborations from many sectors
- To close the health equity gap in a generation

WRHA Health Equity Vision:
"Health for all" Everyone reaches their full health potential without barriers due to socially determined and modifiable circumstances.

WRHA Health Equity Values ("principles")
- Availability
- Accessibility
- Affordability
- Appropriateness
- Accountability
- Comprehensiveness
- Equity
- Participation
- Social Justice
- Sustainability
- Universality

Appendix VI – Additional Readings

Canadian Public Health Association. (2010). Public health ~Community health nursing practice in Canada. Roles and activities Retrieved from http://www.cpha.ca/uploads/pubs/3-1bk04214.pdf

Community Health Nurses of Canada. (2011). Canadian community health nursing professional practice model & standards of practice. Retrieved from http://www.chnc.ca/nursing-standards-of-practice.cfm

Community Health Nurses of Canada. (2009). Public health nursing discipline specific competencies. Retrieved from http://www.chnc.ca/phn-nursing-competencies.cfm

World Health Organization. (1986). The Ottawa charter for health promotion. First International Conference on Health Promotion. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html

WRHA Health Equity Information
http://www.wrha.mb.ca/about/healthequity/index.php

Appendix U: Reflective Journal

The journal entries that I kept during the process are below. The entries were guided by the three stage model of reflection.

Adapted Three stage model of reflection (Sherwood & Horton-Deutsch, 2008)

1. Objectively describe the experience. Prompts to describe the scenario may include:
    a. Where and when did it take place?
    b. What was the purpose?
    c. Who was there?
    d. What happened and was said?
    e. What did I do?
    f. What did the other participants do?

2. Analyze the experience based on learning goals
    a. Personal growth
        - How did I feel?
        - What expectations or assumptions did I have?
        - How could past experiences impact my actions or responses?
        - Were there difficulties - why or why not?
        - What skills did I use?
        - What skills would I like to develop further?

    b. Engagement
        - What was I/others hoping to accomplish?
        - Was there collaboration or did I act unilaterally – why?
        - Did group members assume any roles – why?
        - How might the situation be interpreted by someone else?
        - Could I have handled the situation differently?
        - "what is the interest of the common good?"

    c. Professional knowledge
        - What resources pertain to the experience?
        - What were the similarities and differences between the perspective offered by the resources and situation as it was experienced?
        - How was my knowledge enhanced based on this experience and specific literature, theories, or concepts?

3. Articulation of learning
        - What can I learn from the situation?
        - How was it learned?
        - Why does it matter?
        - How do I plan to use this learning? How it will change future experiences? What goals will I set for self-improvement?

RWG November 21, 2012

Objective description. The RWG took place on the scheduled date of November 21st, 2013. The RWG meeting was assigned to the family room at the 3401 Roblin public health office. The room contained 2 couches, a table, a couple of chairs, and a desk with a computer. The room was small, so it was crowded. The RWG consisted of 5 PHNs and me. The purpose was to begin the official research process. Although there had been many previous meetings in preparation, ethics approvals had been obtained and this meeting marked the start of data generation. I arrived early at 8:00 and brought Starbuck's coffee and a snack for the group. I set up the room and two recording devices. I placed enough chairs around the table for all RWG members. I placed a digital recorder and a microphone on opposite ends of the table, and my laptop that connected to the microphone was sitting on the couch. The participants had requested the discussion guide before the RWG. I had had numerous conversations with RWG members individually and as a group, and also had provided some materials to read in preparation. The RWG participants began arriving at 8:30, and were excited to talk about their feelings of nervousness in engaging in this process.

Analysis.

Personal growth. Prior to and beginning the session, I felt very nervous and anxious and said this as we began. I trusted the PHNs but wondered if my facilitation and research skills would be adequate, if the right questions had been asked, how I would elicit data that was new, and if this process would work for my PhD. I could sense nervous energy among the PHNs. During the discussions leading up to today, anxiety about the process had been expressed by the participants. I too am not fully confident in the process and how we will get to the end point of developing a model but do not want to let the group down. I recognize that I have been

immersed in the development of the proposal and methodology for close to a year, so realize that my understanding of the process has evolved over this time. I have to trust in the knowledge that has been gained over that time, and recognize that I also have had the benefit of guidance by very experienced researchers. I tried to be positive and encouraging regarding the skills and knowledge that each PHNs brings to this experience, and to hide my own fears and concerns regarding the process.

Engagement. Participants were initially nervous, and so was I. Being the first RWG, I was anxious to get through the semi-structured interview guide and promote constructive conversations that would elicit rich research data. I also kept in mind the role of the participatory action researcher as a group facilitator and wanting to promote trust and comfort within the group. Once the conversation started to flow, I didn't want to interrupt it. I found it difficult to maintain the correct balance between meeting my needs for data and following the interview guide, and allowing the PHNs to engage in the discussion.

The RWG had great synergy – participants would finish off one another's sentences and build on one another's thoughts. Members were engaged and focused on the person who was speaking. They were smiling and laughing when jokes were made. There was inflexion and intonation in the conversation that reflected how much these PHNs cared about their practice. There was also a great deal of agreement among the group that was displayed through reaffirming the stories and views shared. Differing styles and comfort levels were reflected in member's participation. One individual was slower to engage and more quiet, perhaps reflecting less understanding of the concepts or discomfort with the group format. Perhaps I could have directly asked for her opinion but I wanted to promote an environment where members felt comfortable and did not feel singled out. She did participate and was engaged, but had less detail

to offer then some of the others. She was also one of the newer PHNs, so that may also have been a contributing factor. For all participants, considering some of the more difficult questions pertaining to equity and measuring PHN practice contributed to a pauses in the conversation. I felt uncomfortable when there were lapses in the conversation due to difficult questions and wanted to support the PHNs and promote group safety and trust.

Professional knowledge. I have had numerous conversations with the co-chairs since embarking on this process, and they have requested reading material to frame the issues. They have stated that they view this as a real opportunity to influence their practice, and want to be as prepared as possible. I appreciate that they want to do a good job and contribute in a meaningful way, but I also don't want to overwhelm the PHNs with too much literature. I have provided some resources pertaining to equity, growing gaps, and the role of public health. These resources were very simplistic and high level, and are not directly related to the WRHA current context. I was intending to raise awareness and generate momentum by helping to frame equity as an important public health intervention amenable to PHN intervention. Based on my extensive review of the nursing literature, I see opportunities for advancing PHN practice using an equity focus.

Articulation of learning. I have successfully facilitated research group interviews for my Masters and have to trust that I have the skill and ability to complete these interviews. It is easy to become overwhelmed with the process and feel a lack of control, based on the emergent nature of the study, the unknown, and the size of the project. While this experience is at a higher level, there are also similarities to past work I have done. I do feel that the group looks to me to provide leadership, even though there are co-chairs. The RWG also still has discomfort with the process, in not understanding how we are going to get to the end-point, which I have too. The

RWG members do not have the benefit of completing formal research in the past, or a Masters degree. I want to act as a mentor and provide reinforcement and assurance to the RWG members, while also continuing to move forward in an orderly process to meet the research objectives. It feels scary, but not completing the research is not an option for me.

RWG January 16, 2013

Objective description. The RWG took place on the scheduled date, Jan 16th. The RWG was assigned to the family room at the 3401 Roblin, the same as last time. The room contains 2 couches, a small table, a couple of chairs, and a desk with a computer. The room itself is quite small, so it is fairly crowded. The RWG consisted of 5 PHNs and me. There were 2 new people who hadn't participated during the last RWG. One person ('Kira') changed jobs and moved to a new office, so her replacement ('Danielle') will participate on an ongoing basis. The other new person ('Aryanna') offered to attend nursing practice council and participate in the RWG on behalf of 'Helena,' who was on vacation. I contacted both of the new PHNs in advance, and offered to speak/meet with them if they had any questions or wanted assistance in preparing. 'Danielle' contacted me prior to the meeting, and we had quite a lengthy conversation regarding her role as the new office representative on the RWG.

The purpose of the meeting was to complete the 2nd RWG. An agenda was provided in advance to assist the participants in preparing and to facilitate the process according the participatory action research framework. The goal of the meeting was outlined on the top of the agenda, and also reviewed at the beginning of the group. The intention of this RWG was to review the summary documents and agree on themes and also to consider new themes based on the inclusion of other documents that could enrich the process. As a starting point for discussion, 5 documents central to PHN practice were included with the agenda for the group's

consideration. These documents were the PHN position description, Population & Public Health conceptual model, Community Health Nurses of Canada standards, PHN discipline specific competencies, and the Canadian Public Health Association PHN roles and activities.

I arrived early at 8:15, and brought Starbuck's coffee and a snack for the group. The weather was cold – it was -35 with the wind-chill and the roads were icy. There was increased activity in the office because it was determined that the side streets where people normally parked during the meeting were scheduled for snow removal and cars would be towed. The "know your zone" advertisements had been well circulated, with the messaging that there would be fines. I was waiting in the family room, and others began to arrive around 8:25. As we were waiting for the others to arrive, several people came to the family room to advise the group about the need to move cars from the street. People were also trickling in because of the driving conditions, and then needing to leave again to move their cars. Aryanna had not yet made it to the meeting but around 8:40 I thought we'd better get started. Aryanna arrived about 10 minutes later, was introduced to the group, and then also needed to go and move her car, which meant regrouping once she joined the second time.

Analysis.

Personal growth. I always feel nervous prior to and at the beginning of the RWGs. I worry that the group will not go well, about my preparation and that the equipment will malfunction. I try to be as prepared as possible, for the sake of providing group leadership, as well as to reduce my anxiety. To assist the group, I set an agenda and try to provide materials in advance. The group is struggling with understanding the process, and have continued to request information to feel more prepared. I try to provide helpful information that will build their knowledge, but not overwhelm them with the volumes of information that I have. I too am struggling to understand

the process. While the process is emergent, based on my experience there also has to be some structure to move forward, and stay focused otherwise we will continue to discuss the same issues without moving to a higher level of analysis and action. I hope that we will reach an outcome that the group finds satisfying.

In facilitating the group, I tried to be engaging, respectful, and supportive. I tried to keep the group on track while also allowing them to share their views and stay engaged. I felt like I did too much talking, but I also didn't want participants to feel uncomfortable, so I tried to offer a perspective or information that would stimulate their thinking. I tried to respect contributions but also encourage them to move beyond the discussions that we had last time, and to consider alternate perspectives and how it might inform the process. For individuals who may be quiet, I tried to offer positive reinforcement to encourage participation. I also tried to elicit feedback by routinely asking if others had anything more to add, to create an opportunity for them to interject in the discussions. I haven't pinpointed specific individuals, because I have focused on creating a safe and trusting environment where people feel comfortable.

I felt pressure to keep the process moving forward but also found it more difficult to get the group focused. I watched the clock and tried to attend to the needs of group, as well as move things along in the time available, but time ran short. The group added many valuable concepts from reviewing other documents, but it was challenging to move towards thinking about a model. I would like to further develop skills regarding group facilitation, and in particular keeping the group on task and action oriented. However, being conscious of the participatory action research process, I am trying to balance my needs with promoting group discussion and safety. In an upcoming RWG, perhaps timing aspects of the discussion may assist.

Engagement. The group went well and people were engaged, but this group was definitely more difficult than the last one. As the group began I found it somewhat disjointed, with people arriving and leaving and interruptions regarding the parking. I tried to be respectful of the fact that it is January in Winnipeg and these things happen, and not let my anxiety impact group functioning. I had assumed that the two new PHNs would be able to review the summaries and contribute to the conversation because the content was similar to discussion that has taken place previously at the offices. Both of the new PHNs were also fairly young and inexperienced PHNs, which was a complicating factor. One of the previous PHNs had made notes after reflecting on the summary and the other documents, but most were not prepared to that extent. Being fully prepared may not be realistic to the extent I would like to see, based on current PHN workloads. I also have been immersed in this process for a very long time, so recognize that others may be at different points in their understanding.

There was repetition in the discussion. Some members were offering similar perspectives and comments to the November RWG. I sensed that some people hadn't reviewed the notes or supplemental information in advance. I knew the information in much greater depth from being immersed in the data, listening to the audio tapes, as well as developing the summary. Another possibility is that the PHNs did not have adequate time to prepare. Recent additions to PHN workload included influenze and Grade 6 clinics, without additional resources. Manitoba Health released a statement about increased rates of flu and RSV a couple of weeks ago, encouraging people to get the vaccine and inviting them to contact their healthcare provider or local public health office. Many physicians no longer offer the flu shot, and the communicable disease unit instructed all offices to organize public clinics to respond to the increased demand.

In addition to increased immunization clinics, there have also been several extra training requirements for the Families First Program. All PHNs were required to attend two full days of Towards Flourishing training, as well as up to three training sessions regarding the roles of the FF home visitor, lead role, and case manager. All PHNs attended case manager training, while those who were lead roles attended the other two FF training sessions in addition. January and February are generally busy times when school is back in, groups are running, and all PHN activities are in full swing. Not long into January staff start taking winter holidays, but PHN staffing is not replaced due to vacation or illness. With the last PHN collective agreement, an extra week of vacation was added for PHNs with more than 20 years of seniority. In the teams that I work with, there are at least 5/19 PHNs with this extent of vacation – which is now 7 weeks. Many other teams have greater proportions of senior PHNs, so there is rarely a time where staffing is full.

I do not believe that members assumed any roles that impacted group dynamics. Even with two new members, the participants had all met previously and everyone appeared comfortable. One of the new PHNs asked question of clarification, and seemed to be looking to me to provide the answers. As I responded, I felt that the other PHNs were also looking to me for direction. This may be because the current system doesn't support and encourage the PHNs to think critically or work to full scope, and direction is provided by those in positions of authority. I tried to reinforce that I am equally concerned about the process for my PhD, while this group is central in developing a model.

Professional knowledge. There are multiple resources pertinent to this experience. There is literature regarding practice and service delivery models; public health and public health nursing; nursing theory; group theory and functioning; and transformational leadership to foster high

quality nursing practice environments. I was particularly interested in information describing nursing practice environments and organization influences, in particular the importance of power, language, and history. The information I reviewed has made me concerned for the current state of PHN practice in the WRHA. Practice is not utilizing a shared governance or inter-professional approach that values the input and knowledge of PHNs. In fact, the system seems to be moving in the wrong direction, with more decisions that impact PHN practice being made by medical officers of health and team managers without the input of PHNs or clinical nurse specialists.

***Articulation of learning*.** I have learned several things as a result of this RWG. To begin with, the RWG challenges me to improve skills in group communication and facilitation. I am better at developing a written document than verbally expressing myself. I need to develop these skills more, to be viewed as knowledgeable and credible by decision-makers.

The RWGs also reminds me to value PHNs and nursing practice. The voice of PHNs is important and critical, but often missing. The PHNs regularly tell me that the RWG is a positive experience and is reminding them to think critically. I want the group to feel empowered, and to appreciate the knowledge and skills that they have and bring. They are the experts in PHN practice.

While I have practice experience, I see the value of my current skill set as applying knowledge, theory, and current literature, to advance the PHN role. While I am working each day and examining the system from that perspective, I am increasingly aware that system transformation is imperative. Yet I find that I am getting more disappointed in the organizational leadership and feeling that the role of the PHN is not valued. Though everyone is nice and respectful, based on principles of interprofessional collaboration and transformational leadership,

the organization is hierarchal and directive. It is not surprising that PHNs have lost the desire to challenge the status quo because their voice isn't heard or valued. The same is true of the clinical nurse specialists, because of the way the system is structured and decisions are made. While I try to remain optimistic that the system will embrace an approach that is evidence-based, current, and innovative, this has not been my experience regarding several situations over the last couple of years. A goal that I have set for myself is to advocate and speak on behalf of the PHNs, as a nurse with advanced education and knowledge.

RWG March 20, 2013

Objective description. The RWG took place on the date scheduled for the 3rd meeting, March 20th. The RWG was assigned to the family room at the 3401 Roblin, as with previous RWG meetings. The couches have been removed from the room, so it now contains a small round table with chairs, a desk with a computer, and a tiny corner table. The room feels much more comfortable and spacious now, with more room surrounding the main table and chairs. The RWG consisted of the regular 5 PHNs and me.

The purpose of the meeting was to complete the 3rd RWG. An agenda was provided in advance to assist the participants in preparing and to facilitate the process according the participatory action research framework. The goal of the meeting was outlined on the top of the agenda, and reviewed at the beginning of the group. The intention of this RWG was to agree on goals, objectives and priorities, to begin to draft an action plan.

I arrived early at 8:10, and brought Starbuck's coffee and a snack for the group. The building was locked this time however and I could not locate the receptionist inside who has previously let me in. Typically, I am able to knock on the window or enter with other staff to gain earlier access to the building. On this day however, there was no one entering the building

or inside that I could see, so I ended up staying in my car until close to 8:30. The weather was cold for March, but there was nothing unusual to interfere with members' ability to get to the meeting. I felt slightly rushed setting up. I was in the family room at 830. Others began to arrive almost immediately, as I was setting up my computer and recorder, and getting ready for the session. Members seemed nervous or excited and wanted to discuss their articles as they entered the room. Within 5 minutes, all but one person had arrived. It was probably about 10 minutes before the final person entered, and it was difficult to deter the group from talking about the articles until we were officially ready to start.

Analysis.

Personal growth. I always feel nervous prior to and starting the RWGs, though I am typically able to refocus that energy as soon as group members begin to arrive. At the last RWG, an identified theme was the importance of a common understanding of terminology and goals. Members were confused as to our purpose, whether we were developing a model or choosing a model to adapt.

I developed a different approach for this meeting, to attempt to increase participation of the full RWG. Eleven articles were distributed one month in advance of the RWG. I was concerned about the volume of literature and the members' ability to find the articles meaningful. I tried to find readings that would be most relevant to the group, though this was extremely difficult. The articles were divided up so that each person had 5 items to review. There were 3 readings suggested for the full group; one was a literature review done by the Community Health Nurses of Canada on practice models in community health, and the other two were extremely brief. In addition, each PHN had one article specific to development of a practice model and one specific to public health nursing. The public health nursing articles were more diverse, in that one gave

an example of a public health practice model in the United States, one was a United States review article on conceptual models, one was about the foundation of PHN practice, and the others pertained to PHN practice in Canada but did not discuss models. The literature pertaining to practice models was primary based on the acute care system in the United States.

I had been immersed in such a large volume of literature, that I recognized my interpretation was perhaps at a deeper level than would be possible for the RWG members. I changed the readings several times, as I was determining the ones to use. In the end, I tried to offer literature that would further the goals of the group in completing the project, and readings I hoped they could relate to that would peak their interest. I would like to become more proficient in the skill of developing a plan and implementing it, as opposed to wondering if I could do it better. I think I need to be a little less of a perfectionist. In the end, I was happy with the articles that were chosen and the reasons for doing so. Likely even if I had not changed the articles, the group outcome would have been the same.

Engagement. After reviewing the assigned readings, I hoped that RWG members would be better equipped to agree to goals, objectives, and priorities for the project. The aim of the readings was to:

- Increase understanding of terminology – model, theory, conceptual framework
- Raise awareness of the theory- practice gap in PHN practice
- Stimulate thinking and discussion about the process of socialization into the PHN role and the influence of organizational/medical/system influences on perceptions
- Generate discussion regarding aspects of the role that are the responsibilities of PHNs and define the fundamental characteristics of the job

Members commented that they didn't feel confident, prior to beginning the discussion. As the group progressed however, based on the brief synopsis provided by each person, people seemed to develop greater understanding. I tried to stick to the plan of the round table, and not promote discussion prior to everyone sharing their summaries. Perhaps I could have let the discussion develop more freely, which might be interpreted as more participatory and less researcher focused. I have done that in the past to foster participation, but this time I tried to keep the group more focused, and to follow the agenda. This approach didn't appear to deter the group discussion. Individuals wanting to comment during the roundtable raised their points in the subsequent discussion.

Professional knowledge. I reviewed literature on PHN practice and nursing theory that described difficulties in articulating nursing practice. The experience that the RWG is having in articulating the PHN role appears to be a common theme in the nursing literature. I also reviewed literature on professional practice and service delivery models. There was a limited amount of literature specific to practice models in public health, although there was literature available from a general nursing focus. The lack of literature on PHN practice models perhaps is a result of the diversity of PHN roles across Canada and in other countries. Based on the literature, a draft action plan was developed for the March RWG, to begin to outline the components of a practice model in public health. There appears to be inconsistency regarding use of language pertaining to service delivery and professional practice models in the literature. Based on the literature, the importance of articulating a PHN service delivery and practice model have become more evident to me.

Articulation of learning. Through the process of being immersed in the literature and the RWG, I have recognized the importance of language to adequately articulate the value that PHNs

and nurses add to the healthcare system. There appears to be a gap and a devaluing of the role that nurses and PHNs play.

Defining PHN practice using a model of practice is one way to articulate the role. Through my graduate education, at times I have struggled with the application of nursing theory and models to practice. It didn't seem to fit – which I considered was the nursing practice gap. I now have a greater understanding of practice theories and the need for nursing language and research to advance the practice. I still find nursing theory complex, and have a goal to continue to improve my knowledge and understanding in this area that is fundamental to the nursing profession. Similar to the RWG, exploring literature about professional practice models compared to service delivery models has helped me better understand the terminology and also to appreciate the value that a model could play in Population & Public Health . It will provide PHNs and others who do not fully understand the role with common language and a starting point for discussion.

RWG April 4, 2013

Objective description. The RWG took place on April 4th at the 755 Portage Avenue office. This meeting was added by the RWG, as an outcome of the March meeting. The meeting was scheduled from 9-12, and we used one of the board rooms on the 2nd floor. The room contained one large square table, about 20 chairs, a small desk, and a TV. I had arranged to have supplies in the room, so there was also a flip chart, markers, tape, and memo pads on the table. The RWG consisted of the regular 5 PHNs and me.

The purpose of this additional meeting was to build on the momentum of the March RWG idea, to incorporate feedback received by the teams and apply it to the Population & Public Health conceptual framework. Since the plan had been developed at the last RWG, there

was no agenda provided in advance. I had drafted an agenda for myself, to help me to have a plan in mind.

I arrived at 8:30. I brought Starbuck's coffee and this time had more food since we had blocked off the morning. The PHN from the 755 office arrived at about 8:50 and talked to me for a few minutes while I was setting up. She then offered to go downstairs to meet the other group members, since they did not have building access. The full group returned back upstairs at 9:00 am. I was still in the process of setting up as they came in. I forgot to take the microphone to plug into the computer, which assists with the sound, so was concerned about that.

Analysis.

Personal growth: For this RWGs I did not feel particularly nervous. Perhaps that was because the RWG had developed the plan, and I felt that group had a better sense of their goal. I did prepare in order to understand the group process that was going to be undertaken. While I have participated in many sessions of this type, I have not actually facilitated one myself. I had a plan in mind based on my own experiences but think it would be helpful to find out more about how to use this technique in the future. I'm not sure if I didn't manage the time well, there was too much to do, or else I didn't do it correctly, but we weren't able to get as far as I had hoped. All of the information provided by the teams was classified individually and added to the Population & Public Health conceptual framework headings. The group had good discussion but I wasn't able to collate the stickies and collapse the information into smaller themes. I attempted to do this with the full group, and perhaps what I could have done was broken the group in half and asked each small group to work on this. This was a good reminder for me to ensure that I fully prepared and have a written detailed plan for important meetings. I would like to be

someone who is able to figure things out in the moment but I have learned that I am reflective and am most effective when I am well prepared.

Engagement. The group was hoping to populate the Population & Public Health conceptual framework, based on the feedback that was provided by the teams. The group was fully engaged, with all members sharing openly and working well together. I think this situation would have been viewed as a well functioning or “”performing” team. Members who have in the past been quieter contributed more. I wish that my facilitation skills were better in this situation. Perhaps a more skilled facilitator would have been able to get further in this process, although there was a lot of information to account for. An example of the group’s engagement is concern that this work will not be valued at the management level. There are a couple of projects that are in the works, which have had no PHN input. One is a project to schedule the initial PHN home visit, in an attempt to increase efficiency; the other is the development of two additional practice guidelines which will impact PHN practice. The PHNs want to impress upon the director the energy this project has created, and the risk that failing to value PHN input could extremely damaging to morale. The RWG found a block of time outside of nursing practice council helpful in becoming immersed in the process. Another 3-hour RWG meeting was scheduled to continue with this work on April 24th.

Professional knowledge. For this experience, pertinent resources include group facilitation and consensus building strategies. Other pertinent literature is to articulate PHN role, for instance I had a popular Canadian community health nursing text that was used to better understand the Population & Public Health headings and application to nursing. Any literature to assist in articulating the PHN role is helpful. One of the most important resources is PHN time that is being committed to this project. I am somewhat concerned that the organization would not

support these additional working groups, but also have personal reasons for wanting to move forward. The first is my research but the second reason is to continue to engage the full population of PHNs and to complete the project in a timely manner. Too often in the organization PHN input is asked for but either not included, or the project isn't completed. The topic of the service delivery model is one example since this issue has been unresolved for a decade. It is critical in this situation to move forward in a timely manner with the development of a report.

Articulation of learning. I share the PHNs concerns that this will not be valued at the management level. Within my position, I have been attempting to create organizational change using the structure to which I have access. I have had several meetings with the director to keep her informed, and have also brought forward information at the monthly clinical nurse specialist meetings. However, I am concerned that my opinion and current evidence is not really valued. To attend to the fears of the group, as well as to attempt to update the director, I have organized a meeting. I hope that I can use my position within the organization to bridge that gap, and that when the RWG describes the passion and engagement of the PHNs to the directorthis will be meaningful. In preparation for this meeting, I will ask the group if it would be helpful to develop the action plan based on discussions to date, and use that to guide the discussion. One of the things that I am surprised by, is the impact that the readings that were assigned for discussion in the March group has had. That seemed to have had an impact for several of the group members, as they have referred back to them as we have progressed.

RWG April 25, 2013

***Objective description*.** The RWG took place on April 25th at the 755 Portage Avenue office. This meeting was added by the RWG, as an outcome of the March meeting. The meeting

was scheduled from 9-12, and this time we used one of the board rooms on the 1st floor. It is a clinic room, which does not appear to be used for clients, but functions more as a storage room. There was a larger room with doors to 2 smaller clinic spaces. The larger room contained a desk in one corner, 2 small knee-high round tables in the centre, there were several stacks of chairs against one wall, and another wall consisted of a counter with a sink. I arranged the 2 small tables so that they were touching in centre of the room and placed chairs around them for the RWG members. The RWG consisted of the regular 5 PHNs and me.

The purpose of this additional meeting was to build on the momentum of the earlier RWG that took place in April, and to incorporate the feedback provided by the teams into the Population & Public Health conceptual framework. I drafted an agenda that outlined our plan, and also to ensure that the RWG felt that the feedback was being incorporated. I arrived at 8:30. I brought Starbuck's coffee and snacks for the morning. The PHN from the 755 office arrived just before 9 and then had to go back upstairs. The full group came in about 9:10 am. They had been waiting in the lobby but didn't realize the location of the meeting room

Analysis.

Personal growth. I am feeling increasingly more comfortable and confident with each RWG that passes. I had worked on the draft report the night before to incorporate the feedback from the earlier RWG. The time between the groups was short, and with accessing the transcripts, I didn't have adequate time to distribute information prior to the meeting. I assumed that would be OK with the group and that they would be able to review the information as we were discussing. I had suggested language to define each section of the service delivery model from our discussions as well as by incorporating key Canadian documents on public health

nursing. The group went very well. I tried to engage the group and encourage their participation, reinforcing their expertise.

Engagement. For this session, I had done a draft and was hoping to review it in entirety. Since this was probably unrealistic though, my main goal was to get group feedback on the service delivery model. Again the group was fully engaged, with all members sharing openly and working well together and functioning as a “”performing” team. All members shared equally. Again, I wish that my facilitation skills were better. I do wonder if as a facilitator there is a method to keep the group moving along. However, I am also conscious of meeting the group agenda and not only mine, so do not want to rush. The depth of conversation is important to stimulate critical thinking among members.

Based on the group’s direction, I have scheduled a meeting with the director of the public health. The PHNs want to highlight the energy this project has created, and the risk that failing to value PHN input could be extremely damaging to staff morale. Since this will be the last meeting before that time, I wanted to spend some time preparing. I had hoped to impress upon the group the importance of their participation in that meeting. I appreciate it may be intimidating; however, hope that the director will be able to see some of the enthusiasm.

*Professional knowledge***.** The purpose of this meeting was to continue to develop the action plan, and to move towards resolution of the issue paper. To develop a report that will be meaningful to participants, it is critical that their voices be heard, and team feedback incorporated. The principles of participatory action research were at the critical in terms of the highlighting the lived experience of PHNs and promoting an environment that was empowering.

Articulation of learning. As the RWG discussed the model, the enthusiasm generated regarding the sharing of examples and stories was surprising to me. As each section was

reviewed, the RWG was excited about developing a common meaning but wanted the feedback of all PHNs reflected. For me, the importance of a participatory action approach was highlighted. PHNs want and are excited to contribute to the development of their practice. They have the ability and answers, but my role has been important in facilitating the process.

RWG May 15, 2013

***Objective description*.** The RWG took place on the scheduled date of the nursing practice council meeting, May 15th, 2013. The RWG was assigned to the family room at the 3401 Roblin, as previous nursing practice council meetings. The room contains 2 couches, a small table, a couple of chairs, and a desk with a computer. The room itself is quite small, so it is fairly crowded. The RWG consisted of the regular 5 PHNs and me.

The purpose of the meeting was to continue the process of developing and refining the professional practice model. I did not provide an agenda in advance this time. We had met twice in April, and at the last meeting had not completed all of the items on the agenda, so I thought we would continue to work on those items. The agenda for that meeting was consistent with my PhD proposal, although it was more flushed out. The purpose of this meeting was to continue to refine the professional practice model, and to develop a plan for moving forward, as well as to debrief the meeting with the program director.

I arrived early at 8:15, and brought Starbuck's coffee and a snack for the group. The room required some set up, there were not enough chairs, and the food had to be put out. The room door was open and a women from my Pilates class walked by and stopped to talk to me. I had some trouble signing into my new computer and I was trying to do this while she was talking to me without being rude. The first participant arrived shortly after, and others began to come. I was still trying to sign in to my computer (Windows 8), as well as welcome the RWG members.

Analysis

Personal growth. I was feeling more hopeful about the process, as the professional practice model document continued to be developed. Hopeful that the process has been productive and that we are well on the way to accomplishing the goal that was initially set out. I am also hopeful that I will be able to complete the data generation, and will then have opportunity to move on in the process of analysis and writing the dissertation. My assumption is that the RWG is feeling the same way. I recognize that there is still considerable work to come, if the professional practice model is to be implemented in the WRHA, and I remain a little apprehensive about willingness to move forward at higher organizational levels. I am conscious however that as a participatory action research project, the RWG has to also agree that this initial step is complete, so that we can move forward with the process evaluation. I engaged the group in making decisions about process. Knowing there was limited time for this meeting, I asked the group to prioritize the items to be addressed, and what would they like to start with.

Engagement. The engagement and enthusiasm of the RWG has continued to grow throughout the course of this project. As an example, when I hadn't sent out an agenda for this meeting, one of the co-chairs took the initiative to e-mail the group regarding the plan for the meeting. Participants were well prepared and had the document with them. Many had the other materials that had been previously reviewed with them, and went back to them during the process of revisions for additional clarification. During the meeting, all members were engaged in the discussion; providing thoughtful and critical suggestions for organizing and improving the professional practice model. The RWG made specific suggestions about formatting and appendices, so that the document would be meaningful for a diverse audience, but also readable. The RWG focused on sections in the document to clarify, to really highlight and clarify the PHN

role. This meeting also followed our meeting with the director and the group was interested in her appraisal of the document, and ensuring her feedback, as well as that of the teams was reflected.

Professional knowledge. Through Community Health Nurses of Canada , I had received a visual of a professional practice model which was .being launched at the upcoming conference in June. I shared the document with the RWG, and asked whether this visual should be included in our model, and whether any adjustments were required as a result. The group was excited to be consistent with the Community Health Nurses of Canada professional practice model graphic being launched at the conference. The only component that differed from the Community Health Nurses of Canada graphic and ours was that the 'rewards and recognition' section had been omitted. The RWG felt strongly that they wanted to keep this component in our model.

***Articulation of learning*.** A key learning for me was the importance of communication. It was not very thoughtful or inclusive of me to not send out a message to the RWG regarding the agenda for the this meeting. I am so immersed, and because it was clear to me that we needed to continue where we had left off, I assumed the RWG would recall this as well. They are involved in multiple work activities however, and between meetings do not devote the same amount of time to this project. The RWG is very invested though, and communication is always an important thing. Communication is especially important given that it has been a recurrent theme throughout the process. PHNs have not been included in making decisions, and in my role in the organization, I have navigated the communication between the director and the RWG. The communication has not been clear, and I have not felt comfortable with it. I have purposively tried to be transparent, and to make the management structure feel a level of accountability to the staff through the process of facilitating these meetings. I have also coached and mentored the

RWG members to lead the discussions and messaging, so that it is their voice. At times, I have been caught in the middle though, as the director will speak openly with me, as will the RWG, and both have divergent ideas. For this reason, it is especially important for me not to be in the middle, but for the communication to be direct.

RWG July 3, 2013

***Objective description*.** The RWG took place on July 3rd, 2013. The RWG decided to meet at the Fort Garry office. The room was a large boardroom with ample table room and chairs. The RWG consisted of the regular 5 PHNs and me. The purpose was to complete the evaluation regarding the outcome of the project, as well as to evaluate the participatory action research process used. I provided a copy of the discussion questions in advance, in response to the RWG's request. I arrived early at 8:25, and brought Starbuck's coffee and snacks for the group. The rest of group began to arrive prior to the start time of 9:00 am. One participant came late around 9:25, due to an unexpected situation at home. Upon entering, one of the participants stated that she had a busy day, and was hoping to leave by 11:15.

Analysis

Personal growth. I am happy with the process and outcome of the project, and based on the comments and participation of the RWG I assume that they are as well. I am feeling confident in the skills and contributions of the members. For this RWG, I felt pressure to "get good data," but at the time it is hard to know what that is. The RWG went smoothly, people spoke openly and contributed. I tried to engage the group and also to follow the interview guide. I know that I am reflective, and always feel that I could be sharper in the moment. That is a skill that I know I will always need to continue to work on and develop. I find it challenging to purposively guide the discussions and am often not clear where to probe to elicit more

information in the moment, which I recognize would have contributed to the analysis. I had an appointment with another PHN near noon that I hoped to make, so also wanted to keep the discussion concise.

Engagement. My hope was to complete the data generation for my PhD. The others, I believe wanted to be clear regarding the process for completion of their work. Recognizing that there is still a lot of work to be done in terms of implementation of the professional practice model, I think that the RWG was unclear regarding their role and were somewhat overwhelmed with the enormity of the task. The RWG members all contributed to the process and were respectful of each other. I do think the RWG was an example of a well performing and effective team. As this part of the work is wrapping up, the RWG mentioned the importance of celebrating the successes achieved.

Professional knowledge. The main resource applicable to this RWG pertained to the research process. While the research process was important for each RWG, this being the final meeting and evaluation was particularly significant. Throughout the process, I have had multiple roles that included researcher for a PhD, and a facilitator to keep the process moving forward. These were "extra" roles, in addition to my daily work as a clinical nurse specialist, with lead responsibilities for nursing practice council. In my clinical nurse specialist role, outside the work of the RWG, I have also had to work at the system level to keep this project moving forward. In doing that, I have volunteered to be involved with several committees and simultaneous work that is taking place, so that the professional practice model will be acknowledged and incorporated. All of the work is consistent; however, being more invested in the success of this project, I believe that I underestimated the amount of work that would go along with that.

Articulation of learning. From this situation, I have gained more appreciation of the value and importance of PHNs having input into decisions. Health systems are not organized to value the input of the grass roots staff, and decisions are made in hierarchal structures, assuming that nursing managers, directors or clinical nurse specialists speak on their behalf. While there are others who may have knowledge and skill to speak on their behalf, it is unlikely to create system change or evidence uptake. It is the participation in the process that is important in developing buy-in. I will continue to try to advocate for PHN input, and to promote flattened and less hierarchal organization structures. Those structures are more consistent with inter-professional collaboration and transformational leadership in nursing.