

**Standards of Practice in Community Health Nursing:  
A Literature Review Undertaken to Inform Revisions to the  
Canadian Community Health Nursing Standards of Practice**

Prepared for the Community Health Nurses of Canada

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**Introduction**

This literature review was undertaken to inform a review and revisions to the Canadian Community Health Nursing Standards of Practice (hereafter referred to as the Standards). The Standards were first published by the Community Health Nurses Association of Canada (CHNAC) in 2003 and were edited and re-printed in 2008. The specific purpose of this literature review was to determine the degree to which the Standards remain comprehensive, current and relevant for contemporary community health nursing practice. This document reports the process and results of the literature review in the context of the standards.

The description of community health nursing in the Standards (CHNAC, 2008, p. 9) notes that the various characteristics of the organizations that employ community health nurses (CHNs) act as enablers or barriers for their practice. Accordingly, because nurses enact standards of practice within the context of their work environments, this document reflects the assumption that a quality setting is a requirement for nurses to be able to practice according to standards (Mackay and Risk, 2001; Underwood et al., 2009).

***Standards of Practice***

Standards of practice have been defined as “a published set of behavioral and professional expectations of certificate holders” (Professional Testing Inc., 2010). As noted in the introduction to the Standards (CHNAC, 2008, p. 5), the development of standards of practice is linked to nursing’s designation as a self-regulating profession. Self regulation acknowledges that the profession alone has the unique knowledge required to develop standards of practice that are based on its identified values (CNA, 2002). Nursing regulators in each jurisdiction are legally required to set the basic or minimum standards of professional practice, and to monitor and enforce the standards in the interest of the public (CNA, 2002). Standards set by the regulatory bodies for registered nurses (RN) in each province and/or territory of Canada must be adhered to by every RN in that jurisdiction, “regardless of their role, job description or area of practice” (College of Nurses of Ontario, 2009a, p. 1). In contrast, standards developed for a specialty nursing practice such as community health nursing are endorsed by CNA, are national in scope (CNA, 2002) and are intended to complement nursing practice sub-specialties and regulatory standards. Consequently, a community health nurse practices according to both the provincial/territorial standards of practice, and the Canadian Community Health Nursing Standards of Practice.

**Section One: Literature Review Methodology**

This literature review utilized the scoping study methodology described by Arksey and O’Malley (2005) to summarize the research evidence relevant to the Canadian Community Health Nurse Standards of Practice. Scoping studies undertake to include the most relevant literature irrespective of study design and do not rate the quality of the literature. In keeping with the methodology, strict limitations were not placed on search terms, identification of relevant studies or criteria for inclusion of specific studies. Each of the five stages that characterize scoping studies (Arksey and O’Malley, 2005) was completed as follows.

The following two research questions (stage one) guided the scoping review:

1. Does the literature provide evidence that each of the standards remains valid?
2. Are there content gaps in the standards?

Relevant studies were identified (stage two) through a search of the Cinahl and Medline databases. Studies suggested by community health nursing experts were also included. Studies were selected (phase three) if they addressed the context or content of one or more of the standards or provided evidence from studies examining one or more of the standards. Complete copies of articles were reviewed for all studies that appeared most relevant to the study questions. Data were grouped according to each of the standards (stage four). Lastly the results are summarized in this report (stage five).

### **Literature Search Strategy**

The CINAHL and Medline databases were searched for the time period of 2005 – 2010. This time period was selected to capture the most recent literature while also promoting an efficient and timely review. The key words utilized were as follows:

- Community health nursing and practice
- Community health nursing and standards of practice
- Public health nursing and practice
- Public health nursing and standards of practice
- Home health nursing and practice
- Home health nursing and standards of practice

The search was limited to citations printed in English. It did not limit citations to those that were peer reviewed because it was expected that relevant literature would be found in newsletters or journals published by regulatory colleges or associations which are generally not peer-reviewed.

### **Inclusion Criteria**

Articles were included if they were primarily concerned with aspects of community health nursing practice. Articles that described practice in countries other than Canada were considered for inclusion as it was speculated that they might reveal additional standards or practice indicators that would be relevant to community health nursing practice in Canada. However, preference was given to Canadian publications.

### **Exclusion Criteria**

Articles that provided historical background to community health nursing were excluded as the literature review focused on current practice. Articles were also excluded if they focused on financial or legal matters, or were book reviews, editorials, commentaries or announcements.

### **Supplementary Literature**

A convenience sample of community health nursing textbooks was accessed and relevant content is reported in this literature review. Additionally, upon the advice of experts in community health nursing, standards for specific practice specialties such as parish nursing, telehealth and occupational health nursing as well as several recent publications in the field of community health nursing were also retrieved and reviewed. Some of the suggested publications stand alone as valuable practice guides or resources while also serving as companion documents to the Canadian Community Health Nursing Standards of Practice because they provide foundational information, add context to the practice, and/or further detail and clarify the standards by articulating action based competencies. The specific titles are listed below.

1. Public Health ~ Community Health Nursing Practice in Canada (Canadian Public Health Association, 2010), which provides a foundational overview of public health/community health nursing in the field of public health in Canada including essential functions, roles, activities and qualifications.
2. Home Health Nursing Competencies (Community Health Nurses of Canada [CHNC], 2010a), which reflect the “integrated knowledge, skills, judgment and attributes” (p. 6) for home health nursing practice in Canada.
3. Public Health Nursing Discipline Specific Competencies, Version 1.0 (CHNC, 2009a), which are “the integrated knowledge, judgment and attributes” (p. 2) required for public health nursing practice in Canada.
4. Core Competencies for Public Health in Canada, Release 1.0 (Public Health Agency of Canada, 2008), which are the “essential knowledge, skills and attitudes necessary for the practice of public health [and] transcend the boundaries of specific disciplines” (p. 1).
5. Community Health Nursing Vision for 2020: Shaping the future (Schofield et al., 2010). This article describes a research study undertaken to identify and advance understanding of priority issues for community health nurses and inform the development of a national vision for community health nursing in Canada by the Community Health Nurses of Canada. The resulting CHNC vision statement (CHNC, 2009b) emphasized diversity, partnership and collaboration and promoting and advocating for health across the lifespan as attributes of Community Health Nursing.

Other reports recently released by the Community Health Nurses of Canada (CHNC) further complement the findings of this literature review. These include the CHNC Environmental Scan (CHNC, 2009c) and the Pan-Canadian Survey of Community Health Nurses’ Continuing Education/Learning Needs (Schofield et al, 2009). The environmental scan includes the topics of environmental health, disaster preparedness and response and leadership. The continuing education/learning needs report identified some editorial issues in the CCHN Standards (2008) and also noted that “knowledge items such as health promotion concepts and frameworks are not usually included in standards documents and may be confusing to nurses if they are unfamiliar with them” (Schofield et al, 2009, p.34). “A Synthesis of Canadian Community Health Nursing Reports” (CHNC, 2010b) also provides context for the standards review and update. The synthesis reports recommendations and findings from eight recent reports addressing community health nursing including: health systems, community health nursing domains of practice (role clarity), leadership, access to capacity (i.e. resources to support practice), interprofessional issues and nursing education.

### **Gray Literature**

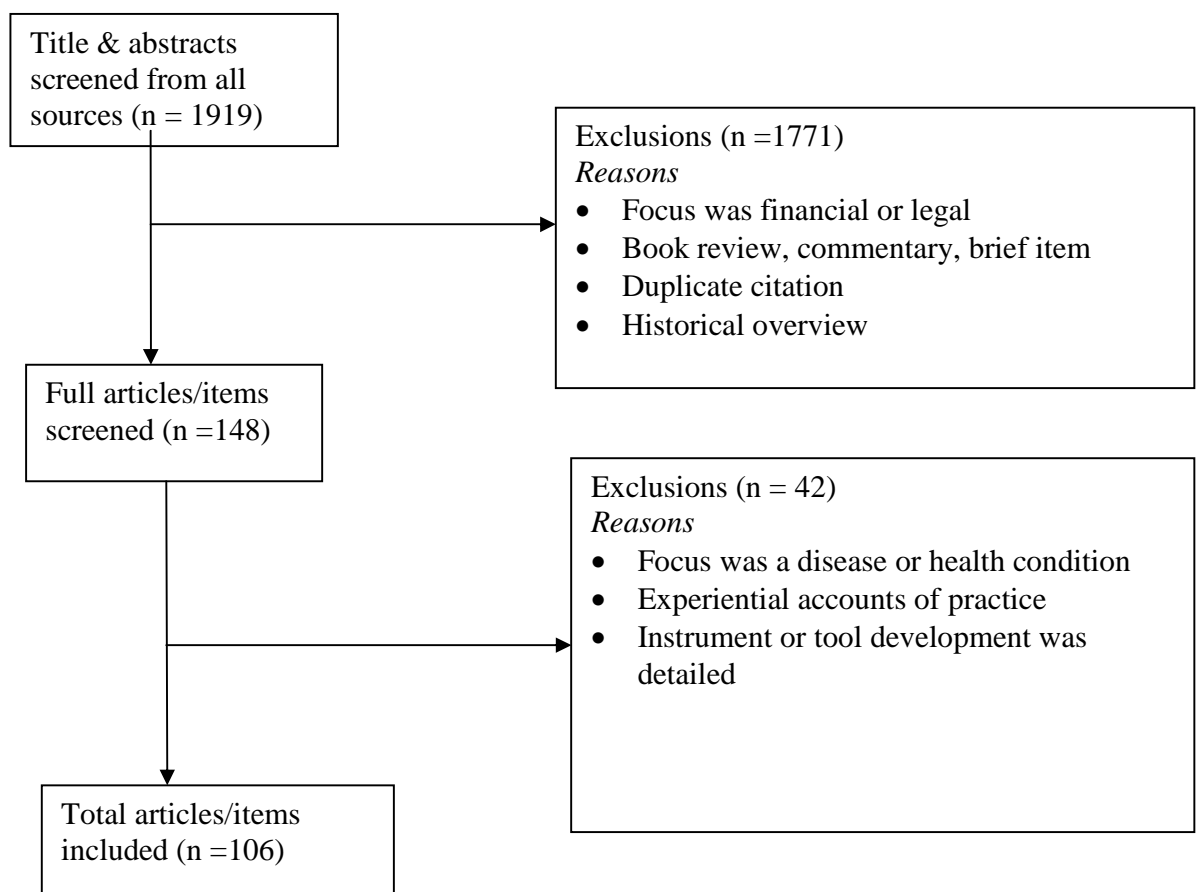
Lastly, selected google searches were conducted for specific topics (e.g. telehealth) and the Internet sites listed below were searched to identify and retrieve gray literature that had the potential to inform revisions to the standards.

- Canadian Health Services Research Foundation ([www.chsrf.ca](http://www.chsrf.ca))

- Canadian Association for Parish Nursing Ministry (<http://www.capnm.ca/>)
- Canadian Home Care Association (<http://www.cdnhomecare.ca>)
- Canadian Nurses Association ([www.cna-aiic.ca](http://www.cna-aiic.ca))
- Canadian Occupational Health Nurses Association Inc. (<http://www.cohna-aciist.ca/pages/default.asp>)
- Community Health Nurses of Canada ([www.chnc.ca](http://www.chnc.ca))
- Community Health Nurses Initiatives Group of RNAO ([www.chnig.org](http://www.chnig.org))
- Canadian Public Health Association (<http://www.cpha.ca>)
- Public Health Agency of Canada (<http://www.phac-aspc.gc.ca>)
- Saint Elizabeth Health Care ([www.saintelizabeth.com](http://www.saintelizabeth.com))
- Victorian Order of Nurses ([www.von.ca](http://www.von.ca))
- World Health Organization, Canada (<http://www.who.int/countries/can/en>)

The reference lists in all publications retrieved for the review were examined and citations that met the inclusion criteria were included. Figure 1 illustrates the flow of literature.

Figure 1. Flow of Literature



## **Section Two: Results**

### **General Findings from the Literature**

The literature review revealed general findings relevant to the Standards. For example, role clarity for the Public Health Nurse was the subject of a study in Ireland, where the title/role of Public Health Nurse (PHN) encompasses midwifery, home health nursing and population health nursing (Nic Philibin, Griffiths, Byrne, Horan, Brady and Begley, 2010). Three main trends were found to be increasing the size and complexity of the PHNs' workload in the study area: 1) a rise in immigration and an associated increase in birth rates; 2) the aging of the population, and 3) shorter hospital stays resulting in earlier discharge from the hospital. The study found that the different responsibilities assigned to PHNs often created work overload and stopped them from fulfilling health promotion activities (Nic Philibin et al., 2010). The study compared the PHN role in Ireland to that of several other countries including Canada and suggested that consideration be given to identifying the core elements of the role.

Support for the overall functions of the CHN was evident in a discussion of community health nursing in Australia (Woods, 2010). The author observed that the common understanding of community [health] practice "stems from the facilitation, promotion, and maintenance of health for individuals and families" (p. 1), nursing aims and activities which are clearly revealed in the Canadian Community Health Nursing Standards of Practice.

### **Research Question 1: Does the literature provide evidence that each of the current Canadian Community Health Nursing Standards remains valid?**

Evidence was found to support each of the standards and is presented below.

#### **Standard 1: Promoting Health**

Considerable evidence was found to support promoting health as a standard of practice. Cohen (2008) observed that health promotion has become the "primary goal of nursing practice" (p. 102). She discussed the biomedical, behavioural and socio-environmental approaches to health enhancement/promotion, noting that the socio-environmental approach has become the dominant approach used in public health nursing. The socio-environmental approach not only takes into account the physical and emotional well-being of individuals and communities, but also encompasses social and environmental well-being. Therefore, the role of the CHN includes exposing inequities, addressing the "root causes of illness and disease, and facilitating planned change" (p. 102). Cohen asserted that "there can never be one universally accepted definition of health promotion" (p. 104) and suggested that a gap exists between the rhetoric and reality of health promotion in nursing practice. The reality is that health promotion at the level of nursing practice remains largely concerned with influencing change in the behaviour of individuals while focusing on disease prevention and functional ability, while the rhetoric is that the practice of health promotion reflects values and principles such as social justice, equity and participation and focuses on changing the social, political and economic environment that shapes behaviour (p. 105). Cohen provided suggestions to assist CHNs to narrow the gap between rhetoric and reality in their health promotion practice.

Tagliareni and King (2006) asserted that nurses play a critical role in health promotion programs and services. They described the development of a data-collection tool that documented the

scope of health promotion activities and the characteristics of the clients served by the programs. The tool categorized the health promotion activities as: 1) Health teaching, guidance and counseling; 2) surveillance; 3) case management or 4) administration of treatments or procedures. For one year, nurses used the tool to document and categorize their health promotion activities and noted whether the activity had entailed an encounter with a group or an individual. The tool was found to be generic enough for use by 7 different nursing centres while also able to capture the variation in the range of services and client characteristics amongst the centres.

The development of a health promotion game called “Rides and Slides” was the subject of an article by two CHNs working in Richmond, British Columbia (Lacey and Salgado, 2005). The game was the result of efforts to address the unique health needs of children and youth. The game was piloted for a year in schools and feedback was highly positive.

Health promotion has been identified as one of the required competencies for home health nurses (CHNC, 2010b, p. 12) and for parish nurses (Canadian Association for Parish Nursing Ministry [CAPNM] 2007). Young and Duggan (2010) advocated for home health care nurses to conduct a thorough history-taking in order to identify the assets and needs of the individual and family and thus provide the foundation for health promotion initiatives.

#### *Social Determinants of Health*

The preface to Standard One (CHNAC, 2008) identifies three categories of health determinants: social, economic and environmental. It outlines the *expectation* that CHNs know about the determinants of health and the influence they have on health. Standard Two (Building Individual and Community Capacity) identifies the *actions* expected from CHNs to influence the determinants of health and therefore the literature findings related to social determinants are discussed in association with that standard later in this paper.

#### *The Environment as a Determinant of Health*

The environment was identified as a determinant of health in a joint position statement by the Canadian Nurses Association and the Canadian Medical Association (CNA/CMA 2009). The statement situates the health-care sector as a significant consumer of energy, plastics, paper and other resources, and a producer of several pollutants. The statement calls on health care professionals to champion environmental stewardship and to provide leadership in influencing the implementation of environmentally friendly policies in their practice environments and personal lives. Specific examples of environmentally friendly practices are listed including safe disposal practices, lowered energy consumption and reduction in the use of toxic substances. Additionally, actions that can be undertaken by professional and regulatory bodies to support environmental health are identified. The preface to the standards for occupational health nursing in Canada (Canadian Occupational Health Nursing Association [OHNA], 2003) points out that “the environment can be social, economic, political, physical, and cultural as well as the internal psychological status of the individual” (Environment section, para. 1). This observation is also highly relevant for the practice of community health nursing.

#### *Prevention and Health Protection*

Practice indicators currently listed in the standards for this category include helping individuals, groups, families and communities to identify potential risks to health (item 4), using harm

reduction principles (item 5) and engaging in partnerships to address risks to individuals, families communities or population health (item 7). These elements of practice were supported by a Canadian study by Browne, Doane, Reimer, MacLeod and McLellan (2010) that examined how PHNs “understood, contextualized and addressed risk” (p. 28) when working with high-priority families. The essence of practice in this area of risk is reflected in the following study finding: “Contrary to dominant discourses that tend to locate risk to people/families, the PHNs brought a contextual understanding of risk to their work with families, locating disadvantage and risk within structural inequities such as poverty, unemployment, geographical isolation, and so on” (p. 29). Additionally the authors identified the capacity of the PHNs to simultaneously focus on both the strengths of their clients and the risks they confronted.

One component of disease prevention practice in home health nursing was illustrated in a study of home health clients by Hirdes et al., (2006). The study found that many home care clients in Ontario were not immunized against influenza, thus highlighting the need for home care professionals to include disease prevention in their roles.

Harm Reduction was situated as an ethical obligation of nursing in an experiential account of practice within a supervised injection site (Lieberman, 2007). The author shared her reflection that harm reduction is value neutral and involves acknowledges individuals’ right to make choices and applying one’s nursing expertise to reducing the harm associated with their behaviour.

#### *Disaster Planning/Emergency Preparedness*

Standard 1c, item 9 identified that CHNs facilitate health maintenance and healing ...in response to “significant health emergencies...that negatively impact health” (p. 12). The integral role played by the nursing profession in emergency situations was the focus of a position statement by the Canadian Nurses Association (CNA, 2007a). Emergency situations in which nurses have made major contributions include the 1998 ice storms in Ontario (Mildon, 1998), the SARS crisis in 2003 (Registered Nurses Association of Ontario, 2003) and the mass immunization campaign for the H1N1 Influenza virus in 2009/10 (New Brunswick Department of Health, 2010; Arkansas State Board of Nursing, 2010).

In the aftermath of the terrorist attack on the New York City twin towers on September 11, 2001, awareness regarding emergency preparedness was heightened. Hyde, Kim, Martinez, Clark and Hacker (2006) conducted interviews with local public health authorities in the Boston area to explore the benefits and challenges involved in being prepared for emergencies. The study concluded that funding made available to enhance emergency planning had been effective in enhancing equipment and technology. However, emergency preparedness was compromised by a thinly stretched public health workforce and stable funding was required to achieve adequate staffing levels. Literature accounts of other recent disasters in the United States such as Hurricanes Katrina and Rita in the United States also highlighted the importance of community health nurses’ involvement in the development of disaster plans and in their enactment (Hendriks and Bassi, 2009). Weeber (2007) discussed the impact of those hurricanes on community health, including the impact of power failures on ventilator-dependent individuals; evacuation considerations; and safety issues.



Polivka et al. (2008) implemented a Delphi approach to identify and gain consensus about public health nursing competencies required to respond to public health surge events that might include mass casualties or bioterrorism. Twenty-five competencies were identified in the categories of: 1) preparedness; 2) response; and 3) recovery.

In home care, the function of “safety netting” was discussed by Young and Duggan (2010). The authors gave the example of a patient with a wound who needed to receive information about what to watch for such as worsening pain, discharge, redness, swelling or odour and what to do if these symptoms appear. Home care nurses may recognize this function as “emergency planning.” As with disaster planning, this function is alluded to in Standard One (b), item 4 and perhaps by Standard One (c) item 4 and some of the indicators in Standard Two, item 3 (uses empowering strategies). However, adding more explicit language regarding nurses’ role in emergency preparedness and response is a consideration arising from this literature review and is included in section 3 of this paper.

## **Standard 2: Building Individual and Community Capacity**

### *Social determinants of health.*

In the years since the standards were developed, increasing attention has been focused on the determinants of health which are now consistently called the social determinants of health. The notion of addressing the social determinants of health is not new. It has been the focus of many organizations, governments and individuals for more than 50 years. However, despite this level of interest, significant, tangible health gains have not been realized and moving from rhetorical openness to substantive action and power-sharing has been identified as a major challenge (Irwin and Scali, 2007, p. 253).

In an attempt to galvanize action to address the determinants of health globally, the World Health Organization (WHO) convened a Commission on the Social Determinants of Health in 2005. The Commission focused on the global and national structures of social hierarchy and the socially determined factors that contribute to create the conditions in which people grow, live, work, and age (WHO, 2008, p. 42). In its final report the Commission took an action oriented approach and proposed three principles of action. First, improve the conditions of daily life—i.e. the circumstances in which people are born, grow, live, work, and age. Second, tackle the inequitable distribution of power, money, and resources i.e. the structural drivers of those conditions of daily life globally, nationally, and locally. Third, measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health (WHO, 2008). The WHO Commission made a significant contribution to raising awareness about the social determinants of health by compiling the scientific evidence and fostering policy action to address inequities in social determinants of health.

A Canadian focus on the social determinants of health was taken by Mikkonen and Raphael (2010). The authors identified 14 social determinants of health (Appendix A), discussed their importance and described actions taken in Canada to address them. Raising public awareness about the social determinants of health was identified as a key action that could be taken to

improve the quality of the social determinants of health and the example of a flyer developed by the Sudbury & District Health Unit for that purpose was included in the book (p. 55).

The Canadian Nurses Association (2009) stated that by being aware of and taking action to address the broad range of determinants of health, registered nurses can positively influence the health of individuals and their communities and assist them to realize improved health outcomes and to reduce health inequalities. There is evidence that nursing educators are raising awareness of the determinants of health amongst students by incorporating opportunities for students to learn about the social determinants of health into curricula. For example, a Canadian study by Cohen and Gregory (2009a) included an exploration of the views and experiences of educators in arranging clinical education opportunities that facilitated the ability of students to become aware of the social determinants of health and to learn about interventions to address them.

Community health nurses and other practitioners including educators, decision makers, policy makers and researchers can draw on the evidence base provided in the WHO Commission Report, the work of Mikkonen and Raphael, the CNA Position Statement and other resources to address the determinants of health in their individual practice, in the education of future practitioners, and in their collaboration with others to promote healthy public policy. As community health nurses make up more than 50% of the health workforce that is charged with the responsibility of addressing the determinants of health, it is critical for the Standards to address this expectation of practice, which is identified in the home health nursing competencies (CHNC, 2010a, p. 12) and the public health nursing discipline specific competencies (CHNC, 2009a, p.7). The concepts of social justice and equity are at the root of efforts to address the social determinants of health and are now discussed.

### *Social Justice and Equity*

Standard 2, item 6 of the Standards identifies the requirement for the CHN to apply principles of social justice in community health nursing practice. This requirement is further reinforced in the *Public Health Nursing Discipline Specific Competencies Version 1.0* (CHNC, 2009a) that describe the knowledge, skills, judgment, and attributes required of a public health nurse to practice safely and ethically in Canada. The concepts of social justice, equity and health for all are at the core of the competencies. Social justice is also identified as a component of practice for home health nurses in the Home Health Nursing Competencies, Version 1.0 (CHNC, 2010a) and in the American Nurses' Association's Home Health Nursing Standards (American Nurses Association, 2008, p. 50).

Social justice is the fair distribution of society's benefits and responsibilities and is based on the concepts of human rights and equity (Canadian Public Health Association, 2010, p. 37). The concept of social justice is a recurring theme in the literature. In a major policy discussion paper, the Canadian Nurses Association (2006) described social justice as "a means to an end [and] an end in itself" (p. 2). The Code of Ethics for Registered Nurses in Canada (Canadian Nurses Association, 2008) identifies the ethical values of registered nurses and outlines the ethical endeavors for social justice in the practice of all registered nurses in Canada. Within the document, social justice is defined as the "fair distribution of society's benefits and responsibilities and their consequences" (p. 28). Benefits might include health protection, access to health care, clean water or culturally safe care whereas responsibilities might include the cost of healthcare, the incidence

of disease or injury, or mortality. Social justice encompasses working collectively to promote the conditions under which people can have control over their lives and influence their health and that of their families and communities. The Canadian Nurses Association's social justice gauge encourages the guiding principles of recognition and responsible action to be considered in efforts involving social justice. Recognition means that the organization or policy acknowledges the existence of broad, systematic inequities and oppression. Responsible action arises from an inherent obligation to work towards the elimination of oppression and replace inequities with social, political and economic parity (CNA, 2006).

Social justice encompasses changing social relationships and institutions to promote equitable relationships (Boutain, 2005). Social justice is about how nurses break down barriers and work to end inequality as individual members of a profession as well as through the action of the collective [nursing] profession itself (Barnes, 2005, p.18; CAPMN, 2007, Standard 4). As this statement suggests, it is an imperative that nursing work extends beyond the care of individuals and families to encompass communities and their issues. The potential to address those issues resides in the collective actions of nurses as a whole working with the people who are affected (Barnes, 2005). In contrast, contributors to inaction include "colonizing and racializing ideologies that are deeply rooted in historical notions of the essentialized "other" and social relations that are gendered, classed and raced" (Anderson et al., 2009, p. 283). Green and Labonte (2008) declared: "A critical public/community health practice is built upon moral, theoretical, empirical and experiential knowledge and reflection [and] does not arise from a list of how-to's" (p. 9). In a critical approach to social justice, each stated fact or policy is queried followed by a deeper probing that is "fundamentally concerned with the social practices of power and how these practices (political, economic, engendered, cultural) work to stratify individuals into hierarchies, and so stratify their risk, vulnerability and access to resources for health" (Green & Labonte, 2008, p. 10).

A recent examination of social justice as it was described in the nursing literature, found that while it is not a new concept, there was not a coherent and complex understanding of its implications (Boutain, 2005). Social justice was most often mentioned in relation to ethics with few articles actually defining justice beyond notions of ethical fairness (Boutain, 2005, p. 22). Boutain found that social justice was often mentioned in the last section of articles [i.e. the conclusion]; giving the impression it was an afterthought. Without depth in the analysis, the subtle variations in how social justice is conceptualized and therefore used may "inadvertently result in nursing practice, research, and education that are antithetical to a social justice agenda (Boutain, 2005, p. 19). Social justice puts a very specific focus on equity because equal does not necessarily mean just. This form of justice was rarely addressed in the nursing literature as being used to guide nursing administration, practice, education, and research (Boutain, 2005, p. 23).

The previously mentioned study by Cohen and Gregory (2009a) identified the importance educators placed on facilitating students' knowledge and understanding of social justice and equity. Study participants identified a curriculum "that promotes the values of social justice/equity and which focuses on the social determinants of health throughout the program" (p. 5) as an enabler for students' acquisition of that knowledge and understanding. While social justice is a value that has been acknowledged and given importance in a wealth of literature, evidence of concrete, effective, and sustained action with demonstrable outcomes is difficult to locate. Fahrenwald (2003) observed that nurses continue to tolerate disparities in health status

and health care, especially as they exist in minority and vulnerable populations on local, regional, provincial, national and international levels. Community health nurses, working at the front line, in management or in policymaking positions literally come face-to-face with these disparities every day.

Chinn and Kramer (2008) defined emancipatory knowing as “the capacity not only to notice injustices in a social order, but also to critically examine why injustices seem to go unnoticed or remain invisible, and to identify social and structural changes that are required to right social and institutional wrongs”(p. 78). Praxis is the bringing together of knowing and doing. Chinn and Kramer (2008) described nursing praxis as involving “the continual process of questioning the social and political contexts that limit full human potential, and acting to change social and political policy” (p. 16). This process constitutes the critical action/reflection dimension of emancipatory knowing. They further defined praxis as “a value-motivated process that changes nursing practice and the larger social and political environment to end injustice and inequities” (p. 302).

Cohen & Reutter (2007) envisioned an expansion in the role of public health nursing to include that of social activist or population health change agent. Similarly, Reimer, Kirkham and Browne (2006) stated that social justice holds imminent relevance to guide nursing practice in the future (p. 338) and to inspire hope even though nurses find themselves in a time of heightened racial tensions, widening social inequities, and deepening health disparities. Schim, Benkert, Bell, Walker and Danford (2007) proposed the inclusion of social justice as an additional metaparadigm concept for the practice of community health nursing.

Boutain (2009) suggested that collective knowledge sharing as a social justice strategy generates solutions and actions to promote health equity. The aim is to develop ‘just’ relationships that enable dialogue and critique regarding disparities with the people who are affected by those disparities (p.78). This approach has significant potential and reflects the principles of community development.

#### *Community Development Principles*

Standard Two identifies practice expectations related to community development (item 3, p. 12). Community development has been defined as “the process of involving the community in identifying and strengthening the aspects of daily life, cultural life and political life which support health” (Canadian Public Health Association, 2010, p. 32). As a philosophy, community development: “entails the fundamental belief that people can identify and solve their problems” (Racher & Annis, 2008, p. 183). Actions guided by this philosophy support citizens as they find the power to effect change and engage in the work required to achieve change in their communities (Racher & Annis, 2008). As an approach, community development includes a range of practices within many sectors. It may include the development of cooperatives, movements, activism, self-help or mutual aid and/or organizing local events (Labonte, 1998). It might also include support for political action to change the total environment and strengthen resources for healthy living (Canadian Public Health Association, 2010). In working to improve health through community development, people are not viewed as individuals in isolation of one another. Instead it is people’s connections to one another and to organizations in the community, as well as the context in which they live (e.g. social, political) that inform community development practice. The Ottawa Charter for Health Promotion (WHO, 1986) called for

concrete and effective community action to set priorities for health, make decisions, and plan and implement strategies in order to achieve better health for all. The Charter declared that “At the heart of this [community development] process is the empowerment of communities – their ownership and control of their own endeavours and destinies” (p. 2). Empowerment was also discussed in a Canadian study by Aston, Meagher-Stewart, Edwards and Young (2009). The authors examined the ways in which a sample of public health nurses fostered citizen participation and described associated tenets of primary health care including establishing a “provider-as-partner role with clients and an “asset-based” (p. 25) approach to community development” that focuses on the strengths of the community.

#### *Political Action and Advocacy*

Community health nurses have worked throughout history to address the determinants of health at an individual, family, community and societal level—work which continues to characterize today’s community health nursing practice (McKay, 2009). Early nurse leaders emphasized political activism and broad system change as community health interventions aimed at improving the health of all groups and populations. Where the leaders of the past worked to change the structural and environmental constraints, the current emphasis is to support individuals and families to cope with the situation or make healthier choices. Falk-Rafael (2005) contended that public health nurses work at the “intersection where societal attitudes, government policies, and people’s lives meet...[which]...creates a moral imperative not only to attend to the health needs of the public but also, like Nightingale, to work to change the societal conditions contributing to poor health” (p. 219). It is at this intersection that action can be taken to address the determinants of health and CHNs are well-positioned to engage in political action and advocacy efforts (Falk-Rafael, 2005). However, efforts that are directed at influencing policy related to poverty, housing and other social determinants of health are complex and require multi-faceted support.

In their everyday practice, community health nurses witness the effects of inequity in access to the determinants of health and yet have little opportunity for recourse or substantive action. Chinn and Kramer (2008) stated that moral distress can result when ethically significant behavior is blocked (p. 302). Critical reflection and discourse are required to close the gap between rhetoric and action (Anderson et al., 2009). Community Health Nurses “advocate for and work with the communities in which they practice, focusing on the social determinants of health and the creation of communities committed to the just and equitable distribution of material resources and political power” (McKay, 2009, p. 251; see also Home Health Nursing Competencies, 2010, p. 12). Strong leadership and organizational support for those efforts is essential.

Edwards and Smith (2008) undertook a retrospective examination of community health nursing research. They found that concerns about social justice were foundational to the development of community services. They also found a growing interest in the determinants of health and in developing the knowledge base regarding interventions to protect and promote the health of populations and of individuals.

#### **Standard 3: Building Relationships**

Support for this standard was evident in several publications. For example, the earlier mentioned study by Browne et al., (2010) situated nursing as a relational practice in which the nurse not

only establishes an interpersonal relationship, but also understands how the client's (read individual, family or community) capacity and socioenvironmental circumstances influence their experience of health and illness, decision-making and management of health and illness. The authors noted that "...the findings of this study illuminate how working relationally enabled the PHNs to simultaneously recognize, contextualize, and respond to risks and capacities, and attend to the multidimensional whole of the family" (p. 29). Aston, Meagher-Stewart, Edwards and Young (2009) also highlighted "the relational work between clients and public health nurses" (p. 31), and asserted that it created empowering processes that supported citizens to actively participate in their health care.

Further support for relationship-building was provided by Ailinger, Martyn, Lasus and Garcia, (2010). They described the importance of "personalismo" (p. 116) in the Latino culture which is a personal relationship with a professional characterized by warmth and friendliness and is highly valued. Similarly, parish nurses "form partnerships that connect individuals, clergy, pastoral care teams, health professionals and volunteers to create relationships that support health and healing" (CAPMN, 2007, Standard 3).

#### **Standard 4: Facilitating Access and Equity**

##### *Primary Health Care*

The preface to the Standards lists the principles of primary health care and identifies them as core values and beliefs for community health nursing. Moreover, the introduction to Standard 4 states that CHNs "embrace the philosophy of primary health care" (CHNAC, 2008, p. 13). Woods (2010) suggested that the philosophical approach of primary health care underpins community practice and reflects a socio-ecological view of health in which the health status of individuals and populations is influenced by cultural, political, geographical, socio-economic and individual lifestyle factors. Woods described barriers to the application of primary health care within nursing practice and reported on a study that utilized an adapted Public Health Intervention Model to develop the ability of undergraduate nursing students to understand and provide nursing care based on the principles and philosophy of primary health care. Within this framework, health is not given to people, but generated by them. Community health nursing's role is therefore one of "mediating, enabling and facilitating the processes, people and systems they can be mobilized to achieve health goals" (McMurray, 2007, p.45).

The study by Browne et al. (2010) examined the relationships between high-priority families (i.e. those considered as high-risk or vulnerable with infants and young children) and PHNs working in rural and remote areas of Northern British Columbia. The authors described the social inequities that formed the context for the PHNs' work, including economic hardship, a high rate of teen pregnancies and a high number of children in foster care. Their discussion supports Standard Four and each of its constituent indicators.

Frohlich and Potvin (2008) proposed a vulnerable populations approach that addresses the conditions that put social groups "at risk of risks" (p.1). They defined a vulnerable population as "a subgroup or subpopulation who, because of shared social characteristics, is at higher risk of risks" (p. 3). They identified two key characteristics of interventions using this approach. First, the interventions must be based on an intersectoral approaches in which the health sector can take a leadership role, and second, the interventions should be participatory and include members

of the populations “in the articulation of the problem and the development of the program and its evaluation” (Frohlich & Potvin, 2008, p. 5).

#### *Culturally Sensitive Care*

This practice indicator was supported by a study that implemented a culturally sensitive intervention in the Latino population to increase adherence to the drug regimen to treat latent tuberculosis (Ailinger, Martyn, Lasus and Garcia, 2010). The authors also noted the importance of the availability of culturally specific education materials in the relevant language and at the appropriate literacy level. Nielsen, Bullock-Piasek, Sabiston and Scott (2010) discussed the culturally sensitive teaching strategies they implemented from a home health care perspective while providing wound care education in First Nations communities in Manitoba, Canada. These strategies included review of the curriculum by nurses working in First Nations communities to “ensure cultural integrity” (p. 17), the use of a “virtual talking stick” and a virtual graduation ceremony that includes the participation of elders. The Canadian Nurses Association believes that nurses must provide culturally competent care in order to promote the best possible patient outcomes (CNA, 2004), and culturally relevant care is a competency for home health nurses (CHNC, 2010a, p. 11) and for public health nurses (CHNC, 2009a, p. 7).

### **Standard 5: Demonstrating Professional Responsibility and Accountability**

#### *Evidence-based Practice*

The introduction to this standard includes “ensuring that [community health nurses’] knowledge is evidence-based and current” (p. 14). Support for evidence-based practice was found in several references. Spitz, Fraker, Meyer and Peterson (2007) discussed developing and implementing clinical practice guidelines in home health practice as a component of evidence-based practice. Cohen and Gregory (2009b) pointed out the need for evidence-based practice in their discussion about Canadian approaches to clinical education for undergraduate community health students. Edwards and MacDonald (2009) described a research internship program focused on building research capacity amongst community health nurses that was developed in the context of “the movement towards evidence-informed decision-making and practice” (p. 1). Respondents to the CHNC environmental scan identified standards, barriers, and facilitators for evidence-based practice as key priorities for the future of community health nursing in Canada.

#### *Decision-Making*

The decision-making required of the CHN is addressed in the introduction to Standard Five. It was identified as a component of practice by Nic Philibin et al. (2010). Additionally, Browne et al. (2010) named comprehensive clinical decision-making as one of the elements of practice demonstrated by PHNs working with high-priority families. The standards of practice for occupational health nurses (COHNA, 2003) identifies decision-making as a component of professional responsibility and accountability, stating that “the occupational health nurse utilizes a systematic, problem-solving approach to clinical decision making based on a conceptual framework for occupational health nursing practice” (Standard II).

#### *Contributing to the Quality of the Work Environment*

The work environment is addressed in CHNAC Standard 5 which specifies the requirement for the CHN to contribute to the quality of the work environment (item 10) and to “advocate for effective and efficient use of community health nursing resources” (item 13). A quality setting is

also referred to as a healthy work environment which has been described as “the totality of all factors that influence satisfaction and performance of the job” (Kramer and Schmalenberg, 2008, p. 59). The quality of the healthcare work environment has been linked to the effectiveness and efficiency of healthcare services, and thus to the sustainability of the Canadian health care system (Quality Worklife, Quality Healthcare Collaborative [QWQHC], 2007). In their “Healthy Workplace Action Strategy for Success and Sustainability in Canada’s Healthcare System”, the QWQHC called for immediate action by health care leaders to make workplaces healthier and thereby improve the health of healthcare providers and the quality of the care provided to patients/clients (QWQHC, 2007). In a joint position statement on practice environments, the Canadian Nurses Association and Canadian Federation of Nursing Unions (CFNU) identified effective leadership as an “essential element for quality practice environments” (CNA/CFNU, 2006, p. 2).

Research studies have examined the effect of leadership on various outcomes. One study found evidence that leadership attitudes and behaviours influenced the retention of nurses and their degree of job satisfaction (Sturm, 2009). Job satisfaction was the focus of a Canadian study by Best and Thurston (2006) who examined job satisfaction levels amongst Canadian public health nurses. Nurses ranked the importance of several job components, identifying autonomy, pay, professional status and organizational policies as the four components most important to their job satisfaction. In another study, nurses cited “autocratic management styles, failure of team building, unreasonable expectations and a lack of vision” as contributors to problems in clinical leadership (Carney, 2009, p. 439). Evidence from the above studies supports CHNs in advocating for healthy work environments as a strategy to optimize their care and associated outcomes.

#### *Quality Monitoring*

Standard 5, item 17 identifies the requirement for CHNs to evaluate various aspects of their care, including its quality. The parish nursing standards are clear that the nurse “is responsible for the quality, impact and development of his/her own practice and for maintaining professional competence” (CAPMN, 2007, Standard 5). Measurement of outcomes associated with home care nursing was the focus of a study by Ervin, Chen and Upshaw (2006). The authors developed “The Community Nursing Care Quality Model” (p. 177) and then tested relationships between the variables in the model. Process variables were identified as “affective support, health information adequacy and decisional control whereas outcome variables were identified as patient adherence to nursing and medical recommendations, presence or absence of symptoms, and general well-being” (p.177). The study found that the technical quality of nursing care influenced the patient’s perception of affective support, health information adequacy and decisional control.

#### *Reflective Practice*

Reflective practice appears as item 14 in Standard 5 (CHNAC, 2008, p. 15). Beam, O’Brien and Neal (2010) identified reflective practice as a “foundational concept” (p. 132) of public health nursing practice in their discussion of implementation of the Nurse-Family Partnership program. Reflective practice is also identified as a competency for home health nurses (CHNC, 2010b, p. 13) and is included in the scope and standards of practice for home health nursing by the American Nurses Association (2008). Reflective practice contributes to nurses being responsible



and accountable at all times for their practice, as prescribed in the standards for occupational health nurses (COHNA, 2003). Nursing regulatory colleges in some jurisdictions within Canada include reflective practice in their expectations of registrants. For example, a reflective practice approach underpins the Continuing Competence Program for RNs in Alberta (College and Association of RNs of Alberta, 2005) and the College of Nurses of Ontario has identified “supporting nurses to become reflective practitioners” as an indicator of continuing competence for a nurse in an administrator role (College of Nurses of Ontario, 2009b, p. 5).

### *Telehealth*

The literature revealed evidence of the need for community health nursing practice to encompass telehealth and emerging technologies. For example, in the area of home care Maeder (2008) noted: “Much effort is currently being invested in *home-based health care*, with an expectation that telemonitoring of a patient’s personal situation, including changes in health condition, response to medication and treatment, and adherence to care plan or lifestyle choices, will be achieved [through] Telehealth” (p. 4). Demiris, Oliver and Courtney (2006) discussed ethical considerations regarding the use of telehealth technologies in home and hospice care. Li, Morrow-Howell and Proctor (2004) discussed telephone follow-up as a nursing intervention, and Goodwin (2007) discussed the implementation of telephone advice services in numerous provinces in Canada. Nursing regulatory colleges including the College of Nurses of Ontario (2009c) and the College and Association of Registered Nurses of Alberta (2009) have developed and published standards of practice or practice expectations related to telephone practice and/or health informatics. Lokanc-Diluzio, Nelson, Wayne and Hettler (2008) identified the importance of telehealth and web-based resources in community health nursing related to health education and prevention of Sexually Transmitted Infections and Blood Borne Pathogens and the support for those living with HIV. Telehealth and public health was addressed in detail by Edison (2009) who identified the ways in which telehealth is helping to address current public health challenges or could be used to meet future challenges.

### *Technology in Nursing Practice*

The use of technology in practice was evident in an account of the implementation of PDAs (personal digital assistant) by a public health nursing service (Rogoski, 2005). The author described the challenges experienced by the PHNs in using the devices from both technical and practice perspectives. From a technical perspective, the screens are small and so visibility was an issue. From a practice perspective, PHNs felt that the device interfered with the ability to establish a connection with the patient. There is evidence that PDAs are also being widely used by home care nurses (Doran and Mylopoulos, 2008; ParaMed, 2008; Saint Elizabeth Health Care, 2010; Victorian Order of Nurses, 2008). The literature also describes nurses’ use of computers, cameras and web-based applications for professional development and to support their delivery and documentation of client care (Buckley, Adelson and Hess, 2005; Goodwin et al., 2008; Nielsen, Bullock-Piascik, Sabiston and Scott, 2010; Sanchez, 2009).

### *Mentoring Students and New Practitioners*

Standard 5 includes indicators related to mentoring students and new practitioners (item 5) and contributing proactively to the quality of the work environment. It has been reported that four generations are working in today’s nursing workforce: the Silent Generation, born between 1922 and 1942; the Baby Boomers, born from 1943 to 1960; Generation X, born from 1961 to 1980

and Generation Y, born after 1981 (Hu, Herrick and Hodgins, 2004). This demographical reality has prompted research to understand differences amongst the generations and thus promote optimal working relationships and job satisfaction. For example, differences in perceptions related to retirement, computer technology, commitment to employment and desired traits in health care leaders were identified in the above mentioned study of four generations of nurses working in acute care in the U.S. (Hu, Herrick and Hodgins, 2004). One difference was that nearly half of respondents in the Silent Generation and Baby Boomer groups viewed computers as “frightening and complicated” (p. 339) in contrast to the views expressed by the younger generations. Additionally, older workers valued professionalism, integrity and empowering behaviours in their managers, whereas younger generations valued knowledge, good communication and receiving affirmations about their performance so that they could build their self-confidence. The study recommended that generational differences be acknowledged and addressed in order to promote a supportive work environment.

A Canadian study also identified four generations in the nursing workforce, and named them as: Veterans, born before 1945; Baby Boomers, born between 1946 and 1964, Generation X, born 1965 to 1979, and Generation Y or Millennials, born 1980 onwards (Wilson, Squires, Widger, Cranley and Tourangeau, 2008). The study explored differences in job satisfaction amongst nurses in the Baby Boomer, Generation X and Generation Y cohorts. There were no significant differences amongst the three generations regarding satisfaction with co-worker relationships or with opportunities for interaction. Implications for nursing management based on the results of the study were identified, including the need to implement strategies such as career development opportunities or shared governance to enhance job satisfaction for younger generations.

### **Research Question 2: Are there content gaps in the standards?**

Some trends and issues either newly identified or expanded upon in the literature reported in this review are relevant to the standards for community health nursing practice in Canada and are now discussed.

#### ***Surveillance***

In the Canadian Community Health Nursing Standards of Practice, surveillance as a nursing activity is alluded to in “empirics”, one of the five ways of knowing in nursing (CHNAC, 2008, p. 7). Additionally, Standard 1 b) Prevention and Health Protection (item 6) identifies the requirement for CHNs to apply epidemiological principles when engaged in strategies including surveillance. Surveillance may also be construed from Standard 5, item 1 in which the CHN’s responsibility to take preventive or corrective action to protect individuals and communities from unsafe circumstances is outlined. The literature reveals that increasing attention has been paid to surveillance as a component of public health nursing practice in recent years. For example, a historical overview of the contributions of medicine and epidemiology to the development of public health nursing was provided by Earl (2009). Using tuberculosis as an example, the paper demonstrated nurses’ progressive use of data and statistics to achieve improvements in public health.

The description of an obesity surveillance program for pre-school children in Alberta, Canada was the focus of a study by Flynn et al. (2005). The study tested a multi-faceted intervention that began with a weight and height assessment for children of approximately 4.5 years old attending

a pre-school public health immunization clinic. On the basis of the weight and height data children were categorized as underweight, healthy weight or obese. Following the assessment an information package was given to parents that discussed healthy eating, active living and positive body image. Nurses sent an information letter to the family physicians of children who were underweight or obese. The program was found to be acceptable to both staff and families.

A Canadian study by Meagher-Stewart, Edwards, Aston and Young (2009) reported the population health surveillance functions of public health nurses and identified factors that challenge PHNs' ability to fulfill those functions. The authors described health surveillance as "an essential epidemiological strategy that involves identifying changing risk profiles and health status patterns and forecasting future disease trends" (p. 553). The expectation was identified that public health nurses and other health care practitioners would be vigilant in conducting traditional disease surveillance activities to achieve the goals of early recognition and reporting of suspicious cases. The authors also noted emerging advocacy for an expanded surveillance function termed "ecosocial surveillance" (p. 554) that would attend to the broader societal influences on health status. Their study revealed a variety of ecosocial population health surveillance functions carried out by PHNs, prompting the conclusion that while traditional surveillance activities such as immunization and detection of child abuse and neglect remain important, there is support for an ecosocial approach to surveillance to be further developed and implemented.

Another emerging aspect of surveillance was associated with bioterrorism preparedness (Akins, Williams, Silenas and Edwards, 2005; Agency for Healthcare Research and Quality, 2006). The study by Akins et al. acknowledged PHNs for the essential services they provide, including disease surveillance. The authors linked disease surveillance to the early recognition of diseases caused by bioterrorism agents. However, they identified factors which impede nurses' ability to engage in more proactive surveillance such as fragmentation of the public health system and a confusing array of expectations and responsibilities of PHNs.

Developing surveillance skills amongst the public health workforce was the focus of the "Skills Enhancement for Public Health Online Program" by the Public Health Agency of Canada (Public Health Agency of Canada, 2007). Through a series of on-line modules and coaching by an on-line facilitator, participants were able to advance their knowledge, understanding and use of health information data. The first module reviewed basic epidemiological concepts including the steps of the surveillance cycle. Another module focused entirely on surveillance—it discussed the principles and practices of public health surveillance, examined the major categories of health events for which public health surveillance systems exist, described basic concepts related to the communication and dissemination of public health surveillance information, reviewed emerging trends and activities in public health surveillance and shared a framework "for the components and evaluation of a public health surveillance system in a public health environment" (p. 4 of 7).

### ***Practice and Professional Regulation***

While Standard 1 b), item 9 identifies that the CHN "Practices in accordance with legislation relevant to community health practice..." (p. 11) no mention was found in the standards of practicing in accordance with "regulatory" requirements (St. Pierre, 2007). As scope of practice

for nurses is articulated within a regulatory framework (CNA, 2007b), omission of regulation may represent a content gap.

### ***Health Teaching/Providing Health Information***

Studies such as that of Hirdes et al. (2006) reinforced health teaching as an important function of community health nursing. Standard One (a), item 6 encompasses “increasing knowledge” and the introduction to Standard One (Health maintenance, restoration and palliation) mentions provision of health education. Although health teaching is implicit in many of the standards and indicators it is not explicitly identified and thus represents a potential gap in content.

## **Section 3: Revisions for Consideration Based On the Literature Review**

The following recommendations arise from the literature review findings and are offered for consideration in updating the standards.

### ***1. Surveillance***

Content about surveillance is limited in the current version of the standards. As reported in this literature review, the literature reveals that increasing attention has been paid to surveillance as a component of public health nursing practice in recent years. Accordingly, it is recommended that additional content related to surveillance be included in the revised standards.

### ***2. Determinants of Health and Social Justice and Equity***

Content related to the determinants of health is found throughout the Standards as follows:

- Description of Community Health Nursing, p. 8
- Standard One: Introduction, p. 10; a) Health Promotion, items 4 and 6, p. 11
- Standard Two: Introduction, p. 12
- Standard Four: Introduction, p. 13; items 10 and 12, p. 14
- Standard Five: Introduction, p. 14; item 15, p. 15

This fragmentation of content makes it difficult to obtain a clear and comprehensive understanding of what is expected from the CHN in addressing the determinants of health in their practice, therefore the following recommendations are made:

- Consider grouping all content related to determinants of health in a single standard, or as a component of a standard (e.g. standard one has three components);
- Add the word “social” when discussing the determinants of health, thus reflecting current literature;
- Combine content about social justice and equity with that about the social determinants of health or link them in order to reduce confusion; and
- Update content to reflect attention to the environment as a determinant of health.

### ***3. Practices in Accordance with Legislation***

Consider revising Standard 1b, item 9 as follows: Practices in accordance with legislation *and regulation* relevant to community health practice (e.g. public health legislation, child protection legislation and *provincial/territorial regulatory frameworks*).

#### **4. Health Teaching/Providing Health Information**

Standard One (a), item 6 encompasses “increasing knowledge” and the introduction to Standard One (Health maintenance, restoration and palliation) mentions provision of health education. Although health teaching is implicit in many of the standards and indicators it is not explicitly identified. Therefore consider explicitly naming health teaching as an expectation in one of the indicators.

#### **5. Disaster Planning/Emergency Preparedness**

In keeping with the literature findings, consider grouping the indicators relevant to disaster planning/emergency preparedness together, and/or make the language more explicit regarding nurses’ role in emergency preparedness and response from both public health and home care perspectives.

#### **6. Evaluation of Practice Quality**

Consider revising Standard 5, item 17 as follows: Uses available resources to *identify desired outcomes and related indicators for clients, communities or the workplace and to systematically measure the achievement of those outcomes including the availability, acceptability, quality, efficiency, and effectiveness of community health nursing practice and the work environment.*

#### **7. Identifying Potential Risks to Health**

Consider revising Standard 1(b), item 4 as follows: Helps individuals, groups, families and communities to identify potential risks to health *including contributing to emergency and/or disaster planning, being knowledgeable about specific emergency/disaster plans and promoting awareness of the plan(s) amongst individuals, groups and families.*

#### **8. Evidence-Based Practice**

The requirement for CHNs to base their practice on current evidence is only explicitly mentioned in the *introduction* to Standard 5 (Demonstrating Professional Responsibility and Accountability). Accordingly, consider incorporating the requirement to base CHN practice on current evidence explicit in an existing indicator or develop a separate indicator for that purpose.

### **Summary and Conclusions**

This literature review has identified opportunities for minor changes to the wording of the standards and some additional content. It is recommended that these opportunities be considered in the context of the companion documents identified in this report which complement the standards by expanding and further detailing practice. Overall, this review of the literature revealed evidence that the Canadian Community Health Nursing Standards of Practice (2008) remain current, accurate and comprehensive in documenting the expectations of community health nurses.

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Appendix A

14 Social Determinants of Health (Canadian Perspective)  
*(Mikkonen and Raphael, 2010, p. 9)*

1. Income and Income Distribution
2. Education
3. Unemployment and Job Security
4. Employment and Working Conditions
5. Early Childhood Development
6. Food Insecurity
7. Housing
8. Social Exclusion
9. Social Safety Network
10. Health Services
11. Aboriginal Status
12. Gender
13. Race
14. Disability