QANE AFI | Quality Advancement in Nursing Education Avancées en formation infirmière | CASN ACESI

Volume 10 | Issue 3 Article 2

Understanding the Current State of Community Health Nursing Education in Canada: An Exploration of the Erosion and Devaluation of Community Health Theoretical and Practice Education in Canadian Nursing Programs

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Recommended Citation

Sanders, Tanya; Avanthay Strus, Jacqueline; Chyzzy, Barbara; Chircop, Andrea; Currie, Genevieve; Fillion, Francoise; Mercer Riselli, Dawn; Miller, Catherine-Anne; Schofield, Ruth; and van Daalen-Smith, Cheryl (2024) "Understanding the Current State of Community Health Nursing Education in Canada: An Exploration of the Erosion and Devaluation of Community Health Theoretical and Practice Education in Canadian Nursing Programs," *Quality Advancement in Nursing Education - Avancées en formation infirmière*: Vol. 10: Iss. 3, Article 2.
DOI: https://doi.org/10.17483/2368-6669.1447

Understanding the Current State of Community Health Nursing Education in Canada: An Exploration of the Erosion and Devaluation of Community Health Theoretical and Practice Education in Canadian Nursing Programs

Cover Page Footnote

The views and opinions expressed by the members of the Nurse Educators Interest Groups (CASN) do not necessarily reflect the views of CASN. | Les points de vue et opinions exprimés par les membres des nécessairement les Groupes d'intérêt pour infirmières et infirmiers enseignants (ACESI) ne reflètent pas points de vue de l'ACESI.

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The Canadian Association of Schools of Nursing (CASN) Community Health Nurse Educator Interest Group (CHNEIG) consists of community health nurse (CHN) educators from across Canada who meet regularly to discuss ideas and to exchange information related to community health nursing education, to build research and scholarship capacity, and to promote quality of community nursing education at a national level (Canadian Nurse Educators Institute, 2023). For more than a decade, an erosion of community and population health content in baccalaureate curricula across Canadian schools of nursing has been occurring (Schofield et al., 2022; Schofield et al., 2011). Additionally, during the COVID-19 pandemic, CHN educators in Canada observed a disproportionate impact on community nursing practice placements because of pandemic-related public health measures.

CHN educators in Canada are gravely concerned by the reduction of community health nursing theory and practice framed in health equity, social, ecological, and structural determinants of health, and intersectionality, which are vital to nursing and to the health of Canadians. For these reasons, we identified the devaluing of community health nursing theory in baccalaureate nursing curricula and the reduction in community nursing student placements as a priority action during our 2021–2022 working year for our CHNEIG. Our research study aimed to describe the current state of community and population health nursing education in Canadian schools of nursing. This knowledge serves as a foundation for evidence-informed community health nursing educational practices that align with CASN's (2014) *Entry-to-Practice Public Health Nursing Competencies for Undergraduate Nursing Education*.

Background

Baccalaureate nursing education in Canada must prepare nurses to identify and address health inequities and transform systems to meet the needs of diverse populations (CASN, 2022; Duncan et al., 2020; Schofield et al., 2023). The COVID-19 pandemic clearly exposed an inequitable distribution in the burden of illness and mortality across certain populations and communities in Canada (Public Health Agency of Canada, 2022). These avoidable health inequities included a higher number of COVID-related deaths within equity-denied populations, particularly in racialized communities (Public Health Agency of Canada, 2022). Colonialism, racism, economic inequality, and other social determinants of health were highlighted as leading factors that shaped these inequitable distributions of health risk during the pandemic (Public Health Agency of Canada, 2022). Community nursing education plays a critical role in addressing health inequities by preparing baccalaureate nursing students with knowledge and skills related to social justice, health equity, advocacy, and political action (Schofield et al., 2022).

The importance of community health nursing has been recognized nationally and internationally since its inception. In Canada, the National Nursing Education Framework outlines the essential elements for excellence in baccalaureate nursing education and highlights that all nurses be able to provide care not only to individuals but also to communities and populations (CASN, 2022). Specifically, this framework highlights key community health nursing knowledge that is required by all baccalaureate-prepared nurses in Canada, including "the intersection of social, structural and/or ecological determinants on the health of individuals, families (biological or chosen), communities and populations" (CASN, 2022, p. 10); advocacy strategies to "address racism, social injustices, and health inequities" (CASN, 2022, p. 21); and an understanding of "population health, public health, home health, primary health care principles" (CASN, 2022, p. 15), health promotion, preventive care, population assessment and program evaluation (CASN, 2022). *The Canadian Community Health Nursing Professional Practice Model and Standards of*

Practice (Community Health Nurses of Canada [CHNC], 2019) defines the scope and expectations for practice of community health nurses in Canada. These standards provide guidance for safe, competent, and ethical nursing care in multiple community nursing domains, including home health, public health, and primary care. The standards are intended to be embedded into baccalaureate nursing curricula (CHNC, 2019). The International Council of Nurses reinforces the importance of primary health care (Burton, 2023), a foundation for community health nursing education, as the cornerstone of health systems for every nation worldwide. Additionally, the World Health Organization (WHO, 2017) endorses the significance of community health nursing as having "the potential to make significant contributions to meet the health care needs of various population groups in a variety of community settings" (p. 3).

However, despite the requirement and benefits of community health theory and practice education, there is a lack of knowledge about the current state of curriculum for theory and practice in undergraduate nursing programs in Canada. Previous research conducted within baccalaureate curricula across Canadian schools of nursing have looked at aspects of community health nursing education, such as social justice and advocacy (Cohen & Gregory, 2009a, 2009b) and public health nursing (Schofield et al., 2011). Furthermore, research has focused on community nursing practice education (Cohen & Gregory, 2009a, 2009b; Hoe Harwood et al., 2009; Pijl-Zieber & Kalischuk, 2011; Pijl-Zieber et al., 2015a, 2015b; Schofield et al., 2011) or public health guidelines and competencies (Schofield et al., 2022). Gaps in community nursing theory and practice in Canadian curricula were noted by Schofield et al. (2011) and Valaitis et al. (2014) over a decade ago, and recent research suggests these gaps still exist in relation to entry-to-practice public health nursing education (Schofield et al., 2022). As an example, concepts of harm reduction, community development, social justice, and the use of nursing informatics in community health practice were identified as high learning needs for CHNs' preparedness for practice, indicating a need for enhanced education in undergraduate preparation (Valaitis et al., 2014). Practicum hours in community health clinic practice ranged from a low of 14 hours to a high of 390, with a variety of models for how the practice education is integrated into theory or separated into stand-alone practicum courses (Cohen & Gregory, 2009a). Very few practice courses across Canadian undergraduate nursing programs used the primary health care framework to inform practice courses in community health (Cohen & Gregory, 2009a). Previous studies offered recommendations to strengthen curriculum through additional resources for faculty and the incorporation of the entry-to-practice competencies (Schofield et al., 2022; Valaitis et al., 2014). Additionally, developing resources for community health nursing and strengthening partnerships with community agencies for practice learning were recommended to better prepare nurses for future practice (Valaitis et al., 2008).

Anecdotal evidence suggested a decreasing presence and valuing of community and population health–focused curriculum content and practice opportunities. Canadian literature has shown that over the past 10 years, the number of qualified community/public nursing educators has decreased, and there has been a reduction in the number of appropriate community-based placements (Pijl-Zieber et al., 2015a; Schofield et al., 2022). Anecdotally, the use of a new licensing exam in Canada with a prevailing biomedical focus has been identified as impacting curriculum focuses and content. A shift in focus to prepare students for this exam has resulted in decreased community health content and increased biomedical content.

There is emerging evidence of positive learning outcomes with the use of virtual simulation in community health nursing education in Canada (Chircop & Cobbett, 2020; Chircop et

al., 2022). Simulated learning experiences in community health nursing increased during the pandemic (Schofield et al., 2023). Exploration of the use of multi-contextual pedagogies has been recommended from this initial work (Chircop et al., 2022). It is timely to review current theory, practice, and simulated learning experiences in community health nursing across Canada.

Purpose

The purpose of this study was to determine the current state of community and population health theoretical and practice education for baccalaureate nursing students in Canada. The overarching research question was: What is the current state of community health/population health theoretical and practice education for baccalaureate nursing students prior to graduation in Canada? This study took a comprehensive approach to explore both community health nursing theoretical and practice education within baccalaureate curricula across Canadian schools of nursing programs. Questions were designed to elicit information from nurse educators about theory and educators' preparation, practice education hours and models, changes over time, practice placements and use of simulation to inform and contribute to the state of knowledge about Canadian undergraduate nursing preparation in community and population health.

Methods

Meleis (2018) and Godrie (2017) stressed the importance of valuing multiple ways of knowing in research, including experiential learning and lived experience. Therefore, personal and anecdotal evidence from the CHNEIG helped identify aspects of the research problem and questions. The surveys were meant to elicit the experience and insights of CHN educators across Canada.

Goals

The goals of this research were (a) to identify methods of teaching theory and practice in community/population health nursing; (b) to identify models being used in practice education placements (including timing of practice opportunities in the program, types and sizes of practice groups, student supervision models, and types of placement sites); (c) to identify how simulation is being used for community/population health education; (d) to identify causes and impacts of curricular erosion as determined by participants; (e) to identify COVID-19 related impacts to community practice opportunities and placements; (f) to map a comprehensive picture of different approaches to community/population health education, the use of national frameworks and standards, areas of commonality, novel approaches, and potential gaps; (g) to identify concerns and successes raised by Canadian community health nursing educators; and (h) to identify recommendations for community health/population health baccalaureate nursing education in Canada.

Design

This study used a mixed-methods research design. An online survey, consisting of 32 questions (22 closed ended and 10 open ended; see Appendix A) related to the research goals, was administered to schools of nursing in Canada. A triangulation design-convergence model was chosen for this study, collecting quantitative and qualitative data simultaneously and giving equal importance to both methods of data collection (Creswell & Plano Clark, 2007). Quantitative and qualitative data were analyzed simultaneously but separately, and the two sets of results converged during the interpretation (Creswell & Plano Clark, 2007).

Ethical Considerations

Ethical approval was obtained through York University's Research Ethics Board (#2021-341). Given the small number of community health nurse educators in Canada, it was made explicit in the ethics application that members of the research team could also potentially fill out the survey, given that several CHNEIG members also hold academic positions in Canadian baccalaureate nursing programs. Indeed, such insider knowledge is viewed as beneficial to the study's overall purpose and goals. Coupled with separate analysis teams exploring similar data to seek saturation, routine analytical check-ins included attention to ensuring individual research team members did not sway the analysis towards their own individual views.

Recruitment and Data Collection

National recruitment was conducted using convenience sampling. A link to the survey was sent via email to all accredited CASN schools of nursing in November 2021 with CASN administrative support, representing 86 schools of nursing (CASN, 2021). The email invitation indicated that the study was voluntary and asked participants to self-select community health nursing educators in their school to participate in the study, with only one survey to be completed per school. Participants therefore were included if they taught community health and/or population health courses at their respective institutions. The survey did not collect the information of who or what role those completing the survey had. The study was promoted through CHNEIG and the Community Health Nurses of Canada. The questionnaire was linked to a webpage connected to the participant's email, ensuring that participants could not be identified. Participants had the option of completing the survey in French or English. All responses were saved onto a secure CASN server. Only the CHNEIG and CASN staff had access to the aggregated survey results, with no identifying information connected to the results.

Data Analysis

Quantitative data cleaning was conducted by a research team member before data analysis. Twenty-four of the 52 responses were incomplete (46%). The research team opted to remove surveys with incomplete data. The rationale for removing incomplete data is based on Mirzaei et al.'s (2022) algorithm for handling missing data: if greater than 40% of case data is missing, alternative methods for dealing with missing data (such as imputation or likelihood methods) are not recommended. Therefore, data were analyzed from the 28 participants who consented and answered the 22 closed-ended and 10 open-ended survey questions (response rate = 32%).

Quantitative data were analyzed by employing descriptive statistics. Qualitative data were analyzed using thematic analysis following a 6-step process as outlined by Clarke and Braun (2021) who defined thematic analysis as "a method for identifying, analyzing and reporting patterns within data" (p. 79). The team reviewed the data from each question with this 6-step process to (a) become familiar with the data, (b) generate initial codes, (c) search for themes, (d) review themes, (e) define themes, and (f) write up the findings. First, research team members read and reread the qualitative responses separately to become familiar with the data, and they generated initial codes. Then, team members met as a group to discuss and came to a consensus about the codes, emerging patterns, and common themes. Themes were reviewed by the teams and discussed by reflecting on the data, including convergence and divergence with the qualitative data.

Results

Table 1 outlines the number of surveys submitted by province. Participants identified working at schools of nursing in nine provinces in Canada. There were no responses from participants in Prince Edward Island or the Northwest Territories. There are currently no baccalaureate nursing programs in Nunavut or Yukon. The majority of participants were located in Ontario (43%), followed by Alberta (13%).

Table 1

*Number of Submitted Surveys by Province (*n = *28)*

	Frequency	%
Alberta	5	17.8
British Columbia	2	7.1
Manitoba	3	10.7
New Brunswick	1	3.5
Newfoundland and Labrador	1	3.5
Nova Scotia	3	10.7
Ontario	11	39.3
Quebec	1	3.5
Saskatchewan	1	3.5

The following results correspond to goal A of this research. Responses revealed that CHN theory is delivered across all 4 years of baccalaureate programs, with the majority of schools teaching content in years 3 (32%) and 4 (31%) of their program. CHN content was delivered less often in year 2 (18%) and year 1 (15%). Public health (21%) and community health (20%) were the most dominant foundational community health content areas taught in theory courses, followed by primary care (17%), home health (16%), disaster planning (15%), and occupational health (9%). One participant indicated that no CHN theory content was taught in their program.

CHN practice was offered most often (43%) in year 4, followed stepwise by years 3, 2, and 1. One participant indicated that no CHN practice was offered in their program, and one participant indicated that a CHN practice course was offered as an elective.

Four themes were identified based on the data analysis: (a) theoretical and practice models for CHN education relating to goals A, B, and F; (b) use of national frameworks and standards relating to goal F; (c) COVID-19-related impacts and use of simulation relating to goals C and E; and (d) ongoing concerns of erosion within CHN education relating to goals D, G, and H.

Theoretical and Practice Models for CHN Education

The total number of practice hours that focused on community health practice ranged from 0 to 336 hours. Of the nursing programs that had community practice hours, the average number of hours in year 1 was 98 hours (*SD* = 88.6), the average number of hours in year 2 was

91.5 hours (*SD* = 49.8), the average number of hours in year 3 was 137 hours (*SD* = 37.1), and the average number of hours in year 4 was 178 hours (*SD* = 55.3). If students completed a consolidated practice course in CHN, the total number of hours increased to 432 hours. For most programs (67%), CHN practice hours had stayed the same for the past 5 years. Direct supervision was the most common model of supervision for students in years 1 and 2 (50% and 80%, respectively), with indirect supervision being the most common model in year 4 (44%). Both direct and indirect supervision of practice were most prevalent in years 3 and 4 (53% and 40%). The number of students per practice group ranged from 1 to 22 students, with a median of 12 students. The majority of participants (60%) stated that the number of students in their practice groups had stayed the same over the past 5 years, while 36% indicated their group size had increased.

Most of the participants (71%) asserted that CHN was important and relevant in their curriculum. A total of 74.2% of participants responded that their nursing program provided an opportunity to advocate for CHN in their curriculum, and 64.5% agreed or strongly agreed that leadership supported CHN content in their program.

Participants stated that nursing faculty who teach CHN theory and practice had CHN experience (59%), while many had no CHN experience (47%). Nursing faculty with CHN experience across the country voiced concerns about having faculty and practice educators without relevant CHN experience teaching community health nursing. Some participants voiced the belief that any nurse can teach community health: "There is a belief that anyone can teach and/or supervise CHN without experience in CHN. As a result, we've seen a decrease in theoretical content as well as practice placements that are limited to a few agencies." Another participant explained a desire for "greater recognition of the need for instructors with relevant experience—actual CHN to provide best teaching and learning opportunities for students." The underlying recommendation proposed by participants was to ensure theoretical and practice education is supported by educators with CHN expertise.

An instructor-supervision (student group) model was reported throughout all 4 years in nursing programs; however, this model was more common in years 1 and 2 (66% and 64%, respectively) compared to years 3 and 4 (31% and 24%). The preceptor (single student) model was most used in year 4 (33%).

Use of National Frameworks and Standards

Participants were asked to comment on how the CASN entry-level public health nursing competencies are used in their respective curricula. For many, the updated competencies were incorporated, pulled through, guided placements and theory, and were foundational to the practice evaluation components, often explicitly. They were described as underpinning both the syllabus and the assignments for some and for others were named as foundational. Others shared that they were used for curricular redesign, forming the basis of how students were evaluated in practice and guiding revised theory content. For others, they were used very little, not used at all because of a devaluation by leadership, or were used to inform course design but not found in the curricular content.

Participants were asked to comment on how the Canadian community health nursing standards (CHNC, 2019) are used in their program's curriculum. For many, these are discussed as a reference point for future practice, used as a reflective discussion activity in practice, used in class for application to populations to highlight CHN roles, and suggested as a reflective guide for students to discuss their experiences in their placements. Others, to a lesser degree, were integrated

into theory classes, at times in the form of case studies, and others used them for evaluative purposes. Some respondents indicated that the standards underpinned the syllabus and assignment structure used for practice goals, and for one person, assignment rubrics were rooted in the standards. Interestingly, one respondent characterized them as ideals.

Participants were also asked to comment on how the *National Competencies for Registered Nurses in Primary Care* (Canadian Family Practice Nurses Association, 2019) are used in their program's curriculum. For some respondents, they were not sure, for others they knew that they were discussed if students had placements in these primary care settings or were preceptored by a primary care nurse, and for others these were not used at all. Overall, educators were not familiar with them, with minimal uptake. Participants also indicated the CASN (2014) entry-to-practice competencies have helped make it necessary to include community content and practice in curricula.

COVID-19-Related Impacts and Use of Simulation

The COVID-19 pandemic provided unique opportunities for some nursing programs in Canada. During the pandemic, several nursing programs were involved with different interventions to support the effort to control the spread of COVID-19. For example, mass immunization clinics, contact tracing, and case management provided learning opportunities for some students in baccalaureate nursing programs. One participant stated:

> Student groups placed at public health have been primarily doing contact tracing and case investigation during the pandemic. This was supplemented by community assessment of a nearby neighbourhood to provide some community level experience since their placement was narrowly focused.

Some schools stressed the importance of in-person practice placements and relationship building, and shadowing in labs or public health settings, and others said that simulation was the only option because of a lack of practice placements.

Most participants (68%) reported that the number of practice hours stayed the same during COVID-19, while 29% indicated that the number of practice hours decreased. While practicum hours remained consistent, some placements were switched to fully virtual or a hybrid model. Almost half of the participants (47%) mentioned using both traditional community-based clinical and population-focused virtual simulation learning in community health practice courses, and 55% of participants shared that they replaced traditional community-based practice with simulation. A variety of types of simulations and domains of practice were identified; however, the participants voiced discontent with using simulations to replace practicum hours. Some participants shared that community-based practica (access to preceptors or community agencies) were totally replaced with simulations and it was not conducive to experiential learning. The limited opportunities of community-based practice education were justified with the evidence-based strength of some simulation programs (Sentinel City) (Chircop et al., 2022) and the perceived need to focus on acute care placements by some schools.

Simulation use for community health education was also impacted by the COVID-19 pandemic. A total of 61% of participants reported using simulation before the pandemic, while 36% said they did not. A blended model, combining simulation and community nursing practice, was common, with 66% of participants using both. High-fidelity simulation in lab settings before practica provided students with the opportunity to participate in public health activities such as

immunizations, health assessments, and interviews. A total of 50% of participants mentioned their school planned on using simulation in future CHN practice education, while 34% said maybe, and 16% replied no, they would not. Some participants mentioned that virtual simulation games and products, such as Sentinel City, will continue to be an important base to community practice; however, there was concern over whether the schools would continue to pay for this resource after the pandemic.

Concerns of Erosion Within CHN Education

Nursing faculty across the country identified concerns related to barriers to community health nursing education and causes of curricular erosion. Many faculty did not have relevant community health nursing experience and theoretical knowledge yet were expected to teach community health courses. In addition, participants highlighted the lack of quality practice placements as a major issue and devaluing of community nursing education. Approximately 40% of participants stated that their school of nursing had sufficient practice placements in community health. As one participant stated: "Finding enough individual student placements within the preceptor-student-faculty advisor triad model is a huge challenge. We have several excellent community placements, but they are a challenge to find and sustain." Participants linked the scarcity of community health nursing placements to the use of simulation in nursing education, indicating it was a stopgap measure that had merit but that should not give way to further erosion. A few voiced concerns about simulation being used to replace practice hours. One participant shared: "Simulation replacing clinical is not conducive to experiential learning. Students are not exposed to community health and are not appreciative of the skill sets developed as a CHN." Another identified concern with the replacement of practice with simulation: "Real life placements and relationship building are preferable to simulation learning when possible."

The theme of erosion of community health nursing in baccalaureate education was supported by concerns with cost-containment decisions impacting quality education, lack of experienced faculty, and a focus on the biomedical model in nursing. Indeed, during COVID-19, many schools, out of concern for declining available hours, made the decision to cancel community course practicum, opting for the "more urgent" need for novice nurses to have acute care training. Further, another participant stated: "There has been serious erosion of the importance of community courses at our school." Another theme identified in the qualitative data was that placement agencies did not necessarily understand the nursing student learner role in community health nursing practice, which may limit their willingness to contract with post-secondary institutions to take students.

Most participants (65%) stated their faculty leadership supported community health in content and practice in nursing education. However, most participants (58%) felt that the National Council Licensure Examination-Registered Nurses (NCLEX-RN exam), which has limited community health content, had negatively affected the community health nursing content in their program: "Cost containment is the biggest driver of decreased CHN content and clinical. Devaluing of CHN content due to a focus on NCLEX is also a factor." Participants noted a clear need for sustained leadership to push back against the barriers and the general devaluing of community health in the nursing curricula:

> There has been a diminishing respect for CHN in my current program. There was a leadership change a few years back. Since that time there has been a decrease in the number of hours instructors/professors are paid to oversee the placement. Group size

increased. Experienced part time CHN instructors left because of these reasons. They have been replaced by people with NO CHN background.

Participants highlighted the need for CASN to take a leadership role in terms of accreditation and support for ensuring CHN theory and practice are maintained. Participants stated that there is "too much emphasis on the NCLEX and the biomedical model in our curriculum. CASN could perhaps put more emphasis on CHN content in the accreditation," and "there needs to be serious leadership from CASN and other nursing organizations to bring back CHN in nursing programs." Participants also identified the need for investing in local community health champions in advocating for CHN, as well as ensuring faculty with CHN experience are recruited.

Discussion

The purpose of this study was to examine the current state of community and population health theoretical and practice education for baccalaureate nursing students in Canada. Our findings indicate there is a strong message of concern from nursing educators about the eroding and devaluing of community health nursing theory and practice in Canada. There are a variety of systemic factors underpinning curricular erosion. This erosion is multi-layered in cause but can be tethered, in part, to the overall general weakening of public health systems and services in Canada, which has resulted in an inability to effectively promote and protect the health of all Canadians (Guyon et al., 2017). Our findings are consistent with current research indicating that an erosion of public health nursing theory and practice already exists in baccalaureate nursing education curricula in Canada (Schofield et al., 2022). Duncan et al. (2020) also warned of the peril of public health nursing, stating that the "current state of public health nursing may well be the canary in the coal mine of what is happening to nursing and how nursing education for the practice of community health nursing is actualized" (p. 9).

Community health theory and practice are essential components of baccalaureate nursing education. However, our findings suggest that there is no minimum standard or benchmark for community nursing theory and practice (in terms of hours, practice models, theoretical content, etc.) within nursing curricula across Canada. While schools indicated that practice hours may have remained consistent over the last 5 years, many responses indicate that these hours were replaced with simulation learning and virtual experiences that impacted the quality of learning experiences. The fact that one nursing program in Canada did not have any CHN theory and one nursing program had CHN practice only as an elective indicates that some schools of nursing may not be incorporating the National Nursing Education Framework (CASN, 2022). This could impact accreditation status since community and population health are compulsory components of accredited baccalaureate generalist nursing programs in Canada. Furthermore, in several provinces the public health legislation requires public health nurses to have a baccalaureate degree (Canadian Legal Information Institute, 1990). Of note, baccalaureate nursing programs are approved at the regulatory level within the local jurisdiction (province/territory), which has different criteria from the voluntary CASN accreditation process.

As well, many schools of nursing across Canada have faculty without a background in community health nursing, teaching community health theory and/or practice courses. This could jeopardize meeting another CASN accreditation standard (CASN, 2020). Likewise, the CASN (2010) *Guidelines for Quality Community Health Nursing Clinical Placements for Baccalaureate Nursing Students* state that it is essential for faculty advisors and practicum instructors teaching CHN practice courses to be able to explain the CHN role within placements. It is preferred that

faculty in these roles have had prior CHN experience. Our findings show that a greater number of faculty who teach CHN theory have a background in CHN practice compared with faculty who teach CHN practice, indicating that there may be a devaluing of the importance of CHN practice within some schools of nursing in Canada. Recent literature explains that community health nursing is at risk of being eliminated or diluted because of a strong focus on acute care and the biomedical model in nursing curriculum (Jones & Avanthay Strus, 2022; Kirk, 2020; Mcharo et al., 2021) and the adoption of the NCLEX-RN. With a predominant focus on the medical model, it can be difficult for nursing students to understand the value of community health placements (Mcharo et al., 2021). Furthermore, as Etowa et al. (2017) mentioned, this biomedical focus and invisibility of community health nursing can negatively influence baccalaureate nursing students, leading to stereotypes about the role of CHNs and hindering new graduates from pursuing careers as CHNs. This analysis highlights opportunities and recommendations to ensure quality community health nursing education.

Recommendations

Community health nursing and its requisite focus on population health and health equity is an essential component of generalist nursing education in Canada, as evidenced by the inclusion in accreditation standards (CASN, 2020) and in the National Nursing Education Framework (CASN, 2022). Schools of nursing must ensure CHN theory and practice are embedded in baccalaureate education. There is a need to strategically integrate community health nursing (Duncan et al., 2020) or at the very least key community health concepts, such as primary prevention, population health promotion, social justice, health equity, and intersectionality throughout the baccalaureate nursing curriculum. Ensuring that faculty have experience and a solid grounding in community health to facilitate practice education is critical (Cohen & Gregory, 2009b). Participants in this study spoke to the value of experience to ensure quality practice experiences for students and the challenges of having colleagues without that knowledge supporting students in their CHN practice education. Faculty teaching community health nursing theory or practice require preparation and experience with a connection to community health nursing practice; this is supported by CASN (2020) accreditation standard three, key element two and three. Placement coordinators play a key role in facilitating relationships and fostering partnerships; knowledge of community health nursing roles is essential in supporting practice placements. Ensuring appropriate quality practice learning experiences is essential for student learning. Appropriate placements allow for students to learn the scope of practice of a novice community health nurse that is upstream, midstream, and downstream, and that considers prevention through an equity and population health lens. Traditional community placements in the health sector (e.g., public health, home care, primary care) in which students are working with RN preceptors are needed. Additionally, practice placements outside the health sector (e.g., schools, childcare settings, shelter programs) where students learn with experienced community health educators are critical. In these learning environments, students develop skills in nursing practice with communities and populations, CASN accreditation standards four key element seven (CASN, 2020), and students learn about intersectoral collaboration, CASN accreditation standard two key element thirteen (CASN, 2020).

There is an increasing use of simulation as a teaching modality in nursing education (Luctkar-Flude & Tyerman, 2021). Simulation offers learning opportunities that can augment clinical and classroom learning. Participants in this study provided a reflection on simulation in CHN that is similar to research findings that concluded simulation should be used to augment

learning but should not replace practice experiences (Chircop & Cobbett, 2020; Chircop et al., 2022).

Community health nurses are required to act as champions for health and health equity. Community health nursing education emphasizes structural factors influencing health, acknowledging the complex interaction between social systems, systemic disparities, and individual health outcomes. These connections are a vital focal point for addressing health disparities and the wider social and environmental inequalities that significantly affect health outcomes (Jones & Avanthay Strus, 2022), reinforcing the need for a greater emphasis on CHN theory and praxis that is critical (e.g., a lens that enables nursing students to understand their role in both identifying and ameliorating health inequities). Consistent with previous research, nurse educators and leaders must advocate for a continued and vibrant presence of CHN theory and practice education in baccalaureate nursing education (Duncan et al., 2020; Valaitis et al., 2014). Our findings indicate that when nursing education leaders understand the wide-angle lens of Canadian community health nursing, their leadership efforts can be called upon to ensure the integration of critical CHN theory and practice in their programs. Faculty members with expertise in community health nursing theory and practice are essential in each school of nursing, and we call on all of them to continue to speak up, challenge, and ensure that CHN education is embedded in curricula. CHNs are used to asking tough questions and drawing upon their moral courage to affect change. The erosion we have identified requires these same skills to ensure the next generation of Canada's nursing students receive the rich experience of community health nursing education and practice that is known to be a substantive lens changer for so many.

Additional research is needed in several areas. To begin, an exploration is needed of how CHN theory and nursing education integrates CHN core concepts to determine the best ways to include concepts relating to social justice, socio-environmental approach to health, determinants of health, equity, community assessment and planning, population health and prevention. Additional research is also needed in relation to the effects of community health nursing education being delivered by nurse educators with limited education and practice experience in this area. Finally, further research is also needed to better integrate simulation into community health nursing education. The current study could be replicated with a larger number of Canadian schools of nursing within the next few years using a modified version of our existing tool (such as adding questions specific to CHN concepts and refining questions to reduce respondent fatigue) to determine whether anything has changed with CHN education in Canada.

Limitations

This study was conducted with schools of nursing in Canada. There was a low participation rate in the study given the broad distribution to schools of nursing across Canada, which impacts the ability to determine a comprehensive view of the state of undergraduate nursing education. As well, the use of self-reported data for the survey increases the potential for response bias. Finally, there was a high percentage of missing data, which may have been related to the length of the questionnaire, causing respondent fatigue. This missing data may have influenced the results of this study.

Conclusion

The survey was identified as a helpful way for CHN educators to have their voices heard regarding the troubling trend of eroding CHN education in baccalaureate nursing programs. Given the findings, there is a need for continued advocacy and leadership for CHN education's place

within accredited baccalaureate nursing programs. CHN champions and CHN faculty are needed to advocate for and facilitate quality CHN education opportunities. The development of partnerships with community practice sites and the support for student learning in community health provide transformational experiences for students with diverse populations. These experiences supported the development of learning cultural safety, working with diverse populations, and creating inclusive practice. However, there was a strong message of concern about the erosion and devaluing of CHN education in Canada—necessitating timely advocacy and collaborative strategizing to remedy this troubling trend.

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Appendix A: Questionnaire

Definitions of Concepts

CHN: Community health nurse or community health nursing.

Instructor: RN who is either a faculty member or hired on a short-term basis by an educational institution to teach clinical.

Preceptor: Nurse preceptor: RN in a clinical setting mentoring students.

Non-nurse preceptor: A person employed or working as a volunteer in a non-health agency or setting mentoring students.

Direct supervision: Instructor present for a portion of or all clinical hours in a placement.

Non-direct supervision: Instructor not on site to supervise. Instructor may receive evaluation feedback from others who directly supervise the students.

Virtual simulation: We use the term virtual simulation as defined by Verkuyl and Mastrilli (2017): "computer-based simulation that includes; a) a realistic client case study; b) an activity requiring knowledge application; and c) learner engagement in the role of the care provider" (p. 40).

Questions:

CHN Overview

1. Please indicate the Province or Territory where your school is located. Provinces & Territories are listed

2. In what year of your program is CHN **theory** content delivered? (Select all that apply). Year 1, 2, 3, 4, No CHN theory course, do not know (comment box provided)

3. What foundational community health content areas are taught in the **theory course(s)**? (Select all that apply.) List includes: Community health theory, public health, home health, primary care, occupational health, disaster planning, none of the above, no CHN theory course in the program, other, please describe.

4. In what year of your program is CHN **clinical** offered? (Select all that apply). Year 1, 2,3, 4, No CHN clinical offered, Elective, do not know (comment box provided) If no CHN clinical go to question #7

Clinical Hours

5. Please indicate the total number of hours for CHN clinical in each year of your program. (Text boxes below are listed Year 1, Year 2, Year 3, Year 4)

6. Has the number of CHN clinical hours increased or decreased and by how much in the past 5 years (pre-pandemic)? Increased/Decreased/Stayed the same (text box provided under each)

7. Has the number of CHN clinical hours increased or decreased and by how much since the start of the pandemic? Increased/Decreased/Stayed the same (text box provided under each)

8. Do faculty members who teach CHN **theory** have a clinical practice background in CHN? Yes/No/Not always Add comment box

9. Do faculty members who teach CHN **clinical** have a clinical practice background in CHN? Yes/No/Not always Add comment box

Clinical Practice Models

10. Please describe the type of clinical practice model(s) for CHN in your program. Select all that are used in each year of the program. Add comment box below the table

	Instructor supervision (Student Group)	RN preceptor (single student)	RN preceptor (group of students)	Non-nurse preceptor (single student)	Non-nurse preceptor (group of students)
Year 1					
Year 2					
Year 3					
Year 4					

11. Please describe your school's model(s) of clinical supervision for CHN in each year of the program. Add a text box – Further Comments/explanation

	Direct	Indirect	Both
Year 1			
Year 2			
Year 3			
Year 4			

12. Over the last 5 years, how many students are in a CHN clinical group with one instructor? Open text box to reply

13. Over the last five years, the ratio between the number of students and clinical instructor per CHN clinical group has: Choices are: Increased, Decreased, Stayed the Same Add comment box

CHN Clinical Placements

14. What traditional health care placements are used for community health nursing **clinical**? (Select all that apply). List includes public health, home health, primary care, occupational health, long term care, other, please describe, none of the above

15. What types of non-traditional (outside health care system) placement agencies are used for community health nursing **clinical** practice? (Select all that apply). List includes schools, daycares, parenting programs, shelters, drop-in programs, Indigenous serving organizations, Multicultural services, corrections facilities, other (text box)

16. What types of CHN activities are nursing students involved in for clinical practice? (Select all that apply) Open text box response

17. What position in your program has an ongoing collaborative relationship with community organizations to foster the academic-community partnerships (health and non-health)? Options provided are: course professor, clinical instructors, clinical placement office, other Select all that apply.

Simulation

18. Have you used a virtual simulation program for community health? Choices are Yes/No

19. If yes, which type of virtual simulation learning is in use: Choices are: Community-based or Population-focussed – Add option for both Select all that apply

20. What kinds of simulations have you used? (Please be specific). Open text box

21. Have you used simulations prior to the pandemic? Yes/No/Don't Know

22. Did simulation(s) replace clinical hours during the pandemic? Yes/No/Don't Know Comment box

23. Are you using a blended model for CHN clinical practice with a combination of simulation and clinical practice? Yes/No/Don't Know

24. Do you plan to use simulation in future community health nursing practice education? Yes/No/Don't Know Comment box

25. Is your program involved with mass immunization or contact tracing/case investigation during the pandemic? Yes/No

26. If yes, please explain how you are involved in the mass immunization clinics or contact tracing/case investigation and the student learning experiences. Open text box

27. How are CASN's Entry to practice Public Health Nursing Competencies for Undergraduate Nursing Education (2014) used in your program's curriculum?

28. How are *Canadian Community Health Nursing Standards* (2019) used in your program's curriculum?

29. How are *the National Competencies for Registered Nurses in Primary Care* (2019) used in your program's curriculum? National Competencies for RN in Primary Care (2019)

30. Please answer the following questions using this scale. On a scale from 1 to 5, where 1 = Strongly Agree, 2 Agree, 3 Neutral, 4 Disagree, and 5 Strongly Disagree –Add Do Not Know/Not applicable

My program is able to find appropriate CHN placements to met course objectives.My program recruits and/or hires instructors with the academic qualifications and professional experience for CHN clinical teaching.

Community health nursing is important (relevant) in your nursing curriculum

In my program there is opportunity to advocate for community health nursing in the curriculum.

My leadership supports community health nursing content in the program.

In my program the CHN content has been affected by the introduction of the NCLEX exam.

In my program the CHN content is affected by the regulators program evaluation requirements.

31. Comments related to the questions above: Open text box

32. Final thoughts/comments: Open text box

Thank you for taking the time to provide us with this input.