

CHNC Educational Package

Developing Leadership Skills for a Community of Practice:

The purpose of this educational package is to provide community health nurses and organizations with the resources and a process to organize and use a community of practice to increase the use of evidence in nursing practice. The package is made up of five modules:

- Module 1: Introduction to Modules and Key Concepts
- Module 2: Forming a CoP
- Module 3: Learning to Work Together
- Module 4: Developing a Shared Body of Knowledge
- Module 5: Towards Sustainability.

The modules take you through the process of forming a community of practice and provide tips on how to provide effective leadership. Each module includes an audio presentation with study guide and resource materials. The discussion questions for each module are provided throughout the resource guide and as a full list in Appendix A. Communities of practice aim to bring together people with a shared interest. These modules provide questions to encourage dialogue either with colleagues in the workplace, or as part of group learning, face-to-face or by posting responses to the questions online. The modules contain many practical examples using resources developed in nursing communities of practice with a focus on chronic disease prevention and self-management.

The following general agenda is provided for the focused discussion for each module:

Proposed Agenda for a focused discussion on the questions on each module

1. Introductions and Check-in
2. Module Work
 - a. Learning objectives and preliminary material
 - b. Discussion of questions
3. Preparation for next module, round table and wrap-up including informal evaluation (eg. What went well? What could be changed for next time?)

The suggested length of time for the introductory module is 2 hours, modules 2 to 5 1 to 1.5 hours.

Discussion question:

- 1. Before starting the modules, take a few minutes to write down how you or your organization might use the educational package.***

Module 1: Overview and Introduction of Key Concepts

This module is the first in a series of five on developing leadership skills for forming and maintaining a community of practice (CoP). This introductory module provides an overview of the modules and introduces the concepts that will be developed throughout the series: Community of Practice, (CoP), Community Health Nursing Standards of Practice (CCHN Standards), evidence based practice and concludes with a discussion of the resources needed to support a successful CoP.

Learning Objectives

By the end of this module, you will be able to:

1. Describe the modules and modular approach
2. Explain the concepts of:
 - a) A community of practice (CoP)
 - b) Model for CoP development
 - c) Canadian Community Health Nursing Standards of Practice (CCHN Standards)
 - d) Evidenced based practice
3. Describe the resources needed to support a CoP including:
 - a) Leadership knowledge and skills
 - b) Administrative processes
 - c) Technology

Possible Agenda for a Focused Discussion on Module 1 (2 hours)

- 1) Introductions and Check-in (30 minutes)
- 2) Module Work (60 minutes)
 - a) Learning objectives and preliminary material
 - b) Discussion of questions
- 3) Preparation for module 2, round table and wrap-up including what you would like to keep and change for next discussion (30 minutes)

Concepts used in Modules

Four concepts provide an important foundation for this series of modules:

- a) Community of practice (CoP)
- b) Model for CoP development
- c) Canadian Community Health Nursing Standards of Practice (CCHN Standards)
- d) Evidenced based practice

Each concept will be considered individually and in relation to each other.

Community of Practice (CoP). The audio presentation summarizes the main components of a community of practice. A more in depth discussion of a CoP is provided in the report “*Developing a Community of Practice Model for Cancer and Chronic Disease Prevention*” (Barwick, 2008) on pages 5 to 13.

The report is available at:

http://www.partnershipagainstcancer.ca/sites/default/files/prevention/COP_CPAC%20report%20_5_Final.pdf

Also, others in reference list: Wenger et al, 2002, Garcia & Dorohovich (2005).

Discussion question:

2. What do you feel would be the main focus of a CoP for your organization?

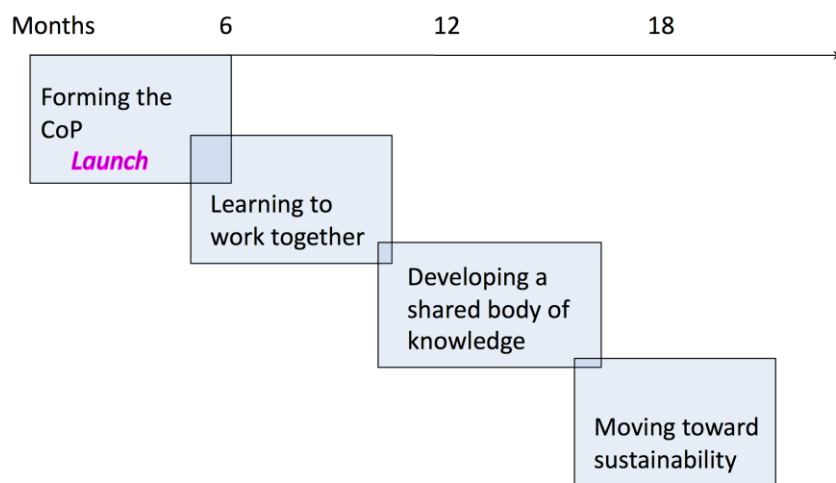
Model for CoP Development. A model for CoP development in community health nursing was formulated from an action research study led by Liz Diem and Alwyn Moyer from the University of Ottawa School of Nursing. Action research is an orientation to research that aims to bring together action and reflection, theory and practice in shaping research methods (McArdle & Reason, 2004). The 18 month study (October 2007 to March, 2009) funded by the Community Health Nurses of Canada brought together researchers and practice leaders from Ontario, Nunavut and British Columbia to design, implement and evaluate the use of a community of practice with community health nurses working in public health, home care, primary health care (e.g. community health centres and clinics), case management and education.

Four CoPs were initiated in Ottawa, Cornwall, Vancouver Coastal Region and the territory of Nunavut. These four sites provided a mix of urban and rural settings, cultures and languages, and access to different systems for organizing community health services.

Each CoP was supported by the research team with one or more people performing the role of a facilitator, knowledge broker, and research assistant. The common process used at each site was to obtain organizational support and recruit participants, set up and launch the CoP, face-to-face or by teleconference and arrange monthly meetings or teleconferences for an hour to an hour and a half. Ottawa and Cornwall held a half day workshop every six months; Nunavut held a workshop twelve months after the launch. A comparison of the process and outcomes at the four sites helped to formulate a model for CoP development.

The following figure indicates the phases of the model and the approximate time for each phase. Because the study had a variation in sites and nurses working in different organizations or with different focuses to their community practice, the timing of the phases of the model could be a bit faster for nurses who know each other or who have the same type of practice.

Model of CoP Phases & Timing (18 month timeframe of study)



Discussion question:

- 3. Would you find it difficult to 'sell' a CoP in your organization if it takes at least 6 months to see some results?***

Canadian Community Health Nursing Standards of Practice (CCHN Standards). The following figure summarizes the CCHN Standards and the underlying values and beliefs. Examples for each Standard, applied to public health, home health and community health, are provided in Appendix B. If you are not familiar with the CCHN Standards or would like an update, a full copy can be obtained from the CHNC website. For a more complete introduction to the Standards, view the PowerPoint presentation introducing the Standards in the Community Health Nursing Standards Tool Kit _____ (link).

The CCHN Standards and CoP strongly support each other. For example:

Standard 1 – Promoting Health which includes:

- a) health promotion,
- b) prevention and health protection,
- c) health maintenance, restoration and palliation provides the ‘what’ for the direction the CoP will take. ‘What’ includes both the focus (health promotion, prevention, or maintenance) and the population health issue which guides the work of the CoP.

Standard 2 – Building individual and community capacity provides one ‘how’ of accomplishing Standard 1 in the CoP. For the CoP, community capacity building includes both intra/inter-professional and the priority population associated with the topic of interest. The basic premise of the CoP is to combine and increase the knowledge and skills of members to improve the care provided to the population.

Standard 3 – Building relationships provides the second ‘how’ of accomplishing Standard 1 in the CoP. Building relationships includes several aspects: within the CoP, across nursing and health professions and with the priority population. Each module of the CoP includes a section on building relationships.

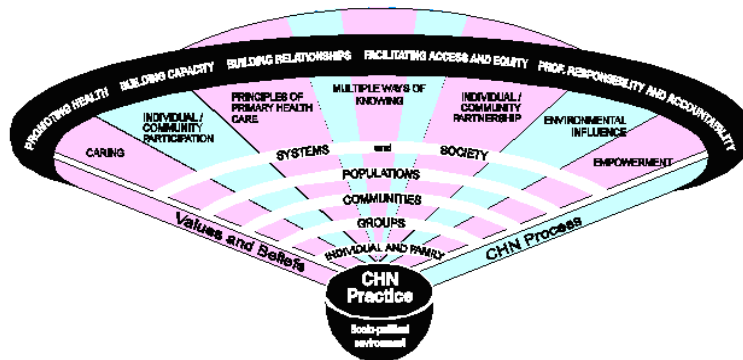
Standard 4 – Facilitating access and equity provides the third ‘how’ of accomplishing Standard 1 in the CoP. The CoP members will have the opportunity to gain a broader perspective of health care in community by hearing about the experience of people working in other organizations, learn who works with different populations and cultural groups; and hear how some groups have particular access problems. Many of the issues tackled by a Cop will involve providing appropriate care for underserved populations such low income women, seniors, and multicultural groups.

Standard 5 - Demonstrating professional accountability provides the final ‘how’ of accomplishing Standard 1 in the CoP. This broad Standard includes many aspects that are relevant to the CoP: taking appropriate action, advocating for social change, use of technology, involvement in research, seeking help in problem-solving, working proactively, seeking professional

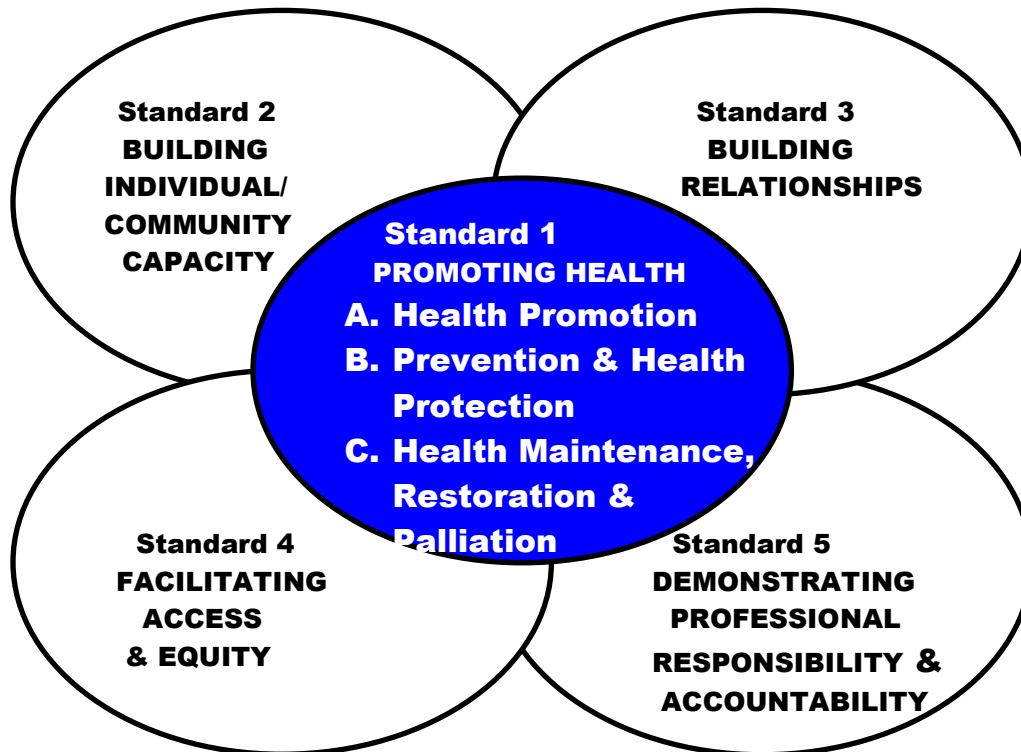
development experiences, and using resources efficiently and effectively. The CoP will allow members to fulfill many of these expectations such as basing practice on evidence, increasing discussion and debate of evidence with others and taking responsibility to identify and address gaps in service.

Discussion question:

- 4. How important would it be to you or your organization that the work of the CoP supports the CCHN Standards?***



Canadian Community Health Nursing Standards, 2003/2008



- **Values & Beliefs**
 - Caring
 - The principles of Primary Health Care
 - Multiple ways of knowing
 - Individual/community partnership
 - Empowerment
- **Socio-political environment**
- **Community Health Nursing Process**
 - Assess ⇒ Plan ⇒ Act ⇒ Evaluate

Evidence based practice. Evidence based practice is one way to demonstrate professional accountability, as exemplified in CCHN Standard 5. According to the Canadian Nurses Association (2002) position statement, evidence based nursing draws on evidence from research, clinical expertise, client preferences and other available resources to make decisions about clients. The full document can be viewed at: http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS63_Evidence_based_Decision_making_Nursing_Practice_e.pdf

A CoP brings together people who have a keen interest in practice and want to expand the knowledge base for practice. Approaches to developing practice knowledge are discussed fully in module 3.

Evidence on the value of CoP to change practice is slowly emerging. In one study Barwick, Peters, and Boydell (2009) found that participants who belonged to a CoP were more likely to initiate a change to using evidenced based protocols in children's mental health services than those who were not involved. A Cochrane Data Base systematic review on 'Continuing education meetings and workshops: the effects on professional practice and health care outcomes' found that higher attendance at meetings was associated with greater effects, that mixed interactive and didactic education was more effective than either alone, and that the effects were less for more complex behaviours and less serious outcomes (Forsetlund et al., 2009). This finding supports the use of many of the aspects of a CoP; such as ongoing meetings, presentation of research evidence, and comparison of that evidence to practice, to bring about a change in practice.

Discussion question:

5. How do you/does your organization support evidence based practice?

Resources needed to support a CoP

By definition, communities of practice meet regularly to share experience and develop common practices. To do this, they need resources. When planning to start a community of practice, it is wise to plan ahead to ensure the resources will be available. Garcia and Dorohovich (2005) identify three types of resources needed for a healthy infrastructure: people, process, and technology. People refer to the roles and responsibilities of people involved in the CoP; process refers to the proper management of the community building process. Technology includes providing the appropriate means to communicate and store the work of the CoP.

Leadership knowledge and skills. Two resources are provided below that give different perspectives on the needed leadership knowledge and skills. On reviewing the material, you are likely to find that at first the roles and

responsibilities are overwhelming. The important thing to remember is that roles are manageable as long as dedicated time has been allocated. Dedicated time to perform the roles will increase the successful functioning of a CoP.

Garcia and Dorohovich (2005) identify several roles that need to be filled in a CoP, these are listed below.

- **Community sponsor:** the sponsor provides high level support for the community and acts as the champion, promoting the value of the community across an organization or sector, thereby encouraging growth and commitment of in kind and substantive resources.
- **Community leader:** the community leader is an active member and helps to guide the purpose and strategic intent, energizes the process, and provides intellectual nourishment for the community.
- **Subject Matter Experts:** Subject matter experts are knowledgeable and experienced members of the community who use their knowledge of the field to help shape what is important and useful and to integrate new information into the existing knowledge base.
- **Content Editor:** Content editors are responsible for content within a certain defined scope, e.g., manages the process for review and approval of member contributions.
- **Facilitator:** The facilitator fosters and facilitates member interaction, often acting as knowledge broker.
- **Community Member:** Membership that is voluntary and supported by the value derived through participation.

Barwick (2008) concurs that CoPs need the support of a knowledge broker and administrative personnel to thrive but does not mention the other roles specifically. Often roles are undertaken informally and one person may take on more than one role at any one time by choice or by necessity. However, Barwick (2008) cautions that planning is needed to be sure that someone takes responsibility for the different functions. Along the same lines, Garcia and Dorohovich (2005) point out that when the knowledge broker role “is designated entirely as collateral duty to someone with other higher priorities, it is difficult to sustain a viable community of practice (p. 25)”.

The roles may vary in content and importance at different stages of CoP development. Barwick (2008, p. 8) discusses different community evolution models in terms of Wenger’s (2002) principles for community success. These principles provide more understanding of the types of facilitation required in a CoP, including the need to build and maintain relationships among members.

The Barwick report is available at:

http://www.partnershipagainstcancer.ca/sites/default/files/prevention/COP_CPAC%20report%20_5_Final.pdf

The facilitator plays a central role within a CoP. Specific tasks of a CoP facilitator are discussed in two webinars provided by the Community of Facilitators for Education and Exchange (COFFEE) which is situated at Red Deer College in Alberta. The webinars were delivered on Feb 23 and March 30, 2010. The preparation material and audio (approximately one hour) of the webinars are available at:

<http://www.coffee-ab.ca/knowledge-sharing.php>

Processes for conducting a CoP. The organizers must put in place processes that support people coming together to talk about practice. This will include determining the time and location of meetings and workshops, finding means to collect and distribute the CoP information, and determining when and how to evaluate the CoP. These processes may vary with each phase of the CoP, Each module will indicate the most relevant administrative processes.

Technology. All CoP will need a website to collect and distribute information and resources. This website serves as a virtual home for the CoP and needs to be easily accessed by members and regularly updated. Technology is also needed to support communication particularly if members are dispersed and if the CoP crosses organizational boundaries. Connecting people electronically can include teleconferences, videoconferences, and/or computer conferences. Check CHNet-Works for a comparison of options for online conferencing. The presentation date was March 3, 2010 and the link is:

<http://www.chnet-works.ca/>

Discussion questions:

6. ***Would your organization provide dedicated time for people to lead a CoP?***
7. ***What types of meetings and timings work best in your organization?***
8. ***What technology would you have available to provide information and support communication?***

Preparation for Module 2

1. Review the discussions from this module within your organization or team. Document questions or comments that you can post or bring up at next focused discussion.
2. Review materials and discussion questions for Module 2, including discussing questions with others. Post responses on website two days before Module 5 workshop.

References

Barwick M. (2008). Developing a Community of Practice Model for Cancer and Chronic Disease Prevention. Retrieved from Canadian Partnership Against Cancer website:

http://www.partnershipagainstcancer.ca/sites/default/files/prevention/COP_CPAC%20report%20_5_Final.pdf

Barwick, M., Peters, J. & Boydell, K. (2009) Getting to uptake: Do communities of practice support the implementation of evidence-based practice? *J Can Acad Child Adolesc Psychiatry*, 18(1). Retrieved from:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2651208/>

Canadian Nurses Association (2002). Position statement: Evidence-based decision-making and nursing practice. Retrieved from http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS63_Evidence_based_Decision_making_Nursing_Practice_e.pdf

Garcia J & Dorohovich M. (2005). The truth about building and maintaining successful communities of practice. *Defense Acquisition Journal Review* 12 (1), 19-33. Retrieved from Defense Acquisition University Press Web site:

<http://www.dau.mil/pubs/arg/2005arg/2005arg-38/Dorohovich-pb1.pd>

Forsetlund L, Bjørndal A, Rashidian A, Jamtvedt G, O'Brien MA, Wolf F, Davis D, Odgaard-Jensen J, Oxman AD. Continuing education meetings and workshops: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews* 2009, Issue 2. Art. No.: CD003030. DOI: 10.1002/14651858.CD003030.pub2.

Wenger, E., McDermott, R., & Snyder, W. M. (2002). *Cultivating communities of practice: A guide to managing knowledge*. Boston, MA: Harvard Business School Press

Additional websites:

CHNet-Works at <http://www.chnet-works.ca/>

Community of Facilitators for Education and Exchange (COFFEE) at <http://www.coffee-ab.ca/knowledge-sharing.php>

Appendix A- List of Discussion Questions

1. *Before starting the modules, take a few minutes to write down how you /your organization might use the educational package.*
2. *What do you feel would be the main focus of a CoP for your organization?*
3. *Would you find it difficult to 'sell' a CoP in your organization if it takes at least 6 months to see some results?*
4. *How important would it be to you or your organization that the work of the CoP supports the CCHN Standards?*
5. *How do you/does your organization support evidence based practice?*
6. *Would your organization provide dedicated time for people to lead a CoP?*
7. *What types of meetings and timings work best in your organization?*
8. *What technology would you have available to provide information and support communication?*

Appendix B - Practice Examples for using Standards Public Health Nurse (PHN)

Standard 1: PROMOTING HEALTH

Standard 1a: Health Promotion

- PHNs work with a community and use social marketing to promote the development of more recreational space and activities for families.
- PHNs promote physical activity and healthy eating through such programs as the Supermarket Safari and the Schools Awards Program.

Standard 1b: Prevention and Health Protection

- PHNs track immunization schedules for each child so that families and practitioners can access information when needed (in case of an outbreak, travel, school records, etc.).
- PHNs work with HHNs and CHNs to develop and distribute information that is appropriate in terms of culture and reading level on identifying and reducing risk factors such as falls, medication errors, and communicable diseases.
- PHNs work with a parent's organization, parent resource centres, and the police to promote proper installation of car seats through the media and conduct several clinics to provide one-on-one assessment and teaching.

Standard 1c: Health Maintenance, Restoration and Palliation

- A PHN provides ongoing nursing care to families with infants and children who are experiencing difficulties. The care may be provided directly or through supervision of unregulated workers. This may include telephone follow-up, home visits or referrals to other community based services.

Standard 2: BUILDING COMMUNITY CAPACITY

- A PHN encourages a school to mobilize a school health committee that includes students, parents, teachers, administration, and community partners. Committee members identify the school community's strengths and needs, and prioritize, plan, implement, evaluate and celebrate action for a healthier school. The school community's capacity to take its own action for health is enhanced via a sustainable structure (the committee). The PHN is a partner in the process.

Standard 3: BUILDING RELATIONSHIPS

- A PHN has been selected as the ideal person to coordinate a Heart Health coalition because she listens to community members, is able to help people find a goal they all believe in, and communicates effectively and regularly.
- A group of PHNs working with families experiencing child care difficulties identify that post natal visits based on issues or tasks does not allow them to develop a continuing relationship with families. They bring their concern to the attention of management.

Standard 4: FACILITATING ACCESS AND EQUITY

- PHNs identify that newcomers to Canada are especially vulnerable to communicable diseases such as TB and make limited use of prevention services. They decide to work with the teachers in English as a Second language classes and staff in immigration centres to develop and provide health information and services at those locations.
- A PHN works with business owners and volunteer community groups to promote breast feeding friendly businesses and public places.

Standard 5: DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY

- A PHN is assigned to work in a needle exchange program based on harm reduction. He has difficulty accepting the tenets of harm reduction and uses reflective practice personally and with his supervisor to understand and change his assumptions.
- PHNs work together to identify how they can incorporate the CCHN Standards in their provincial/territorial Registered Nurses association continuing competence or quality assurance program.
- The Nursing or Professional Practice Council initiate action on integrating the Standards by following the steps in the Community Health Nurses Association of Canada's Standards Toolkit (2007):
 - 1) forming a committee to work on the initiative,
 - 2) conducting a stakeholder and environmental scan,
 - 3) developing a plan after determining that staff and management want an orientation, policies, and professional development based on the Standards.

Practice Examples for a Home Health Nurse (HHN)

Standard 1: PROMOTING HEALTH

Standard 1a: Health Promotion

- HHNs encourage families dealing with a chronic illness to participate in regular physical and social activities.

Standard 1b: Prevention and Health Protection

- HHNs work with PHNs to develop and distribute information that is appropriate in terms of culture and reading level on identifying and reducing risk factors such as falls, medication errors, and communicable diseases.
- HHNs observe high rates of smoking by caregivers and clients. The concern is raised and a task group is formed to find ways to address the issue.

Standard 1c: Health Maintenance, Restoration and Palliation

- HHNs provide long term nursing care in the home, school, or work for children, youth, and adults living with Acquired Brain Injury. Collaboration is required with the client, unregulated care providers, family, teachers, and/or employers to promote capabilities, prevent secondary illness, and improve response to treatment.
- HHNs adapt the care provided to acute care and long term clients and their families according to their choices and personal skills, and the resources available in the setting and community.

Standard 2: BUILDING INDIVIDUAL/FAMILY CAPACITY

- A HHN encourages a mother and teens to work out a schedule for ROM exercises for the grandmother. The family is happy that they were able to work out the problem together.
- A HHN teaches a client and family member how to change dressings and assess for deterioration and healing of a wound. Within a short period, they take over the dressing changes and report steady improvement.

Standard 3: BUILDING RELATIONSHIPS

- A HHN working in palliative care listens to the concerns of stressed and exhausted caregivers and supports them in making decisions about respite and hospice care.
- HHNs and management work together to provide 'continuity of care' so that a high percent of clients have the same nurse most of the time.

Standard 4: FACILITATING ACCESS AND EQUITY

- A HHN and Case Manager work together to advocate for families caring for medically fragile children by:
 - Seeking respite care for a family exhausted by the required intense care,
 - Contacting the local provincial/territorial member of parliament to encourage enhanced funding for respite services ,
 - Planning for a resolution through the provincial/territorial Registered Nurses association.
- HHNs are joined by PHNs and CHNs to lobby authorities to retain home visiting and case management by Registered Nurses for people living with mental illness in the community.

Standard 5: DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY

- A HHN is asked by an ALS client to be present when his wife removes his Bi-PAP machine, which will result in his death. The nurse explores the client's reasons for this decision and discusses the ethics around responding to this request with the health care team as well as the nursing practice advisor at their provincial/territorial Registered Nurses association.
- HHNs work together to identify how they can incorporate the CCHN Standards in their provincial/territorial Registered Nurses association continuing competence or quality assurance program.
- A group of nurses in the organization initiate action on integrating the Standards by following the steps in the Community Health Nurses Association of Canada's Standards Toolkit (2007):
 - 1) organizing themselves,
 - 2) conducting a stakeholder and environmental scan,
 - 3) developing a plan after determining that staff and management want an orientation, policies, and professional development based on the Standards.

Practice Examples for a Community Health Nurse: Nurses working in health centres, clinics, family practice, churches, schools, on-reserve etc.

Standard 1: PROMOTING HEALTH

Standard 1a: Health Promotion

- CHNs encourage families dealing with a chronic illness to participate in regular physical and social activities.

Standard 1b: Prevention and Health Protection

- CHNs work with PHNs to develop and distribute information that is appropriate in terms of culture and reading level on identifying and reducing risk factors such as falls, medication errors, and communicable diseases.
- A CHN observes high rates of smoking within a particular client group. The concern is raised with the practice team and a plan is developed to find ways to address the issue.

Standard 1c: Health Maintenance, Restoration and Palliation

- A CHN provides ongoing nursing care or care coordination to workers and families who are experiencing poor health. The care may be provided directly or through telephone follow-up, home visits or referrals to other community based services.

Standard 2: BUILDING INDIVIDUAL/FAMILY CAPACITY

- A CHN initiates a mother-to-mother group for women speaking a specific language so they can share resources and experiences in raising children
- A CHN teaches a client and family member how to live with diabetes by monitoring blood sugar, taking medication, exercising, and moderating diet. Within a few weeks, the client's blood sugar has returned to normal and the pair agree to join a program that buddies people living successfully with diabetes with a person who has been newly diagnosed.

Standard 3: BUILDING RELATIONSHIPS

- The CHNs in the primary health care team ask to be assigned to work with a defined case load of clients rather than been assigned each day to different tasks. This arrangement will allow them more opportunity to develop an ongoing relationship with clients.
- The CHNs provide options and asks clients and caregivers how they want learn about coping with an acute or long term illness or disability.

Standard 4: FACILITATING ACCESS AND EQUITY

- A CHN and manager work together to advocate for families new to Canada by:
 - Hosting a multicultural celebration featuring the food from the cultural groups served by their organization.

- Lobbying municipal councilors for funding for a community garden and food bank.
- Planning for a resolution on health literacy at the provincial/territorial Registered Nurses association.
- A CHN organizes an exercise class at a time and place that is convenient for workers, caregivers or seniors.

Standard 5: DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY

- A CHN works in a clinic serving the homeless. He has difficulty accepting the harm reduction approach adopted by the clinic and uses reflective practice personally and with his supervisor to understand and change his assumptions.
- CHNs work together to identify how they can incorporate the CCHN Standards in their provincial/territorial Registered Nurses association continuing competence or quality assurance program.
- A group of nurses in the organization initiate action on integrating the Standards by following the steps in the Community Health Nurses Association of Canada's Standards Toolkit (2007):
 - 1) organizing themselves,
 - 2) conducting a stakeholder and environmental scan,
 - 3) developing a plan after determining that staff and management want an orientation, policies, and professional development based on the Standards.