McMaster University

School of Nursing

PHASE 2: STRENGTHENING THE QUALITY OF COMMUNITY HEALTH NURSING PRACTICE:

A PAN-CANADIAN SURVEY OF COMMUNITY HEALTH NURSES' CONTINUING EDUCATION NEEDS

Final Report Submitted to the Community Health Nurses Association of Canada

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TABLE OF CONTENTS

INTRODUCTION AND PURPOSE

The Canadian Community Health Nursing Standards of Practice (CCHN Standards) were released in 2003 and updated in 2008 by the Community Health Nurses Association of Canada (CHNAC). However, there has been no research to explore the capacity of nurses to meet these standards, with the exception of the Phase 1 work that was completed by this research team in 2008 (Schofield et al, 2008). In addition, there has been an identified need to strengthen capacity of the community health workforce in Canada (PHAC, 2005). To support this aim, it is necessary to understand community health nurses' (CHNs) education needs to inform the development of professional development programs to assist nurses in meeting the CCHN Standards. The purpose of this second phase of the study was to identify current practice activities of CHNs across all Canadian Provinces and Territories and to measure their continuing education needs in relation to the CCHN Standards.

The research questions for this Phase II of the study were as follows:

1. What are the practice activities of CHNs in Canada in relation to the CCHN Standards?
2. What are the learning needs of CHNs in Canada in relation to the CCHN Standards?
3. What differences are there in CHNs practice activities and learning needs by province and territory in Canada?
4. What differences are there in CHN practice activities and learning needs by place of work (home health, public health and other community health settings)?

The results of this pan-Canadian survey will inform the Public Health Agency of Canada (PHAC), the Community Health Nurses Association of Canada, community health nursing employers, and others who are involved in continuing education program development in order to build capacity in the community health nursing workforce in Canada. The report outlines methods, results, the development of an online version of the survey, implications for practice and research, limitations and conclusions.

METHODS

THE INSTRUMENT

Phase I of this two-part study involved the development and pretesting of a learning needs questionnaire as well as an analysis of 329 responses from CHNs in Ontario and Nova Scotia who were surveyed. Using exploratory factor analysis, the reponses to this survey were used to further refine the instrument for Phase II. Questionnaire development was done by the research team who have expertise in community health nursing and the CCHN Standards. Nursing practice activity statements were developed as described in detail in our first report, which reflected the CCHN Standards, so that nurses could identify their needs for education in relation to each practice activity and the frequency of engaging in the practice activity. The final activity statements were based on behavioural performance beginning with "I…" and used wording from the original standard where possible. For example, the item statement was "I develop a mutually agreed upon plan of care with the individual/family." The final activity statements were listed under the corresponding five core CCHN Standards (e.g. *Standard 1: Promoting Health*; S*tandard 3: Building Relationships*) to assist respondents in associating the nursing activity with each standard.

CHNs' activities vary to a certain degree depending on their workplace setting. For example, an occupational health nurse may not conduct community assessments as a routine practice while a public health nurse may do so frequently. Therefore, two survey questions were developed to determine the frequency of nurses' current practice activities as well as their corresponding needs for continuing education in relation to each activity. Stem questions for the survey were worded in behavioural terms beginning with "I.." . The stem question "**I perform the stated activity**:" was meant to obtain information about the frequency of nurses' activities associated with each standard while the stem question, "**I need more education related to this activity**:**"** measured continuing education needs for each activity. This was important to capture since, a nurse who is not expected to conduct a particular activity in her workplace would likely not identify it as a learning need. This would greatly impact on the interpretation of the results of nurses' learning needs.

Two scales were developed for each stem question. A scale was developed to measure the frequency that nurses conduct particular activities ("**I perform the stated activity**:") as follows: never, rarely, sometimes, frequently and always. "Not applicable" was added to give the respondent an option to indicate that the activity was not performed in their current practice, but would allow the nurse to still recognize it as a learning need. In addition, "unsure" was included as a respondent category. This response category could help nurses indicate they are uncertain about an activity in their current practice and would also allow them to then identify it as a learning need. A scale was also developed to measure the continuing education needs for each nursing activity. Respondents were expected to review each activity statement and then indicate their level of agreement on the statement "I need more education related to this activity." The scale included: completely agree, generally agree, neither agree or disagree, generally disagree and completely disagree.

Face and content validity testing was conducted on the Phase 1 tool. Test-retest reliability was also conducted in Phase 1; respondents completed the tool twice at approximately a 2 week interval. The questionnaire had good test-re-test reliability (scale 1- learning need $R=.890$, $p<0.01$; scale 2 activities $r=.889$, $p<0.01$).

Data from the survey in Phase I were used to refine the survey tool. First, using correlation analysis, we identified all items that were highly correlated. For example, the following items were highly correlated (r≥=0.80): "*In a variety of contexts, including home, neighbourhood, workplace, school, and street, I utilize harm reduction principles to identify risk factors*" and "*In a variety of contexts, including home, neighbourhood, workplace, school, and street, I utilize harm reduction principles to reduce risk factors*". Therefore, one of these items could be dropped. We generally chose items that we agreed were at a higher level conceptually. So in this example, we dropped the first statement, since a nurse would have to first identify the risk factor in order to reduce it (see Table 14 in Appendices).

Second, we conducted a factor analysis of all remaining items for each Standard. This procedure provided useful information about the robustness of items to be included in each Standard in the revised tool (Tables 13.1 to 13.7 in Appendices). Using this method each set of multiple items that loaded on one factor were viewed as measuring a similar construct. For instance, under Standard 1 a, five items loaded on Factor 1 where the researchers agreed each item was conceptually important and relevant. Each factor will be named in our next stage of analysis; we anticipate that this process may be useful in reviewing the CCHN Standards in future revisions. Items that did not load on any factors were also carefully reviewed. Decisions were made whether or not to keep the item based on the importance of the concept. For example, the item "64b. I act upon legal obligations to report to authorities situations where care provided by caregivers (e.g., family, friends, or other individuals) to children or vulnerable adults is: unethical." This item was dropped since it was felt that this action was expected of all nurses regardless of their area of nursing work (Table 14).

There were 138 activity statements in the Phase I questionnaire compared to 88 in the revised questionnaire used in Phase II. This analysis process allowed for refinement and shortening of the tool. Some very minor edits were also made to a few statements to adjust for grammar, which were required when some items were dropped.

The demographic items in the survey were also slightly adjusted to meet the particular needs of regions. For example, community health agency, outposts/nursing station, and community nursing clinic were additional choices appended to the question regarding place of work.

French translation and reverse translation were completed for the survey in Phase I. A review of the final survey was also conducted by a linguist to assist in the translation of items that were unclear in the reverse translation. In Phase II, materials were translated again, where edits were made, for example in mail out materials (letters of introduction, reminders, consents, etc.) and the questionnaire. Face validity testing was also conducted by bilingual nurses on the French version of the questionnaire for phase II.

This report focuses on the Phase II study, which involved a random survey of CHNs across all provinces and territories across Canada between September 2008 and March 2009.

SAMPLE

Participants' names for the survey were obtained from the regulatory Associations and Colleges of Nurses from each of the provinces and territories in Canada. Table 1 lists them all and includes the target sample, the number that met our criteria, the month of mailing, the type of mailing (Local=mail outs conducted at McMaster University; Distance=mail outs conducted through the Colleges) and the total number of eligible nurses for the study.

Table 1: Associations and Colleges of Nurses in Canada Used for Sampling, including Target Sample Size, Total Number Sampled and Type of Mailing Strategy Used

Province/ Territory	Participating Regulatory Association and College	Target Sample	# sampled	# met inclusion criteria	Percentage sampled of CHNs who met inclusion criteria	Month of mailing	Type of mailing**
Québec	Ordres des Infirmières et Infirmiers du Québec	350	350	6033	100	September 2008	Local
Newfound-land & Labrador	Association of Registered Nurses of Newfoundland and Labrador	350	307	307	100	September 2008	Local
British Columbia	College of Registered Nurses of BC	350	350	1737	20	September 2008	Distance
Yukon	Yukon Registered Nurses Association	100	96	96	100	October 2008	Distance
New Brunswick	Nurses Association of New Brunswick	350	350	1459	24	October 2008	Distance
Alberta	College and Association of Registered Nurses of Alberta	350	350	3262	10	October 2008	Distance
Manitoba	College of Registered Nurses of Manitoba	350	350	2264	15	October 2008	Distance
Saskatch-ewan	Saskatchewan Registered Nurses Association	350	350	1349	26	November 2008	Distance
Ontario†	College of Nurses of Ontario	350	350	13355	2.6	December 2008 – January 2009	Local
PEI	Individual Nurse Managers	150	99	99*	100*	December 2008 – January 2009	Distance
Nova Scotia†	College of Registered Nurses of Nova Scotia	350	350	367	95	January 2009	Local
Northwest Territories †	Registered Nurses Association of Northwest Territories and Nunavut	50	74	74	100	January 2009- February 2009	Distance
Nunavut †	Registered Nurses Association of Northwest Territories and Nunavut	50	19	19	100	January 2009- February 2009	Distance

**Local=mail outs conducted from McMaster University; Distance=mail outs conducted locally through the College

†required ethics review

Criteria for inclusion were as follows:

- CHNs who agreed to participate in research when they registered with the registration body;
- CHNs of any age, ethnicity, race, or gender;
- any nurse who self identified on the annual registration form as working with any of the following employers: mental health centre, community health centre, community health agency, community nursing clinic, home care agency, public health unit/department, private nursing agency, visiting nursing agency, nursing station (outpost or clinic), physician's office/family practice unit, business/industry/occupational health, educational institution, association/government, self-employed/independent practice, extra-mural program, parish nursing, outpost/nursing station, Indian Reserve employed, First Nations and Inuit Health Branch, armed forces, addiction centre, and other community;
- French or English speaking nurses,;
- RNs, Primary Health Care NPs, RN (EC), Graduate Nurses, Psychiatric Nurse, Full, Part Time and Casual employees.

Criteria for exclusion were as follows:

- Licensed practical nurses (LPNs);
- Retired nurses;
- any nurse who self identified on the annual registration form as working with any of the following nursing employers: hospital, rehabilitation/convalescent centre, extended care, long term care/nursing home;
- CHNs from Ontario who already participated (by returning a completed questionnaire) in Phase 1 of this study. [Note: CHNs in Nova Scotia were also included in Phase I; however, since there are fewer of them in the province we could not exclude them from the second phase as was done in Ontario to obtain adequate sample size. Therefore, some of the Nova Scotia CHNs may have been invited to complete the survey once in Phase I and once in Phase II.]

Sample Size Calculation

Once a list of CHNs has been formed from each province/territory based on the above inclusion criteria, a random sample of participants was chosen. To estimate the mean of needs assessment with a 95% confidence and with a maximum error of 0.5 on standard score scale, we needed a sample size of 16 for each setting (using the formula $n = (z^2\sigma^2)/d^2$). Allowing for a response rate of 40% (supported by Phase I of the study) the sample size increased to 40. To be able to conduct statistical testing for the second objective this sample size was multiplied by 4 (home health, public health, primary care, and other) sectors. Therefore, the maximum sample size for each province was 160. To further increase the power of the study for confirmatory factor analysis we anticipated randomly selecting 350 nurses from Nova Scotia, Newfoundland and Labrador, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia; 150 nurses from PEI; 100 nurses from Yukon, and 50 nurses each from Northwest Territories and Nunavut. Therefore, the total sample size for this study was approximately 3500 CHNs across Canada. This sample size was enough to estimate the different components of the education needs, to test the differences of these components between different sectors and based on

different classifications, and to conduct a confirmatory factor analysis to re-assess the factor analysis finding from Phase I.

THE SURVEY PROTOCOL

The survey protocol followed a modified Dillman method as outlined below:

1. Day 1: Pre-notice Postcard: A simple notification that the potential participant will be receiving a request to complete an important questionnaire concerning the continuing education needs of CHNs across Canada.
2. Day 4: First Questionnaire: An ethics approved information letter concerning the nature of the study and providing answers to any ethics or confidentiality issues, the questionnaire, and a stamped return envelope was included in this package.
3. Day 11: Thank you/Reminder Postcard: A short note thanking the participant for returning their completed questionnaire or kindly reminding them to return it.
4. Day 24: Second Questionnaire: A one page letter encouraging the participant to complete and return the survey, a replacement survey, and a stamped return envelope was included in this package.

ETHICS

This study was approved by the Hamilton Health Sciences/McMaster University Faculty of Health Sciences Research Ethics Board, the Health Sciences Human Research Ethics Board of Dalhousie University, and the Aurora Research Institute, Aurora College, Inuvik, NT.

DATA ANALYSIS

Data was entered into and analyzed using SPSS 17.0. A data processing plan was developed including how records would be kept and how to handle unclear or readable answers. Data cleaning was completed and all refusals were noted. Descriptive statistics, frequency counts, measures of central tendency, and measures of dispersion were completed. Further descriptive statictics, and testing between and among different groups (ANOVA) was completed to explore differences by sector, title in nursing, province/territory and number of years in practice. A confirmatory factor analyses will be conducted to examine the consistency of factors that emerged from Phase 1 and to identify the strength of the tool.

RESULTS

RESPONSE RATE

Of all CHNs who were contacted 1677 responded, resulting in a 49% response rate. The total number of useable questionnaires was 1344 or 40% of the total population surveyed. Survey responses were not included where respondents: a) did not see themselves as CHNs (n=179), b) were retired (n=26), c) were not found at the address provided (n=28), d) did not wish to participate (n=86), and, e) were on leave or not working (n=14). Although some nurses indicated that they were not CHNs, some were in fact considered a CHN based on the nursing position provided in their comment. The highest response rates were from Nunavut (74%), Yukon (50%), Alberta (50%) and PEI (48%) (Table 2). The lowest response rate was from the Northwest Territories (19%).

TABLE 2: RESPONSE RATE BY PROVINCE AND TERRITORIES

Province (# mailed)	Completed returns	Response Rate %
BC (350)	147	42
AB (350)	174	50
SK (350)	155	44
MB (350)	128	37
ON (350)	123	35
QC (350)	122	35
NB (350)	104	30
NS (350)	145	41
PEI (99)	48	48
NL (307)	122	40
NU (19)	14	74
NT (74)	14	19
YT (96)	48	50
Total (3395)	1344	40

STUDY PARTICIPANTS

The study participants were 94.5% female, and 3.9% male with missing data on 1.6%. The mean age of the respondents was 49.2 years. The majority of nurses who responded to the survey were registered nurses (82.2%) while 15.5% were either extended class registered nurses/nurse practitioners (Table 3).

TABLE 3: TITLE IN NURSING

Title	n	%
RN	1105	82.2
RN Extended Class	160	11.9
Nurse Practitioner	48	3.6
Missing	31	2.3
Total	1344	100

The highest level of education attained in nursing was a Masters degree (4.5%), however the vast majority of nurses held a diploma (38.9%) or degree (53.57%) in nursing. Almost half (47.5%) of the nurses who were surveyed were employed in nursing for more than 25 years and 26.4% had been in the field for 16-25 years (Table 4).

TABLE 4: TOTAL NUMBER OF YEARS IN NURSING

Range	n	%
Under 2 years	14	1.0
2-5 years	76	5.7
6-10 years	101	7.5
11-15 years	144	10.7
16-20 years	162	12.1
21-25 years	192	14.3
More than 25 years	639	47.5
Missing	16	1.1
Total	1344	100

Table 5 illustrates that respondents had a broad range of years of experience of nursing in the community; with the largest group (21.4%) working in the community for 6-10 years while 12.8% of nurses had worked in the community for more than 25 years and 8.2% had less than 2 years of experience.

TABLE 5: NUMBER OF YEARS NURSING IN THE COMMUNITY

Range	n	%
Under 2 years	110	8.2
2-5 years	228	17.0
6-10 years	287	21.4
11-15 years	241	17.9
16-20 years	173	12.9
21-25 years	120	8.9
More than 25 years	172	12.8
Missing	13	1.0
Total	1344	100.0

Almost half of the nurses indicated that they worked either in a public health unit/department (22.7%) or in an agency such as home health (CCAC/Extra Mural Program/ home health/private nursing agency/visiting nursing agency) (23.5%) (Table 6). Other workplaces included primary care settings (physician's office and community health centre) (18.5%), community health agency (9.9%), and mental health centre (4.7%).

TABLE 6: PLACE OF WORK, BASED ON ONE PRIMARY EMPLOYER

Place of work	n	%
Addiction Centre	6	0.4
Ambulatory	2	0.1
Armed Forces	4	0.3
Association/Government	28	2.1
Business/Industry/Occupational Health	45	3.3
CCAC (ON only)	14	1.0
Community Health Agency	133	9.9
Community Health Centre	176	13.1
Community Nursing Clinic	38	2.8
Correctional Facility	5	0.4
Dentist's Office	2	0.1
Educational Institution	13	1.0
Extra Mural Program (NB Only)	32	2.4
First Nations and Inuit Health Branch	12	0.9
Home Health	190	14.1
Indian Reserve Employed	19	1.4
Mental Health Centre	63	4.7
Outposts/Nursing Stations	40	3.0
Physician's Office/Family Practice Unit	73	5.4
Private Nursing Agency	14	1.0
Public Health Unit/Department	305	22.7
Self-Employed/Independent Practice	15	1.1
Tele Health Centre	11	0.8
Travel Clinic	1	0.1
Visiting Nursing Agency	67	5.0
Other Community	19	1.4
Missing	17	1.3
Total	1344	100

The most common positions based on primary employers were public health nurses (21.2 %) followed by home health nurses (14.1 %). However, it is not clear whether nurses in such positions as coordinator/case manager, staff nurse, manager/supervisor, visiting nurse, and community health nurse could also be considered public health nurses or home health nurses (Table 7).

TABLE 7: POSITION, BASED ON PRIMARY EMPLOYER

Position	n	%
Public Health Nurse	285	21.2
Home Health Nurse	190	14.1
Coordinator/Case Manager	148	11.0
Staff Nurse	132	9.8
Manager/Supervisor/Administrator	107	8.0

Visiting Nurse	72	5.4
Mental Health Nurse/Reg. Psychiatric Nurse	55	4.1
Occupational Health Nurse	50	3.7
Outpost Nurse	43	3.2
Family Practice Nurse	42	3.1
Consultant	36	2.7
Clinical Nursing Specialist	35	2.6
Nurse Practitioner/Extended Practice	32	2.4
Clinical Resources Nurse/Clinical Educator	30	2.2
Community health nurse	23	1.7
Chief Nursing Officer/CEO/Director/Asst Director	16	1.2
Tele Health Nurse	6	0.4
Self Employed/Independent Practice Nurse	5	0.4
Instructor/Professor/Educator	6	0.4
Other (Correctional Nurse, Liaison Nurse, Outreach/Street Nurse, Researcher, Policy or Informatics Analyst, Addictions Nurse, Travel Clinic Nurse)	17	1.2
Missing	14	1.0
Total	1344	100.0

ACTIVITIES AND LEARNING NEEDS OF CHNS IN CANADA BY STANDARD

This section reports the results for two research questions to identify CHNs' 1) current practice activities and 2) their continuing education needs based on the Canadian Community Health Nursing Standards of Practice. Tables 8.1 through 8.7 report on activities, where CHNs' mean scores indicating a need for more education on an activity was equal to or greater than 0.50. Activities which scored less than 0.50 on the learning needs scale were excluded from the results below. The results are presented in order of the CCHN Standards.

STANDARD 1 A: HEALTH PROMOTION

Table 8.1 illustrates that CHNs across Canada have a strong need for education related to all activities related to the Population Health Promotion Model and the Ottawa Charter for Health Promotion. CHNs indicated needing education on the item "*I facilitate planned change through applying the Population Health Promotion Model*" (MEAN=1.09; n=1225) and of those who answered, they indicated that they performed the activity rather frequently (MEAN= 3.16; n=534). CHNs also indicated that they had a learning need for the item "*I implement health promotion strategies based on the Ottawa Charter*" (MEAN=1.17; n=1215) and reported performing the activity frequently (MEAN=3.43; n=389). For these two items most respondents answered *not sure, not applicable* or skipped this question altogether in relation to their activities relating to this model.

Table 8.1 also illustrates that CHNs have learning needs in relation to *using research findings*, *addressing the root cause of illness and disease*, *using social marketing strategies to shift social norms,* and *working with stakeholders to systematically evaluate health promotion programs.* CHNs also report rarely using social marketing strategies to shift social norms and rarely evaluating health promotion programs in practice.

TABLE 8.1 STANDARD 1A: HEALTH PROMOTION; ACTIVITIES WHERE CHNS IDENTIFIED A LEARNING NEED (MEAN ≥0.50)

Standard 1A: **HEALTH PROMOTION** *Learning needs only reported for items where Mean is ≥0.50	LEARNING NEED * "I need education related to this activity" -2 completely disagree to +2 completely agree			ACTIVITY "I perform the Stated Activity" 1 – Never to 5- Always		
STATEMENTS	Mean	SD	(n)	Mean	SD	(n)
I use research findings.	0.59	0.95	1249	3.52	0.91	1303
I address root causes of illness and disease.	0.50	0.99	1229	3.88	0.95	1265
I use social marketing strategies to: shift social norms.	0.50	1.00	1192	2.40	1.05	1112
In partnership with stakeholders, I evaluate population health promotion programs systematically.	0.53	1.02	1172	2.51	1.16	1066
I facilitate planned change through applying the Population Health Promotion Model.	1.09	0.98	1225	3.16	1.31	534
I implement health promotion strategies based on the Ottawa Charter.	1.17	0.97	1215	3.43	1.21	389

STANDARD 1B: PREVENTION AND HEALTH PROTECTION

Table 8.2 reports the learning needs for standard 1B and the level of activities associated with each. Under Standard 1B, CHNs indicated that they have learning needs in relation to *utilizing harm reduction principles to reduce risk factors (Mean=0.50)* and that they perform these activities frequently (Mean=3.91). They also specified they have a need to learn more about *engaging in collaborative intersectoral partnerships to address health prevention* issues (Mean=0.50) and evaluating collaborative intersectoral partnerships (Mean=0.50) and reported that they sometimes perform these activities (Mean=3.27 and 3.49 respectively). Another key learning area under the standard of Prevention and Health Protection was *applying epidemiological principles in using strategies such as a) screening, b) surveillance, c) communicable disease response, d) outbreak management, and e) education;* however, indicate their performance is frequent.

TABLE 8.2 STANDARD 1B: HEALTH PREVENTION AND HEALTH PROTECTION: ACTIVITIES WHERE CHNS IDENTIFIED A LEARNING NEED (MEAN ≥0.50)

Standard 1B: **PREVENTION AND HEALTH PROTECTION** *Learning needs reported for items where Mean is ≥ 0.50	LEARNING NEED * "I need education related to this activity" -2 completely disagree to +2 completely agree	ACTIVITY "I perform the Stated Activity" 1 – Never to 5- Always

STATEMENTS	Mean	SD	(n)	Mean	**SD**	**(n)**
In a variety of contexts, including home, neighbourhood, workplace, school and street, I utilize harm reduction principals to reduce risk factors.	0.50	0.98	1206	3.91	0.97	1224
I engage in collaborative intersectoral partnerships to address *prevention* issues.	0.50	0.97	1194	3.27	1.12	1081
I evaluate collaborative practice (i.e., personal, team, and/or intersectoral) in achieving individual/community health outcomes.	0.50	0.95	1208	3.49	1.08	1228
I apply epidemiological principles in using strategies (such as, a) screening, b) surveillance, c) communicable disease response, d) outbreak management, and e) education).	0.62	1.02	1202	3.66	1.10	1114

STANDARD 1C: HEALTH MAINTENANCE, RESTORATION AND PALLIATION

Under the Standard of Health Prevention and Health Protection, CHNs identified needing more education in recognizing trends in epidemiological data (Mean=0.75) and facilitating maintenance of health in response to significant emergencies that negatively impact upon the health of clients (Mean=0.5) (Table 8.3). They reported sometimes and frequently performing these activities respectively (Mean=3.29 and 3.80).

TABLE 8.3 ACTIVITIES WHERE CHNS IDENTIFIED A LEARNING NEED (MEAN ≥0.5) RELATED TO STANDARD 1C HEALTH MAINTENANCE, RESTORATION AND PALLIATION

Standard 1C. **HEALTH MAINTENANCE, RESOTORATION AND PALLIATION** *Learning needs reported for items where Mean is ≥ 0.50	LEARNING NEED * "I need education related to this activity" -2 completely disagree to +2 completely agree			ACTIVITY "I perform the Stated Activity" 1 – Never to 5- Always		
STATEMENTS	Mean	SD	(n)	Mean	SD	**(n)**
I recognize trends in epidemiological data.	0.75	0.99	1197	3.29	1.03	1100
I facilitate maintenance of health in response to significant emergencies that negatively impact upon the health of clients.	0.50	0.97	1196	3.80	1.02	1131

STANDARD 2: BUILDING INDIVIDUAL AND COMMUNITY CAPACITY

Under Standard 2, CHNs identified that they have a need to learn more about *community development skills* including when *a) engaging in a consultative process* (Mean=0.58), b) *using empowering strategies* (Mean=0.50), c) *using facilitation skills to support group development* (Mean=0.52), and d) *assisting the group or community in marshalling available resources to support taking action on their own issues* (Mean=0.52) (Table 8.4). They reported performing these activities sometimes (Means= 3.71, 3.74, 3.41 and 3.3 respectively). CHNs also indicated a need to learn about *using a comprehensive mix of community/population based strategies (such as*

coalition building, intersectoral partnerships, and networking) to address issues of concern to groups/populations. (Mean=0.55) and indicated that they sometimes performed this activity (Mean=3.02).

Similar to the findings pertaining to the Population Health Promotion Model and the Ottawa Charter for Health Promotion, the majority of CHNs identified *facilitating action in support of the five priorities of the Jakarta Declaration* as a strong learning need (Mean=1.31). In addition, respondents reported that they rarely performed these activities (Mean=2.64), however, it should be noted that only 230 respondents scored this need. Table 9 illustrates that most respondents were unsure, found it not applicable or skipped replying to this item.

TABLE 8.4 ACTIVITIES WHERE CHNS IDENTIFIED A LEARNING NEED (MEAN ≥0.5) RELATED TO STANDARD 2, BUILDING INDIVIDUAL AND COMMUNITY CAPACITY (MEAN, STANDARD DEVIATION AND SAMPLE)

Standard 2: **BUILDING INDIVIDUAL AND COMMUNITY CAPACITY** *Learning needs reported for items where Mean is ≥0.50	LEARNING NEED * "I need education related to this activity" -2 completely disagree to +2 completely agree			ACTIVITY "I perform the Stated Activity" 1 – Never to 5- Always		
STATEMENTS	Mean	SD	(n)	Mean	SD	**(n)**
I use community development principles when I engage the individual/community in a consultative process.	0.58	0.98	1188	3.71	1.01	1082
I use community development principles when I use empowering strategies (such as mutual goal setting, visioning, and facilitation).	0.50	0.99	1214	3.74	0.98	1185
I use community development principles when I use facilitation skills to support group development.	0.52	1.00	1182	3.41	1.12	1052
I use community development principles when I assist the group/community to marshal available resources to support taking action on their health issues.	0.52	0.98	1175	3.30	1.05	1040
I use a comprehensive mix of community/population based strategies (such as coalition building, intersectoral partnerships, and networking) to address issues of concern to groups/populations.	0.55	1.01	1167	3.02	1.14	992
I use principles of social justice to support those who are unable to take action for themselves.	0.57	0.99	1215	3.54	1.13	1167
I facilitate action in support of the *five* priorities of the Jakarta Declaration.	1.31	0.90	1223	2.64	1.40	230

STANDARD 3: BUILDING RELATIONSHIPS

The only item identified as a learning need under standard 3— Building Relationships— was *being aware of* and *using culturally relevant communication in building relationships* (Mean=0.50). This activity was reported as being frequently performed by CHNs (Mean= 4.29) (Table 8.5).

TABLE 8.5 ACTIVITIES WHERE CHNS IDENTIFIED A LEARNING NEED (MEAN ≥0.5) RELATED TO STANDARD 3: BUILDING RELATIONSHIPS (MEAN, STANDARD DEVIATION AND SAMPLE)

Standard 3: BUILDING RELATIONSHIPS *Learning needs reported for items where Mean is ≥ 0.50	LEARNING NEED * "I need education related to this activity" -2 completely disagree to +2 completely agree			ACTIVITY "I perform the Stated Activity" 1 – Never to 5- Always		
STATEMENTS	Mean	SD	(n)	Mean	SD	(n)
I am aware of culturally relevant communication in building relationships.	0.50	1.02	1246	4.29	0.77	1305

STANDARD 4: FACILITATING ACCESS AND EQUITY

Similar to the learning need above under the Building Relationships standard, CHNs also identified *providing culturally relevant care in diverse communities* as a learning need under the standard for Facilitating Access and Equity (Mean=0.50) (Table 8.6). This was reported to be a frequently performed activity by CHNs (MEAN=3.72).

Taking action, based on evidence, with individuals/communities at the federal level to address service accessibility issues was another learning need (mean=0.5) for CHNs, although this activity was rarely performed (Mean= 1.91).

An additional item identified as a learning need was *advocating for healthy public policy, by participating in legislative and policymaking activities that influence health determinants (Mean=0.54).* This was reported as rarely being performed by nurses (Mean=2.27).

TABLE 8.6 ACTIVITIES WHERE CHNS IDENTIFIED A LEARNING NEED (MEAN ≥0.5) RELATED TO STANDARD 4 FACILITATING ACCESS AND EQUITY (MEAN, STANDARD DEVIATION AND SAMPLE)

Standard 4: **FACILITATING ACCESS AND EQUITY** *Learning needs reported for items where Mean is ≥ 0.50	LEARNING NEED * "I need education related to this activity" -2 completely disagree to +2 completely agree			ACTIVITY "I perform the Stated Activity" 1 – Never to 5- Always		
STATEMENTS	Mean	SD	(n)	Mean	SD	(n)
I provide culturally relevant care in diverse communities.	0.50	1.00	1211	3.72	1.03	1192
To address service accessibility issues, I take action, based on evidence, with individuals/ communities at the federal level.	0.50	1.04	1152	1.91	1.15	1000
I advocate for healthy public policy, by participating in legislative and policymaking activities that influence health determinants.	0.54	1.01	1183	2.27	1.14	1094

STANDARD 5: DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY RESULTS

Two items stood out as learning needs for CHNs related to Standard 5: Demonstrating Professional Responsibility and Accountability. CHNs reported learning needs for *using nursing informatics (i.e., information and communication technology) which includes generation, management, and processing of relevant data to support nursing practice* (Mean= 0.73) and *using available resources to systematically evaluate community health nursing practice (e.g., availability, acceptability, quality, efficiency, and effectiveness)* (MEAN= 0.53) (Table 8.7). Both of these activities were reported as being performed sometimes or frequently (MEAN= 3.67 and 3.40, respectively).

TABLE 8.7 ACTIVITIES WHERE CHNS IDENTIFIED A LEARNING NEED (MEAN ≥0.50) RELATED TO STANDARD DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY RESULTS (MEAN, STANDARD DEVIATION AND SAMPLE)

Standard 5: DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY *Learning needs reported for items where Mean is ≥ 0.50	LEARNING NEED * "I need education related to this activity" -2 completely disagree to +2 completely agree			ACTIVITY "I perform the Stated Activity" 1 – Never to 5- Always		
STATEMENTS	Mean	SD	(n)	Mean	SD	(n)
I use nursing informatics (i.e., information and communication technology) which includes generation, management, and processing of relevant data to support nursing practice).	0.73	0.96	1250	3.67	1.06	1255
I use available resources to systematically evaluate community health nursing practice (e.g., availability, acceptability, quality, efficiency, and effectiveness).	0.53	0.95	1208	3.40	1.05	1188

Table 9 indicates that from 49.0% – 68.4% of all respondents were *unsure* about whether they performed various activities related to the Population Health Promotion Model, the Ottawa Charter of Health Promotion, and the Jakarta Declaration. In addition, 9.5% to 12.1% of all respondents indicated that these activities were *not applicable to their practice*. These two categories of responses combined make up between 60 and 82% of respondents. It is unclear if CHNs are simply unfamiliar with these theoretical concepts, do not see their relevance within their practice or for other reasons do not actually perform these activities. Further exploration of the above findings will be conducted in the next phase of analysis to identify if those who answered *unsure* or *not applicable* for these theoretical concepts differed by practice setting, position or years working as a CHN.

TABLE 9: FREQUENCY AND PERCENTAGE DISTRIBUTION OF "UNSURE" AND "NOT APPLICABLE" RESPONSES FOR SCALE 1 – "I PERFORM THE ACTIVITY" – FOR STATEMENTS RELATED TO THEORETICAL CONCEPTS (POPULATION HEALTH PROMOTION MODEL/ OTTAWA CHARTER/ JAKARTA DECLARATION)

	Item 58: Population Health Promotion Model	**Item 59: Ottawa Charter**	**Item 60: Jakarta Declaration**
	n (%)	n (%)	n (%)
Unsure	658 (49.0)	773 (57.5)	919 (68.4)
N/ A	128 (9.5)	152 (11.3)	162 (12.1)
Score 1-5	534 (39.7)	389 (28.9)	230 (17.1)
Missing*	24 (1.7)	30 (2.3)	33 (2.5)
Total	1344 (100)	1344 (100)	1344 (100)

*Missing includes items with errors

SUMMARY OF LEARNING NEEDS AND ASSOCIATED ACTIVITIES

Table 10 summarizes the learning needs which were identified by CHNs across Canada as a whole. The items were selected based on mean scores of 0.50 or greater.

TABLE 10: SUMMARY OF LEARNING NEEDS AND LEVEL OF ACTIVITY RELATED TO THESE LEARNING NEEDS FOR ALL CHNS IN CANADA

The following main topics were identified as **learning needs** for CHNs including:

Standard 1a: Health Promotion

- Applying the theoretical concepts of the Population Health Promotion Model, and the Ottawa Charter of Health Promotion.
- Using research findings.
- Using social marketing strategies to shift social norms.
- Addressing the root causes of illness and disease.
- Evaluating population health promotion programs systematically.

Standard 1b: Prevention and Health Protection

- Utilizing harm reduction principles to reduce risk factors.
- Engaging in collaborative intersectoral partnerships to address prevention issues.
- Evaluating collaborative practice in achieving individual/community health outcomes.
- Applying epidemiological principles

Standard 1c: Health Maintenance, Restoration and Palliation

- Facilitating maintenance of health in response to emergencies that negatively impact upon client health.
- Recognizing trends in epidemiological data.

Standard 2: Building Individual and Community Capacity

- Using community development principles and principles of social justice.
- Using a comprehensive mix of community/population based strategies to address issues of concern to groups/populations.
- Applying the theoretical concepts of the Jakarta Declaration.

Standard 3: Building Relationships

- Being aware of culturally relevant communication

Standard 4: Facilitating Access and Equity

- Providing culturally relevant care.
- Taking action to address service accessibility issues at the federal level.
- Advocating for healthy public policy by participating in legislative and policymaking activities.

Standard 5: Demonstrating Professional Responsibility and Accountability

- Using available resources to systematically evaluate community health nursing practice.
- Using nursing informatics to support practice.

Of the learning needs identified above, CHNs reported performing the activities related to these learning needs sometimes or frequently. Exceptions were the following activities, which CHNs reported as rarely being performed.

- Using social marketing strategies to shift social norms.
- Systematically evaluating population health promotion programs in partnership with stakeholders.
- Facilitating action in support of the 5 priorities of the Jakarta Declaration.
- Taking action to address service accessibility issues at a federal level.
- Advocating for healthy public policy.
- CHNs sometimes implemented the concepts of the Population Health Promotion Model, and the Ottawa Charter of Health Promotion, although the majority of respondents stated that these activities were not applicable, they were unsure or they did not respond.

LEARNING NEEDS BY PRACTICE SETTING

Separating CHNs by practice setting across Canada has been a difficult process. Many CHN workplaces across Canadian provinces and territories have different models of health care and therefore great variability in "place of work". Our demographic section was adjusted to include all labels of place of work that were found in the college and associations' registration forms. This resulted in many work places being listed in the questionnaire, some of which may have been unclear to respondents. For example, community health centre, community health agency, and community nursing clinics might not be similarly defined in all regions in Canada. Therefore, it is unclear how accurately respondents answered the workplace question.

In Phase 1 we were able to easily capture the place of work and then separate what was thought to represent places of work in the following sectors: primary care, public health, home health and other community health nursing. These were used for comparisons in our analysis. In phase II, this has become much more difficult. For this phase, we have separately collapsed home care, public health and other since these categories were the clearest groups to distinguish. We also examined learning needs rather than activities.

The following tables (Tables 11.1 through 11.4) report on results from one-way ANOVAs indicating where statistically significant differences were found in learning needs by sector, number of years in nursing, title in nursing and province/territory. This was reviewed for the activities that were found to be the top 10 learning needs (highest means scores for the entire sample). ANOVAs were also conducted for the questions related to the theoretical models (as a grouped mean for the 3 items) by sector. One way analysis of variance (ANOVA) with the post-hoc Tukey test was conducted to examine if there is any statistically significant differences between means of groups.

Out of the top 10 learning needs with means greater than 0.5, there was no significant difference between the sectors except for one item (8: "In partnership with stakeholders, I evaluate population health promotion programs systematically") which showed a significant difference between public health and home health care (p=0.046). Public health had a higher learning need than home health on this item.

TABLE 11.1 LEARNING NEED BY SECTOR (MEAN, STANDARD DEVIATION, F VALUES)

Learning Need	Public Health Mean (SD)	Home Health Mean (SD)	Other Mean (SD)	F (df^1,df^2)
8. In partnership with stakeholders, I evaluate population health promotion programs systematically ❖ Public Health differs from • Home Health	0.66 (0.95)	0.39 (1.1)	0.54 (1.0)	6.03 (2, 1156) p=0.046

In addition, Table 11.2 illustrates that there was a statistically significant difference found for the grouped mean for the three theoretical items (Jakarta Declaration, Ottawa Charter of Health Promotion and Population Health Promotion Model). CHNs in the public health sector had lower learning needs compared to CHNs in the "other category".

TABLE 11.2: DIFFERENCES BETWEEN SECTOR AND LEARNING NEEDS FOR THE THEORETICAL MODELS (MEAN, STANDARD DEVIATION, F VALUES)

Learning Need*	Public Health Mean (SD)	Home Health Mean (SD)	Other Mean (SD)	F (df^1,df^2)
58. I facilitate planned change through applying the Population Health Promotion Model. 59. I implement health promotion strategies based on the Ottawa Charter. 60. I facilitate action in support of the *five* priorities of the Jakarta Declaration. ❖ Public Health differs from • Other	1.09 (0.82)	1.22 (0.9)	1.25 (0.88)	3.6 (2, 1228) p=0.051

*Mean score obtained for the 3 theoretical models

LEARNING NEEDS BY YEARS IN NURSING

Table 11.3 illustrates that in comparing there were statistically significant different learning needs. Nurses with over 25 years had lower learning needs compared to nurses who worked 6 to 10 years for the items: (Q.23) "I recognize trends in epidemiology data" and (Q.55c) "I advocate for: c) healthy public policy, by participating in legislative and policymaking activities that influence health determinants". This difference was statistically significant [P=0.020 (Q.23); P=0.036 (Q.55c)]. Although not statistically significant, nurses who were in the nursing workforce for less than 2 years also had higher learning needs than the other groups for these two items.

TABLE 11.3: DIFFERENCES BETWEEN **NUMBER OF YEARS IN NURSING IN TOTAL** AND LEARNING NEEDS (MEANS, STANDARD DEVIATIONS AND F VALUES)

	Number of years in nursing in total							
Learning Need	Under 2 years Mean (S.D)	2-5 years Mean (S.D)	6-10 years Mean (S.D)	11-15 years Mean (S.D)	16-20 years Mean (S.D)	21-25 years Mean (S.D)	25 + years Mean (S.D)	F (df_1,df_2)
23. I recognize trends in epidemiology data. ❖ 25 + years differs from • 6-10 years	1.14 (0.77)	0.79 (1.02)	1.01 (0.84)	0.90 (0.97)	0.71 (0.91)	0.76 (1.99)	0.86 (1.04)	2.47* (6,1176) p=0.020
55c. I advocate for: c) healthy public policy, by participating in legislative and policymaking activities that influence health determinants. ❖ 25 + years differ from • 6-10 years	1.08 (0.76)	0.67 (1.02)	0.84 (0.81)	0.53 (1.07)	0.58 (1.03)	0.63 (0.92)	0.44 (1.03)	3.33* (6,1163) p=0.036

LEARNING NEEDS BY TITLE IN NURSING (RN VERSUS NP/ RN EXTENDED CLASS)

There were no statistically significant differences in learning needs by "Title in Nursing" (RN versus NP or RN Extended Class).

LEARNING NEEDS AND ACTIVITIES BY PROVINCE AND TERRITORY

This section reports the results for two research questions to identify CHNs' 1) current practice activities and 2) their continuing education needs based on the CCH Standards by province or territory. As noted earlier, CHNs were asked to report how often they performed an activity (1 =never; 2 =rarely; 3 =sometimes; 4 =frequently; 5 =always; unsure; and not applicable), where the activities were derived from the Canadian Community Health Nursing Standards of Practice. CHNs were also asked if they agreed or disagreed with the statement "I need more education related to this activity" (-2 =completely disagree; -1 =generally disagree; 0 =neither agree nor disagree; +1 =generally agree and +2 =completely agree). Means and standard deviations for learning needs and activities were reviewed for all items by province and territory. Results are reported below and are presented by learning needs followed by activities for all items in order of the CCHN standards. Detailed tables reporting means and standard deviations (Tables 12.1 to 12.14) can be found in the Appendices.

STANDARD 1 A

STANDARD 1 A: HEALTH PROMOTION BY ACTIVITY

Table 12.1 illustrates the following key findings:

- CHNs across Canada reported frequently performing individual assessments in collaboration with their clients; however, they reported only sometimes conducted community assessments, with the exception of CHNs in Nunavut.
- CHNs in the majority of the provinces reported rarely using social marketing strategies except in Ontario, the Yukon, Northwest Territories and Nunavat where they reported sometimes used them.
- CHNs in BC, Alberta, Quebec, PEI, Nova Scotia and Northwest Territories rarely reported systematically evaluating population health promotion programs compared to other provinces/territories, although all regions generally reported evaluating programs infrequently.
- CHNs across the country reported frequently assisting the individual/community to take responsibility for improving their health by increasing their knowledge of the determinants of health.
- Research findings were reported as frequently used by CHNs across Canada with lowest means reported in Quebec and highest means in Nunavut.
- CHNs in Quebec reported performing health promotion activities described in Standard 1A less frequently overall compared to CHNs in Nunavat who reported performing these activities more frequently than all others.
- Overall the majority of CHNs who responded to activities related to the Ottawa Charter for Health Promotion and the Population Health Promotion Model reported sometimes performing these activities with one exception. Quebec and PEI CHNs reported performing activities related to the Ottawa Charter rarely.

STANDARD 1 A: HEALTH PROMOTION BY LEARNING NEEDS

Table 12.2 illustrates the following key findings:

- CHNs across Canada, except for Nunavut, reported having very little or no need for learning about conducting individual assessments; however, they all reported having a slightly higher need for learning about conducting community assessments.
- Using research findings was generally identified as a learning need amongst CHNs across Canada.
- Nunavut CHNs reported having higher mean scores for learning needs of most health promotion activities listed under this standard. On the other hand, Ontario CHNs generally reported lower mean scores than the other provinces and territories for items under this standard.
- Of all items in this standard, the highest reported learning needs for all CHNs except the Yukon, were related to the implementation of the Ottawa Charter for Health Promotion and the Population Health Promotion Model. As noted earlier, it is important to note that many respondents scored this item as "unsure" or "not applicable."
- The item "I use research findings" was among the top 10 learning needs reported by Canadian CHNs; although there were no statistically significant differences found for this item by province/territory (p=0.256) (Table 11.4).
- For the item "In partnership with stakeholders, I evaluate population health promotion programs systematically" responses differed significantly; the Territories (Nunavut, Northwest Territories and Yukon combined) had much higher learning needs compared to BC, Alberta, Ontario and Nova Scotia (p=0.001) (Table 11.4).

STANDARD 1 B

STANDARD 1B: PREVENTION AND HEALTH PROTECTION BY ACTIVITY

Table 12.3 illustrates the following key findings:

- CHNs across Canada reported frequently using various levels of prevention and assisting individuals and communities to make informed choices. They reported sometimes engaging in intersectoral partnerships to address prevention issues, with Nunavut having the highest score for this activity.
- Nunavut CHNs most frequently reported engaging in all prevention and health protection activities compared to other provinces and territories.

STANDARD 1B: PREVENTION AND HEALTH PROTECTION BY LEARNING NEEDS

Table 12.4 illustrates the following key findings;

- In general, Nunavut, Quebec and PEI CHNs had the highest mean learning needs scores related to prevention and health protection activities, while Ontario and BC CHNs reported the lowest learning needs in this standard.
- Statistically significant differences by province/territory were seen for the item "I apply epidemiological principles in using strategies such as a) screening, b) surveillance, c) communicable disease response, d) outbreak management and e) education; the Territories (Nunavut, Northwest Territories and Yukon combined) had higher learning needs compared to SK (p=0.000) (Table 11.4).
- The majority of CHNs identified using harm reduction principles and evaluating collaborative personal and team as well as intersectoral partnerships as learning needs.

STANDARD 1 C

STANDARD 1C HEALTH MAINTENANCE, RESTORATION AND PALLIATION BY ACTIVITY

Table 12.5 illustrates the following key findings:

- CHNs in Canada reported frequently performing most activities listed under Standard 1C such as conducting assessments, collaboratively planning, supporting informed choice, and using a range of interventions with clients that maximize abilities and respect clients' requests.
- Nunavut CHNs reported frequently recognizing trends in epidemiological data whereas CHNs in other provinces and territories reported sometimes being involved with this activity.
- CHNs reported they less frequently adapted epidemiological principles in their health maintenance activities with the exception of Nunavut.
- They also reported they less frequently facilitated health maintenance in response to emergencies with little differences seen among regions.

STANDARD 1C HEALTH MAINTENANCE, RESTORATION AND PALLIATION BY LEARNING NEEDS

Table 12.6 illustrates the following key findings:

- The greatest learning need reported by CHNs across Canada under this standard was recognizing trends in epidemiological data and adapting epidemiological principles in screening, surveillance, communicable disease response etc..
- Lower mean scores for learning needs were seen on most topics under this standard in the western region, compared to the eastern provinces and the Territories.
- Nunavut CHNs reported higher learning needs for all items listed under this standard compared to all other regions.
- The item "I recognize trends in epidemiology data" was one of the top 10 learning needs of all CHNs; there were no statistically significant differences among Provinces and Territories for this item (p=0.000) (Table 11.4).

STANDARD 2

STANDARD 2: BUILDING INDIVIDUAL/COMMUNITY CAPACITY BY ACTIVITY

Table 12.7 illustrates the following key findings for activities:

- CHNs in the Northwest Territories reported the least activity in engaging in community development compared to all other provinces and territories.
- CHNs in BC, Alberta, Ontario, Nova Scotia, Yukon and Nunavut reported more frequently applying principles of social justice than other provinces.
- Ontario CHNs generally reported engaging in many individual and community capacity building activities compared to other provinces.
- CHNs in Quebec reported the least involvement with group facilitation skills, supporting development of self-advocacy, and applying principles of social justice and the priorities of Jakarta Declaration
- Nunavut CHNs reported engaging more in facilitating action of the 5 priorities of the Jakarta Declaration than all other provinces. However, as noted previously, only 389 (28.9 %) CHNs scored this item; of the remainder, 773 (57.5%) were unsure, 152 (11.3%) reported the item was not applicable and 30 (2.3%) were missing.

STANDARD 2: BUILDING INDIVIDUAL/COMMUNITY CAPACITY BY LEARNING NEEDS

Table 12.8 illustrates the following findings:

- Nunavut CHNs reported the highest learning needs in all items under this standard followed by the Yukon and PEI.
- Saskatchewan CHNs reported lower learning needs related to this standard overall followed by Ontario and the Northwest Territories.
- Learning needs related to using community development principles was identified as the highest in the majority of provinces and territories. The item "I use community development principles when I a) engage the individual/community in a consultative process" was one of the top 10 learning needs for all CHNs and also showed statistically significant differences by province/Territory; Saskatchewan CHNs had significantly lower learning needs for this item compared to PEI and the Territories (Nunavut, Northwest Territories and Yukon combined) (p=0.006) (Table 11.4).
- Similar to the finding above, the following item was also among the top 10 learning needs for all CHNS— "I use community development principles when I d) assist the group/community to marshal available resources to support taking action on their health issues." The CHNs in the Territories had higher learning needs compared to Saskatchewan (p=0.104)(Table 11.4).
- The item "I use principles of social justice to support those who are unable to take action for themselves, was one of the top 10 learning needs for all CHNS; there were no statistically significant differences for this item by Province/Territory (p=0.230) (Table 11.4).
- The item "I use a comprehensive mix of community/population based strategies (such as coalition building, intersectoral partnerships, and networking) to address issues of concern to groups/population" was one of the top 10 learning needs for all CHNs; there were no statistically significant differences for this item by Province/Territory (p=0.652) (Table 11.4).

STANDARD 3

STANDARD 3 BUILDING RELATIONSHIPS BY ACTIVITY

Table 12 9 illustrates the following key findings:

- Overall, CHNs in Canada reported they frequently engage in activities related to building relationships.
- Using culturally relevant communication in building relationships was reported to be frequently performed by CHNs across Canada.

STANDARD 3 BUILDING RELATIONSHIPS BY LEARNING NEEDS

Table 12.10 illustrates the following key findings:

- Despite frequently using culturally relevant communication, compared to all other items listed in this standard, learning about culturally relevant communication in building relationships was the highest learning need for everyone without any major provincial/territorial differences.
- Nunavut CHNs reported higher learning needs than all other provinces and territories for all items in Standard 3. PEI, the Yukon and Northwest Territories had slightly higher learning needs than others, although all items under this standard were not identified as particularly high learning needs.

STANDARD 4

STANDARD 4 FACILITATING ACCESS AND EQUITY BY ACTIVITY

Table 12.11 illustrates the following key findings:

- CHNs across Canada rarely reported addressing accessibility issues at the municipal, provincial/territorial and federal levels; in contrast, CHNs in Nunavut frequently or sometimes engaged in this activity. They tended to engage at the organizational level the most frequently , with less frequent engagement at each higher systems level (municipal, provincial/territorial and federal)
- Referring and coordinating access to services and using individual approaches with vulnerable populations were frequently performed activities reported by CHNs across Canada.
- The item "I advocate for c) healthy public policy, by participating in legislative and policy making activities that influence health determinants" was among the top 10 learning needs of all CHNS; this learning need differed significantly by Province/Territory where Quebec was found to have a much lower learning need compared to PEI, Newfoundland and the Territories (Nunavut, Northwest Territories and Yukon combined) for this item (p=0.915) (Table 11.4).

STANDARD 4 FACILITATING ACCESS AND EQUITY BY LEARNING NEEDS

Table 12.12 illustrates the following key findings:

- Nunavut CHNs reported the highest learning needs related to all the items in this standard.
- Overall CHNs across Canada reported few learning needs related to facilitating access and equity with little variation among the provinces/territories except for Nunavut.
- Providing culturally relevant care in diverse communities was recognized as the key learning need in Ontario, BC, New Brunswick, PEI, the Yukon, the Northwest Territories and Nunavut.

STANDARD 5

STANDARD 5 DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY BY ACTIVITY

Table 12.13 illustrates the following key findings:

- CHNs across Canada consistently reported frequently performing activities related to taking preventive action, addressing factors that influenced quality of care, seeking professional development opportunities, making ethical decisions, seeking assistance with problem solving, documenting, and advocating effective/ efficient use of resources.
- CHNs across Canada reported rarely advocating for healthy public policy.
- Nunavut CHNs most frequently reported engaging in professional responsibility and accountability activities, whereas Quebec CHNS scored lower means compared to other provinces/territories for a large number of activities under this standard.

- The item “I use nursing informatics (i.e. information and communication technology) which includes generation, management, and processing of relevant data to support nursing practice” was one of the top 10 learning needs for all CHNs; there were no statistically significant differences for this item by Province/ Territory (p=0.000) (Table 11.4).

STANDARD 5 DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY BY LEARNING NEEDS

Table 12.14 illustrates the following key findings:

- The highest learning need identified by CHNs across Canada under standard 5 was the use of nursing informatics.
- Nunavut CHNs had the highest mean scores for most items related to this standard followed by PEI and the Yukon
- Overall many items in this standard were not identified as learning needs by most CHNs.

TABLE 11.4: DIFFERENCES BETWEEN PROVINCE/TERRITORY AND LEARNING NEEDS (MEANS, STANDARD DEVIATIONS AND F VALUES)

Top 10 Learning needs (mean >0.5)	**BC**	**AB**	**SK**	**MB**	**ON**	**QC**	**NB**	**PEI**	**NS**	**NL**	**TERR***	**F (df^1, df^2)**
23. I recognize trends in epidemiology data. ❖ No significant Difference	0.71 (1.07)	0.70 (1.06)	0.74 (1.00)	0.69 (1.09)	0.79 (1.00)	0.49 (1.15)	0.78 (0.88)	1.05 (0.81)	0.78 (0.93)	0.88 (1.86)	0.97 (0.89)	1.83 (10,1186) p=0.000
3. I use nursing informatics (i.e., information and communication technology) which includes generation, management, and processing of relevant data to support nursing practice. ❖ No significant difference	0.58 (1.01)	0.64 (0.93)	0.65 (0.97)	0.61 (1.02)	0.84 (0.96)	0.94 (0.84)	1.05 (0.82)	0.72 (0.96)	0.72 (0.96)	0.81 (0.95)	0.97 (0.78)	2.47 (10,1239) p=0.000
22. I apply epidemiological principles in using strategies (such as, a) screening, b) surveillance, c) communicable disease response, d) outbreak management and e) education. ❖ Territories differs from SK	0.60 (1.07)	0.51 (1.04)	**0.42** (1.09)	0.50 (1.11)	0.53 (1.04)	0.71 (0.96)	0.70 (1.10)	0.88 (0.84)	0.65 (0.94)	0.79 (0.87)	**0.92** (0.80)	2.31* (10,1191) p=0.000
2. I use research findings. ❖ No Significant difference	0.46 (1.00)	0.57 (0.88)	0.55 (1.01)	0.58 (0.91)	0.44 (1.01)	0.69 (0.97)	0.73 (0.92)	0.53 (0.88)	0.57 (0.87)	0.70 (0.96)	0.81 (0.93)	1.50 (10,1238) p=0.256
25a. I use community development principles when I: a) engage the individual/community in a consultative process. ❖ Sask. differs from PEI and the Territories	0.67 (1.03)	0.51 (0.99)	**0.34** (1.05)	0.69 (0.99)	0.52 (0.91)	0.52 (0.85)	0.58 1.02)	**0.90** (0.86)	0.51 (1.02)	0.61 (0.92)	**0.93** (0.83)	2.68* (10,1177) p=0.006
28. I use principles of social justice to support those who are unable to take action for themselves. ❖ No Significant difference	0.67 (0.95)	0.52 (1.03)	0.46 (0.98)	0.47 (0.96)	0.56 (0.95)	0.50 (1.02)	0.59 1.02)	0.72 (1.08)	0.512 (0.88)	0.66 (1.05)	0.81 (0.97)	1.18 (10,1204) p=0.230

26. I use a comprehensive mix of community/population based strategies (such as coalition building, intersectoral partnerships, and networking) to address issues of concern to groups/populations. ❖ Territories differ from Saskatchewan and Quebec	0.56 (1.02)	0.46 (1.03)	**0.41** (1.02)	0.66 (1.02)	0.49 (0.98)	**0.39** (1.02)	0.64 (1.02)	0.65 (1.00)	0.49 (1.02	0.66 (0.97)	**0.89** (0.88)	1.94 (10,1156) p=0.652
55c. I advocate for: c) healthy public policy, by participating in legislative and policymaking activities that influence health determinants. ❖ Quebec differs from PEI, NL and the Territories	0.58 (1.02)	0.41 (1.03)	0.56 (0.97)	0.62 (0.10)	0.57 (0.96)	**0.18** (1.02)	0.53 (1.04)	**0.79** (0.97)	0.57 (1.02)	**0.71** (0.99)	**0.70** (0.94)	2.57 (10,1172) p=0.915
8. In partnership with stakeholders, I evaluate population health promotion programs systematically ❖ Territories differs from BC, Alberta, Ontario, and Nova Scotia	**0.45** (0.97)	**0.43** (1.10)	0.53 (1.06)	0.52 (1.07)	**0.32** (1.06)	0.51 (0.92)	0.58 (1.01)	0.86 (0.87)	**0.39** (1.04)	0.73 (0.93)	**0.97** (0.84)	3.17* (10,1161) p=0.001
25d. I use community development principles when I: d) assist the group/community to marshal available resources to support taking action on their health issues. ❖ Territories differs from Saskatchewan	0.40 (1.05)	0.47 (1.01)	**0.39** (1.01)	0.57 (1.04)	0.41 (0.95)	0.57 (0.85)	0.57 (1.01)	0.86 (0.84)	0.51 (1.02)	0.51 (0.92)	**0.86** (0.86)	2.055 (2,1164) p=0.104

*significant where p<0.05

Online Survey Research

This survey was also prepared for delivery in an online modality which can easily be made available to CHNAC or any other agency who may wish to repeat this survey within their agency. It was prepared in SurveyMonkey which is simple to transfer to another account upon request. Please note, however, that this survey format has not been tested for reliability and validity. Therefore, any reference to reliability or validity of the questionnaire which was conducted on the paper-based instrument cannot be assumed for the online version. A link to the SurveyMonkey site can be found at: http://www.surveymonkey.com/s.aspx?sm=WUV7_2buT_2fOCljFBR3xMU0AQ_3d_3d

Practice Implications and Future Research

Consistent with Phase 1, CHNs identified similar learning needs for topics under each of the Standards. Topics identified as top learning needs suggest content areas for continuing education programming (e.g. PHAC Skills Enhancement Modules), for CHN orientation programs in the workplace as well as undergraduate nursing programs. Nurses reported needing more education on the theoretical concepts of health promotion (Ottawa Charter and Population Health Promotion Model as well as the Jakarta Declaration). However, it was surprising once again that the bulk of responses about activities related to these concepts (unsure, not applicable, and missing) indicated a lack of clarity about them in practice. For the low percentage of CHNs who responded to these items, there were minimal provincial differences seen except in Nunavut where CHNs reported practice activities related to these theoretical concepts. Further since almost 47.5% of our respondents have been in the workforce for more than 25 years, it is highly likely that many of these CHNs have not had any exposure to these concepts in their education. It is also possible that they do not have access to relevant literature about these theoretical approaches to health promotion. It is not surprising that CHNs working in public health reported a lower learning need for these three items (as a grouped mean score) compared to "other" CHN, since health promotion is one of their major roles and it would be expected that they would be working with these theories to a greater degree.

Surprisingly, there were only two statistically significant differences in learning needs by number of years in nursing which included: a) recognizing epidemiology trends and b) advocating for public policy for influencing determinants of health. Younger CHNs (6-10 years) had higher learning needs for these activities compared to nurses with more than 25 years of experience. There also appeared to be a general trend to nurses with less experience reporting slightly higher learning needs on the top 10 items.

Equally as surprising was the finding that there were no statistically significant differences by position as an RN or NP/Extended Class RN for the top 10 learning needs suggesting that programs are equally needed for nurses with advanced practice training as well as RNs. These results need to be interpreted cautiously given the small numbers of nurse practitioners participating in the survey (n=208). According to the Canadian Institute for Health Information (2007) the total number of nurse practitioners in Canada in 2007 was 1,346.

CHNs reported that they frequently used culturally relevant communication in building relationships. As was also found in phase 1 there was a need for more education on culturally sensitive communication and care. This further

stresses the relevance to practice in light of the changing Canadian demographic make up and the rise in immigrant populations. The need for more education on program evaluation and the application of epidemiologic data and service delivery may reflect the value placed on evidence-based practice in nursing. The fact that home health and public health differed significantly on their reported learning needs in relation to the item on program evaluation (public health had a higher learning need than home health) likely reflects the recent emphasis on this activity in public health.

Of importance in phase 2, are the topics such as the use of research findings, strategies to address roots cause of illness and disease, harm reduction principles, emergency preparedness, community development, range of community/population health approaches and healthy public policy advocacy, which were not identified in our first phase as learning needs (greater than 0.5). Though the results do indicate common learning needs across all provinces and territories, variations suggest there are likely unique characteristics of the nursing workforce and workplaces for CHNs such as in Nunavut and Quebec, and western compared to eastern provinces. These variations suggest that continuing education programs may need to be tailored at the provincial and territorial level. However, it is also important to note there are substantial commonalities in learning needs of Canadian CHNs. Statistical analysis of the top 10 learning needs by sector has shown that there were only two items with statistically significant differences. Nurses working in public health reported higher learning needs for evaluating population health promotion programs than home health, yet public health reported lower learning needs for the theoretical items (Jakarta Declaration, Ottawa Charter for Health Promotion and Population Health Promotion Model) compared to CHNs in the "other" category. The need to learn more about evaluation could be a reflection of a greater emphasis on program evaluation in public health as evidenced in the recent Core Competencies for Public Health in Canada 1.0 document (PHAC, 2007).

There were activities which were performed rarely by CHNs (working at the provincial/ territorial and federal levels, social marketing, engaging in healthy public policy advocacy, and conducting program evaluation). However there was also interest shown in learning more about these topics. This may indicate that although nurses are keen to learn more about these topics, these activities have been taken on by other members of the health care team or are typical for particular positions and thus nurses have fewer opportunities to perform them. Also, nurses typically work at a local level and therefore may rarely see their role as working at provincial and/or federal levels. Also, these activities may be often executed by other health professionals or organizational factors may hinder CHNs from these roles. Furthermore, the reduced involvement in these activities may indicate that the CCHN Standards no longer reflect current practice and require revision or that the role of community health nurses has changed since the standards were released in 2003.

ISSUES FOR CONSIDERATION FOR REVISION OF THE CCHN STANDARDS

A number of issues were identified in the wording of the CCHN Standards that may have caused difficulties when these statements were written for use in the survey. Problems that were noted follow:

THEORETICAL CONCEPTS:

The inclusion of knowledge items such as health promotion concepts and frameworks in the CCHN Standards may be confusing to nurses if they are unfamiliar with them. Standards typically refer to tangible activities that are related to level of services, interventions or an outcome rather than conceptual frameworks. The activity items listed under these standards assume that nurses know these theoretical concepts and conduct activities in relation to them. The study results which showed a high number of responses of unsure and or non applicable, may indicate a significant gap in knowledge related to each concept that underlies the various activities, rather than a

lack of knowledge or skill in the activities themselves. The items below provide the actual activities in the original standard that arise from the conceptual models.

Standard 1 A
Facilitates planned change with the individual/community/population through the application of the Population Health Promotion Model.

- Identifies the level of intervention necessary to promote health
- Identifies which determinants of health require action/change to promote health
- Utilizes a comprehensive range of strategies to address health-related issues.

Standard 1 A
Demonstrates knowledge of and effectively implements health promotion strategies based on the Ottawa Charter for Health Promotion.

- Incorporates multiple strategies addressing: a) healthy public policy; b) strengthening community action; c) creating supportive environments; d) developing personal skills, and e) re-orienting the health system
- Identifies strategies for change that will make it easier for people to make a healthier choice.

Standard 2
Facilitates action in support of 5 Priorities of the Jakarta Declaration to:

- Promote social responsibility for health
- Increase investments for health development
- Expand partnerships for health promotion
- Increase individual and community capacity
- Secure an infrastructure for health promotion.

SEPARATION OF RELATED STATEMENTS ACROSS MORE THAN ONE STANDARD

Related statements (related to epidemiology) in the Standards were placed under different components of Standard 1. Understanding and applying epidemiology may be better clumped together under the same Standard; the example below illustrates where items pertaining to epidemiology were found under Standard 1B and 1C.

Standard 1 B

- Applies epidemiological principles in using strategies such as screening, surveillance, immunization, communicable disease response and outbreak management and education.

Standard 1C

- Recognizes patterns and trends in epidemiological data and service delivery and initiates improvement strategies

USE OF THE TERM CLIENT

There was inconsistent use of term “client” and this varied in the standards from individual, family, or community. In addition, the use of “and/or” was not inclusive of families where activities were with families. See example below.

Standard 1B

- Helps individuals/communities make informed choices about protective and preventative health measures such as immunization, birth control, breastfeeding, and palliative care.

LACK OF LANGUAGE CLARITY

The language was vague often with multiple concepts and activities which can lead to various interpretations and confusion for the reader. For example support and respect are different activities and it is unclear the interpretation of diversity, unique characteristics and abilities. More examples are noted below.

Standard 1C

- Supports informed choice and respects the individual/family/community's specific requests while acknowledging diversity, unique characteristics and abilities.

Standard 4

- Assesses and understands individual and community capacities including norms, values, beliefs, knowledge, resources and power structure.

Standard 1A

- Understands and uses social marketing and media advocacy strategies to raise consciousness of health issues, place issues on the public agenda, shift social norms, and change behaviours if other enabling factors are present.

EXAMPLES DO NOT ALWAYS CLEARLY MATCH CONCEPTS

The fit between examples provided in the CCHN Standards and key concepts are sometimes unclear and can lead to confusion. For example protective and preventive measures are very different concepts. The alignment of the examples with the concepts is not always clear.

Standard 1B

- Helps individual and communities make informed choices about protective and preventive health measures such as immunization, birth control, breastfeeding and palliative care.

USE OF AMBIGUOUS LANGUAGE

The use of ambiguous terms such as "appropriate" may contribute to a lack of clarity in ideas. Examples are shown below.

Standard 1B

- Collaborates in developing and using follow-up systems within the practice setting to ensure that the individual/community receives <u>appropriate</u> and effective service.

Standard 1C

- Adapts community health nursing techniques, approaches and procedures as <u>appropriate</u> to the challenges inherent to the particular community situation/setting.

NONSENSICAL STATEMENTS

Some statements do not make sense. For example, how does a CHN monitor access to the determinant of health?

Standard 4

Monitors and evaluates changes/progress in access to the determinants of health and appropriate community services.

Building on the factor analysis which was conducted in Phase 1 (Tables 11.1 to 11.8), we plan to conduct further confirmatory analysis to determine which items load under factors. This process will help to refine the items used in the survey and may assist in the future revision of the CCHN Standards.

LIMITATIONS

A number of limitations have been identified in this survey:

- The definition of "community health nurses" was unclear and a number of CHN did not identify themselves as community health nurses (10.7%) even though they worked in community health settings. Though there were 18 different possible places of work in the community, nurses still identified many other places of work in the "other" category.

- The sampling method for PEI was different than the other provinces and territories. The PEI nursing regulatory organization did not participate in circulating the questionnaire rather referred us to various employers who hired community health nurses. Contact with each employer was made making out sampling strategy inconsistent across all provinces and territories.

- There was a duplication of questions 48a and 51. For analysis, question 51 was removed.

- The distance mailings were out of our control so we are unsure if the colleges and regulatory associations adhered strictly to the mail out schedule.

- The findings related to learning needs for the items related to the health promotion models/theory reflect a small sample of respondents and need to be viewed with caution. More research is required to understand the high number of respondents reporting "unsure" or "not-applicable" for these items in the questionnaire.

- The language used in the original Canadian Community Health Nursing Standards of Practice lacks clarity, which may have resulted in a variety of interpretations by respondents eg. applying epidemiological principles in Standard 1B and recognizing patterns and trend in epidemiology in standard 1C. However, face and content validity testing has helped to mitigate some of these concerns.

- Though the length of the questionnaire was shortened from phase 1 resulting from correlational analysis, the length of the questionnaire was still potentially a disincentive for respondents to complete.

- The response rate was relatively low.

CONCLUSIONS

Results from phase II suggest a number of important topic areas for continuing education of CHNs including a) health promotion theory, b) program evaluation, c) engaging in collaborative intersectoral partnerships, d) principles of epidemiology, e) nursing informatics, f) culturally relevant care, g) harm reduction, h) emergency

management, i) addressing service accessibility issues at the federal level, j) and advocating for health public policy. Results also indicate that there are some differences by province and territory both in performing CHN activities identified in the CCHN standards as well as learning needs related to them. For the top 10 learning needs, results show statistically significant differences by province/territory on many of the items warranting tailoring of continuing education programs for certain provinces or territories. The general lack of differences seen by years in nursing and title was somewhat surprising and indicates that there are more commonalities than differences in learning needs of CHNs across Canada. The variety of roles that CHNs play as well as the large range of community settings in which they work made it difficult to disaggregate CHNs into sectors. Further analysis will continue to be conducted to disaggregate groups and thereby obtain a stronger understanding of differences by place of work.

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APPENDICES

TABLE 12.1: **STANDARD 1A: HEALTH PROMOTION**: **ACTIVITIES PERFORMED BY CHNS BY PROVINCE/TERRITORY** [(MEAN (M) AND STANDARD DEVIATIONS (SD). SCALE "I PERFORM THE STATED ACTIVITY" 1= NEVER, 2= RARELY, 3 = SOMETIMES, 4= FREQUENTLY, 5= ALWAYS. N= 1,344]

Item	BC N=		AB		SK		MB		ON		QC		NB		PEI		NS		NL		YT		NT		NU	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
1.	4.1	0.8	4.0	0.8	4.1	0.8	4.1	0.9	4.2	0.8	**3.6**	1.1	4.1	1.0	3.9	0.9	4.0	0.8	4.1	0.8	4.4	0.6	3.9	0.9	**4.5**	0.8
2.	3.6	0.8	3.7	0.8	3.5	0.9	3.5	1.0	3.6	0.8	**3.0**	1.0	3.5	0.9	3.3	1.0	3.5	0.9	3.7	0.8	3.6	0.9	3.5	0.9	**4.1**	0.6
4a	4.7	0.7	4.7	0.6	4.6	0.8	4.7	0.7	4.6	0.8	4.5	0.8	4.6	0.6	4.5	0.9	4.7	0.6	**4.3**	0.9	4.6	0.6	4.5	0.5	**4.9**	0.4
4b	4.3	1.0	4.5	0.8	4.2	0.9	4.2	0.9	4.2	1.0	**4.0**	0.9	4.2	1.0	4.4	1.0	4.3	0.9	**4.0**	1.0	4.4	0.7	4.2	0.7	**4.6**	0.5
4c	3.8	1.0	3.6	1.1	3.7	1.0	3.6	1.1	3.7	1.1	**3.0**	1.2	3.4	1.2	3.5	1.1	3.5	1.1	3.7	1.0	3.9	1.0	3.8	1.0	**4.6**	0.8
4d	4.0	0.9	3.8	1.0	3.7	1.0	3.7	1.0	3.9	1.1	**3.2**	1.2	3.8	1.1	3.7	1.1	3.7	1.0	3.7	1.0	3.8	0.9	3.7	0.8	**4.5**	0.9
5	4.0	0.9	3.9	1.0	3.9	1.0	3.9	0.8	4.1	1.0	**3.5**	1.0	3.9	1.0	3.6	1.0	3.8	0.9	3.9	0.9	4.0	0.8	3.8	0.8	**4.2**	1..0
6	4.2	0.8	4.2	0.8	4.1	0.8	4.3	0.8	4.2	0.8	4.4	0.7	4.3	0.7	4.1	0.8	4.2	0.8	4.1	0.9	4.3	0.8	**4.0**	0.8	**4.6**	0.7
7a	2.7	1.1	2.6	1.1	2.7	1.0	2.7	1.1	3.0	1.2	**2.0**	1.1	2.6	1.1	2.5	0.9	2.4	1.1	2.8	1.1	3.0	0.9	3.0	1.1	**3.4**	1.0
7b	2.4	1.0	2.4	1.1	2.4	0.9	2.4	1.1	2.7	1.1	**2.0**	1.0	2.3	1.1	2.4	1.0	2.3	1.0	2.6	1.1	2.8	1.0	2.5	0.8	**2.9**	1.0
8	2.4	1.1	2.3	1.2	2.5	1.1	2.5	1.2	2.8	1.2	**2.2**	1.1	2.7	1.2	2.4	1.1	2.4	1.2	2.9	1.1	2.8	1.1	2.4	0.8	**3.1**	0.9
58	3.4	1.2	3.4	1.2	3.2	1.1	3.5	1.2	3.4	1.1	3.4	1.1	3.8	1.0	3.2	1.1	3.3	1.3	3.5	1.2	3.2	1.2	2.5	1.4	3.8	1.2
59	3.3	1.4	3.2	1.3	3.2	1.2	3.2	1.4	3.3	1.1	2.1	1.3	3.5	1.3	2.1	1.2	2.8	1.3	3.5	1.4	3.2	1.2	3.0	1.1	4.1	1.1

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

1. I use relevant information sources from multiple jurisdictional levels (e.g. local, regional, provincial/territorial, and national)
2. I use research findings.
4. In collaboration with the individual/community, I conduct assessments of:
    a. individual needs.
    b. individual assets, including available resources.
    c. community needs.
    d. community assets, including available resources.
5. I address root causes of illness and disease.
6. I assist the individual/community to take responsibility for improving their health by increasing their knowledge of the determinants of health.
7. I use social marketing strategies (i.e. media advocacy) to:
    a. Raise consciousness of health issues
    b. Shift social norms
8. In partnership with stakeholders, I evaluate population health promotion programs systematically.
58. I facilitate planned change through applying the Population Health Promotion Model.
59. I implement health promotion strategies based on the Ottawa Charter.

TABLE **12.2: STANDARD 1A: HEALTH PROMOTION: CHN'S LEARNING NEEDS BY PROVINCE/TERRITORY**. [MEAN (M) AND STANDARD DEVIATIONS (SD). "I NEED MORE EDUCATION RELATED TO THIS ACTIVITY" (SCALE -2 = COMPLETELY DISAGREE, -1 = GENERALLY DISAGREE, 0 = NEITHER AGREE NOR DISAGREE, +1 = GENERALLY AGREE, +2 = COMPLETELY AGREE)]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=28)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
1.	0.4	1.1	0.5	1.0	0.3	1.0	0.4	1.0	**0.3**	1.0	0.5	1.00	0.6	1.0	0.6	0.9	0.5	1.0	0.4	1.0	0.5	1.0	0.6	0.8	**1.1**	0.9
2.	0.5	1.0	0.6	0.9	0.6	1.0	0.6	0.9	**0.4**	1.0	0.7	1.0	0.7	0.9	0.5	0.9	0.6	0.9	0.7	1.0	0.8	1.0	**1.0**	0.6	0.8	1.1
4a	0.0	1.2	0.0	1.0	0.1	1.0	0.0	1.0	**-0.1**	1.1	0.3	1.1	0.1	1.1	0.3	1.2	0.2	1.0	0.0	1.1	0.3	0.9	0.2	0.6	**0.5**	1.0
4b	0.1	1.1	0.2	1.0	0.1	1.0	0.1	1.0	**0.0**	1.1	0.5	1.0	0.3	1.1	0.3	1.1	0.2	1.0	0.3	1.1	0.3	0.9	0.3	0.5	**0.7**	1.0
4c	0.4	1.1	0.4	0.9	0.3	1.1	0.5	1.0	**0.2**	1.0	0.4	1.0	0.6	1.1	0.6	1.0	0.5	1.0	0.4	1.0	0.6	0.9	0.5	0.5	**0.8**	1.0
4d	0.4	1.1	0.5	0.9	0.4	1.0	0.4	1.1	**0.2**	1.1	0.4	1.1	0.6	1.0	0.7	1.0	0.5	1.0	0.5	1.0	0.5	0.9	0.6	0.5	**0.8**	1.0
5	0.3	1.1	0.5	0.9	0.5	1.1	0.5	1.0	**0.2**	1.0	0.6	0.9	0.5	0.9	0.6	1.0	0.6	0.9	0.5	1.0	0.6	0.9	0.6	0.8	**1.0**	1.0
6	**0.2**	1.1	0.4	1.0	0.2	1.0	0.3	1.1	0.3	0.9	0.6	1.0	0.3	1.1	0.4	0.9	0.3	1.0	0.3	1.0	**0.7**	0.8	0.6	1.0	0.7	1.2
7a	0.5	1.0	0.4	1.0	0.4	1.0	0.5	1.0	0.4	1.1	**0.3**	1.0	0.4	1.0	0.8	0.9	0.4	1.0	0.5	0.9	0.8	0.9	**0.9**	0.6	0.9	1.0
7b	0.5	1.0	0.4	1.0	0.5	1.0	0.5	1.0	0.5	1.0	**0.3**	1.0	0.5	1.1	0.7	1.0	0.4	1.0	0.6	2.9	0.7	1.0	0.9	0.7	**0.9**	1.1
8	0.5	1.0	0.4	1.1	0.5	1.1	0.5	1.1	**0.3**	1.1	0.5	0.9	0.6	1.0	0.9	0.9	0.4	1.0	0.7	0.9	**1.0**	0.9	0.8	0.6	1.0	1.0
58	1.1	1.0	1.0	0.9	0.9	1.0	1.2	1.0	1.1	1.0	1.2	0.9	1.1	1.0	**1.3**	0.8	1.1	0.9	1.1	1.0	1.2	0.9	**0.9**	1.1	1.0	1.1
59	1.1	1.1	1.1	1.0	1.0	1.0	1.3	0.9	1.2	1.0	**1.4**	0.8	1.1	1.0	1.4	0.8	1.3	0.9	1.2	1.0	1.2	1.0	**0.9**	0.8	1.1	1.1

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

1. I use relevant information sources from multiple jurisdictional levels (e.g. local, regional, provincial/territorial, and national)
2. I use research findings.
4. In collaboration with the individual/community, I conduct assessments of:
    a. individual needs.
    b. individual assets, including available resources.
    c. community needs.
    d. community assets, including available resources.
5. I address root causes of illness and disease.
6. I assist the individual/community to take responsibility for improving their health by increasing their knowledge of the determinants of health.
7. I use social marketing strategies (i.e. media advocacy) to:
    a. Raise consciousness of health issues
    b. Shift social norms
8. In partnership with stakeholders, I evaluate population health promotion programs systematically.
58. I facilitate planned change through applying the Population Health Promotion Model.
59. I implement health promotion strategies based on the Ottawa Charter.

TABLE 12.3 **STANDARD 1B: PREVENTION AND HEALTH PROTECTION: ACTIVITIES PERFORMED BY CHNS BY PROVINCE/TERRITORY**. [(MEAN (M) AND STANDARD DEVIATIONS (SD). SCALE "I PERFORM THE STATED ACTIVITY" 1= NEVER, 2= RARELY, 3 = SOMETIMES, 4= FREQUENTLY, 5= ALWAYS. N= 1,344]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
9	4.1	1.0	4.2	0.9	4.0	1.0	4.1	1.0	4.1	1.1	4.1	0.9	4.3	0.8	4.0	1.1	3.8	1.1	4.2	1.0	4.5	0.7	4.5	0.7	**4.7**	0.5
10 a	4.1	0.9	4.2	0.8	**4.0**	0.9	4.2	0.8	4.2	0.9	4.2	0.7	4.3	0.7	4.4	0.7	4.1	0.8	**4.0**	0.8	4.3	0.8	4.1	0.7	**4.6**	0.7
10 b	4.2	0.8	4.3	0.8	**4.1**	0.9	4.3	0.7	4.2	0.9	4.3	0.6	4.4	0.6	4.4	0.8	4.2	0.7	4.2	0.7	4.3	0.8	4.2	0.6	**4.7**	0.5
10c	4.3	0.7	4.3	0.8	**4.0**	0.9	4.3	0.7	4.2	0.8	4.3	0.7	4.4	0.7	4.4	0.7	4.3	0.8	4.2	0.7	4.3	0. 8	4.1	0.5	**4.6**	0.5
11	**4.1**	1.0	3.9	1.0	3.9	0.9	3.9	1.0	3.9	1.0	3.9	0.9	4.0	1.1	**4.1**	0.7	4.0	0.9	**3.7**	1.0	**4.1**	1.0	**3.7**	0.9	4.0	1.0
12a	4.0	0.9	3.7	1.1	**3.6**	0.9	3.7	1.0	3.9	1.0	3.7	0.9	**4.1**	0.9	4.0	0.9	3.7	1.0	4.0	0.9	3.9	0.9	3.8	0.9	**4.1**	0.8
12b	3.3	1.2	3.1	1.2	3.2	1.0	3.3	1.1	3.4	1.2	**2.9**	1.1	3.4	1.1	3.5	0.9	3.3	1.2	3.6	1.1	3.5	1.1	3.1	1.0	**3.7**	1.0
13	3.8	1.0	4.1	0.9	3.7	0.9	3.9	0.9	4.0	1.0	3.7	1.1	4.1	0.9	4.2	0.7	4.0	0.9	**3.6**	1.0	4.2	0.6	4.0	0.9	**4.5**	0. 8
14	3.4	1.0	3.5	1.2	3.4	1.0	3.5	1.1	3.6	1.1	**3.1**	1.2	**3.8**	1.0	3.4	1.0	**3.8**	1.0	3.4	1.0	3.5	1.1	3.6	1.0	3.7	1.3

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

9. I select the appropriate level of preventative intervention [i.e. primary (immunization); secondary (screening); and tertiary (treatment and palliation)]
10. I help individuals/communities:
    a. Make informed choices about protective measures.
    b. Make informed choices about preventative measures.
    c. To identify potential risks to health.
11. In a variety of context, including home, neighbourhood, workplace, school, and street, I utilize harm reduction principles.
12. I engage in collaborative
    a. Interdisciplinary partnerships to address prevention issues
    b. Intersectoral partnerships to address prevention issues
13. To ensure that the individual/community receives effective service, I collaborate in using follow-up systems.
14. I evaluate collaborative practice (i.e.., personal, team, and/or intersectoral) in achieving individual/community health outcomes.

TABLE 12.4: **STANDARD 1B: PREVENTION AND HEALTH PROTECTION: CHN'S LEARNING NEEDS BY PROVINCE/TERRITORY**. [MEAN (M) AND STANDARD DEVIATIONS (SD). SCALE "I NEED MORE EDUCATION RELATED TO THIS ACTIVITY" -2 = COMPLETELY DISAGREE, -1 = GENERALLY DISAGREE, 0 = NEITHER AGREE NOR DISAGREE, +1 = GENERALLY AGREE, +2 = COMPLETELY AGREE]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=28)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
9	0.2	1.1	0.3	1.0	0.2	1.0	0.3	1.0	**0.1**	1.0	0.7	1.0	0.2	1.2	0.5	0.8	0.3	1.0	**0.1**	1.1	0.4	0.9	0.4	0.8	**0.9**	1.2
10 a	**0.2**	1.0	**0.2**	1.0	0.3	1.0	0.3	1.0	**0.2**	1.1	**0.7**	1.0	0.4	1.1	0.5	0.9	0.4	0.9	0.3	1.0	0.4	0.9	0.4	0.8	0.6	1.0
10 b	0.2	1.0	0.2	1.0	0.2	1.0	0.4	1.0	**0.1**	1.1	**0.7**	1.0	0.3	1.1	0.6	0.9	0.4	0.9	0.3	1.0	0.4	0.9	0.4	0.7	0.6	0.9
10c	**0.2**	1.0	0.3	1.0	**0.2**	0.9	0.3	1.0	**0.2**	1.0	0.7	1.0	**0.2**	1.0	0.6	0.9	0.4	1.0	0.3	1.0	0.5	0.9	0.6	0.8	**0.8**	0.9
11	**0.3**	1.1	0.5	1.0	**0.3**	1.0	0.5	1.0	**0.3**	1.0	0.6	1.0	0.4	1.1	0.7	0.8	0.4	1.0	0.6	0.9	0.7	0.9	0.9	0.8	**1.2**	0.8
12a	**0.2**	1.0	0.4	0.9	0.4	0.9	0.4	0.9	**0.2**	0.9	0.5	1.0	**0.2**	1.0	0.6	0.9	0.5	1.0	0.3	1.0	0.5	0.9	0.5	0.8	**0.7**	1.1
12b	**0.4**	1.0	0.5	1.0	**0.4**	0.9	0.5	1.0	**0.4**	1.0	**0.4**	1.1	0.5	1.0	0.8	0.9	0.6	1.0	0.5	0.9	0.7	1.0	0.7	0.7	**1.0**	1.1
13	0.3	1.0	**0.2**	1.0	0.3	1.0	0.3	0.9	**0.2**	1.1	**0.7**	1.0	0.5	1.1	0.6	0.9	0.3	1.0	0.5	0.9	0.6	0.8	0.4	0.9	**0.7**	0.8
14	0.5	0.9	**0.3**	1.0	0.5	1.0	0.4	0.9	0.4	1.0	0.5	0.9	0.5	1.0	0.6	0.9	0.4	1.0	0.6	0.9	0.7	0.8	**0.3**	1.0	**0.8**	0.8

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

9. I select the appropriate level of preventative intervention [i.e. primary (immunization); secondary (screening); and tertiary (treatment and palliation)]
10. I help individuals/communities:
    a. Make informed choices about protective measures.
    b. Make informed choices about preventative measures.
    c. To identify potential risks to health.
11. In a variety of context, including home, neighbourhood, workplace, school, and street, I utilize harm reduction principles.
12. I engage in collaborative
    a. Interdisciplinary partnerships to address prevention issues
    b. Intersectoral partnerships to address prevention issues
13. To ensure that the individual/community receives effective service, I collaborate in using follow-up systems.
14. I evaluate collaborative practice (i.e.., personal, team, and/or intersectoral) in achieving individual/community health outcomes.

TABLE 12.5 **STANDARD 1C HEALTH MAINTENANCE, RESTORATION AND PALLIATION: ACTIVITIES PERFORMED BY CHNS BY PROVINCE/TERRITORY.** [(MEAN (M) AND STANDARD DEVIATIONS (SD). SCALE "I PERFORM THE STATED ACTIVITY" 1= NEVER, 2= RARELY, 3 = SOMETIMES, 4= FREQUENTLY, 5= ALWAYS. N= 1,344]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=24)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
15a	4.2	1.0	4.2	0.9	4.0	0.9	4.2	0.9	4.0	1.0	4.0	0.9	4.1	0.9	**4.3**	0.7	4.2	0.9	4.0	0.9	**4.3**	0.8	**3.7**	0.7	3.9	1.1
15b	4.3	0.9	**4.4**	0.8	4.0	0.9	4.1	0.8	4.2	0.9	**3.9**	1.0	4.1	0.9	**4.4**	0.7	4.2	0.9	4.0	0.9	4.3	0.8	4.0	0.8	4.1	1.0
15c	4.2	0.9	**4.3**	0.9	3.9	1.0	4.0	1.0	4.1	0.9	3.9	1.0	4.0	1.1	**4.3**	0.8	4.2	1.0	3.9	1.0	4.1	1.0	**3.7**	0.7	3.9	1.0
16	4.4	0.8	4.5	0.8	4.3	0.9	4.3	1.0	**4.6**	0.8	**4.0**	1.0	4.4	0.9	4.5	0.7	**4.6**	0.9	4.2	1.0	4.4	0.8	4.2	0.9	4.5	0.7
17	4.4	0.7	4.3	0.9	4.2	0.8	**4.1**	0.9	4.2	1.0	4.0	1.0	4.3	0.9	4.2	0.9	4.4	0.8	4.2	0.8	4.3	0.7	4.2	0.4	**4.6**	0.7
18	4.3	0.7	4.3	0.7	**4.1**	0.8	4.2	0.9	4.2	0.8	4.4	0.7	**4.5**	0.7	4.4	0.6	**4.5**	0.7	4.2	0.8	4.4	0.6	4.2	0.7	4.4	0.6
19a	**4.7**	0.6	4.6	0.6	4.5	0.7	4.6	0.6	**4.7**	0.7	**4.1**	0.9	4.6	0.6	4.6	0.7	4.6	0.7	4.5	0.8	**4.7**	0.8	4.6	0.7	4.6	0.7
19b	**4.7**	0.5	4.6	0.5	4.5	0.7	4.6	0.6	**4.7**	0.6	**4.4**	0.7	**4.7**	0.6	**4.7**	0.6	**4.7**	0.6	4.5	0.8	**4.7**	0.5	4.5	0.7	4.6	0.7
20	**4.7**	0.5	4.6	0.6	4.6	0.6	4.6	0.6	**4.7**	0.5	4.6	0.6	**4.7**	0.6	**4.7**	0.6	**4.7**	0.6	4.6	0.6	4.6	0.5	**4.5**	0.5	**4.7**	0.5
21	4.4	0.7	4.3	0.8	**4.2**	0.8	4.3	0.7	4.5	0.7	4.3	0.8	4.5	0.7	4.3	0.8	4.5	0.7	4.3	0.7	4.6	0.6	4.4	0.7	**4.7**	0.6
22	3.7	1.1	3.5	1.1	3.6	1.0	3.6	1.1	3.9	1.1	**3.2**	1.3	3.7	1.0	3.8	1.0	3.7	1.1	3.8	1.0	3.7	1.0	3.9	1.3	**4.3**	0.8
23	3.3	1.0	3.2	1.0	3.4	0.9	3.3	1.0	3.5	1.0	**2.5**	1.2	3.3	1.0	3.4	0.9	3.4	1.1	3.5	1.0	3.5	0.9	3.5	1.0	**4.1**	1.0
24	3.9	1.0	3.8	1.1	3.6	1.0	3.7	1.1	**4.0**	1.0	3.9	1.0	3.9	1.1	3.6	0.9	**4.0**	0.9	3.6	1.0	3.8	1.1	**3.4**	1.2	3.9	0.9

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

15. I assess the individual/ family/population's:
    a. Health status within the context of their environmental support.
    b. Health status within the context of their social supports.
    c. Functional competence within the context of their environmental support.
16. I develop a mutually agreed upon plan of care with the individual /family.
17. I identify a range of interventions, including health promotion, disease prevention, and direct clinical care strategies (including those related to palliation)
18. I maximize the ability of an individual//family/community to take responsibility for their health needs according to available resources.
19. I support informed choice of the individual/family/ community's specific requests while recognizing their
    a. diversity
    b. Abilities
20. I respect the individual/family/community's specific requests whole recognizing their abilities
21. I adapt community health nursing techniques/approaches/procedures to the challenges inherent to the particular community situation/setting.
22. I adapt epidemiological principles in using strategies [such as a) screening, b) surveillance, c) communicable disease response, d) outbreak management and e) education]
23. I recognize trends in epidemiological data.
24. I facilitate maintenance of health in response to significant emergencies that negatively impact upon the health of clients.

TABLE 12.6: **STANDARD 1C HEALTH MAINTENANCE, RESTORATION AND PALLIATION: CHN'S LEARNING NEEDS BY PROVINCE/TERRITORY.** [MEAN (M) AND STANDARD DEVIATIONS (SD). SCALE "I NEED MORE EDUCATION RELATED TO THIS ACTIVITY" -2 = COMPLETELY DISAGREE, -1 = GENERALLY DISAGREE, 0 = NEITHER AGREE NOR DISAGREE, +1 = GENERALLY AGREE, +2 = COMPLETELY AGREE]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
15a	**0.2**	1.0	**0.2**	1.0	**0.2**	1.0	0.3	0.9	**0.2**	0.9	0.6	0.9	0.3	1.0	0.5	0.9	0.3	1.0	0.4	1.0	0.5	0.9	0.3	0.6	**0.7**	0.9
15b	**0.1**	1.0	0.2	1.0	0.2	1.0	0.3	0.9	0.2	0.9	0.6	0.9	0.3	1.0	0.5	0.9	0.3	1.0	0.4	1.0	0.5	0.9	**0.1**	0.8	**0.8**	0.9
15c	0.3	1.0	0.3	1.0	0.4	1.0	0.4	0.9	0.3	0.9	0.6	0.9	0.4	1.1	0.6	0.9	0.3	1.0	0.4	1.0	0.6	0.9	**0.2**	0.6	**0.9**	0.8
16	**0.1**	1.1	**0.1**	1.0	0.1	1.0	**0.1**	1.0	0.1	1.0	0.5	1.1	0.1	1.1	0.5	0.9	0.0	1.0	0.0	1.0	0.3	0.8	0.2	0.9	**0.8**	0.8
17	**0.2**	1.0	0.3	1.0	0.3	0.9	0.3	1.0	**0.2**	1.1	0.6	1.0	0.4	1.1	0.5	0.8	0.3	1.0	0.3	1.0	0.4	0.9	0.5	0.8	**0.9**	0.8
18	0.3	1.1	0.2	1.0	0.2	1.0	0.2	1.1	**0.1**	1.0	0.5	0.9	0.3	1.0	0.5	0.9	0.4	1.0	0.2	1.0	0.4	0.9	0.4	0.9	**0.7**	1.0
19a	0.2	1.1	0.2	1.0	**0.0**	1.0	0.1	1.1	0.1	1.0	0.4	1.0	0.1	0.9	0.5	1.0	0.3	1.0	0.1	1.0	0.3	0.9	0.2	0.8	**0.7**	1.0
19b	0.1	1.1	0.1	1.0	**0.0**	1.0	0.1	1.0	0.1	1.0	0.4	1.0	**0.0**	0.9	0.4	1.0	0.2	1.0	0.1	1.0	0.4	0.8	0.2	0.7	**0.7**	1.0
20	**0.1**	1.0	0.1	1.0	**0.1**	1.0	0.0	1.0	0.0	1.0	0.3	1.0	0.1	1.0	0.4	1.0	0.1	0.9	0.1	0.9	0.4	0.8	**0.1**	0.6	**0.6**	1.0
21	0.3	1.1	0.4	1.0	**0.2**	1.0	0.4	1.0	**0.2**	1.0	0.6	0.9	**0.2**	1.0	0.6	0.9	0.3	1.0	0.3	1.0	0.7	0.8	0.3	0.8	**1.0**	0.7
22	0.6	1.1	0.5	1.0	**0.4**	1.1	0.5	1.1	0.5	1.0	0.7	1.0	0.7	1.1	0.9	0.8	0.7	0.9	0.8	0.9	0.9	0.8	0.9	0.7	**1.0**	0.9
23	0.7	1.1	0.7	1.1	0.7	1.0	0.7	1.1	0.8	1.0	**0.5**	1.2	0.8	0.9	**1.1**	0.8	0.8	0.9	0.9	0.9	1.0	0.9	0.6	0.8	**1.1**	1.0
24	0.4	1.0	0.5	1.0	**0.3**	1.1	0.4	1.1	0.4	0.9	0.6	0.9	0.5	1.0	0.7	0.9	0.6	0.9	0.6	0.9	0.6	0.9	0.7	1.0	**1.2**	0.6

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

15. I assess the individual/ family/population's:
    a. Health status within the context of their environmental support.
    b. Health status within the context of their social supports.
    c. Functional competence within the context of their environmental support.
16. I develop a mutually agreed upon plan of care with the individual /family.
17. I identify a range of interventions, including health promotion, disease prevention, and direct clinical care strategies (including those related to palliation)
18. I maximize the ability of an individual//family/community to take responsibility for their health needs according to available resources.
19. I support informed choice of the individual/family/ community's specific requests while recognizing their
    a. diversity
    b. Abilities
20. I respect the individual/family/community's specific requests whole recognizing their abilities.
21. I adapt community health nursing techniques/approaches/procedures to the challenges inherent to the particular community situation/setting.
22. I adapt epidemiological principles in using strategies [such as a) screening, b) surveillance, c) communicable disease response, d) outbreak management and e) education]
23. I recognize trends in epidemiological data.
24. I facilitate maintenance of health in response to significant emergencies that negatively impact upon the health of clients.

TABLE 12.7 **STANDARD 2 BUILDING INDIVIDUAL/COMMUNITY CAPACITY: ACTIVITIES PERFORMED BY CHNS BY PROVINCE/TERRITORY**. [(MEAN (M) AND STANDARD DEVIATIONS (SD) (SCALE "I PERFORM THE STATED ACTIVITY" 1= NEVER, 2= RARELY, 3 = SOMETIMES, 4= FREQUENTLY, 5= ALWAYS) N= 1,344]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
25a	3.8	1.1	3.7	1.1	3.6	1.0	3.5	1.0	3.8	1.0	3.5	1.0	3.7	0.9	3.7	0.9	3.8	1.0	**3.9**	1.0	3.8	1.0	**3.3**	0.9	3.7	1.1
25b	3.8	1.0	3.7	1.1	3.6	0.9	3.7	0.9	**4.0**	0.9	3.6	1.1	3.8	1.0	3.7	0.8	3.9	1.0	3.6	1.0	3.8	1.0	**3.2**	0.7	3.9	0.8
25c	3.5	1.2	3.2	1.2	3.3	1.0	3.4	1.0	**3.8**	1.1	**3.1**	1.2	3.4	1.1	3.4	1.0	3.4	1.2	3.6	1.0	3.6	1.2	3.2	0.8	3.4	1.2
25d	3.4	1.1	**3.0**	1.1	3.1	0.9	3.3	1.0	**3.7**	0.9	3.2	1.1	3.6	0.9	3.3	1.0	3.3	1.1	3.4	1.0	3.3	1.2	3.2	0.7	3.5	1.2
26	3.4	1.1	**3.0**	1.1	3.1	0.9	3.3	1.0	**3.7**	0.9	3.2	1.1	3.6	0.9	3.3	1.0	3.3	1.1	3.4	1.0	3.3	1.2	3.2	0.7	3.5	1.2
27	3.1	1.1	2.8	1.2	2.8	1.1	2.9	1.1	**3.4**	1.1	**2.7**	1.1	3.1	1.1	2.9	1.2	3.1	1.2	**3.4**	1.1	3.0	1.1	3.1	1.0	**3.4**	1.2
28	**3.9**	1.0	**3.9**	1.0	3.5	1.0	3.7	1.0	**3.9**	0.9	**3.2**	1.1	3.8	1.0	3.8	1.1	**3.9**	1.0	3.7	1.1	**3.9**	0.9	3.4	1.2	**3.9**	1.0
60	3.7	1.1	3.5	1.2	3.3	1.1	3.5	1.1	3.6	1.1	**3.1**	1.3	3.6	1.1	3.7	1.1	3.8	1.1	3.6	1.1	3.6	1.1	3.5	1.0	**4.3**	1.0

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

25. I use community development principles when I:
    a. engage the individual/community in a consultative process
    b. use empowering strategies (such as mutual goal setting, visioning, and facilitation).
    c. use facilitative skills to support group development
    d. assist the group/community to marshal available resources to support taking action on their health issues.
26. I use a comprehensive mix of community/population based strategies (such as coalition building, intersectoral partnerships, and networking) to address issues of concern to populations/groups.
27. I support individual/family/community/population in developing skills of self-advocacy.
28. I use principles of social justice to support those who are unable to take action for themselves.
60. I facilitate action in support of the five priorities of the Jakarta Declaration.

TABLE 12.8: **STANDARD 2 BUILDING INDIVIDUAL/COMMUNITY CAPACITY: CHN'S LEARNING NEEDS BY PROVINCE/TERRITORY.** [MEAN (M) AND STANDARD DEVIATIONS (SD) "I NEED MORE EDUCATION RELATED TO THIS ACTIVITY" (SCALE -2 = COMPLETELY DISAGREE, -1 = GENERALLY DISAGREE, 0 = NEITHER AGREE NOR DISAGREE, +1 = GENERALLY AGREE, +2 = COMPLETELY AGREE)]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
25a	0.7	1.0	0.5	1.0	**0.3**	1.1	0.7	1.0	0.5	0.9	0.5	0.9	0.6	1.0	0.9	0.9	0.5	1.0	0.6	0.9	1.0	0.9	0.7	0.6	**1.1**	0.9
25b	0.5	1.0	0.4	1.1	**0.3**	1.0	0.4	1.0	**0.3**	0.9	0.5	1.0	0.5	1.1	0.7	0.9	0.6	1.0	0.5	1.1	0.8	0.8	0.4	0.5	**1.1**	0.9
25c	0.5	1.0	0.4	1.1	0.4	1.0	0.6	1.1	0.2	1.0	0.6	0.9	0.6	1.1	0.7	1.0	0.6	1.0	0.5	1.0	0.9	0.8	**0.4**	0.7	**1.2**	0.8
25d	**0.4**	1.1	0.5	1.0	**0.4**	1.0	0.6	1.0	**0.4**	1.0	0.6	0.9	0.6	1.0	0.9	0.8	0.5	1.0	0.5	0.9	0.9	0.9	0.5	0.5	**1.1**	1.0
26	**0.4**	1.1	0.5	1.0	**0.4**	1.0	0.6	1.0	**0.4**	1.0	0.6	0.9	0.6	1.0	0.9	0.8	0.5	1.0	0.5	0.9	0.9	0.9	0.5	0.5	**1.1**	1.0
27	0.6	1.0	0.5	1.0	**0.4**	1.0	0.7	1.0	0.5	1.0	**0.4**	1.0	0.6	1.0	0.7	1.0	0.5	1.0	0.7	1.0	1.0	0.8	**0.4**	1.0	**1.1**	0.9
28	0.5	1.0	0.4	1.0	0.4	1.0	0.4	1.0	0.4	1.0	0.4	1.0	0.4	1.1	0.6	0.9	0.4	1.0	0.4	1.0	0.7	0.9	**0.3**	0.9	**1.1**	0.9
60	0.7	1.0	0.5	1.0	**0.3**	1.1	0.7	1.0	0.5	0.9	0.5	0.9	0.6	1.0	0.9	0.9	0.5	1.0	0.6	0.9	1.0	0.9	0.7	0.6	**1.1**	0.9

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

25. I use community development principles when I:
    a. engage the individual/community in a consultative process
    b. use empowering strategies (such as mutual goal setting, visioning, and facilitation).
    c. use facilitative skills to support group development
    d. assist the group/community to marshal available resources to support taking action on their health issues.
26. I use a comprehensive mix of community/population based strategies (such as coalition building, intersectoral partnerships, and networking) to address issues of concern to populations/groups.
27. I support individual/family/community/population in developing skills of self-advocacy.
28. I use principles of social justice to support those who are unable to take action for themselves.
60. I facilitate action in support of the five priorities of the Jakarta Declaration.

TABLE 12.9: **STANDARD 3 BUILDING RELATIONSHIP: ACTIVITIES PERFORMED BY CHNS BY PROVINCE/TERRITORY**. [(MEAN (M) AND STANDARD DEVIATIONS (SD) (SCALE "I PERFORM THE STATED ACTIVITY" 1= NEVER, 2= RARELY, 3 = SOMETIMES, 4= FREQUENTLY, 5= ALWAYS) N= 1,344]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
29	4.45	0.6	4.4	0.6	**4.3**	0.7	4.4	0.6	4.5	0.7	**4.3**	0.7	**4.7**	0.5	4.5	0.6	4.5	0.7	4.5	0.6	4.5	0.5	4.6	0.5	4.6	0.6
30	4.3	0.8	4.2	0.7	**4.2**	0.7	4.3	0.8	4.4	0.7	**4.2**	0.8	**4.4**	0.8	**4.4**	0.7	**4.4**	0.7	4.3	0.6	4.2	0.7	**4.4**	0.5	**4.4**	0.8
31	4.4	0.7	4.2	0.8	4.3	0.7	4.5	0.6	4.4	0.7	**3.7**	1.0	4.2	0.9	4.2	0.9	4.4	0.7	4.3	0.7	**4.7**	0.5	4.5	0.5	4.6	0.6
32	4.2	0.7	**4.1**	0.7	4.1	0.7	4.1	0.8	4.2	0.7	4.2	0.7	4.2	0.7	4.3	0.7	4.3	0.7	4.2	0.7	4.2	0.7	4.1	0.8	**4.5**	0.9
33a	4.1	0.8	3.9	0.8	**3.8**	0.8	3.9	0.8	4.0	0.8	**4.2**	0.7	4.0	0.8	4.0	0.9	4.0	0.8	3.9	0.9	3.9	0.8	**3.8**	0.8	4.0	1.1
33b	4.5	0.6	4.4	0.7	4.1	0.7	4.3	0.7	4.4	0.8	**4.0**	0.8	4.4	0.6	4.5	0.6	4.3	0.7	4.3	0.7	4.5	0.6	4.1	0.5	**4.6**	0.5
34	4.0	0.9	3.9	1.1	3.4	1.1	3.8	1.0	4.0	1.0	**3.2**	1.3	3.8	1.3	**4.2**	0.8	3.8	1.1	3.6	1.0	3.5	1.1	3.7	1.0	4.1	0.8
35	4.5	0.6	4.4	0.6	**4.3**	0.7	4.4	0.6	4.5	0.7	**4.3**	0.7	**4.7**	0.5	4.5	0.6	4.5	0.7	4.5	0.6	4.5	0.5	4.6	0.5	4.6	0.6

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

I recognize my own personal perspective (such as attitudes, beliefs, assumptions, feelings, and values) about their potential effect on interventions with individuals/communities.

29. I identify the individual/ community's perspective (such as beliefs, attitudes, feelings, and values) about health.
30. I am aware of culturally relevant communication in building relationships.
31. I trust and respect the individual/family/community's ability to:
    a. Identify their health issues.
    b. Solve their own problems.
32. I maintain awareness of community resources.
33. I negotiate an end to the individual/family/community relationship.

TABLE 12.10: **STANDARD 3 BUILDING INDIVIDUAL/COMMUNITY CAPACITY: CHN'S LEARNING NEEDS BY PROVINCE/TERRITORY**. [MEAN (M) AND STANDARD DEVIATIONS (SD) "I NEED MORE EDUCATION RELATED TO THIS ACTIVITY" (SCALE -2 = COMPLETELY DISAGREE, -1 = GENERALLY DISAGREE, 0 = NEITHER AGREE NOR DISAGREE, +1 = GENERALLY AGREE, +2 = COMPLETELY AGREE)]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
29	0.1	1.1	0.1	1.0	0.0	0.9	0.1	1.0	0.0	1.0	0.3	1.0	**-0.1**	1.1	0.3	0.9	0.1	1.0	**-0.1**	1.1	0.3	0.9	0.1	1.0	**0.9**	1.0
30	0.2	1.1	0.2	1.0	0.1	1.00	0.2	1.0	0.1	1.0	0.4	1.0	**0.0**	1.1	0.5	0.9	0.2	1.0	0.1	1.0	0.6	0.8	0.3	1.0	**1.1**	0.8
31	0.6	1.1	0.6	1.0	**0.3**	1.0	**0.3**	1.0	0.4	1.0	0.7	1.0	0.6	1.1	0.8	0.9	0.4	1.0	0.5	1.0	0.5	0.9	0.6	0.8	**1.1**	0.8
33a	0.1	1.0	0.2	0.9	0.1	0.9	0.2	1.0	0.1	0.9	0.4	1.0	0.2	1.1	0.5	0.9	0.2	0.9	**0.0**	1.0	0.4	0.8	0.5	0.9	**1.0**	0.8
33b	0.2	1.0	0.2	0.9	**0.1**	0.9	0.2	1.0	**0.1**	0.9	0.5	1.0	0.2	1.0	0.6	0.9	0.3	0.9	**0.1**	1.0	0.6	0.8	0.2	0.6	**1.2**	0.8
34	**0.2**	1.1	0.3	1.0	0.3	1.0	0.3	1.0	**0.2**	1.0	0.6	1.1	0.4	1.1	0.6	1.0	0.4	1.0	**0.2**	1.0	0.4	0.8	0.4	0.8	**1.1**	0.6
35	0.2	1.0	0.1	1.0	0.1	1.0	0.2	1.0	**0.0**	0.9	0.2	1.1	0.1	1.0	0.3	1.0	0.3	1.0	0.3	1.0	0.3	0.8	0.3	0.6	**0.9**	0.8

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

29. I recognize my own personal perspective (such as attitudes, beliefs, assumptions, feelings, and values) about their potential effect on interventions with individuals/communities.
30. I identify the individual/ community's perspective (such as beliefs, attitudes, feelings, and values) about health.
31. I am aware of culturally relevant communication in building relationships.
33. I trust and respect the individual/family/community's ability to
    a) identify their health issues
    b) solve their own problems.
34. I maintain awareness of community resources.
35. I negotiate an end to the individual/family/community relationship.

TABLE 12.11 **STANDARD 4 FACILITATING ACCESS AND EQUITY: ACTIVITIES PERFORMED BY CHNS BY PROVINCE/TERRITORY.** [(MEAN (M) AND STANDARD DEVIATIONS (SD) (SCALE "I PERFORM THE STATED ACTIVITY" 1= NEVER, 2= RARELY, 3 = SOMETIMES, 4= FREQUENTLY, 5= ALWAYS) N= 1,344]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
32	3.8	0.9	3.6	1.0	3.8	0.9	3.9	0.9	3.8	1.0	3.6	1.2	3.6	1.1	**3.3**	1.2	3.6	1.1	3.5	1.1	4.3	0.7	4.3	0.6	**4.4**	0.6
36	3.9	0.9	3.7	0.9	3.6	0.9	3.8	0.9	4.0	0.9	3.9	1.0	4.0	0.9	3.8	1.1	3.9	0.9	3.6	0.9	3.7	0.9	**3.4**	0.9	**4.3**	0.7
37	4.0	0.9	4.0	0.8	3.8	0.8	4.0	0.9	**4.2**	0.8	**3.5**	0.9	4.0	0.8	3.9	1.0	4.1	0.9	3.9	1.0	4.3	0.9	3.9	0.8	3.8	0.8
38a	4.3	0.7	4.4	0.6	4.3	0.6	4.3	0.7	4.3	0.7	4.2	0.6	4.3	0.6	4.6	0.5	4.2	0.7	4.3	0.8	4.5	0.6	**4.1**	0.5	**4.7**	0.6
38b	3.7	1.0	3.6	1.0	**3.5**	1.0	3.6	1.1	3.7	1.1	3.6	0.9	3.6	1.0	4.0	0.8	**3.5**	1.0	3.8	1.0	3.9	1.0	3.8	0.8	**4.1**	1.1
39a	4.0	0.8	4.2	0.9	3.9	0.9	4.0	0.9	4.0	1.0	**3.6**	1.2	4.0	1.0	4.0	0.9	3.9	0.9	4.0	1.0	4.2	0.8	4.2	0.6	**4.6**	0.7
39b	3.3	1.1	3.4	1.1	3.1	1.1	3.4	1.2	3.3	1.2	**3.0**	1.2	3.2	1.1	3.6	1.0	3.1	1.1	3.5	1.1	3.6	1.0	3.5	0.8	**3.8**	1.3
40	3.9	0.9	3.9	1.0	3.7	0.9	3.9	1.0	**4.0**	1.0	**3.4**	1.1	3.7	1.1	3.6	1.1	3.8	1.1	3.8	0.9	3.9	0.8	3.5	1.1	**4.0**	0.9
41	4.2	0.9	4.0	1.1	3.9	1.1	4.0	1.1	4.1	1.1	**3.5**	1.4	3.7	1.4	**4.3**	0.8	4.0	1.1	4.0	1.0	4.2	0.9	3.9	0.8	4.0	1.1
42a	3.7	1.0	3.5	1.1	**3.4**	1.1	3.5	1.0	3.8	1.0	3.5	1.2	3.7	1.1	3.5	1.0	3.8	1.1	3.7	1.0	3.8	0.8	3.6	1.1	**4.1**	0.9
42b	2.6	1.2	2.5	1.3	2.5	1.1	2.7	1.3	3.0	1.2	**1.9**	1.2	2.5	1.3	2.8	1.2	2.7	1.2	2.9	1.1	3.0	1.2	2.8	1.1	**3.5**	1.3
42c	2.4	1.2	2.1	1.3	2.2	1.1	2.4	1.3	2.5	1.3	**1.8**	1.1	2.3	1.1	2.8	1.0	2.7	1.3	2.7	1.3	2.7	1.3	2.4	1.1	**3.6**	1.4
42d	1.9	1.2	1.7	1.1	1.9	1.1	2.1	1.3	2.1	1.0	**1.3**	0.8	1.7	1.0	1.9	0.8	2.1	1.2	2.1	1.2	2.3	1.3	2.0	1.0	**3.0**	1.6

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

32. I provide culturally relevant care in diverse communities.
36. I assess individual and community capacities (Such as norms, values, beliefs, knowledge, resources and power structures.
37. I support individuals, communities in their choice to access alternative health care options.
38. I refer to services within:
    a. the health sector.
    b. other sectors.
39. I coordinate access to services within:
    a. the health sector.
    b. other sectors.
40. I provide programs to individuals/communities using delivery methods that are responsive to their needs.
41. I use strategies (such as home visits, outreach, and case findings) for vulnerable populations to ensure access to services.
42. To address service accessibility issues, I take action, based on evidence, with individuals/communities at the:
    a. organizational.
    b. municipal.
    c. Provincial/territorial.
    d. federal levels.

TABLE 12.12: **STANDARD 4 FACILITATING ACCESS AND EQUITY: CHN'S LEARNING NEEDS BY PROVINCE/TERRITORY.** [MEAN (M) AND STANDARD DEVIATIONS (SD) "I NEED MORE EDUCATION RELATED TO THIS ACTIVITY" (SCALE -2 = COMPLETELY DISAGREE, -1 = GENERALLY DISAGREE, 0 = NEITHER AGREE NOR DISAGREE, +1 = GENERALLY AGREE, +2 = COMPLETELY AGREE)]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
32	0.6	1.1	0.5	1.0	**0.3**	1.0	0.4	1.0	0.6	1.0	0.5	1.0	0.6	1.2	1.0	0.9	0.5	0.9	0.4	1.0	0.6	1.0	0.7	0.8	**0.9**	0.8
36	0.4	1.0	0.4	1.0	**0.3**	0.9	0.4	1.0	**0.3**	1.0	0.5	0.9	0.4	1.1	0.5	1.0	0.4	1.0	0.5	0.9	0.8	0.8	0.5	0.8	**1.1**	0.9
37	0.2	1.1	0.3	0.9	0.3	1.0	0.3	1.0	**0.1**	1.0	0.4	0.9	0.5	1.0	0.6	0.9	0.5	1.0	0.4	0.9	0.6	0.9	0.5	0.9	**0.7**	0.9
38a	0.0	1.1	0.0	0.9	0.0	0.9	0.1	0.9	0.2	1.0	0.3	0.9	0.1	1.0	0.3	1.0	0.3	0.9	**0.1**	1.0	0.2	0.8	0.2	1.2	**0.6**	0.7
38b	0.2	1.1	0.3	1.0	0.3	1.0	0.3	1.0	0.2	1.0	0.3	0.9	0.3	1.0	0.5	1.0	0.5	0.9	**0.1**	1.0	0.5	0.9	0.3	1.2	**0.9**	0.7
39a	0.0	1.0	0.0	0.9	0.0	1.0	0.2	1.0	0.1	1.0	0.3	1.0	0.0	1.0	0.3	0.8	0.3	0.9	**0.1**	1.0	0.3	0.9	0.2	1.2	**0.9**	0.7
39b	0.2	1.0	0.2	1.0	**0.1**	1.0	0.3	1.0	0.2	1.0	0.3	0.9	0.3	1.1	0.4	0.9	0.5	0.9	**0.1**	1.0	0.4	0.9	0.3	1.0	**1.1**	0.7
40	0.3	1.1	**0.2**	1.0	0.3	0.9	0.3	1.0	**0.2**	0.9	0.4	1.0	0.3	1.1	0.4	0.9	0.3	0.9	**0.2**	1.0	0.5	0.9	0.5	0.9	**0.9**	0.6
41	**0.0**	1.1	0.1	1.0	0.1	1.0	0.1	1.0	**0.0**	1.0	0.4	1.0	0.1	1.1	0.2	0.9	0.2	1.0	0.1	1.1	0.3	1.0	0.2	0.8	**0.9**	0.9
42a	0.3	1.0	0.2	1.0	0.3	1.0	0.2	1.1	**0.1**	1.0	0.2	1.0	0.2	1.1	0.5	0.9	0.3	1.1	0.2	1.0	0.4	0.9	0.2	0.6	**1.1**	0.8
42c	0.4	1.0	0.4	1.0	0.4	1.0	0.4	1.1	**0.2**	1.1	**0.2**	1.0	0.4	1.1	0.5	0.9	0.4	1.0	0.4	1.0	0.5	0.9	0.5	0.8	**1.1**	0.8
42c	0.5	1.0	0.5	1.0	0.5	1.0	0.4	1.1	0.4	1.1	**0.2**	1.0	0.6	1.1	0.5	1.0	0.5	1.1	0.4	1.0	0.6	0.9	0.5	0.8	**1.2**	0.7
42d	0.5	1.0	0.5	1.0	0.5	1.0	0.5	1.2	0.4	1.1	**0.2**	1.0	0.6	1.1	0.6	1.0	0.5	1.1	0.5	1.0	0.7	0.9	0.5	0.7	**1.2**	0.7

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

32. I provide culturally relevant care in diverse communities.
43. I assess individual and community capacities (Such as norms, values, beliefs, knowledge, resources and power structures.
44. I support individuals, communities in their choice to access alternative health care options.
45. I refer to services within:
    c. the health sector.
    d. other sectors.
46. I coordinate access to services within:
    a. the health sector.
    b. other sectors.
40. I provide programs to individuals/communities using delivery methods that are responsive to their needs.
41. I use strategies (such as home visits, outreach, and case findings) for vulnerable populations to ensure access to services.
42. To address service accessibility issues, I take action, based on evidence, with individuals/communities at the:
    a. organizational.
    b. municipal.
    c. Provincial/territorial.
    d. federal levels.

TABLE 12.13: **STANDARD 5 DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY: ACTIVITIES PERFORMED BY CHNS BY PROVINCE/TERRITORY.** [(MEAN (M) AND STANDARD DEVIATIONS (SD) (SCALE "I PERFORM THE STATED ACTIVITY" 1= NEVER, 2= RARELY, 3 = SOMETIMES, 4= FREQUENTLY, 5= ALWAYS) N= 1,344]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
3	3.8	1.1	3.8	1.1	3.6	1.0	3.5	1.0	3.8	1.0	**3.3**	1.2	3.8	1.0	3.8	1.0	3.6	1.1	3.8	1.0	3.6	1.0	3.6	1.2	**3.9**	0.9
43a	4.2	0.9	4.2	0.9	4.1	0.8	4.2	0.8	**4.4**	0.9	**3.9**	1.0	4.1	1.0	4.3	0.9	**4.4**	0.7	4.0	0.9	4.2	0.9	4.2	0.7	4.3	0.9
43b	4.0	1.0	3.9	1.1	3.8	1.1	3.9	1.1	4.1	1.1	**3.5**	1.2	3.8	1.3	3.9	1.2	4.1	1.0	3.7	1.0	4.0	0.9	4.1	0.9	**4.4**	0.8
44a	3.7	1.1	3.6	1.1	3.6	1.0	3.8	1.1	**4.0**	1.0	**3.5**	1.0	3.9	1.0	3.9	1.1	3.9	1.0	3.6	0.9	3.9	0.9	3.7	0.8	3.6	1.2
44b	4.1	0.9	4.1	0.9	4.0	0.9	4.1	0.9	**4.3**	0.9	**3.9**	1.0	4.2	1.0	4.1	0.9	**4.3**	0.8	4.0	0.9	**4.3**	0.8	**3.9**	1.0	**4.3**	1.0
45a	3.5	1.2	3.6	1.1	3.4	1.1	3.3	1.2	3.4	1.2	**2.9**	1.3	3.5	1.1	**4.0**	0.8	3.1	1.3	3.7	1.1	3.4	1.2	3.6	0.7	3.5	1.3
45b	3.4	1.2	3.5	1.2	3.1	1.2	3.3	1.3	3.5	1.2	**2.9**	1.2	3.1	1.2	**3.8**	1.0	3.0	1.2	3.5	1.2	3.5	1.1	3.5	1.0	**3.8**	1.3
46	3.6	0.9	3.7	0.9	3.6	0.9	4.0	0.9	3.9	0.9	**3.5**	0.9	3.8	0.9	3.9	0.9	**3.5**	0.9	4.0	0.9	3.7	0.9	**4.1**	0.8	4.0	1.0
47	4.2	0.7	4.1	0.7	4.0	0.8	4.0	0.8	4.0	0.8	**3.6**	0.9	4.1	0.9	4.1	0.6	4.0	0.8	4.2	0.8	4.1	0.7	4.3	0.6	**4.4**	0.9
48a	3.5	0.9	3.3	1.0	3.4	0.9	3.4	1.0	3.5	1.0	**2.9**	1.0	3.5	1.0	3.5	0.9	3.5	1.0	3.5	1.0	3.6	1.1	3.5	0.9	**3.9**	1.0
48b	3.2	1.1	3.1	1.1	3.1	1.1	3.1	1.0	3.3	1.0	**2.8**	1.1	3.2	1.2	3.3	1.0	3.0	1.1	3.4	1.1	3.5	0.9	3.1	1.0	**3.8**	1.4
49	4.0	0.9	4.0	0.8	3.8	0.8	4.0	0.9	4.0	0.9	**3.7**	1.0	4.2	0.8	4.1	0.9	4.2	0.8	4.0	0.8	4.0	0.8	**4.4**	0.7	**4.4**	0.5
50a	4.2	0.9	4.2	0.9	3.8	0.9	4.0	0.9	4.1	1.0	**3.7**	1.0	4.1	1.0	4.1	0.9	4.2	0.9	4.1	0.9	4.2	0.9	4.1	0.8	**4.4**	0.8
50b	4.2	0.8	4.3	0.8	4.1	0.8	4.1	0.9	4.2	0.8	**3.9**	0.9	4.2	0.9	4.2	0.8	4.2	0.8	4.2	0.8	4.1	0.9	4.1	0.6	**4.4**	0.8
52a	4.0	0.7	3.9	0.7	3.9	0.8	3.9	0.8	4.1	0.7	**3.8**	0.7	4.0	0.7	4.1	0.7	4.0	0.9	**3.8**	0.8	4.1	0.7	3.9	0.6	**4.3**	0.8
52b	3.7	0.9	3.7	0.9	3.6	0.9	3.7	0.9	3.9	0.9	3.5	0.9	3.7	0.9	3.8	0.9	3.6	1.0	3.5	1.0	3.7	0.9	**3.4**	0.9	**4.1**	0.7
52c	3.9	1.0	3.9	0.9	3.9	0.9	3.8	0.9	**4.2**	0.8	3.8	0.9	3.9	0.9	4.1	0.8	3.7	1.0	3.8	0.9	4.1	0.9	**3.4**	1.1	4.1	0.9
53	3.8	0.8	3.8	0.8	3.7	0.8	3.7	1.0	3.8	0.8	3.7	0.7	3.8	0.9	**3.9**	0.8	3.7	0.9	3.8	0.8	**3.9**	0.9	**3.4**	0.9	**3.9**	0.9
54	4.6	0.7	4.6	0.6	**4.3**	0.8	4.6	0.7	**4.7**	0.6	4.4	0.9	4.5	0.8	4.4	0.8	4.4	0.8	4.5	0.7	4.6	0.6	4.1	0.8	4.6	0.7
55a.	4.0	0.9	**3.9**	0.9	4.0	0.9	4.1	0.9	4.0	1.0	4.0	0.9	4.1	1.0	4.2	0.8	4.0	0.9	4.0	0.9	4.0	1.0	**3.9**	0.9	**4.3**	1.0
55b.	3.5	1.1	3.5	1.0	3.5	1.1	3.8	1.0	3.7	1.1	3.6	0.9	3.6	1.1	3.6	1.0	3.6	1.2	3.7	0.9	**3.8**	1.0	**3.1**	1.2	**3.8**	1.0
55c.	2.2	1.0	2.1	1.2	2.2	1.0	2.2	1.2	2.5	1.2	2.1	1.1	2.1	1.1	2.3	0.9	2.2	1.2	2.7	1.2	2.6	1.2	**2.0**	0.9	**2.9**	1.4
56	4.0	1.0	4.2	0.8	**3.8**	1.0	3.9	0.9	**4.5**	0.8	4.1	0.7	4.0	1.0	**3.8**	0.9	3.9	0.9	3.9	1.0	3.9	1.0	3.9	0.8	4.2	0.7
57	3.3	1.1	3.4	1.0	3.3	1.0	3.3	1.1	3.6	1.0	3.4	1.1	**3.7**	1.0	3.4	0.8	3.4	1.1	3.4	1.0	3.3	1.2	**3.0**	1.2	3.5	1.1

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

3. I use nursing informatics (i.e., information and communication technology) which includes generation, management, and processing of relevant data to support nursing practice.
43. I take preventative action to protect individuals/communities from:
    a. unsafe circumstances.
    b. unethical circumstances.
44. I take action on factors which impinge on:
    a. autonomy of practice
    b. quality of care
45. I participate in the advancement of community health nursing by:
    a. mentoring students.
    b. mentoring novice practitioners.
46. I participate in professional activities.
47. I seek professional development experiences that are consistent with current community health nursing practice.
48. I address nursing issues that will affect the population through:
    a. personal advocacy
    b. participation in relevant professional associations.
49. I make decisions using ethical standards/principles, taking into consideration the tension between individual versus the societal good of all people.
50. I seek assistance with problem solving, as needed, to determine the best course of action in response to:
    a. ethical dilemmas.
    b. new situations.

52. I contribute proactively to the quality of the work environment by:
    a. identifying solutions
    b. mobilizing colleagues.
    c. actively participating in team/organizational structures.
53. I provide constructive feedback to peers to enhance community health nursing practice.
54. I document community health nursing activities, including telephone advice and work with clients, in a thorough manner.
55. I advocate for:
    a. effective/efficient use of community health resources.
    b. resource allocation for of individuals, groups, and populations, to facilitate access to conditions for health and health services.
    c. healthy public policy, by participating in legislative and policy making activities that influence health determinants.
56. I use reflective practice as a means of continually seeking to improve personal community health nursing practice
57. I use available resources to systematically evaluate community health nursing practice (e.g.., availability, acceptability, quality, efficiency, and effectiveness).

TABLE 12.14: **STANDARD 5 DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY: CHN'S LEARNING NEEDS BY PROVINCE/TERRITORY.** [MEAN (M) AND STANDARD DEVIATIONS (SD) "I NEED MORE EDUCATION RELATED TO THIS ACTIVITY" (SCALE -2 = COMPLETELY DISAGREE, -1 = GENERALLY DISAGREE, 0 = NEITHER AGREE NOR DISAGREE, +1 = GENERALLY AGREE, +2 = COMPLETELY AGREE)]

Item	BC (n=147)		AB (n=174)		SK (n=155)		MB (n=128)		ON (n=123)		QC (N=122)		NB (n=104		PEI (n=48)		NS (n=145)		NL (n=122)		YT (n=48)		NT (n=14)		NU (n=14)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
3	**0.6**	1.0	**0.6**	0.9	0.7	1.0	0.7	1.0	**0.6**	1.0	0.8	1.0	0.9	0.8	1.1	0.8	0.7	1.0	0.8	1.0	1.0	0.8	0.7	0.5	**1.2**	0.8
43a	0.2	1.0	0.2	1.0	0.2	1.0	0.2	0.9	**0.1**	1.0	0.5	1.0	**0.1**	1.2	0.4	0.9	0.3	1.0	0.2	1.0	0.3	0.9	0.5	0.8	**1.0**	1.0
43b	0.3	1.0	0.4	1.0	0.3	1.0	0.2	1.0	**0.2**	1.0	0.6	0.9	**0.2**	1.1	0.6	0.9	0.3	1.0	0.4	1.0	0.5	1.0	0.7	0.8	**1.2**	1.0
44a	0.3	1.0	0.4	0.9	0.4	0.9	**0.1**	1.0	0.3	0.9	0.4	1.0	0.4	1.0	0.6	0.8	0.4	1.0	0.4	1.0	0.6	0.8	0.5	0.8	**1.0**	0.8
44b	**0.2**	1.0	0.3	1.0	0.3	0.9	**0.2**	1.0	0.3	1.0	0.5	1.0	0.3	1.0	0.5	0.9	0.4	1.0	0.4	1.0	0.5	0.9	0.5	0.8	**1.0**	0.8
45a	0.2	1.0	**0.1**	1.0	0.2	1.0	**0.1**	1.1	**0.1**	1.0	0.3	1.0	**0.1**	1.1	0.4	0.9	0.2	0.9	**0.1**	1.1	0.6	0.9	0.2	1.1	**0.8**	0.8
45b	0.1	1.0	**0.0**	1.0	0.1	1.0	0.1	1.0	**0.0**	1.0	0.2	1.0	**0.0**	1.1	0.3	0.9	0.1	1.0	**0.0**	1.0	0.6	0.9	0.3	0.9	**0.9**	0.7
46	**0.0**	1.1	0.1	0.9	0.1	0.9	0.1	1.0	**0.0**	1.0	0.5	1.1	0.1	1.2	0.4	1.0	0.1	0.9	0.1	1.0	0.5	0.8	0.2	0.7	**0.7**	1.1
47	0.4	1.1	0.4	1.0	0.3	1.0	0.3	1.1	0.3	1.0	0.8	0.9	0.5	1.2	0.6	1.0	0.5	0.9	**0.2**	1.1	0.6	0.9	0.6	1.0	**1.2**	0.8
48a	0.3	1.0	0.3	0.9	**0.1**	0.9	0.3	1.0	0.2	0.8	0.3	1.0	0.3	1.0	0.3	0.9	0.4	0.9	**0.1**	0.9	0.5	0.8	0.5	0.8	**0.7**	0.8
48b	0.2	1.0	0.2	0.8	0.1	0.9	0.2	1.0	0.2	0.9	0.2	1.0	0.2	1.0	0.4	1.0	0.4	0.9	**0.1**	1.0	0.5	0.9	**0.6**	0.8	**0.6**	0.8
49	0.4	1.0	0.4	0.9	**0.2**	0.9	0.3	1.0	0.4	0.9	0.5	1.0	0.4	1.0	0.5	0.9	0.5	0.9	0.3	1.0	0.6	0.8	0.5	1.0	**1.0**	0.9
50a	0.4	1.0	0.4	1.0	0.4	0.9	**0.3**	0.9	**0.3**	1.0	0.7	0.9	0.5	1.0	0.6	1.0	0.5	1.0	**0.3**	1.0	0.5	0.9	0.4	0.8	**1.0**	0.9
50b	0.3	1.0	0.4	1.0	0.3	1.0	**0.2**	0.9	0.3	1.0	0.6	0.9	0.4	1.0	0.5	0.9	0.4	0.9	0.3	1.0	0.5	0.9	0.4	0.8	**1.0**	0.8
52a	0.2	1.0	0.2	0.9	0.2	0.9	0.2	0.9	**0.1**	0.9	0.4	0.9	0.3	1.0	0.5	0.9	0.3	0.9	0.3	1.0	0.4	0.8	0.3	0.8	**0.8**	1.1
52b	0.3	1.0	0.2	1.0	0.2	0.9	0.2	1.0	**0.1**	1.0	0.4	0.9	0.2	1.0	0.5	0.9	0.3	0.9	0.3	1.0	0.4	0.9	0.3	0.8	**0.7**	1.0
52c	0.2	1.0	0.1	1.0	0.2	0.9	0.1	1.0	**0.0**	1.0	0.4	0.9	0.2	1.0	0.5	1.0	0.3	0.9	0.2	1.0	0.4	0.9	0.3	0.8	**0.9**	0.9
53	0.2	1.0	0.2	0.9	0.2	0.9	**0.1**	1.0	**0.1**	1.0	0.4	0.9	0.2	1.1	**0.6**	0.9	0.3	1.0	0.2	1.0	0.5	0.8	0.3	0.8	0.5	0.8
54	0.1	1.1	0.1	1.0	0.1	1.0	0.1	1.0	0.2	1.0	0.4	1.1	**0.0**	1.2	**0.5**	1.1	0.2	0.9	**0.0**	1.1	0.2	1.0	**0.5**	0.8	**0.5**	1.1
55a.	**0.2**	1.0	0.3	1.0	0.3	0.9	**0.2**	1.0	**0.2**	1.0	0.4	0.9	0.3	1.0	0.5	0.8	0.4	1.0	0.3	1.0	0.5	0.9	0.6	0.9	**0.9**	0.6
55b.	0.3	1.0	0.4	1.0	0.3	0.9	0.4	0.9	**0.2**	1.0	0.4	1.0	0.4	1.0	0.6	0.9	0.5	1.0	0.4	1.0	0.5	1.0	0.4	1.0	**0.8**	0.6
55c.	0.6	1.0	0.4	1.0	0.6	1.0	0.6	1.0	0.6	1.0	**0.2**	1.0	0.5	1.0	**0.8**	1.0	0.6	1.0	0.7	1.0	**0.8**	0.9	0.5	1.0	**0.8**	0.9
56	0.2	1.0	0.3	1.0	0.4	1.0	0.3	1.0	**0.0**	1.0	0.4	0.9	0.5	1.1	**0.6**	0.8	0.4	1.0	0.4	1.0	**0.6**	0.8	0.2	1.1	0.5	1.0
57	0.5	1.0	0.4	0.9	0.5	1.0	0.5	1.0	**0.3**	1.0	0.6	0.9	0.7	0.9	0.8	0.9	0.5	0.9	0.7	0.9	0.8	0.8	**0.9**	0.8	0.8	0.6

Note: Bolded mean indicates highest or lowest score for item.

Item Legend:

3. I use nursing informatics (i.e., information and communication technology) which includes generation, management, and processing of relevant data to support nursing practice.

51. I take preventative action to protect individuals/communities from:
    a. unsafe circumstances.
    b. unethical circumstances.
52. I take action on factors which impinge on:
    a. autonomy of practice
    b. quality of care
53. I participate in the advancement of community health nursing by:
    a. mentoring students.
    b. mentoring novice practitioners.
54. I participate in professional activities.
55. I seek professional development experiences that are consistent with current community health nursing practice.
56. I address nursing issues that will affect the population through:
    a. personal advocacy
    b. participation in relevant professional associations.
57. I make decisions using ethical standards/principles, taking into consideration the tension between individual versus the societal good of all people.
58. I seek assistance with problem solving, as needed, to determine the best course of action in response to:
    a. ethical dilemmas.
    b. new situations.

52.I contribute proactively to the quality of the work environment by:
    a. identifying solutions
    b. mobilizing colleagues.
    c. actively participating in team/organizational structures.

53. I provide constructive feedback to peers to enhance community health nursing practice.

54. I document community health nursing activities, including telephone advice and work with clients, in a thorough manner.

55. I advocate for:
    a. effective/efficient use of community health resources.
    b. resource allocation for of individuals, groups, and populations, to facilitate access to conditions for health and health services.
    c. healthy public policy, by participating in legislative and policy making activities that influence health determinants.

56. I use reflective practice as a means of continually seeking to improve personal community health nursing practice

57. I use available resources to systematically evaluate community health nursing practice (e.g., availability, acceptability, quality, efficiency, and effectiveness).

TABLE 13.1: FACTOR ANALYSIS RESULTS FOR STANDARD 1A: HEALTH PROMOTION

Factor 1	Factor Loading	Factor 2	Factor Loading	Factor 3	Factor Loading
4b. In collaboration with the individual/community, I conduct assessments of individual assets, including available resources.	.857	7c. I use social marketing strategies (i.e., media advocacy) to shift social norms.	.859	2. I use research findings.	.795
4a. In collaboration with the individual/community, I conduct assessments of individual needs.	.739	7a. I use social marketing strategies (i.e., media advocacy) to raise consciousness of health issues.	.763	1. I use relevant information sources from multiple jurisdictional levels (e.g., local, regional, provincial/territorial, and national).	.585
4d. In collaboration with the individual/community, I conduct assessments of community assets, including available resources.	.555	8. In partnership with stakeholders, I evaluate population health promotion programs systematically.	.647		
4c. In collaboration with the individual/ community, I conduct assessments of community needs.	.520				
6c. improving their health by increasing their knowledge of the determinants of health.	.489				
Items which did not load on any factor but were kept: Item 5. I seek to address root causes of illness and disease.					

TABLE 13.2: FACTOR ANALYSIS RESULTS FOR STANDARD 1B: PREVENTION AND HEALTH PROTECTION

Factor 1:	Factor Loading	Factor 2	Factor Loading	Factor 3	
10b. I help individuals/communities: make informed choices about preventative health measures (e.g., breast feeding and immunization).	.870	12b. I engage in collaborative interdisciplinary partnerships to address prevention issues.	.803	15. I evaluate collaborate practice (i.e., personal, team, and/or intersectoral) in achieving individual/community health outcomes.	.745
10a. I help individuals/communities: a) make informed choices about protective health measures (e.g., immunization.	.816	12d. I engage in collaborative interdisciplinary intersectoral partnerships to address prevention issues.	.757	13b. To ensure that the individual/community receives effective service, I collaborate in using follow-up systems.	.592
10c. I help individuals/communities: to identify potential risks to health.	.729				
9. I select the appropriate level of preventative intervention (i.e., primary, e.g., immunization; secondary, e.g., screening; and tertiary, e.g., treatment and palliation).	.533				
11b. In a variety of contexts, including home, neighbourhood, workplace, school and street, I utilize harm reduction principals to reduce risk factors.	.464				
Items that did not load on any factor and were dropped: 14. I practice in accordance with legislation relevant to community health practice (e.g., public health legislation and child protection).* It was assumed that all nurses must abide by the above statement; it was not felt to distinguish CHN practice.					
Items that did not load on any factor and were kept: 24. I apply epidemiological principles in using strategies (such as, a) screening, b) surveillance, c) communicable disease response, d) outbreak management, and e) education).					

TABLE 13.3: FACTOR ANALYSIS RESULTS FOR STANDARD 1C: HEALTH MAINTENANCE, RESTORATION AND PALLIATION

Factor 1	Factor Loading	Factor 2	Factor Loading	Factor 3	
20c. I support informed choice of the individual/family/community's specific requests while recognizing their abilities.	.860	16b. I assess the individual/ family/population's health status within the context of their social supports.	.868	18. I identify a range of intervention, including health promotion, disease prevention, and direct clinical care strategies (including those related to palliation).	.729
20a. I support informed choice of the individual/family/community's specific requests while recognizing their diversity.	.855	16a. I assess the individual/ community/population's health status within the context of their environmental support.	.843	17. I develop a mutually agreed upon plan of care with the individual/family.	.664
21c. I respect the individual/family/community's specific requests whole recognizing their abilities.	.726	16c. I assess the individual/ community/population's functional competence within the context of their environmental support.	.804	26a. In response to significant health emergencies that negatively impact upon health for clients, I facilitate maintenance of health.	.417
19a. I maximize the ability of an individual/family/community to take responsibility for their health needs according to available resources.	.653				
22. I adapt community health nursing technology/ approaches/ procedures to the challenges inherent to the particular community situation/setting.	.630				
Items that did not load on any factor and were dropped: 23. I use knowledge of the community to develop community resources.					
Items that did not load on any factor and were kept: 25a. I recognize trends in: a) epidemiological principles.					

TABLE 13.4: FACTOR ANALYSIS RESULTS FOR STANDARD 2 BUILDING INDIVIDUAL/COMMUNITY CAPACITY

Factor 1	Factor Loading	Factor 2	Factor Loading
27f. I use community development principles when I assist the group/community to marshal available resources to support taking action on their health issues.	.843	29. I support the individual/ family/ community/ population in developing skills of self-advocacy.	.655
27c. I use community development principles when I use empowering strategies (such as mutual goal setting, visioning, and facilitation).	.776	30. I use principles of social justice to support those who are unable to take action for themselves.	.598
27d. I use community development principles when I use facilitation skills to support group development.	.768		
27a. I use community development principles when I I use community development principles when I engage the individual/community in a consultative process.	.768		
28. I use a comprehensive mix of community/population based strategies (such as coalition building, intersectoral partnerships, and networking) to address issues of concerns to groups/populations.	.551		
Items that did not load on any factor and were dropped: 32. I evaluate the impact of change on individual/community health outcomes.			

TABLE 13.5: FACTOR ANALYSIS RESULTS FOR STANDARD 3: **BUILDING RELATIONSHIPS**

Factor 1	Factor Loading	Factor 2	Factor Loading
34a. I identify the individual/community's perspective (such as attitudes, beliefs, feelings, and values) about health.	.759	38b. I trust and respect the individual/family/community's ability to solve their own problems.	.807
33b. I identify the individual/community's perspective (such as attitudes, beliefs, feelings, and values) about their potential effect on interventions with individuals/communities.	.694	38a. I trust and respect the individual/family/community's ability to know the issue they are addressing.	.759
35. I am aware of culturally relevant communication in building relationships.	.518		
39. I maintain awareness of community resources.	.453		
41. I negotiate an end to the individual/family/community relationship.	.405		
Items that did not load on any factor and were dropped: 40. I maintain professional boundaries.			

TABLE 13.6: FACTOR ANALYSIS RESULTS FOR STANDARD 4 **FACILITATING ACCESS AND EQUITY**

Factor 1	Factor Loading	Factor 2	Factor Loading	Factor 3	Factor Loading
49c. To address services accessibility issues, I take action, based on evidence, with individuals/communities at the provincial/territorial.	.951	45a. I coordinate access to services within: the health sector.	.808	42. I assess individual and community capacities (such as norms, values, beliefs, knowledge, resources, and power structures).	.796
49b. To address services accessibility issues, I take action, based on evidence, with individuals/communities at the municipal.	.817	45b. I coordinate access to services within: other sectors.	.747	43. I support individual/communities in their choice to access alternate health care options.	.780
49d. To address services accessibility issues, I take action, based on evidence, with individuals/communities at the federal levels.	.770	47b. I use strategies (such as home visits, outreach, and case finding) for vulnerable populations to ensure access to services.	.477	44a. I refer to services within: a) the health sector.	.557
62c. I advocate for healthy public policy, by participating in legislative and policymaking activities that influence health determinants.	.494	[46. I provide programs to individuals/communities using delivery methods that are responsive to their needs.**	.464		
49a. To address services accessibility issues, I take action, based on evidence, with individuals/communities at the: a) organizational.	.445	44b. I coordinate access to services within other sectors.** This is the same as 45b. is this typo?]	.462		
Items that did not load on any factor and were kept: 37. I provide culturally relevant care to diverse communities. 62b. I advocate for resource allocating for individuals, groups, and populations, to facilitate access to conditions for health and health services					

TABLE 13.7: FACTOR ANALYSIS RESULTS FOR STANDARD 5 DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY

Factor 1	Factor Loading	**Factor 2**	Factor Loading	**Factor 3**	Factor Loading
59d. actively participating in team/organizational structures.	.762	51a. I take action on factors which impinge on: a) autonomy of practice	.705	53. I participate in professional activities.	.706
59c. Mobilizing colleagues	.720	51b. I take action on factors which impinge on: quality of care	.698	54. I seek professional development experiences that are consistent with current community health nursing practice.	.694
59b. identifying solutions.	.689			55b. participation in relevant professional associations.	.664
60. I provide constructive feedback to peers to enhance community health nursing practice.	.631				
56a. I make decisions using ethical standards/principles, taking into consideration the: a) tension between individual versus the societal good of all people.	.567				
55a. I address nursing issues that will affect the population through personal advocacy.	.512				
57a. I advocate for effective/efficient use of community health nurse resources	.435				
Factor 4	Factor Loading	Factor 5	Factor Loading	Factor 6	Factor Loading
61b. I document community health nursing activities, including telephone advice and work with clients, in a thorough manner.	.902	52b. I participate in the advancement of community health nursing by mentoring novice practitioners.	.730	65. I use available resources to systematically evaluate community health nursing practice (e.g., availability, acceptability, quality, efficiency, and effectiveness).	.503

		52a. I participate in the advancement of community health nursing by mentoring students.	.714	3. I use nursing informatics (i.e., information and communication technology) which included generation, management, and processing of relevant data to support nursing practice.	.476
Items that did not load on any factor but were kept: 62a. I advocate for effective/efficient use of community health nurse resources. 63b. I use reflective practice as a means of continually seeking to improve personal community health nursing practice seeking to improve personal community health nursing practice. **Items that did not load on any factor but were dropped as they were felt to be redundant:** 64b. I act upon legal obligations to report to authorities situations where care provided by caregivers (e.g., family, friends, or other individuals) to children or vulnerable adults is: unethical.					

TABLE 14: LIST OF DELETED ITEMS BASED ON CORRELATION ANALYSIS

STANDARD 1: HEALTH PROMOTION	
Question	**Statement***
6a	I assist the individual/community to take responsibility for: maintaining their health by increasing their *knowledge* of the determinants of health.
6b	I assist the individual/community to take responsibility for: maintaining their health by increasing their *influence* on the determinants of health.
6d	I assist the individual/community to take responsibility for: improving their health by increasing their *influence* on the determinants of health.

7b	I use social marketing strategies (i.e., media advocacy) to: place issues on the public health agenda.
7d	I use social marketing strategies (i.e., media advocacy) to: change behaviours if other enabling factors are present.
11a	In a variety of contexts, including home, neighbourhood, workplace, school, and street, I utilize harm reduction principles to: identify risk factors.
12a	I engage in collaborative: interdisciplinary partnerships to address *protection* issues.
12c	I engage in collaborative: intersectoral partnerships to address *protection* issues.
13a	To ensure that the individual/ community receives effective service, I collaborate in: developing follow-up-systems.
14	I practice in accordance with legislation relevant to community health practice (e.g., public health legislation and child protection).
16d	I assess the individual/family/ population's: functional competence within the context of their *social supports*.
19b	I maximize the ability of an individual/family/community to take responsibility for their health needs according to available: personal skills.
20b	I support informed choice of the individual/family/community's specific requests while recognizing their: unique characteristics.
21a	I respect the individual/family/ community's specific requests while recognizing their: diversity.
21b	I respect the individual/family/ community's specific requests while recognizing their: unique characteristics.

23	I use knowledge of the community to develop community resources.
25b	I recognize trends in: service delivery.
26b	In response to significant health emergencies that negatively impact upon health for clients, I facilitate: the healing process.
STANDARD 2: BUILDING INDIVIDUAL/COMMUNITY CAPACITY	
27b	I use community development principles when I: build on the individual/ community readiness for participation.
27e	I use community development principles when I: enable the individual/community to participate in the resolution of their issues.
31	I engage in advocacy to support those who are unable to take action for themselves.
32	I evaluate the impact of change on individual/community health outcomes.
STANDARD 3: BUILDING RELATIONSHIPS	
33a	I recognize my own personal perspective (such as attitudes, beliefs, assumptions, feelings, and values) about: health.
34b	I identify the individual/ community's perspective (such as beliefs, attitudes, feelings, and values) about: their potential effect on interventions.
36	I use culturally relevant communication in building relationships.

40	I maintain professional boundaries.
STANDARD 4: FACILITATING ACCESS AND EQUITY	
47a	I use strategies (such as home visits, outreach, and case finding) for vulnerable populations to ensure access to: health supporting conditions.
48a	To address service gaps, I take action, based on evidence, with individuals/communities at the: organizational level.
48b	To address service gaps, I take action, based on evidence, with individuals/communities at the: municipal level.
48c	To address service gaps, I take action, based on evidence, with individuals/communities at the: provincial/territorial level.
48d	To address service gaps, I take action, based on evidence, with individuals/communities at the: federal level.
62d	I advocate for: healthy public policy, by participating in legislative and policymaking activities that influence *access to services*.
STANDARD 5:	
56b	I make decisions using ethical standards/principles, taking into consideration the: responsibility to uphold the greater good of all people.
57b	I seek assistance with problem solving, as needed, to determine the best course of action in response to: risks to human rights and freedoms.
59a	I contribute proactively to the quality of the work environment by: identifying needs/issues.

61a	I document community health nursing activities, including telephone advice and work with clients, in a: timely manner.
63a	I use reflective practice as a means of continually: assessing personal community health nursing practice.
64a	I act upon legal obligations to report to authorities situations where care provided by caregivers (e.g., family, friends, or other individuals) to children or vulnerable adults is: unsafe.
64b	I act upon legal obligations to report to authorities situations where care provided by caregivers (e.g., family, friends, or other individuals) to children or vulnerable adults is: unethical.

*Note: Numbering of statements are taken from the original questionnaire in Phase 1