Final Report and Resource Package

Model of Communities of Practice for Advancing Practice in Community Health Nursing

Submitted to Community Health Nurses of Canada

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Final Report

Model of Communities of Practice for Advancing Practice in Community Health Nursing

This final report is to bring together the key elements in using the community of practice approach in community health nursing settings. The focus of the report will be on practical information.

The purpose of the project was to increase the capacity of community health nurses to apply public health sciences and the CCHN Standards by using a community of practice as a knowledge exchange strategy to facilitate health promotion and disease prevention across community health nursing organizations in three regions of the country.

The objectives for the project were:

1. To develop an evidence-based process, tools and techniques for engaging nurses in communities of practice.
2. To develop communities of practice in Ontario, British Columbia and Nunavut, involving nurses from public health, home health and primary health care.
3. To evaluate the process and intermediate outcomes of communities of practice on participants and their organizations
4. To determine the utility of communities of practice for professional development and graduate education
5. To determine the applicability of communities of practice to inter-professional and intra-sectoral practice

The project was carried out in two phases between October 2007 and March 31, 2009, a period of 18 months.
Phase 1: October 2007—March 2008: defining the knowledge base, developing the baseline evaluation and forming the community of practice.
Phase 2: April 2008—March 2009: supporting the communities of practice as they address concerns common to the three health sectors using community/population assessment, planning, action and evaluation and disseminate their results.

Organization of Final Report

This report is organized in five parts: the review of the literature on communities of practice; methods; results, and discussion. Additional material is provided in the Appendices, including the monetary value of volunteer time and resources.

Review of Literature

Communities of practice are people who share a concern or a passion for something they do and want to learn how to do it better by meeting regularly and exchanging ideas (Wenger, 1998). Used widely in industry, business and education, communities of practice are emerging within the health sector for different ends (Wenger & Snyder, 2000).

Using communities of practice to facilitate evidence-based practice is a common thread in research initiatives. Collectively, they address the concerns expressed in the

recent US report (Institute of Medicine Quality Health Care Project, 2005) that health systems have not kept pace with the challenges of modern world—the burgeoning information, greater complexity of care and higher expectations for health—and subsequently fail to translate knowledge into practice. Communities of practice provide a way of responding to the agenda for the 21st century, as set out in the report, calling for greater cooperation and knowledge sharing among health providers to provide safe, effective and patient-centred care in a timely, efficient and equitable fashion.

A selective search of the literature and key informant interviews addressed the following questions:

1. What are the identifying features of a community of practice?
2. What are best practices for setting up a community of practice?
3. How are communities of practice evaluated?

Identifying Features of a Community of Practice

According to Wenger (1998), who has written extensively on the subject, a community of practice defines itself along three dimensions: what it is about—its joint enterprise as understood and continually renegotiated by its members; how it functions—the mutual engagement that bind members together into a social entity, and what capability it has produced – the shared repertoire of communal resources (routines, sensibilities, artifacts, vocabulary, styles, etc.) that members have developed over time.

Naturally Occurring or Constructed Communities of Practice

By definition, communities of practice are informal groupings, grounded in practice and drawn together by a common purpose. Participants self-identify and set their own pattern of involvement, which can vary over time (Wenger, McDemott, & Snyder, 2002). Even though the community of practice exists over time, members may come and go and the focus of the community may change (Wenger, 2000).

In summary, the literature supports the idea of constructing communities of practice with community nurses who have a common framework for practice in the Canadian Community Health Nursing Standards of Practice. The challenge is that community nurses are funded through different mechanisms across the country to provide public health, primary care and home care services, each of which tends to emphasize different aspects of health promotion and disease prevention. This means that community nurses work within their respective sectors and do not usually have opportunity to work to full scope of practice.

Bringing together nurses from academia and practice settings in a deliberative process to form communities of practice within a health region has the potential to provide community nurses with an opportunity to share experiential learning, identify common problems, and transfer knowledge across community settings. In the long term, this can increase the capacity of community health nurses to base practice on information about what works. In addition to improving practice, enabling nurses to learn and solving problems together has the potential to break down silos across health sectors in the community, and potentially, to increase access to effective health promotion and disease prevention nursing services.

Best Practices for Setting up a Community of Practice

The three key requirements for setting up communities of practice outlined in the Wenger (2002) quick start-up guide are used to frame the following discussion: Defining the area of shared enquiry and key issues; forming relationships and a sense of community, and creating the body of knowledge, methods, stories, cases, tools, documents.

Defining the Area of Shared Enquiry and Key Issues

With naturally occurring communities of practice, the key issues defined by the community need to engage participants. An additional requirement of constructed communities of practice is that they need to be sensitive to the management environment and have strategic relevance to gain support (Wenger, 2002).

While it can be assumed that practitioners working in the same field will have many interests in common, this may not be sufficient to create a community of practice. A retrospective study of managed regional cancer networks in England (Addicott, McGivern & Ferlie 2006) found that contrary to expectations, practitioner communities of practice did not necessarily emerge from regional mergers to improve cancer treatment. After several years, only one of the five managed regional cancer networks had a community of practice and this one had preceded the merger.

Furthermore, negotiating the common focus can be a slow process. Tolson and colleagues (2006) report that the first year of their study was devoted to bringing together practitioners working in gerontology to create a shared understanding of practice and define standards. From this base, they were able to move toward the development and testing of evidence-base practices. Possibly, having a short list of topics can help to narrow the search for a common focus (Gabbay et al., 2003) but the long-term implications of this approach are not known.

Garcia and Dorohovich (2005) warn that communities of practice can fail to progress if not properly managed. Drawing on over twenty years of experience in the military, they emphasize that the process requires careful thought and intensive effort. They recommend using a 14-step process, which has been adopted widely by other organizations. The steps provide a template, rather than a cookie cutter approach and should be tailored to the particular situation. Forming Relationships

It is the social relationships that hold the community of practice together. Members are drawn together, face-to-face, or in virtual space, because they have a shared purpose and over time develop a shared language, common values, and a shared identity, which bonds the group (Wenger, McDermott, & Snyder, 2002). Over time this can act as a barrier repelling new members (Li, Grimshaw, Nielsen, Judd, Coyte, & Graham 2009). For effective knowledge sharing, communities of practice should be sufficiently diverse to encourage innovative thinking and members must be open to the ideas of others, be willing to share ideas and maintain a thirst for knowledge (Tsui et al., 2006: 21). While participants will self-select on the basis of common goals and interests, the community of practice can be structured to facilitate social relationships. For example, by employing a facilitator (Garcia & Dorohovich, 2005; SHRTN, 2008), or assigning the role to the project leader (Gabbay et al., 2003). Linking practitioners and academics is another way of providing different perspectives of practice (Andrew, Tolson & Ferguson, 2008).

Strategies to support engagement include providing a mix of activities, enabling story telling as a means of sharing practice and bringing in experts (Wenger, 1996; Probst & Barzillo, 2008).

Creating the Shared Body of Knowledge

From ongoing exchanges, the community of practice accumulates a body of knowledge, both tacit knowledge, that is stored in the minds of the community members and experiential or explicit knowledge (also known as prepositional knowledge) which is stored in written or electronic form (Sandars & Heller, 2006). According to Knight (2002), this procedural knowledge, that is, skills, information and rules, expectations and dispositions, are emergent properties of a community of practice. Lave and Wenger's (1991) theory of situated learning (Legitimate Peripheral Participation [LPP]) provides a theoretical explanation of this phenomenon. The theory proposes that skills, knowledge, and identity are developed through participation in day-to-day work activities and interactions with others. The community of practice guides development and in turn group members identify the group's expertise and build shared practices.

In part, the repertoire, or shared body of resources rests within the minds of participants as tacit knowledge. In part it can be stored as explicit knowledge in journal articles, clinical guidelines, in libraries or electronic databases (Sandars & Heller, 2006). This requires human and information systems to store information and make it available and to help community members think together (Tsui et al., 2006). For example, from their research, Gabbay and colleagues (2003) identified ways that the group process for developing evidence-based policy could be enhanced.

Regardless of whether the communities of practice emerge spontaneously or are constructed, they are likely to change over time and the evidence suggests they will not survive unless they are nurtured and supported. Lessons learned from many years experience provide consistent advice on setting up a communities of practice and highlight the importance of a supportive environment such as can be provided by a learning organization (Garcia & Dorohovich 2005; Kerfoot, 2002; Wenger, 2000).

Evaluating Communities of Practice

There are few reports of communities of practice that have been running for long enough to generate products, such as those described by Tolson and colleagues (2004). This community of practice produced best practice guidelines, whose implementation has been tested in practice settings. In a critical review of the literature, Li and colleagues (2009) recommend that evaluation focus on optimizing the conditions required for the community of practice to prosper. They suggest focusing on characteristics such as support for members interacting with each other, knowledge sharing, and building a sense of belonging. This approach is found in Barwick's (2008) examination of the feasibility of using a community of practice for the design and implementation of a community of practice to support shared priorities for cancer and chronic disease prevention. For the most part, the evaluation of communities of practice has examined their process rather than their outcomes. Garcia & Dorohovich (2005) provide practical advice on how to measure the success of the community in reaching goals and providing value to members using surveys and simple counting methods. Others (e.g.: Gabbay et al., 2004; White et

al., 2008) use ethnographic approaches with participant observation, including document review, interview and observation, as the main method of data collection.

Methods

This action research study brought together researchers and practice leaders from Ontario, Nunavut and British Columbia to design, implement and evaluate the use of a community of practice approach in the three regions. 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 study sites of Ottawa, Cornwall, Vancouver Coastal Region and the territory of Nunavut, provide a mix of urban and rural settings, cultures and languages, and access to different systems for organizing community health services. In addition to geography, a key consideration in developing the partnership was the existence of favourable research-practice environments and existing relationships.

The procedures for the study involved the organization, coordination and evaluation of a community of practice in the four sites. Organization and coordination at the national level involved the development of the common procedures that were then tailored to each site. This report will focus on the organization of the communities of practice.

The Model Process

The Wenger (2002) quick start-up guide was used as the initial model for the community of practice. The three areas in the guide were considered mutually reinforcing rather than a step-by-step process.

- Define the area of shared enquiry and key issues
- Form relationships and a sense of community
- Create the body of knowledge, methods, stories, cases, tools, documents

The eventual model was shaped by experience with the four communities of practice, the community building steps identified by Garcia and Dorohovich (2005) and the work of Barwick (2008) and colleagues (Barwick, Peters, Barwick & Boydell, 2008).

Plan for Evaluation

The evaluation was based on a logic model and evaluation plan (See Appendix: Planning & Evaluation). Both quantitative and qualitative data, including summaries from meetings, workshops, teleconferences, and interviews, field notes and planning documents, were collected.

The following table details the timing for each evaluation measure.

Table 1 Evaluation Measures used in each Area

	Ontario		Nunavut	Vancouver
Timing of evaluation	Cornwall	Ottawa		
Pre-workshop assessment	√	√		
Workshop evaluation	√	√	√	

3 –5 months	√	√	√	√
Final				
-questionnaire	√	√	√	
-interview/focus group	√		√	√

Results - Evolution of the Communities of Practice

This first section of the results is a descriptive account of the evolution of the communities of practice. It discusses their context, structure, process and outcomes at various phases of development. Appendices contain the tools and resources to support the development and the resources developed by the communities of practice.

The Four Communities of Practice: Context, Structure, Process and Sustainability

This project engaged community health nurses working in public health, home care, and primary health care (e.g. community health centres and clinics) in four sites: Ottawa, Cornwall, Vancouver Coastal Region and the territory of Nunavut

Phase 1: Forming the Communities of Practice

This phase took place in December 2007 to February 2008 for the communities of practice in Eastern Ontario and Nunavut, and between April and October 2008, in Vancouver where there was a delay in obtaining ethical approval and recruitment difficulties due to the many system changes taking place in the region, such as implementation of a new electronic system, the initiation of integrated health networks, and a resource project underway on the North Shore.

The phase includes the pre-planning and recruitment activities in each region, the launch of the community of practice at a workshop, or similar event, and the workshop report outlining the general direction agreed on by participants. The first three steps identified by Garcia and Dorohovich (2005) are evident in this phase.

Pre-planning. The first community of practice to be organized, Cornwall, provided a template for the others. This site was chosen for practical reasons: together with Ottawa it was part of the Local Health Integration Network (LHIN) planning region. The smallest of the four in area, it had been the setting for a CCHN Standards workshop the previous year so offered the opportunity to build on pre-existing relationships with Public Health practice leaders there.

The arrangements were worked out by teleconference. The health unit partners identified potential participants from the community and provided access to a meeting room. They were instrumental in framing the workshop approach and the pre-workshop interview but, after consideration, declined to be named formally as community partners to avoid the community of practice being perceived as tied to any one agency. For this reason, the invitations were sent out from the research team. A sample workshop package is provided in the Appendix: Launch Workshop Package.

The participatory planning sessions and pre-launch interviews provided valuable information about participants. Most had previous exposure to other community agencies through annual cross community initiatives like flu clinics and participation in disease specific networks and coalitions to do with vulnerable populations, such as families with young children and multicultural groups. Several participants had been involved in

professional nursing organizations and committees, so worked with other health providers in the community through. As well, most had worked with the educational sector to provide student placements.

Another key learning, which helped to guide planning, was the participants had strong motivation to join the community of practice. Generally, practitioners were intrigued by the concept: they thought it offered promise for professional development and support and could lead to a better understanding of community resources and greater awareness of the services provided by other agencies, which might improve access. Several identified the potential to improve the quality and continuity of care for clients in their community, for example, by providing common messaging around healthy lifestyles. In Eastern Ontario, this was seen as especially important since the newly formed, Champlain LHIN was actively promoting collaboration and seamless care through funding opportunities.

Workshop launch. Three of the communities of practice were launched with a face-to-face workshop. The Ontario workshops were specific to the CoP. The Nunavut CoP was launched part of a one-week meeting, that brought together nurses from across Nunavut as part of another research project. The Vancouver Coastal CoP was launched by teleconference.

The workshop was designed to bring people together to get to know each other, to provide an introduction to communities of practice, what they were and how they worked, and to identify a common purpose, and determine how the community of practice would work together. The workshop agenda and other documents are provided in Appendix: Launch Workshop Package.

Between 16-20 participants attended the launch of the communities of practice in Eastern Ontario and Nunavut; Vancouver started with three members. Participants came from across the health sector and education (LD, represented the education sector in Ottawa) and represented staff and management as well as advance practice roles. In both Cornwall and Nunavut, five to seven participants were baccalaureate community health nursing students.

Identifying a common focus was a key element of the introductory workshops. Participants were assigned to one of two groups to provide a mix of experience and asked to generate a list of potential topics for the community of practice. The topics were clustered and discussed in more depth by the group as a whole. This served to explore their implications across the spectrum of health care in the community and achieve a common understanding. The workshop leaders then reorganized the topics to reflect the emerging themes and the group decided on the primary focus. At this stage, the topics were still broad; for example, in Cornwall the topics were hand washing and chronic disease management/prevention.

The proceedings of the workshop were summarized in a report, which participants agreed to discuss within their respective organizations. As well, they were to find out more about their organization's current activities and resources related to the chosen topics and confirm the fit with the organization.

The workshop evaluations showed that participants were satisfied with the process and provided useful direction on next steps.

Table 2 identifies the two main things that the participants from the four sites felt they gained at the launch workshop.

Table 2 Two Main Things Gained from the Workshop Launch

	Cornwall N=8	Ottawa N=19	Nunavut N=11	Total N=38*
Knowledge of working together in a community of practice	6	13	7	*26*
Links with other nurses working in other types of community practice	2	12	5	*19*
Knowledge about how practice issues overlap in the community	2	6	6	*14*
Energy/enthusiasm/motivation	3	3	1	*7*
Ideas that will be useful to my organization	3	3	1	*7*
Other: togetherness, fellowship	0	0	1	*1*

* Respondents were invited to select two items, not all did so.

In summary, three of the four communities of practice—Ottawa, Cornwall and Nunavut—were launched at face-to-face workshops in January-February 2008. The fourth community of practice—Vancouver Coastal—was launched in October 2008.

Phase 2: Working Together

This phase encompasses the first four months of working together after the launch of the community of practice. For the Eastern Ontario and Nunavut communities of practice this occurred between March and June of 2008, in Vancouver between November 2008 and March 2009. Several interdependent activities occurred simultaneously; the group established a logical organizing structure; built relationships, and created a more defined focus (Garcia & Dorohovich, 2005, steps 4-10, 13).

Establishing a Logical Organizing Structure. The communities of practice agreed how they would meet—face-to-face or by teleconference—for how long and how often, at the launch meetings. The Ottawa, Nunavut and Vancouver CoPs chose to meet by teleconference through CHNETworks! The Cornwall CoP preferred to meet face-to-face, at least initially, so the leaders drove to Cornwall for the meetings. During the first four months, the pattern of the meetings became established and the administrative details were made routine. The research teams put considerable effort into refining the procedures of distributing the meeting summaries one week after meeting, sending out resource documents and circulating the agenda one week in advance of the next meeting.

Building Relationships. Bringing together community health nurses from a variety of service delivery areas within large health authorities such as Vancouver Coastal and Nunavut, or from different organizations, as in Eastern Ontario, provided opportunity to learn what others were doing in the community and opened up channels of communication—knowing who to call in an organization. It helped to establish identities; as one participant said: "*It helps you to know and be known, to enhance your reputation as community member*."

Typically, each meeting began with an introduction of participants, or check-in, particularly important when meeting by teleconference, and an opportunity to share

information about current activities and organizational changes. From the outset, CoP members appreciated the opportunity to talk to others with similar interests, sharing knowledge and experience and gaining a better understanding of each other's practice.

In addition to building relationships, these informal exchanges made it possible for members of the community of practice to challenge their own assumptions and increase knowledge of aspects of community health they did not normally see. For example, process evaluations showed that public health nurses were impressed with the level of health promotion going on in the home, and that practitioners wanted to do more. Another community member made the following observation about the value of this sharing:

> *"It increase appreciation of the complexity of the health and social service system in Ontario and the importance of nursing in the matrix [of services]."*

Clearly, the community of practice filled a gap. Relationship building is central to communities of practice and the meetings were organized to accommodate this.

Establishing a Defined Focus. Each community of practice started by defining a broad area of interest but the real work came in narrowing down the focus. This process occurred at a different pace in the different sites. The facilitators found pertinent resources and, or, developed content to address knowledge gaps (Dorohovich & Garcia's step 7) to provoke discussion. The meetings took the form of cooperative enquiry (McArdle & Reason, 2004), with participants pooling information, asking questions, seeking answers and slowly narrowing the focus and building understanding. Techniques based upon an appreciative inquiry approach, emphasizing strengths and possibilities (Ludema, Mohr, Whitney & Griffin, 2003) were used to engage people and move the discussion forward. The resources generated through this process were compiled in a resource inventory and shared with the community of practice members (See Appendix: Developed Resources).

Organizing this inventory was an ongoing requirement and would have been more easily accessible with a web-based system. The website was not user friendly.

There was no common route to focusing the topic other than using an exploratory approach. By the second meeting, the Cornwall members had elected to develop a passport that could be used to support the inclusion of health promotion messages in a variety of care situations. In Ottawa, the community of practice devoted many meetings to examining Chronic Disease Self-Management (CDSM) more broadly to understand the implications for practice. In Nunavut, the group decided to learn more about the role played by drop-in centres in providing pregnant women with access to nutritional information; this was seen as a manageable task that fit with territorial priorities.

Knowledge development integral to this process. Participants commented that activities such as a review of chronic disease self-management clinical practice guidelines contributed to professional development. This learning was being shared and found to be of interest within their organization. Students benefited too. The community of practice showed a different facet of the work of community organizations that students did not normally see in their placements and allowed them to view networking and collaboration between community agencies in a positive light. Equally, the student participation was not lost on practitioners. As one person said, it brought home the importance of mentorship by experienced community nurses.

The opportunity to combine learning and sharing in an informal atmosphere was satisfying to participants and helped to focus practice. Vancouver participants identified the reflective-action process was an important component of the community of practice. As one participant noted:

> "*the opportunity for reflective practice, a protected space to think about what we are doing, how we are doing, about improvement, and how to be more strategic and bring in more innovation, instead of just administrative tasks for operations and problems solving, that is a key difference for the CoP.*

The Four Month Evaluation

Toward the end of the first four months, members of the communities of practice evaluated how the communities of practice were functioning and their potential benefit, to themselves and their organizations. Generally, members were satisfied with the way the communities of practice were evolving and valued being able to participate. In Nunavut, the evaluation was combined with a field work study of maternal-child health services in the territory; in Ottawa, the interview was combined with asset mapping.

Key findings and their implications for the community of practice operations are discussed below.

Maintaining participation in the community of practice. This was an ongoing concern, particularly in the early days before relationships were well established and the community of practice had a clear focus. Inevitably, a few participants "fell off the radar" and last minute regrets because of competing priorities were not unusual.

On balance, most participants said they were able to fit the community of practice meetings into work schedules even though it was challenging. In addition to the demands of the job, a few mentioned organizational changes had resulted in new roles and responsibilities that interfered with participation. Among the suggestions to ease these difficulties were pairing up with a colleague to ensure organizational representation at meetings and scheduling meetings ahead, preferably on the same day of the month, time and place. The practice of rotating meeting sites to involve the different organization was felt acceptable. The feedback on meeting time was divided: some wanted to limit meetings to an hour, others suggested an extension of up to two hours, or recommended shortening the agenda. Some of these solutions were already being implemented; however, the feedback reinforced the need to attend to such details.

In general, participants meeting by teleconference were satisfied with the flexibility this offered. A virtual community of practice (VCoP) can incorporate various electronic modes, such as e-mail, video teleconferences augmented with PowerPoint presentations, and electronic handouts to support participant involvement (Hanlis, & Abbass, 2008; Nagy et al., 2006). In addition, leaders can provide organization specific ideas, reflections, and support to foster successful participation. Several suggested building in more face-to-face meetings. While not possible in Nunavut, this could be accommodated elsewhere.

Even though staff participation was agreed by the organizations, one or two identified management support as a factor. In the absence of protected time, those with more autonomy over work time were more able to attend than those who provided front line services. One participant noted:

"*when I spoke to my immediate manager to be involved, she did not think it was a good use of my time, which was a bit discouraging…it is good to know we have the stamp of approval from the organization, otherwise you feel like you are doing it behind their back"*.

A management and organizational culture that supports staff participation in professional development facilitates the launching stage of a CoP (Dube, Bourhis & Jacob, 2005; Probst & Borzillo, 2008; White et al., 2008). Having the regular involvement of leadership was viewed as an asset that gave the message of organization endorsement.

Most participants felt that being part of a group that supported working collaboratively across health sectors fit with organizational values and priorities and would be beneficial to clients and the community. Besides, building partnerships, working collaboratively and pooling resources were seen as a necessary way of working in the community. A particular value of the community of practice was that it provided a neutral ground to link with other community organizations and a forum to promote the organization's agenda.

A few participants said it was important to raise awareness of the community of practice in the broader community to justify participation. In particular, it was thought important to show that the CoPs did not duplicate existing committees or work groups. Garcia and Dorohovich (2005) suggest that marketing the community of practice is the responsibility of both leaders and members. The steering group members increased action in this area. In Eastern Ontario, one of the investigators (LD) had participated in the Champlain LHIN Chronic Disease Self-management committee, the other (AM) attended a regional workshop on CDSM. As a result, LHIN representatives were invited to attend the fall workshops in Cornwall and Ottawa. Similarly, in Nunavut, one of the community partners facilitated links with a territorial project where there was potential for mutual benefit.

Sustainability of the community of practice. A few questions were raised about the sustainability of their community of practice in the long term. While appreciating the support of the CoP team and their efforts to build cohesiveness, one person commented:

I value the leadership being provided by the CoP team and access to expertise and resources but recognize that to function in the long term, the CoP requires local leadership.

Preliminary deliberations suggested that finding the right leadership would be challenging and that different actors might be required at different stages of CoP development. In addition, there was suggestion that long term plans for the community of practice, beyond the duration of the research, were not clear, and should be discussed with the communities.

Another factor with implications for the evolution and possibly sustainability of the communities of practice was that members were sharing information about the community of practice within the organization and within the community and questions were being raised about broader membership, that is extending membership to other disciplines.

Continuing tensions. There was some frustration with lack of tangible progress and common direction, but no more than at the beginning of any new venture. Nevertheless, maintaining momentum and commitment would be important. Also, there

was a continuing tension in the communities of practice arising from the different mandates and span of practice. Those who worked in health promotion and those providing clinical care had competing priorities, which had to be reconciled.

In summary, during this second phase of the communities of practice, their focus was slowly refined, relationships strengthened and the routines established. At times it felt like a juggling act, trying to achieve a balance of relationship building and productivity. Wenger's exhortation to find the rhythm of the meeting started to make sense.

Phase 3: Developing the Shared Body of Knowledge

In phase 3, the communities of practice built on previous work but started to focus more on working together toward practice improvements. In Eastern Ontario and Nunavut, this happened between September 2008 and March 2009. In tandem with the project work, members of the communities of practice, found opportunities to work together outside of the community of practice and began to express an interest in developing a common vision of an expanded view of practice that brought together health promotion, disease prevention and treatment.

Where possible, people came together again at a face-to-face workshops with invited guests. This arrangement, informed by the process evaluation, served a dual purpose of renewing acquaintances and providing an opportunity to market the community of practice, within workplaces and in the region.

Each community of practice was involved in identifying and categorizing relevant resources. Some of the communities of practice developed resources. The following table identifies what they were able to produce.

Table 3 Developed resources

Ottawa	Cornwall	Nunavut	Vancouver
Broad Focus			
Chronic disease self-management		Maternal-child/family health	Chronic disease self-management
Developed Resources			
Package of Self-management assessment tools	Illustrated and reviewed 'personal health passport' in English and French. NOTE-ATTACHED SEPARATELY AS PDF FILES	Nunavut Report- Executive summary	Identification and sharing of resources- see cumulative resource list
Resources for introducing organizational change to support Self-management approaches		Resource for linking with & supporting Canada Prenatal Nutrition Programs (CPNP) in the communities	

Workshop outline for front line nurses & personal support workers on chronic disease prevention and management		Draft Nunavut specific material related to the CCHN Standards of Practice	

In summary, in this phase of development the communities of practice began to place more emphasis on knowledge generation and start to develop the tools, techniques and resources that members of the community of practice could use to improve their practice. These accomplishments are summarized in Appendix – Developed Resources.

Phase 4: Toward a Sustainable Community of Practice

The communities of practice want to continue and have begun to explore the available options. In Eastern Ontario, representatives from the LHIN made presentations at community of practice workshops and participated in group discussion. They offered advice on how the communities of practice might be integrated within the LHIN structures. Furthermore, the research team submitted a project for LHIN funding. If accepted, this would support the continuation, although the funding may have another focus. There are ongoing discussions in Nunavut and Vancouver Coastal to determine if the communities of practice, or the approach, could be used to support professional development.

From the early days, members identified the need to look for a sustainable process for the communities of practice. Initially it was difficult to do this because of the competing priorities in helping to get the community of practice of the ground and working efficiently. After the first four months of operation, we put together a position paper on sustainability to stimulate discussion and identify common elements. Table 4 indicates the value of communities of practice for individuals and organizations. It has been modified to show that the options for sustaining the communities of practice will vary from site to site.

Table 4 Value of Communities of Practice to Organizations and Members by Site

Value of Communities of Practice (Adapted from Barwick, 2008).	Ottawa & Cornwall	Nunavut	Vancouver Coastal
The CoP can increase the capacity of the organization for knowledge-development projects and knowledge based alliances (partnerships, collaborations) (c)	The CoPs are within the boundaries of the Champlain LHIN	The Government of Nunavut (GN) is the sole employer	VCH employs nurses from all health sectors

Facilitates rapid identification of individuals with specific knowledge/skills/expertise(a) Promotes and facilitates capture & reuse of existing knowledge and retention of organizational memory Improves rate of implementation of evidence-based practices (b) and practice outcomes	The CoP projects aim to increase collaboration and consistency, which fits well within the vision and goals of the Champlain LHIN	The territorial health system is built around nurses .	
Fosters knowledge sharing across organizational and geographic boundaries (boundary spanning) (a)	Chronic disease prevention and self-management is a LHIN priority	Maternal/child/ family health is a high priority and central to the Public Health Strategy	VCH is promoting Chronic disease prevention and management; the CoP could provide a cost effective resource
Improves topical knowledge among practitioners (b)	Knowledge about chronic disease prevention and management greatly increased during discussions and workshops	GN supports professional development as part of a broader recruitment and retention strategy The CoP provides Nunavut nurses with a virtual community and shows potential for supporting professional development in the territory	Fits with professional development approaches currently being used to educate nurses on CDSM
Reduces learning curves for new employees (a)		GN plans to provide mentorship for Nunavut trained nurses	

Fosters interaction between new/junior practitioners and senior/experienced practitioners (a) Facilitates the building of mentor-protégé relationships (a) Provides safe environment for sharing problems, challenges, & testing new ideas (a)	Nurses identify as a high priority the ability to connect with colleagues across the territory and draw on each others experience. The CoP could link the many transient nurses employed in the territory to professional expertise and resources

References in the table: Garcia & Dorohovich 2007(a); Barwick, Peters, Barwick, Boydell 2008 (b); Wenger et al., 2002(c)

Results - Evaluation

Between February 2008 and March 2009, the Ontario and Nunavut CoPs met at least monthly, with a two-month break in the summer. The Cornwall CoP met face-to-face, the Ottawa and Nunavut CoPs met by teleconference. In addition, Ottawa and Cornwall held one half-day and one full day, face-to-face workshops; Nunavut had a one and a half day workshop. Vancouver Coastal community of practice met six times by teleconference.

A concluding element of the project was to evaluate the outcomes of the communities of practice to ascertain if they meet the community's stated purpose and objectives.

Evaluation of the Short-term and Intermediate outcomes of the Communities of Practice on Participants and their Organizations

In March 2009, at least 75% the CoP participants in each of the four sites responded to the final evaluation questionnaire. See Appendix- Planning & Evaluation. The demographics of the respondents indicated that each site had representation from public health, home health, primary care and, in Ontario, case managers. At each site, at least 28% provided direct care, at least 28% were in management, and at least 11% were in professional or staff education.

Summary: In each of the four locations, the participants in the community of practice worked in different aspects of community nursing and included front line as well as managers and professional development staff. The most compelling factor in participating in the community of practice was their interest. The communities of practice were especially successful in providing a forum for debate and sharing information on important topics and working within the values and goals of the organization. After functioning for only six to 14 months, the communities of practice achieved over 77% on half the community of practice goals.

Discussion

This study provided a unique opportunity to define a general model for employing a community of practice approach in community health nursing in Canada. The study sites of Ottawa, Cornwall, Vancouver Coastal Region and the territory of Nunavut, provided a mix of urban, rural, and remote settings; access to different systems for organizing community health services for English, French, and Aboriginal peoples. This variation allows for consideration of the model in most areas of Canada.

Each site included 8 to 16 nurses working in public health, home health, community health centres or clinics and education and had a mix of nurses working at the front line, in management, and professional development, who could provide a range of skills and perspectives to address health issues. While bridging participant interest from practice and management or policy sectors of an organization is noted to be challenging with respect to a community of practice, participants from the different levels is beneficial in creating and sustaining this model of engagement (Burgess, 2008; Dube, Bourhis, & Jacob, 2005; McDonald, & Viehbeck, 2007).

The action research approach integrated cooperative inquiry with consistent processes to create a rich learning environment for knowledge development and exchange. The consistent processes included: 1) a meeting or teleconference each month once the community of practice was launched, 2) an evidenced based process and resources to determine mutual issues and interests and act on them, 3) facilitation and research support to collate relevant resources and organize the discussion and action, and 4) ongoing and consistent evaluation approaches.

The general model of community of practice that evolved from the study has four phases that overlap:

1. Forming the communities of practice
2. Working together
3. Developing a shared body of knowledge
4. Moving toward sustainability

Each phase has characteristic elements, timelines and outcomes and requires a process and resources to support progression.

The study suggests that a community of practice can function face-to-face or with a combination of face-to-face and virtual meetings. The virtual meetings alone showed promise but were not fully tested.

To bring in the appropriate information at the right time, the community of practice will need a facilitator and research support with the knowledge, time and resources to devote to supporting the community of practice. Facilitating the development of this model process is challenging, as it requires a perceptive and purposeful approach in negotiating and creating consensus among participants to address their varied interests and ensure meaningful discussions. This study supports the findings of earlier research (Andrew et al., 2007) that the community of practice approach has potential to foster collaboration and advancement between staff levels of a health care organization.

Implementation of the consistent process used in the community of practice requires infrastructure resources including organizational sponsorship, administrative support for meetings, and effective coordination and facilitation (Dube, Bourhis & Jacob, 2005; Garcia & Dorohovich, 2005; McDonald & Viehbeck, 2007). Possibly this

facilitation could be assigned to a knowledge broker or the person responsible for professional development either within an organization or across organizations. However Lomas (2007) found that such roles are not well supported in health service or universities and end up being done in addition to other responsibilities.

Participants valued the opportunity to participate in the community of practice and the majority felt they had gained from the experience and that their organizations had gained as well. The compelling personal benefit was the synergistic effect of knowledge, networking, and resources. The respondents stated quite definitively that when they had increased knowledge, connections, and opportunities to work collaboratively their organizations would likely have more satisfied staff and provide improved and coordinated services in the community.

As well as the intangible or tacit benefits of the community of practice identified in the final evaluation, actual or expected tangible resources collected or produced by a community of practice were invaluable in helping to market the community of practice. For example, the Cornwall CoP produced a draft personal health passport. At different stages of development, the passport allowed the CoP to discuss the content and use of the passport with their colleagues, management, and potential community partners.

Almost all participants had quite a high interest in attending the community of practice and felt that participation was manageable despite the pressure of workloads. Furthermore, most felt that the community of practice had developed a common purpose, and fostered information, knowledge, and resource exchange across organizations. They identified that the community of practice provided the necessary elements to encourage participation and knowledge exchange relevant to the goals of their organization. Fewer respondents saw changes that took longer to produce and this was reflected in the evaluation of the resources provided by the community of practice such as 'collaboratively develop process or resources'.

A community of practice that brings together people with different perspectives and knowledge from a variety of sources to improve nursing practice will provide a rich clinical experience for graduate students. Graduate students would be expected to attend the community of practice with their advisor or preceptor and have the opportunity to debrief following each discussion. Another opportunity would be for graduate students to work as a research assistant to a community of practice.

A community of practice involving nurses working in different areas of community health has been able to promote professional development, inter-professional and intra-sectoral practice. It seems likely that this approach could provide an ongoing forum to discuss with nurses, other health professionals, and community associations working in different community settings; the theories, evidence, and resources to support the health of populations. According to Mcdonald and Viehbeck, 2007, research-based practices and policies emerge when research producers and users mutually engage one another about specific health promotion problems through negotiation and by creating and sharing technical standards and other resources. Modern healthcare requires emergent forms of work to contain the fragmentation of health-care services. The challenge of the future is to provide a suitable organizational context (Iedema et al, 2005)

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Appendix - Launch Workshop Package

Package Contents – Cornwall example

1. **Recruitment and consent information for managers and participants (English and French)**
2. **Preworkshop information gathering form**
3. **Workshop agenda**
4. **Evaluation form for workshop**

Recruitment and Consent Information
Example - Cornwall

Building a Community of Practice in Health Promotion and Disease Prevention for Community Health Nurses Working Across Health Sectors

Health promotion and disease prevention is a common goal for all community nurses and a priority for health care systems across the country. Yet community health care services are frequently criticized for working in silos. For example, nursing managers working in various regional structures report that nurses providing services to families dealing with chronic disease in the home or clinic rarely if ever have the opportunity to combine their expertise with nurses working in community programming, social marketing or policy development to reduce chronic disease, increase healthy living activities of the population, or address the social determinants of health. The community services are even more separated in jurisdictions such as Ontario where the funding and service providers are separate.

Knowledge development and exchange in the form of a community of practice (CoP) for practitioners provides the opportunity to break down silos through learning and solving problems together. CoP has the following three distinctive features: 1) members of the community of practice come together because they share a purpose or enterprise, 2) members have knowledge related to the issue and develop a social entity, and 3) the practice capability of the group increases through the development of a variety of shared approaches, resources, and knowledge (Wenger, McDemott, & Snyder, 2002).

A community of practice has been used effectively to develop evidence-based practice with nurses and older people in Scotland (Tolson, Schofield, Booth, Kelly, & James, 2006), bring learning and practice together for physicians in Canada (Parboosingh, 2002), develop communication and interpersonal skills in physiotherapy (Plack, 2006) and to promote coordinated and effective health services for children in Ontario and the US (Barwick, Boydell, & Omrin, 2002; Wild, Richmond, de Merode, & Smith, 2004).

This project builds on the 2006-7 research study "Workshop and Teleconference Support Strategy Utilizing the Canadian Community Health Nursing Standards Toolkit" that involved 100 Ontario community health nurses from different community health sectors. In that six month study, the strategy of a workshop followed by teleconferences was found beneficial in providing the support for many participants to initiate the implementation of the Standards in their organizations. This 18 month study (January 2008- June 2009) brings community health nurses together to identify and act on a common issue relevant to their geographical practice area.

The purpose of the project is to increase the capacity of community health nurses to apply public health sciences and the CCHN Standards by using a community of practice as a knowledge exchange strategy. The objectives for the project are:

1. To develop an evidence-based process, tools and techniques for engaging nurses in a community of practice.
2. To develop a community of practice in areas of Ontario, British Columbia and Nunavut, involving nurses from public health, home health and primary health care.
3. To evaluate the process and intermediate outcomes of a community of practice on participants and their organizations
4. To determine the utility of a community of practice for professional development and graduate education
5. To determine the applicability of communities of practice to inter-professional and intra-sectoral practice

Methodology

This exploratory study will use mixed methods to determine the utility of a community of practice in three areas of Canada. The researchers will be working in collaboration with partners in each area and the participants. The quantitative measures are multiple choice questions at the beginning and end of the project. The qualitative methods include open-ended questions on questionnaires, summaries from meetings, workshops, teleconferences, and interviews.

Participants

There are five groups of people with different roles in the study. The investigators lead the study, collect and analyze the data, and support the communities of practice through the development of resources and facilitating education and interactions among partners and participants. The research assistants work under the guidance of the investigators. The partners are part of the steering committee for the project to ensure that the feasibility and relevance of the procedures. The partners from Nunavut are Terry Creagh, Gogi Greely, and Ruth Bainbridge; Vancouver Coastal: Val Munroe and Heather Strosher. A coordinator in Vancouver Costal Region and one Nunavut will manage the administrative procedures in those areas. The participants are expected to be approximately 90 nurses working in public health, home health, community health centres and primary care in the three areas.

Procedure:
Recruitment: Invitations will be sent by email to nurse managers in public health, home health, community health centres and primary care in each area. The invitation will request a representative team of two to four nurses to participate in a 18 month study on a community of practice. The email will include an invitation letter for potential participants. The nurse manager or the designated staff will submit the workshop registration form that will be used for administrative purposes only.

Intervention:

The intervention includes an annual (January) three hour workshop in each area, teleconferences every month initially (February to April, 2008) and every two months there after, and the development of resources and ongoing support to facilitate the communities of practice. At the beginning of the first workshop, the study will be explained, questions addressed and the consents signed by those willing to participate. If new members join the community of practice after the initial workshop, a researcher will review the information and consent form with them individually.

The initial facilitated workshop will include an explanation and examples of a community of practice. The participants will be guided in a process to determine an issue relevant across the community health nursing sectors in the area. Summary notes will be taken during the discussions at the workshops and will be shared with the participants on a website. Participants will be asked to complete a consultation form (questionnaire) at the beginning and end of the workshop to determine present collaboration activities and issues relevant to nurses in the community; and the evaluation of the workshop material and process.

Teleconferences will be organized in each area to continue the collaboration and support initiatives within each organization. The focus of the teleconferences will be group problem solving to identify needed resources, address challenges, and celebrate success. Summary notes will be taken during each teleconference and posted on the website. Individual interviews with participants will be conducted twice to explore the progress and challenges of working within a community of practice.

Analysis of data

The quantitative items in the questionnaire will be entered into an SPSS data base. Descriptive analysis will be conducted on similar items in the consultation forms used in the workshop and teleconferences.

Content analysis will be used with the qualitative data from the open-ended questions and the teleconference summaries to identify reasons for the success or difficulty with different strategies and resources. The reasons will be explored in more detail in the interviews. Quotations will be selected to emphasize comments made by many participants.

Expected results

Participants in the communities of practice are expected to develop knowledge and skills in assessment, planning, implementation, and evaluation using a mutually identified issue. The study will provide knowledge about the best way to support a community of practice generally and specifically within each area. This knowledge will be used in the

preparation of a strategy that can be used in other parts of the country to initiate professional development for changes in practice in community health.

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Recruitment Letter for Managers
Building a Community of Practice in Health Promotion and Disease Prevention for Community Health Nurses Working Across Health Sectors

Date:

Dear [Name]

The Community Health Nurses Association of Canada has provided funding to Dr. Liz Diem and Dr. Alwyn Moyer from the University of Ottawa and Dr. Marjorie MacDonald from the University of Victoria to bring together public health, home health and community health center nurses in a community of practice to identify and address a local issue by the spring of 2009. A community of practice will be formed in Ottawa involving nurses working in public health, home health, community health centers and primary care. A community of practice (CoP) is a group of people who come together to increase their practice capability through the development of a variety of shared approaches, resources, and knowledge (Wenger et al., 2002). A CoP shows promise for supporting evidence-based practice; development of program planning skills; and collaboration with other organizations.

This project builds on previous work to introduce nurses in Ontario to the Community Health Nursing Standards Toolkit through the use of a provincial workshop followed by teleconferences. That strategy provided support for many of the participants to initiate the use of the Canadian Community Health Nursing Standards in organizations. This project using a CoP is to support the use of the Standards in practice.

The CoP will involve 1) two three-hour workshops a year apart, 2) a one hour meeting every month (February to April, 2008) and every two months thereafter until June 2009, and 3) two 30 minute interviews approximately a year apart. The first workshop is planned for February 26, 2008. The purpose of the workshop, is to:

a) Introduce participants to the community of practice
b) Explain and initiate the use of a process to identify a common issue
c) Plan follow-up teleconferences

The purpose of the monthly teleconferences are to:

a) Maintain momentum to take action
b) Identify needed resources that will be obtained by the research team
c) Engage in group problem solving
d) Evaluate progress

You are invited to have two representatives take part in the community of practice. To make full use of this opportunity, the representatives need to be willing to participate fully in the CoP to determine a common health issue and use the information to initiate action within their organization. Your organization needs to be willing to support their efforts to apply what they have learned.

The representatives will have the opportunity to participate in a study of the strategy. Their participation in the study is voluntary, anonymous and confidential for the person and the organization. If the workshop participants want to participate in the study, they will be asked to sign the information and consent form. A copy of the form is at the end of this document.

This project provides an opportunity for organizations and community health nurses to collaborate across health sectors while supported by the knowledge and experiences of others. We hope that you will be able to take advantage of this opportunity and submit the attached registration form.

Expected benefits for each organization:

1. An opportunity to address a need identified by different community health organizations
2. An opportunity to build on staff training and support for professional development
3. An opportunity to build on activities relevant to accreditation or government requirements or initiatives
4. An opportunity to expand partnerships or a network

Recruitment Letter to Participants
Building a Community of Practice in Health Promotion and Disease Prevention for Community Health Nurses Working Across Health Sectors

You are invited to represent your organization in a community of practice (CoP) involving nurses in public health, home health and community health centers. Together you will learn to determine a common health issue, plan to take action, and implement and evaluate your plan. The community of practice study will be initiated in Ottawa in February 2008 and finish in June of 2009. As national organizers, the researchers Dr. Liz Diem and Dr. Alwyn Moyer of the University of Ottawa and Dr. Marjorie MacDonald of the University of Victoria would like to give you some idea of what to expect so that you can get the most out of your experience.

First, a bit of back ground: The Community Health Nursing Standards of Practice were released in 2003 and are available to order or download on the Canadian Community Health Nurses Association of Canada (CHNAC) website (www.communityhealthnursescanada.org). In March 2006, CHNAC developed a Toolkit to support the implementation the Community Health Nursing Standards. In Ontario, the Community Health Nursing Standards Coalition and CHNIG with funding from the Public Health Agency of Canada, provided a workshop on the Toolkit followed by three teleconferences between Oct 2006 and March 2007. The participants who were involved in the workshop and teleconferences found that the strategy helped them to initiate action in their own organization.

This present project using a CoP extends over a longer period to allow community nurses to address a common practice issue. The CoP will involve 1) two three-hour workshops a year apart, 2) a one hour meeting every month (February to April, 2008) and every two months thereafter until June 2009, and 3) two 30 minute interviews approximately a year apart. The first workshop is scheduled for Tuesday, February 26, 2008.

The purpose of the workshop, is to:

a) Introduce you to the community of practice
b) Encourage you to learn about using the community health nursing process with others and within your organization
c) Plan follow-up teleconferences

The purpose of the monthly teleconferences is to:

a) Maintain momentum to take action
b) Identify needed resources that will be obtained by the research team
c) Engage in group problem solving
d) Evaluate progress

To make full use of this opportunity, you and other representatives from your organization are expected to participate as a team in the workshop and when you return to work. You are also expected to attend the one hour meetings is to identify and discuss challenges and opportunities.

You will have the opportunity to participate in a study of the CoP. You will be asked to submit a consultation form on the use and usefulness of the CoP at the workshops. The form is expected to take you 15 to 30 minutes to complete. The workshop and teleconference summaries will also be included in the study. You will be

invited to participate in a 30 minute telephone interview to monitor the utility of the CoP twice during the study. Your participation in the study is voluntary, anonymous and confidential for you and your organization. If you are interested in participating, you will be asked to sign an information and consent form that is included at the end of this document.

This project provides an opportunity for you to collaborate across health care organizations while supported by the knowledge and experiences of others. We expect that you will find it a worthwhile experience.

Expected benefits for each person:

1. An opportunity to work on a community of practice involving nurses from other health care organizations to address a common issue
2. An opportunity to further develop leadership, program planning, and technology (internet teleconferences) skills
3. An opportunity to further develop partnerships or a network

If you have any questions, please contact your manager or the person who sent you this email. You may also contact Liz Diem, Project Lead, at lizdiem@uottawa.ca

Building a Community of Practice in Health Promotion and Disease Prevention for Community Health Nurses Working Across Health Sectors

Registration Form

Name: ____

Name of Organization: ____

Address: __________________________ City/town: _______________
Postal Code: ________

Email: ____

Lettre de Recrutement pour Infirmières Gestionnaires

Bâtir une communauté de pratique pour la promotion de la santé et la prévention des maladies pour les infirmiers et infirmières travaillant à travers les différents secteurs en santé communautaire

Date:

Cher (nom),

L'Association Canadienne des Infirmières et Infirmiers travaillant en Santé Communautaire a fourni un financement aux Dr Liz Diem et Dr Alwyn Moyer, de l'Université d'Ottawa, ainsi qu'à la Dr Marjorie MacDonald, de l'Université de Victoria, pour réunir la santé publique, les soins infirmiers à domicile, et la santé communautaire dans une communauté de pratique afin d'identifier et de répondre à une problématique cible d'ici le printemps de 2009.

Une communauté de pratique sera formée à Cornwall impliquant des infirmières travaillant dans la santé publique, en soins infirmiers à domicile, de centres de santé communautaires et œuvrant en soins primaires. Une communauté de pratique (CdP) est un groupe de personnes qui se réunissent pour accroître leur capacité de pratique professionnelle par la mise au point d'une variété d'approches partagées, de ressources, et de connaissances (Wenger et coll., 2002). La CdP démontre la possibilité de se baser sur de la pratique fondée sur des preuves, sur des programmes de développement de compétences en matière de planification, et par la collaboration avec d'autres organismes. Ce projet s'appuie sur des travaux antérieurs qui ont servi à éduquer des infirmières, en Ontario, sur les normes de soins infirmiers en sante communautaire grâce à l'utilisation d'un outil à titre provincial qui a été présenté par téléconférences. Cette stratégie a fourni un appui pour la plupart des participants à initier des normes acquises à travers l'atelier et les introduire dans leurs divers milieux professionnels. Le but de ce projet, en utilisant une CdP, est de soutenir l'utilisation de ces normes dans la pratique de soins infirmiers.

La CdP sera composée de: 1) deux d'ateliers de trois heures avec une année d'intervalle, 2) une heure de réunion à chaque mois (de février à avril 2008) et tous les deux mois par la suite jusqu'en juin 2009, et 3), deux entrevues de 30 minutes à une année d'intervalle. Le premier atelier est prévu pour le 26 février 2008. Le but de cet atelier, est de:
A) Initier les participants à la communauté de pratique
B) Expliquer et initier l'utilisation d'un processus pour identifier une problématique commune
C) Céduler des téléconférences pour assurer un suivi

Le but des réunions mensuelles est le suivant:
A) Maintenir l'élan à prendre des mesures
B) Identifier les ressources nécessaires qui seront obtenues par l'équipe de recherche
C) S'engager, en tant que groupe, dans la résolution de problématiques
D) Evaluer les progrès

Vous êtes invité à soumettre 2 personnes comme représentants pour prendre part à la communauté de pratique. Pour faire pleinement usage de cette occasion, les représentants doivent être prêts à participer pleinement à la CdP afin de cibler une question de santé problématique et d'utiliser l'information acquise de manière positive au sein de leur organisation. Votre organisation doit être prête à soutenir leurs efforts pour appliquer ce qu'ils ont appris.
Les représentants auront la possibilité de participer à une étude de la stratégie. Leur participation à cette étude est volontaire, anonyme et confidentielle en tant que personne et organisme. Si les participants à l'atelier veulent participer à l'étude, ils seront invités à signer le formulaire de consentement et d'information. Vous trouverez une copie à la fin de ce document.

Ce projet offre une opportunité pour les organisations et la communauté des infirmières œuvrant dans différents secteurs de santé de bénéficié de dialogues mettent en valeurs les connaissances et les expériences de tous et chacun. Nous espérons que vous serez en mesure de tirer parti de cette occasion et remplirez le formulaire d'enregistrement ci-joint.

Avantages escomptés pour chaque organisme:
1. Une occasion de répondre à un besoin identifié par les différents organismes de santé communautaires
2. Une occasion de faire fond sur la formation du personnel et le soutien pour le développement professionnel
3. L'occasion de bâtir sur les activités liées à l'accréditation ou les exigences du gouvernement ou des initiatives gouvernementales
4. L'occasion d'élargir les partenariats ou de se crée un réseau

Lettre de Recrutement aux Participants

Bâtir une communauté de pratique pour la promotion de la santé et la prévention des maladies pour les infirmiers et infirmières travaillant à travers les différents secteurs en santé communautaire

Vous êtes invité à représenter votre milieu professionnel dans une communauté de pratique (CdP) qui sera composée d'infirmières en œuvrant en santé publique, en soins à domicile et membres de centres de santé communautaires. Ensemble, vous apprendrez à cibler un problème de santé, établir un plan d'action, et de mettre en œuvre et évaluer votre plan. L'étude visant cette communauté de pratique sera lancée à Cornwall en janvier 2008 et s'achèvera en juin 2009. Comme organisateurs nationaux, les chercheurs Dr Liz Diem et Dr Alwyn Moyer, de l'Université d' Ottawa, et le Dr Marjorie MacDonald, de l'Université de Victoria, voudrais vous donner un aperçu de cette étude afin que vous pussiez tirer meilleur parti de votre expérience.

Tout d'abord, un peu de retour au sol: les normes de pratique en santé communautaire ont été publiées en 2003 et seront disponibles par commande ou par téléchargement sur le site web Canadian Community Health Nurses Association of Canada (CHNAC) (www.communityhealthnursescanada.org). En mars 2006, le CHNAC a élaboré une trousse à outils pour appuyer la mise en œuvre des normes en soins infirmiers de santé communautaire. En Ontario, le Community Health Nursing Standards Coalition et le CHNIG, avec le financement de l'Agence de santé publique du Canada, a mis au point un atelier sur ces outils en présentant trois téléconférences entre Octobre 2006 et mars 2007. Les participants qui ont participé à l'atelier et aux téléconférences ont constaté que les diverses stratégies leur on permit d'élaborer des plans d'action au sein de leur milieu professionnel.
Le présent projet, en utilisant une CdP, s'étend sur une période plus longue pour permettre à la communauté des infirmières de cibler et d'aborder une problématique commune. La CdP sera composée de: 1) deux ateliers de trois heures chacun à une année d'intervalle, 2) une heure de réunion ou de téléconférence à chaque mois (de février à avril 2008) et tous les deux mois par la suite jusqu'en juin 2009, et 3) deux entrevues de 30 minutes chacune une à année d'intervalle. Le premier atelier est prévu pour mardi le 26 février 2008.

Le but de cet atelier, est de:
A) Initier les participants à la communauté de pratique
B) Expliquer et initier l'utilisation d'un processus pour identifier une problématique commune
C) Céduler des téléconférences pour assurer un suivi

Le but des réunions mensuelles est le suivant:
A) Maintenir l'élan à prendre des mesures
B) Identifier les ressources nécessaires qui seront obtenues par l'équipe de recherche
C) S'engager, en tant que groupe, dans la résolution de problématiques
D) Evaluer les progrès

Afin de bénéficier pleinement de cette occasion vous-mêmes ainsi que les autres représentants de votre organisation devront participer à l'atelier, de même qu'au retour au travail (pour établir des nouvelles méthodes de pratique infirmière), en équipe. Vous êtes également priés de pouvoir faire partie d'une réunion durant une heure afin de pouvoir discuter des défis et des possibilités.

Vous aurez la possibilité de participer à une étude sur la CdP. Vous serez invité à soumettre un formulaire de consultation sur l'utilisation et l'utilité de la CdP lors des ateliers. Le remplissage du formulaire ne devrait pas dépasser les 15 à 30 minutes. L'atelier et les résumés de téléconférence seront également inclus dans l'étude. Vous serez invité à participer à une entrevue de 30 minutes, au téléphone, pour discuter l'utilité de la CdP deux fois au cours de l'étude. Votre participation à cette étude est volontaire, anonyme et confidentielle, pour vous et pour votre organisation. Si vous êtes intéressé à participer, vous serez priés de signer un formulaire de consentement et à titre informatif qui est joint à ce document.
Ce projet vous offre une occasion de bénéficier de dialogues mettent en valeurs les connaissances et les expériences de tous et chacun. Nous sommes convaincus que vous en tirerez divers avantages.

Avantages escomptés pour chaque personne:
1. L'occasion de travailler par l'entremise d'une communauté de pratique avec des infirmières provenant d'autres organismes de soins de santé afin de dialoguer sur une problématique commune
2. L'occasion de développer davantage des compétences en tant que gestionnaires, sur des méthodes de planification de programmes, et de connaître la technologie associée avec l'internet et la téléconférence
3. L'occasion d'élargir les partenariats ou de se crée un réseau

Si vous avez des questions, veuillez contacter votre responsable ou la personne qui vous a envoyé ce courriel. Vous pouvez également contacter Liz Diem, chef de projet, à lizdiem@uottawa.ca

Bâtir une communauté de pratique pour la promotion de la santé et la prévention des maladies pour les infirmiers et infirmières travaillant à travers les différents secteurs en santé communautaire

Formulaire d'Inscription

Nom: ____

Nom de l'organisation: ____

Adresse: _______________________ Ville: _______________Code Postal: _ _______

Courriel: ____

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Building a Community of Practice in Health Promotion and Disease Prevention for Community Health Nurses Working Across Health Sectors

INFORMATION LETTER AND CONSENT FORM

Three nurse researchers are working together to study a community of practice (CoP) to support a change of practice. Liz Diem is the principal investigator and an Assistant Professor at School of Nursing, University of Ottawa; Alwyn Moyer is an Adjunct Professor at School of Nursing, University of Ottawa; Marjorie MacDonald is an Associate Professor at the University of Victoria. The study has been funded by the Community Health Nurses Association of Canada.

We invite public health, home health and community health nurses to participate in this study as representatives of your organization. The purpose of the study is to determine the utility of a community of practice in increasing collaboration across health sectors and developing skills in program planning. The benefits of the study for participants will be the opportunity to further develop leadership and planning skills and contribute to the knowledge on effective learning methods for health professionals.

Participation in the study will involve: 1) a three hour workshop in January 2008 and 2009 including the completion of a consultation form and 2) participation in eleven, one hour meetings or teleconferences over the 18 months of the study, and 3) two interviews of 30 minutes between January 2008 and June 2009. The consultation forms involve questions on the use and usefulness of procedures and resources from the community of practice for your professional development. The workshops and teleconferences will be conducted in English.

Your participation is voluntary and you may refuse to participate in any part or activity, including some questions on the consultation forms or interviews. Summary notes including some quotes will be taken at each meeting, workshop, and teleconference and circulated to participants. You will have the opportunity to correct any material that that you feel is not accurate. Data will also include written comments from the consultation forms. Your name or characteristics including the name of your employer, if present, will be removed or altered and contents of quote will not reveal individual identities.

In the workshops and teleconferences, the researchers cannot guarantee anonymity. However we will ask participants at each session to keep the information confidential. You are expected to say only what you feel comfortable in communicating. You are requested to keep the identity and comments of others confidential to only those people involved in the primary discussion.

No legal, physical, or social risks are expected from your participation. If you must travel more than 30 minutes to a workshop, you will be provided mileage and

parking costs. The study information will be secured for 5 years post publication in E. Diem's office at the University of Ottawa in a locked filing cabinet after which it will be destroyed. Data collected during this study may be used for secondary analysis by a graduate student writing a thesis if written permission is obtained from the principal investigator and ethical approval has been granted.

I, _________________ agree to participate in the study on Building a Community of Practice in Health Promotion and Disease Prevention for Community Health Nurses Working Across Health Sectors conduced by Drs. Liz Diem and Alwyn Moyer of the University of Ottawa and Dr. Marjorie MacDonald of the University of Victoria.

This consent form is in two copies, one I keep and one is for the researchers.
Participant:

Researcher:

Date:

If you have any further questions about the study, you may contact Dr. Liz Diem by sending an email to lizdiem@uottawa.ca or calling: 562-5800, ext. 8441 at the School of Nursing, University of Ottawa, 451 Smyth Road, Ottawa, Ontario, K1H 8M5.

Any information requests or complaints about the ethical conduct of the study can be addressed to: Protocol Officer for Ethics in Research, Tabaret Hall, 550 Cumberland St., Room 159. University of Ottawa, Ottawa, Ontario K1N 6N5, (613) 562-5841, **ethics@uOttawa.ca**

Lettre à Titre Informatif et de Consentement

Bâtir une communauté de pratique pour la promotion de la santé et la prévention des maladies pour les infirmiers et infirmières travaillant à travers les différents secteurs en santé communautaire

Trois infirmières travaillent de concert en matière de recherche pour étudier une communauté de pratique (CdP) qui serait à l'appui d'un changement de pratique. Liz Diem est le chercheur principal et professeur adjoint à l'École d'infirmières de l'Université d'Ottawa; Alwyn Moyer est professeur adjoint à l'École d'infirmières de l'Université d'Ottawa; Marjorie MacDonald est professeur agrégé à l'Université de Victoria. L'étude a été financée par l'Association Canadienne des Infirmières et Infirmiers en Santé Communautaire.

Nous invitons infirmiers et infirmières travaillant en santé publique, en soins à domicile et en centres de santé communautaires à participer à cette étude en tant que représentant de leur milieu professionnel. Le but de cette étude est de déterminer l'utilité d'une communauté de pratique pour accroître la collaboration au sein des différents secteurs de la santé et de développer des compétences dans la planification des programmes. Les avantages de l'étude pour les participants seront innombrables. Ils auront l'occasion de développer davantage leurs habilités de gestionnaires, d'améliorer leurs compétences en planification et de contribuer à enrichir les connaissances sur les méthodes efficaces d'apprentissage pour les professionnels de la santé.
Participation à l'étude comportera: 1) un atelier de trois heures en janvier 2008 et 2009, y compris le remplissage du formulaire de consultation et 2) la participation à onze téléconférences ou réunions d'une heure chacune au cours des 18 mois de l'étude, et 3) deux entrevues de 30 minutes chacune entre janvier 2008 et juin 2009. Le formulaire de consultation comporte des questions concernant l'utilisation et l'utilité des procédures et des ressources de la communauté de pratique pour votre développement professionnel. Les ateliers et les téléconférences seront menés en anglais.

Votre participation est à titre volontaire et vous pouvez refuser de participer à l'activité entièrement ou en partie, y compris certaines questions sur le formulaire de consultation ou durant les entrevues. Des notes de résumé des ateliers et téléconférences, dont quelques citations, seront prises lors de chaque réunion et distribuées aux participants. Vous aurez la possibilité de corriger toute matière qui, selon vous, n'est pas exacte. Parmi les données on aura aussi des observations tirées directement des formulaires de consultation. Votre nom ou les caractéristiques attribuables a votre employeur, seront

supprimées ou modifiées, et le contenu de la citation ne révélera d'aucune façon les identités individuelles.
Dans le cadre des ateliers et des téléconférences, les chercheurs ne peuvent pas garantir l'anonymat. Cependant, nous demandons aux participants à chaque session, de garder l'information confidentielle. On s'attend à ce que communiquiez uniquement ce dont vous vous sentirez a l'aise. Vous êtes priés de conserver l'identité et les commentaires des autres participants secrets et de ne les utiliser que dans la discussion initiale.

En participant à l'étude, vous ne courez aucun risque physique, social, ou juridique. Il pourrait, cependant, y avoir quelques désavantages économiques si vous devez voyager pendant plus de 30 minutes pour un atelier. Cependant, vos serez remboursés pour les frais de transport et de stationnement.
Les informations obtenues au courant de l'étude, et cinq ans après la publication des résultats de la recherche, seront gardées dans un classeur verrouillé dans le bureau d'E. Diem après quoi elles seront détruites. Les données recueillies lors de cette étude pourront être utilisées pour l'analyse secondaire par un étudiant diplômé écrivant une thèse, si une autorisation écrite est délivrée par l'investigateur principal et la personne responsable des critères d'étique en matière de recherche.

Je,_________________, suis en accord pour participer à l'étude qui a pour but d'établir une communauté de pratique dans la promotion de la santé et de la prévention des maladies pour les infirmiers et infirmières travaillant à travers les différents secteurs en santé communautaire, le tout présidée par Dr. Liz Diem et Dr. Alwyn Moyer, de l'Université d'Ottawa, et le Dr Marjorie MacDonald, de l'Université de Victoria.

Ce formulaire de consentement est en deux exemplaires, un que je garde, et l'autre est destiné aux chercheurs.
Participant:

Chercheur:

Date:

Pour toute question concernant la conduite éthique de ce projet de recherché, veuillez vous adresser au Responsable de l'éthique en recherche, Dr. Liz Diem, en envoyant un courriel à lizdiem@uottawa.ca ou appelant: 562-5800, poste. 8441 à l'École des sciences infirmières, Université d'Ottawa, 451, chemin Smyth, Ottawa, Ontario, K1H 8M5.
Toute demande d'information ou pour formuler une plainte au sujet de la conduite éthique de l'étude peut être adressée à: Fonctionnaire du protocole pour l'éthique dans la recherche, Pavillon Tabaret, 550 rue Cumberland, Room 159. Université d'Ottawa, Ottawa, Ontario K1N 6N5, (613) 562-5841, ethics@uOttawa.ca

Community of Practice
Community Health Nurses
Cornwall
Information Gathering Questionnaire
January 2008

Date:

Agency:

Contact:

Address:

Phone:

Email:

In preparation for the upcoming workshop on establishing a community of practice involving agencies that employ community health nurses, I am gathering information on participating agencies' programs and services of particular interest to these nurses. The intent is to understand the dynamics of the various programs and services, how they interlink and ways of optimizing their value to the community. The members of this group include the CCAC, community nursing agencies, a community health centre, public health and the college.

1. **Could you tell me about some issues that you feel could be best addressed through participation in a knowledge and resource sharing group such as this one?**

2. **What programs or services do you offer that might be of interest to members of this group?**

3. **Have you any other information, comments or suggestions that you would like to share at this time?**

4. Any questions that I can answer for you?

Community Practice Workshop
Monday, January 29, 2008 at 8:30 a.m.
Eastern Ontario Health Unit
1000 Pitt Street, Cornwall

Agenda

[Approximately 10- 15 participants]

8:30 a.m. Start of workshop (Coffee will be available)
- Introduction to workshop and study
- Completion of forms

9:00 a.m. Introduction to participants

9:20 a.m. Introduction to Community of Practice

10:00 a.m. Coffee break (go to assigned blue or green table after break)

10:15 a.m. Setting up the CoP

11:55 a.m. Determine date and time for next two 1 hour meetings: (proposed: Feb 21 or 27 and Mar 25 or 26. Bring planning agenda)

12:00 p.m. Lunch

12:30 p.m. Explore chosen focus

12:40p.m. Wrap-up

12:50 p.m. Complete consultation form

Community of Practice Workshop Consultation Form
Cornwall, Jan 29, 2008

Part A: Preliminary Information. Please complete at beginning of the workshop.

1. What is your main area of practice? Please circle or underline one.
   a) public health
   b) home health
   c) community health centre or clinic (open to interpretation)
   d) other (please specify):

2. What is the MAIN focus of your practice? Please circle or underline one.
   a) Direct service (clinical, front line)
   b) Administration
   c) Professional development or staff education
   d) Teaching in University or college

3. Please circle or underline one of the following to indicate the total number of years you have been working in community health nursing (direct practice, administration, staff education, school of nursing).
   a) Less than 1 year
   b) 1 to 2 years
   c) 3 to 5 years
   d) 6 to 10 years
   e) 11 or more years

4. What is your level of understanding of the CCHN Standards? Please check one.
   a) ____ Little or no understanding
   b) ____ Some understanding
   c) ____ Moderate understanding
   d) ____ Considerable understanding

6. How important are the CCHN Standards to you? Please check one.
   a)___not important b)____somewhat important c)___moderately important
   d)___very important

7. How important are the CCHN Standards to your organization? Please check one.
   a)___not important b)____somewhat important c)___moderately important
   d)___very important

8. What is your level of understanding of a community of practice? Please check one.
   e) ____ Little or no understanding
   f) ____ Some understanding
   g) ____ Moderate understanding
   h) ____ Considerable understanding

9. How many others from your organization are in attendance with you to-day? _____

Part B:

10. Please check to indicate how much **understanding** you have gained during the workshop on the following:

Component:	a) little	b) some	c) moderate	d) considerable

	understanding	understanding	understanding	understanding
Community of Practice				
Opportunities for working together across the community				
Common issues that have relevance to my organization				

11. Please indicate your views about this workshop and project:

	Disagree Agree
a) Were the objectives of the workshop clear to you?	**1 2 3 4 5**
b) Did you have the opportunity to share your views and participate fully in the workshop?	**1 2 3 4 5**
c) Did you feel that decisions were made by the group as a whole, not just by a few people?	**1 2 3 4 5**
d) Do you feel that what is decided will be worthwhile for you and your organization?	**1 2 3 4 5**
e) Do you look forward to working with these people in the future?	**1 2 3 4 5**

12. What do you feel would be the highest priority for your organization at this time? Please explain:

13. Please take a few minutes to provide us with some feedback on different aspects of the workshop. On a scale of 1-5 (1 indicating lowest and 5 highest satisfaction), please circle a number to rate each aspect:

Aspect	Low				High
a) Variation of activities	1	2	3	4	5
b) Organization of tables	1	2	3	4	5
c) Amount of time for discussion	1	2	3	4	5
d) Meeting was organized and ran well	1	2	3	4	5
e) Other (please specify)	1	2	3	4	5

14. For any items above with a rating of 1, 2, or 3, please explain how to improve the ratings:

15. Please check the **two** main things that you will be taking away from the workshop:
    a. ___ Knowledge about working together in a community of practice
    b. ___ Knowledge about how practice issues overlap in the community
    c. ___ Energy/enthusiasm/motivation
    d. ___ Ideas that will be useful to my organization
    e. ___ Links with nurses working in other types of community practice
    f. ___ Other: please describe:

We appreciate you taking the time to provide your feedback on the Community of Practice Workshop. Please put this form in the envelope on the table.

Thank-you!