

The Study of Public Health Nurses Primary Health Care Practice

Fostering Citizen Participation and Collaborative Practice:  
Tapping the Wisdom and Voices of  
Public Health Nurses in Nova Scotia



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# executive summary

This qualitative study, commonly called the “PHNs’ Voices Project”, contributes to a deeper understanding of the complex and unique primary health care practice of public health nurses (PHNs) in Nova Scotia. The study also describes the PHNs’ practice in the context of health care restructuring in Nova Scotia and other internal and external organisational factors.

To address the study objectives, a random selection of PHNs across Nova Scotia participated in individual (n=43) and focus group (n=32) interviews, as well key informants in Public Health management from the Department of Health (n=3) and the District Health Authorities (n=4) participated in individual interviews. Documents were reviewed that relate to public policy and funding decisions that significantly affect Public Health and PHN practice. The data was analysed using qualitative methods.

**The findings are categorised under the following headings in this paper:**

- *The Public Health Nurse: Professional Practice*
- *Making a Difference: Working Collaboratively to Promote Accessibility and Citizen Participation*
- *Organisational Context*
- *Visibility*
- *Conclusions*
- *Strengthening Public Health Nurses’ Contribution to Primary Health Care Renewal*

The findings suggest that PHNs in Nova Scotia understand and practice primary health care in accordance with its principles: universal access to health services; focus on the determinants of health; focus on health promotion and illness prevention; active citizen participation in decisions that affect their health; inter-professional and inter-sectoral collaboration; and appropriate use of technology. (World Health Organisation, 1978)

The PHNs make an important difference in building individual and community capacity by working collaboratively to promote accessibility and citizen participation, especially for vulnerable populations. A population health promotion approach is fundamental to their primary health care practice. However, both PHNs and Public Health management face many challenges in addressing their core Public Health functions. This phenomenon is associated with a myriad of internal and external organisational factors. As a result, fragmentation and erosion of Public Health capacity and the PHNs’ full scope of practice is a reality in Nova Scotia.

Strategies to strengthen PHNs’ contribution to primary health care renewal, while meeting the population health goals for Nova Scotia, are proposed in the areas of practice, education, research, and policy.

This study confirms the need for qualitative research to uncover the complex, often unpredictable and invisible practice of PHNs in the social, economic, and political landscape in which it is embedded.

# introduction

This study was undertaken at a pivotal time in health system renewal in Nova Scotia. The voices of PHNs and Public Health management, along with analysis of the policy context in which they work, have the potential to influence the development of an effective primary health care system.

PHNs have quietly delivered primary health care programs and services in Nova Scotia for many years, with minimal investment in evaluation of these programs or understanding of the nature of this work by government, policy makers, and the public. Yet, there are many lessons to be learned from a practice built on community and inter-sectoral relationships and multi-faceted approaches. This study offers an opportunity to gain a deeper understanding of the PHNs' practice, and to apply this knowledge to create a strong, integrated, community-based primary health care system.

PHNs account for the greatest proportion of the Public Health workforce (Naylor, 2003). They are part of the specialty practice of community health nursing, which is rooted in the foundational concept of caring as well as nursing, public health, and social sciences, and informed by the principles of primary health care, a value for multiple ways of knowing, partnership, and empowerment (CHNAC, 2003) and the Code of Ethics for Registered Nurses (CNA, 2002).

PHNs' well established history and experience in promoting, protecting, and preserving the health of individuals, families, groups, communities, and populations positions them to be important contributors to the population health and primary health care agendas in Nova Scotia. PHNs recognise that a community's health is inextricably linked with the health of its constituents and is often reflected first in individual and family health experiences (CHNAC, 2003).

PHNs are accountable to a variety of authorities and stakeholders; the public, the regulatory body, and the employer, and are governed by legislative and policy mandates from multiple sources both internal and external to their employment situation. The structure and process of the organisation in which PHNs work affects their practice; enabling and constraining it through its values, policies, goals, standards, and outcomes (Baumann et al., 2001; Underwood, 2003).

A major challenge for PHNs, Public Health decisions makers, and policy makers is the paucity of empirical evidence that describes the PHNs' scope of practice as primary health care practitioners in the midst of major health care restructuring. Without this evidence, the lessons and opportunities cannot be fully explored.

The **purpose** of this inquiry is to:

- Explore PHNs' primary health care practice in fostering citizen participation and collaborative practice in Nova Scotia.
- Examine how federal, provincial, and district level policies and budgetary decisions since 1992 have affected Public Health and the PHNs' practice in Nova Scotia.
- Enhance the integration of PHNs in the primary health care system in Nova Scotia.

This is **unique research**:

- It partners university researchers and Public Health decision makers.
- It includes the voices of PHNs and Public Health management.
- It generates relevant baseline data on PHNs' primary health care practice.
- It Identifies success factors and stories: when we know what works we can build on it.
- It strengthens existing partnerships and allows continued development of a program of Public Health research and education initiatives.
- It produces foundational data for the development and evaluation of standards and competencies of PHNs in Canada.

# research process

*Ethical* approval for this qualitative study was obtained from Dalhousie University Social Sciences and Humanities Human Research Ethics Board and the nine District Health Authorities (DHAs) in Nova Scotia. The study was conducted over a two year period (Nov 2002-Oct 2004) through a responsive process of inquiry that values the participants as experts in their own lives. The process began with the participants and their situation as the starting point and analysed how the situation was shaped by, and in turn shaped their social world. The process then valued how historical, gender, and social relations can affect the PHNs' practice. This inquiry process allowed for a level of exploration that was needed to obtain a broad, in-depth understanding of the PHNs' everyday primary health care practice. Face-to-face interviews were conducted as well as telephone follow-up interviews and, subsequently focus group interviews with PHNs.

## PARTICIPANTS

### Phase 1: Public Health Management

Seven Public Health management representatives from the Department of Health (n=3) and the DHAs (n=4), who (a) were in their positions for more than 5 years, and (b) had participated in health care restructuring in Nova Scotia, were randomly selected from a roster of eligible participants, who were identified by the investigative team, and were then interviewed individually. The participants represented senior management with 12-30 years of public health experience; 8-17 years of experience in Public Health management; and 2-16 years in their current management position.

### Phase 2: Public Health Nurses

Forty four PHNs from across the nine DHAs were randomly selected for individual interviews by the principal investigators from a roster of potential nurses who were in their positions for at least three years at the time of participant selection. One PHN dropped out of the study. Data from 43 PHNs was used for analysis. A proportional representation of 8-15 PHNs were selected from each of the four Public Health Service areas based on the total number of PHNs.

(Figure 1– Demographic profile)

### Phase 3: Public Health Nurses

Thirty two PHNs from the DHAs volunteered to participate in focus group interviews. Both PHNs, who had participated in the individual interviews, and all other PHNs in Nova Scotia, who had at least three years of experience as a PHN in Nova Scotia, were invited to participate in focus group interviews. The group interviews allowed the PHNs to respond to each other, to respond to emergent thematic analysis, and to explore differences and similarities in their experiences.

**Phase 1 (1-3 months)**  
Face-to-face interviews with public health management (n=7)  
Document analysis

**Phase 2 (3-12 months)**  
Face-to-face individual interviews with PHNs (n=44)

**Phase 3 (12-18 months)**  
Focus groups with PHNs (5 groups, n=32 PHNs)

**Phase 4 (18-24 months)**  
Dissemination of findings

Figure 1  
PHNs Primary Health Care Practice

|                                    | Individual (n=43) | Group (n=32) |
|------------------------------------|-------------------|--------------|
| <b>Avg yrs as PHN</b>              | 14.3              | 14.7         |
| <b>Avg yrs as PHN in NS</b>        | 13.2              | 13.3         |
| <b>Educational Preparation</b>     |                   |              |
| RN & RN with Public Health Diploma | 14%               | 9%           |
| Baccalaureate                      | 70%               | 74%          |
| Master                             | 16%               | 16%          |
| <b>Focus</b>                       |                   |              |
| School                             | 14                | 6            |
| Family                             | 16                | 16           |
| CDC                                | 4                 | 2            |
| <b>Generalist</b>                  | 9                 | 7            |
| <b>Community</b>                   |                   |              |
| Rural                              | 37%               | 55%          |
| Urban                              | 12%               | 13%          |
| Combined                           | 51%               | 32%          |
| <b>FT/PT</b>                       |                   |              |
| Full time                          | 92%               | 88%          |
| Part time                          | 8%                | 9%           |

## **METHODS**

### **Individual Interviews**

Signed consent was obtained from each participant. Face-to-face interviews (approximately 90 minutes) were then conducted, guided by a semi-structured interview guide. These interviews were audio taped and transcribed verbatim. A copy of the transcribed interviews, with all the identifying information removed, were sent to the participants and a follow up telephone interview (15-30 minutes) was arranged two to three weeks after the participants received the typed transcript. The telephone follow up allowed for confirmation of the accuracy of the typed interview, elaboration, removal of any passages, and presented the participants with an opportunity to participate in preliminary analysis.

### **Focus Group Interviews**

Signed consent was obtained from each PHN participant. Five group interviews were then conducted to discuss emergent themes from previous individual interviews with PHNs. The participants engaged in elaboration of emergent themes, provided feedback, explored differences and similarities of their experiences, participated in ongoing analysis, and identified strategies to enhance their primary health care practice. The focus groups were facilitated by the principal investigators and the research coordinator, and were audio taped and transcribed verbatim.

### **Document Analysis**

To provide a context for our inquiry, we reviewed 26 documents that describe public policy and budgetary decisions that have affected Public Health and PHNs' practice since 1992.

## **DATA ANALYSIS**

Analysis was informed by established procedures for thematic analysis in organising and analysing data (Kvale, 1996; Lincoln & Guba, 1985; Miles & Huberman, 1994; Sandelowski, 1995). Preliminary analysis began during data collection with clarification of meanings and interpretations as the interviews proceeded. More in-depth analysis and data reconstruction proceeded with coding and organising the data into broad categories, and synthesised further, in comparison to relevant theory, into descriptive and interpretive themes. The QRS NUD\*IST 6 computer program (Richards & Richards, 1994) assisted with data management and thematic analysis with the PHNs' data. Inter-rater reliability of the coding framework was established by independent coding by the research assistants and principal investigators.

## **ESTABLISHING TRUSTWORTHINESS AND RIGOUR**

The criteria for establishing trustworthiness in qualitative research were incorporated throughout the study (Lincoln & Guba, 1985). Several strategies were used to establish rigour in the research process and credibility in the findings. These strategies included: random sampling, member checking through telephone follow-up to verify accuracy of the data and assist analysis; interviews with key informants in public health management; interviews with a representative number of PHNs across a variety of practice situations, which provided "thick" descriptions; increasing transparency in making the decision-making trail leading to the conclusions; ensuring that the study methods were clear to the participating agencies and the participants in the study; and maintaining process notes and a reflective journal throughout the study.

The PHNs highlighted key values that guide them in their practice as well as certain challenges they face.

### Key Values

- Professional autonomy
- Primary health care and social justice
- Making a difference
- Population health promotion
- Accessibility and equity
- Building relationships of trust
- Citizen participation, ownership, and collaboration

### The Challenges to Professional Practice:

- Pulled between documenting work and valued practice with clients
- Torn between prescribed programs and community partnership activities
- “Never enough time”, especially for higher needs clients
- Increased task orientation, specialisation, and working in silos
- Lack of evaluation of program effectiveness
- Increasing inequity of programs to rural, seniors, and low income populations
- Feeling stretched related to shortage of nursing and administrative support staff
- Staying current on health information
- Loss of connection and visibility with the community

### KEY VALUES

#### Professional Autonomy

PHNs function within the Code of Ethics for Registered Nurses (CNA, 2002). Integrity is the core value that underlies ethical nursing practice and the moral agency of the health professional (Yeo & Ford, 1996). It includes the freedom to direct your own moral code; being counted on; speaking up for what is right; and continuity and consistency across one’s professional and personal life. Professional autonomy meant independence, flexibility, self-directiveness, creativity, and responsibility.

### Primary Health Care and Social Justice

The PHNs understand and practice primary health care as a multi-faceted concept that is firmly rooted in social justice and a social-environmental view of health. Their commitment to work within this vision is possible because they bring to their work a unique set of roles, skills, and attributes.

.....  
*What I value most is being able to do a job that is congruent with my philosophical belief system. I really believe in prevention and in health maintenance versus illness care. And I really enjoy families and communities. The main thing is the philosophy. (Nurse)*

### Making a Difference

The PHNs spoke frequently, and often passionately, about values of the nursing profession and the unique ways in which these apply to their community practice. They described the sense of meaning and gratification they receive from witnessing the difference they can make in peoples’ lives.

.....  
*I love nursing. For me, it’s not just a job. I really want to make a difference in my community. I really want to promote wellness in my community. I think the most important thing we do is raise our young to become our future generation. For me to have the opportunity, it’s like a life-long dream, a privilege. My philosophy is that I’m here to serve. I’m here to serve my community. I’m here to serve families. (Nurse)*

### Population Health Promotion

A population health promotion approach is fundamental to the PHNs’ practice. They spoke enthusiastically about their collaborative work to promote health, prevent illness/injury, and to protect the public’s health. Their work emphasised the determinants of health and a variety of health promotion strategies. The nurses used personal power, were innovative, and several PHNs pushed the limits of their prescribed mandate to foster individual/community health.

### Promoting Accessibility and Equity

PHNs have an awareness of who they are in the world and their role in connecting and building community. One of the ethical cornerstones the PHNs identified was their commitment to ensuring that Nova Scotians receive equitable availability and accessibility to all services. Not only do the



PHNs often work with isolated and at-risk populations, but frequently they feel this is where they can make the biggest difference. PHNs who practised in rural communities had particular concern about the communities receiving equitable access to services.

*Most of the families I see are at high risk for social problems. I see a lot of young mothers on social assistance, a lot of single mothers, addicts, where there's been family violence, where there's been protection issues, where the families don't have parenting skills. This is probably where I do my best work. (Nurse)*

### **Building Relationships of Trust**

The PHNs professed that the nurse-client relationship is foundational to effective practice.

*I'm well established in the community. People know me. People trust me. They know that I'm not a bad person or going to lead them astray in a negative way or whatever. But yes, initially you have a lot of building to do as far as trust in the relationships. (Nurse)*

### **Fostering Citizen Participation, Ownership, and Collaboration**

The PHNs expressed commitment to a holistic, collaborative model of practice that values a partnership role with the public and other professionals. Being a catalyst in this process was seen as "hugely important" in terms of encouraging broader citizen participation and ownership within the community for health promotion. For PHNs, "participation is the basis for therapeutic, professional, and caring relationships that promote empowerment." (CHNAC, 2003)

*You are working at the grassroots level with individuals in the community, but by the same token your whole goal is to make them more independent and make the decisions themselves. So you're there but you're trying to support them to make broader choice to gather their own resources and come up with their own needs assessment and make the changes in the community themselves. (Nurse)*

The PHNs consistently used words such as "we", "together", "working with", to describe their actions with clients. Collaborating and forming alliances were described as a way of working.

*The community as a whole. So that encompasses everyone: ourselves as health professionals, those who are parents to be and are parents, as well as people who own the shopping mall providing space for breast feeding. The whole continuum within the community to me is citizen participation. Cause if you want to move something forward you don't do it in isolation. . . you really do have to focus your attention on your whole community. (Nurse)*

*What I value most is the broadness, the many pieces of my work. Certainly health promotion is a big piece. Because my role is broad, I'm seeing things from a different perspective. It's upstream so that you're seeing things and hopefully have influence prior to people's lives being affected by poor outcomes. I appreciate looking at the whole population being very focused versus looking at the illness entity of health.*

*(Nurse)*

Oh, it's a great team. We work well together. But we all have our own focus and it's starting to feel kind of silo-y. And so it's sometimes hard... it's like "this is my focus" and "this is what I'm interested in" and that's a disadvantage of the focus. You're separated in the little silos, the little groups, you're learning from scratch and you're doing it and it's like there's no opportunity to build on.

(Nurse)

the PHNs identified several inherent challenges in their practice. A Meta theme that emerged was the nurses' increasing **Sense of Conflicted Loyalties and Obligations**. This phenomenon was associated with balancing their multiple obligations, particularly being true to their professional code of ethics and integrity as a PHN while working under growing constraints in their everyday work environment. They named several barriers: lack of infrastructure supports, increasing isolation from their peers, lack of evaluation and research to affirm the PHNs' role and impact, inconsistency in programs and standards, and increasing invisibility and feeling undervalued by other professionals. The nurses expressed feeling increased stress, frustration, being overwhelmed, and being increasingly positioned in a reactive practice. They described various ways they felt pulled in many directions simultaneously.

### **Pulled Between Documenting Work and Valued Practice with Clients**

You have to keep ahead on your paper work and you've got to prepare what you're going to discuss each week to educate the group. And then you'd have to be there physically. That's not counting other things that are sitting on your desk waiting and your calls that come in, and questions. We're there for the general public and walk-ins. You're constantly on a treadmill trying to get your have-to's work done and then there's the statistical. (Nurse)

### **CHALLENGES TO PROFESSIONAL PRACTICE**

The PHNs identified several inherent challenges in their practice. A Meta theme that emerged was the nurses' increasing **Sense of Conflicted Loyalties and Obligations**. This phenomenon was associated with balancing their multiple obligations, particularly being true to their professional code of ethics and integrity as a PHN while working under growing constraints in their everyday

work environment. They named several barriers: lack of infrastructure supports, increasing isolation from their peers, lack of evaluation and research to affirm the PHNs' role and impact, inconsistency in programs and standards, and increasing invisibility and feeling undervalued by other professionals. The nurses expressed feeling increased stress, frustration, being overwhelmed, and being increasingly positioned in a reactive practice. They described various ways they felt pulled in many directions simultaneously.

### **Torn Between Prescribed Programs and Community Partnership Activities**

There are certain times, such as when you're doing your mandated programs – the Hep B times are in October, November, and April – when you might also be involved in a community group that meets every month. That can be really stressful. You don't make it to every meeting and you have to pull back. You support them when you're not so busy and pull back a little bit when you are, and that's really the only way to survive. You do the best you can. (Nurse)

### **"Never Enough Time", Especially for Higher Needs Clients**

As far as the kids, it basically comes down to human resources. To be able to get out to some of these populations of kids that you just aren't reaching because they're not coming to you. I can see that I'm reactive, dealing with the kids who are mostly coming to me because that's all I have time for. (Nurse)

### **Increased Task Orientation, Specialisation, and Working in Silos**

### **Lack of Evaluation of Program Effectiveness**

They don't really put the time into "how do you measure this prevention?" We haven't... provided, enough justification of what we're doing that's good and what theories are good. Public Health has not been strong at evaluation. We have our immunisation rates, we have CDC stats, we have number of visits, we have breast feeding rates... (Nurse)

### **Loss of Connection and Visibility with Community**

### **Increasing Inequity of Programs to Rural, Senior, and Low-income Populations**

### **Feeling Stretched Related to Shortage of Nursing Staff and Administrative Support Staff**

### **The Challenge to Stay Current on Health Information**

### **BUILDING CAPACITY FOR PARTNERSHIP AND CITIZEN CONTROL**

The PHNs expressed a passion for their work and a desire to make a difference in their clients' lives. Making a difference was "doing with" not "doing for" so that the people themselves take ownership of their health decisions. The PHNs' practice stories were corroborated by Public Health management, and clearly demonstrate how the PHNs make a difference in building individual/community capacity for social justice and health. They facilitate planned change by implementing multiple health promotion strategies to achieve intermediate and/or long term health outcomes: developing personal skills; creating supportive environments; strengthening community action; re-orienting health services; and developing healthy public policy. Specific strategies include: starting where people are; establishing rapport and trust; engaging in holistic assessment; creating safe environments; engaging in collaborative practice with clients and other professionals; acting on the determinants of health; promoting universal and equitable access; and tuning in to client readiness. The PHN acts as initiator, organiser, collaborator, enabler, facilitator, educator, advocator, and champion.

*Working at the grassroots level, your goal is to make people more independent so they can make the decisions themselves. You're there to support them to make these broader choices, to gather their resources and come up with their needs assessment and make the changes in the community themselves. You're not there to necessarily say "Do this, do that", but as support. (Nurse)*

### **Promoting Accessibility and Equity**

"Accessibility implies not only that services are affordable and geographically available, but also that they are socially and culturally appropriate and geared toward effectively meeting the critical health needs of diverse communities" (Stevens, 1993). The PHNs' social justice vision of primary health care locates them in a unique and strategic function as linking agents between clients and a broad range of services. They referred to their role as a "connector", especially with vulnerable groups. PHNs often are the "beginning" or first point of contact for clients in accessing health services.

The PHNs work with vulnerable people who may fall in the gaps between existing services. Their most important work is done with those who are vulnerable due to a myriad of social determinants. PHNs' practice fills a gap for families without a family doctor and for isolated women and new babies. Youth and populations, who are not part of the dominant cultures, are a special concern for the PHNs.

*There are all sorts of kids with emotional problems, mental health problems, who need to be seen by psychologists, psychiatrists, social workers, but they don't. It's especially important for those poor people living on the streets, if they become ill, to get support. They go to emergency but it's often because they just want to have some contact with somebody. (Nurse)*

### **Building Confidence and Skill**

Several PHNs said they encourage the participation of community members in an array of groups and activities. They believe in supporting community-driven initiatives. They described ways to increase accessibility to health services; home visits, outreach programs, classes, self-help groups, teen clinics, youth health centres, vaccination programs and clinics, and health fairs. They spoke about how they educate as a consultant on health information or work as a process-focussed planner using an empowerment approach, which builds confidence and skills of the participants.

*The whole continuum within the community is citizen participation. If you want to move something forward you don't do it in isolation... To make a shift you have to focus your attention on your whole community—the individual citizen right up through government – trying to get everyone on the page. It's a community approach.*

*(Nurse)*

*We all want to make the healthiest choices for our families and if the mother's not able to breast feed, then we try to look at a situation from a big picture point of view. (Nurse)*

The PHNs spoke about creating space for vulnerable populations at decision-making and program planning tables. Voices of youth, those living in low socio-economic circumstances, and single moms were sought. An important part of their mandate was asking: "Who is missing?" "Who needs to be here?" "How can we, as a community support you and your family to make the best decision?"

*Change cannot happen unless there's community buy-in. So you have to go to your community to get community support, that means going to the women's groups, the men's groups, church groups, going to your community health boards – the people who are the movers and shakers, and the people who are the champions*

*(Nurse)*

### **Creating Participatory Infrastructures**

Many nurses expressed enthusiasm about collaborative work with individuals, groups, agencies, and communities as a more holistic way of approaching health issues. They described important partnerships, both within the health

sector and inter-sectorally. Creating participatory infrastructures was seen as a first step. Many nurses described the need to "break down the walls" between organisations to increase collaboration.

*When you get to know faces, when you really get to know the people, then it begins to break down the walls. Well, you don't know if you don't even know who the people are or what they are doing, or what those agencies' roles are. So, I think collaboration really does help. (Nurse)*

They felt they made a vital contribution to building partnerships through their visibility, being known to community members, and through their extensive knowledge of the community and networks. They played an important role in laying the groundwork for partnerships to be developed and sustained by valuing different perspectives, establishing open and respectful dialogue, and allowing for role negotiation. The PHNs felt valued for bringing a population health promotion approach. PHNs recognised that they could not build individual and community capacity alone.

### **Natural Collaboration and Building Networks**

For all PHNs collaboration was seen as a natural and integrated part of their daily work. PHNs were involved in successful collaborative initiatives and partnerships with: high school guidance counsellors, family resource centres, Community Services, police, schools, inter-agency networks, nurse practitioners, women's health centres, parents, First Nations nurses, the African Nova Scotian community, and others. The benefits of working in partnership, from PHNs' perspectives, outweigh the negative. It is a way to pool resources, reduce duplication of services, and have a more consistent health promotion message.

*It's a way to deliver a consistent message. In isolation you have very little impact on population health. And there are less and less resources. So unless everybody works together your resources just are petering out. If I deliver the same message as the RCMP, as the teachers in the classroom, as the guidance counsellor, as everybody who has contact with those students in the classroom or the school, then obviously that is going to be less confusing and be better retained. (Nurse)*

*We realise that we do not have the resources to deliver what we want to deliver. We can't stay in our silos if we believe in population health and the determinants of health. We must cross the social, educational, health, whatever boundaries, if we are to work together. (Management)*

Working in partnerships was seen as beneficial to PHNs in promoting an awareness of what they do and in making their role more visible in the community

*None of us is going to solve all the problems by ourselves. It takes a community to deal with issues. If you pool all the years of knowledge and the expertise around the table, and apply that constructively, it's just phenomenal, empowering. And it's not just the agencies, but it's also at that grassroots level. Working together you decide: "This is what we want." "This is what we need to do." (Nurse)*

PHNs and management believed that the PHNs are pivotal in building networks and are a valued member of a reciprocal referral network, especially with vulnerable groups.

*Sometimes a doctor will call us and say this person doesn't have a car, can you make sure you go every week and do a check on this particular baby for whatever reason. Also with the hospital when high-risk births happen, a Public Health liaison will send us a message that there's someone going to be home, or that the mother's home and the baby's still in the hospital, "can you make sure she's doing ok" those kinds of issues. So I think we're really important to the people out there, being part of that network of referral, especially in the case of isolated people. (Nurse)*

*I partner a lot with Mental Health, Addictions Services, interagency groups. It's kind of an ad hoc committee to get a space opened up and to create relationships. It's been a really excellent web, what I call the "web I weave." That's what I call it because it's all about community services, it's all about creating the relationships with service providers so that everyone has a good understanding. And from where I sit, I can see that youth have developed confidence and trust in the centre and in myself. (Nurse)*

Case management with a multidisciplinary team is basic to their practice. Most of the nurses described this approach as part of an informal process rather than a structured program.

*If a mother is isolated and doesn't have family around, or their life circumstances have changed and socialisation would be helpful, then I try to get them out with other parents with children so that they can get out of the house and talk. Just to make them aware of the resources that are available. I might say, "so and so meets in the fire hall every Friday morning and they have a parent-tot playgroup. (Nurse)*

### **Intentional Collaboration**

PHNs and management described an important leadership role in the community. There were numerous stories in which PHNs exercised a leadership role in the successful achievement of health promotion outcomes. This was particularly evident with PHNs working in rural communities, and especially if they lived and worked in the same community.

*Population Health has validated the way Public Health has been practised for a decade. We normally would look at an individual, a community, a population, in a very holistic way. We always paid attention to the socio-economic determinants. We've always worked in partnerships. We've always worked inter-sectorally. So for us, it's a validation of both the philosophy and the practice. And, people are starting to pay attention to Public Health as being a leader in that. (Management)*

*I think that your term natural collaboration is interesting because those of us who took part in the community development workshop that was put on by the Department of Health, I think in 1994, went to this thinking "what is this community development stuff?" After a week we came out saying that's what we've been doing all these years. So it was getting an academic label to the process that we had done which was natural collaboration. That's how PHNs have functioned in their community since, and I've been in this a long time. That whole business of partnerships, because you can not do it alone. It was like sending us to finishing school, putting us in the community development course. (Nurse)*

### Developing Personal Skills

This story illustrates how the PHN supported a new mom to reach her goal of breast feeding by exploring options she could use; making follow-up phone calls; and giving her positive reinforcement.

.....  
*Her baby didn't latch and she was just feeling devastated. So I didn't do anything special except talk to her, and ask her questions. I gave her some ideas...why don't you try this, sometimes this works. I said "How are you feeling about all this?" She started to cry, and said, Well you know I've been back and forth to the clinic for the last two weeks and this is probably more help than I've had any other time. But yet, that baby didn't latch while I was there; she didn't pump, and she didn't get more milk. I said, "How about giving me a call tomorrow and telling me how you're feeling." So she called me, and she said, "Well I did what you suggested and I really think my baby was showing curiosity." I said, "I am so delighted because you couldn't have accomplished anything that was better than to get a baby curious at the breast; so really, you've done so well." And so that's what I think is enabling. I don't think that I need to be the one with the right answers; I just need to be the one to motivate, or to create awareness, or to give accurate information.*  
(Nurse)

### Reorient Health Services

PHNs gave examples of how they have made health service more accessible for youth. A school PHN described her roles in centralising services to increase access in the school through the Youth Health Centre.

.....  
*The idea of the Youth Health Centre is to bring secondary services that would traditionally be community based, trying to centralise them so that youth could have access to them because we know that they didn't access service in the traditional way. If you go to the doctor's office, then you wait at the pharmacy for your prescription, or you go to the hospital and wait for something, to see a social worker or to see the dietician or whatever, you know, it's a very small town. But if they can come here when they're in school, they might be coming in for anything, it just created that easier access. (Nurse)*

### Creating Supportive Environments

PHNs spoke extensively about creating safe social environments for vulnerable populations. One PHN described her best collaborative project, the establishment of a residential recovery centre for women with addictions and experiencing abuse, the first one of its kind in Atlantic Canada.

.....  
*I've been personally involved with a prostitution education program, which is a program that includes the Justice Department, Police Department, and Health. The Centre started with the taskforce on prostitution with the police department... I started doing the sexually transmitted infections part, speaking with [prostitutes] on health issues related to the sex trade. And then I got involved on a couple of the committees... [The Centre] sort of mushroomed from this group. (Nurse)*

### **Building Healthy Public Policy**

One PHN told how she worked for 14 years on a tobacco reduction campaign to implement a smoke-free policy for public places. The by-law change was part of a multi level strategy. The committee, made up of schools, the municipality, and DHAs, is sharing their experiences with the First Nations community.

*In the tobacco reduction committee we have partners from every area; they're from the District Health Authority, from the district health board, from the schools, from the municipality. I have somebody from First Nations because that's our next move on tobacco, that we want to help them and tell them what we went through and how we came to this great success, that we have these smoke-free public places now, that we have the legislation in place. Not that we're going to tell them what to do but we can tell them of our process and what worked and what resources we have. It's a continuous sharing now... We call it tobacco reduction multi-strategy intervention. Cape Breton is smoke-free. I mean, leave it to Cape Breton, to our island; we're so proud of it and they worked so very hard.*

*(Nurse)*

### **Strengthening Community Action**

PHNs have excellent knowledge of the community players and the services they can provide. This story is about forming a mental health support group for the students in the Youth Health Centre. The PHN brought together representatives from many sectors to provide support for youth with mental health issues:

*I don't think I could probably do my work outside of individual care if I didn't have the collaborative [piece], there's just no way... Just to make that program [mental health support group] work for instance we have a medical doctor who's on call for crises; the whole Mental Health team has agreed to hold two emergency slots on that day in case we have someone in crisis. The Guidance Department's on standby for an hour after the session in case we need to direct traffic [to them]. The school administration, we had to get permission to get kids pulled out of class, to have someone from outside the community coming in and doing this. We have people in the community that the Lions' Club donated money to help to support the breakfast, Sobeys, Superstore, all those people. Mental Health dedicated a staff person to come help co-facilitate it with me*

*(Nurse)*

### PHILOSOPHY AND GOVERNANCE CHANGES

Since the early nineties, a series of changes in philosophy, structure, operation, and governance have occurred in the Nova Scotia health care system. Some of the most notable changes that have significantly affected Public Health capacity include:

- Shift of Public Health Services' accountability and reporting from the Department of Health to four Regional Health Boards (1997)
- Decentralisation to nine DHAs with 37 Community Health Boards reporting to the DHAs (2001)
- Public Health Inspectors transferred from the Department of Health to other government departments
- Loss of the Director of Public Health position (2001)
- Legislated accountability for health protection and communicable disease in the office of the Chief Medical Officer of Health, who does not have a direct connection to Public Health Services
- Medical Officers of Health in the DHAs assigned a consultant role with Public Health Services
- Accountability for health promotion, health enhancement, and population health divided between the Department of Health's Population Health Unit, and a new Office of Health Promotion (2003)
- Federal policy and funding decisions that had both positive and negative influences on Public Health programs and services

When the government shifted to primary health care and increased emphasis on population health it was perceived as validating the philosophy and practice of Public Health. Many PHNs felt confident that their history of collaborative practice and their community health experiences and competencies would make a difference in the health of Nova Scotians.

Others felt it was still premature to draw conclusions on the impact of the changes. *"The wheel has not yet come full circle."* While affirming, the terminology being used was seen as different than that used by Public Health professionals.

*Primary health care is a little fuzzy right now. I thought I knew what it meant and now I'm being told that it is something else. The government of course, is supporting primary health care but the way that they describe it primary health care is hospital services moving into the community and more prevention, where I saw it as being a bit broader than that. I see primary health care as really anything you do to prevent disease and disability in the community. (Nurse)*

Although there were many policies and funding decisions that were seen as validating PHNs and their population and primary health care practice, negative impacts of these decisions were described by participants. These included constantly restructuring, and increasing expectations to address a more population-focused and collaborative practice and continuing to carry out mandatory core programs that focus on individuals and families. They identified that federal policy and funding initiatives, accompanied by provincial restructuring, has resulted in: increased role confusion between public health practitioners and other health and

*We're on the cusp of change and it's an exciting time to be a public health nurse. We need to put our energy into helping make these changes in primary health care. I am amazed that Public Health is threaded all through the documents. There is this recognition that we can no longer afford to fund the health care system the way it is. And in order to make change Public Health is going to be one of those venues that is going to drive change. (Nurse)*



community personnel; greater misunderstanding of the PHNs' role; insufficient PHN staff to meet the service demands; decreased visibility of PHNs; and growing dissatisfaction among PHNs.

### **Decentralization**

Several PHNs felt that the decentralised DHA structure had facilitated a more expedited structure for decision-making. Being able to make decisions without having to vet these at a central management level was appreciated. Some PHNs saw the new structure as giving flexibility in determining how programs would be implemented in their areas.

.....  
*Our director has been able to make some decisions that apply to Public Health Services here in this region versus waiting for something downtown to affect [the entire] province. (Nurse)*

Some PHNs felt the creation between districts of "shared services" was a responsible way for health and community service providers and members of the community to work together. The collaboration formalised already-existing working relationships. Community Health Boards were seen as a positive move in terms of pro-actively identifying and addressing the community's needs and were "very affirming of who we are in Public Health."(Nurse) Decentralising power and resources to nine DHAs and decreasing organisational silos was seen as laudable.

However, the process of restructuring was seen as confusing and, leading to fragmentation of Public Health Services by, eroding their critical mass, status, and visibility. Critical aspects of their practice were seen as lost, such as contact with communities, diminished working relationships with other PHNs, increased workloads, heightened expectations, decreased visibility and feeling undervalued. Although many PHNs reiterated their commitment to promoting community health, some questioned their capacity to deliver programs and services in a system that is underfunded and resourced.

Some felt that the new structure simply replaced one set of silos with new "little empires and many commanders." Many participants felt the devolution to nine DHAs created greater fragmentation in health service delivery than integration.

.....  
*We should have maintained Public Health provincially and allowed regional health boards to get the acute care side and long term care in shape. Instead, we plunked Public Health and addictions and some community based programs together. We were mixing apples and oranges. (Management)*

PHNs and management felt that Public Health was not a natural "fit" in the DHA structure because of the dominance of the acute care facilities. Public Health was poorly understood, and PHNs and management felt increasingly marginalised.

### **Provincial Leadership and Political Will**

PHNs and management explained that the monumental restructuring changes have involved changes in leadership at several levels. This has affected Public Health's capacity to deliver programs and services. Fewer provincial consultants are now available to facilitate program planning, evaluation, and resource development. Concern was expressed about the loss of the provincial Director of Public Health position and the Public Health inspectors; the narrowing of Public Health Service's mandate; and change in accountability jurisdiction for Medical Officers of Health. These changes contributed to a perceived loss of a senior Public Health management voice at the policy and decision making table. Without a voice it is easy for government officials and policy makers with no understanding of Public Health to consider "it" "just a small piece of the whole."

.....  
*We need leadership and ownership at the provincial level before we can access what is available federally. If you don't have ownership you will probably not even pursue the*

*Living under its shadow makes us feel a little bit envious, and sometimes inferior, like we're small fish in a big pond. Initially it was nice to feel we're part of the big picture. But when we got there, we discovered we weren't the same fit. The hospital is still seen as the bedrock in health care, although it's really illness care. I can't really say there's been any real benefit to us.*

(Nurse)

*I think the politicians are saying, “Yeah, that looks good and that makes sense and we should go that way. We’ll support you.” But, you have to put some money behind it, too. I mean, it’s going to take a lot from everybody and I think we in Public Health have made some good changes moving in that direction. But there’s got to be political will.*

*(Nurse)*

*funding. It costs, so it has to be a priority. In having the responder mentality, they do not have the sustainability when the funding runs out. They justify their lack of continuation by saying that the federal money ended, rather than declaring it a priority. (Management)*

Some PHNs identified a need at a higher level of decision-making for “someone who can champion” Public Health in terms of promoting policy and budgetary allocations.

PHNs and management expressed frustration with the short-sightedness of decisions that continue to bolster the acute care system without sufficient attention to Public Health priorities. Many participants identified the need for leadership and political will to address health issues from an upstream perspective.

Public Health management at the DHA level noted that on many occasions they were frustrated and limited in taking initiative because they felt caught between provincial and DHA control. *Who do we go to for approval?* They also

described the DHA shared services structure as cumbersome and time consuming. One outcome was reporting to two or three Vice Presidents of Community Health, CEOs, and Board Chairs, some do not share a common understanding of Public Health.

## **FUNDING**

### **Clustering Funding Toward Federal Priorities.**

The federal government’s funding and program priorities were perceived by many participants as exercising significant control over the shape and direction of Nova Scotia’s Public Health system. PHNs and management welcomed the resources to enhance Information Technology capacity and the new resources with the Early Childhood Intervention program with, reservations. Federal funding created clusters of programs and staffing around federal priorities. Concern that the Department of Health did not have the commitment or funding capacity to sustain the programs when federal funding ended was expressed by many.

The decrease of transfer payments for health care from the federal government to the provinces resulted in fewer resources being available for Public Health. Provincial priority has consistently been given to acute care services and away from prevention and health promotion.

*It always seems to be prevention that is affected. The money will always go to acute care because there is always that political will and people are very vocal about it. Prevention is more of a challenge as people don’t see prevention. What we do in Public Health may take many years to measure. It isn’t an immediate gratification. (Management)*

### **The Funding Dance**

The proposed shift from an acute care, medical [illness] focus to a community-based health focus was seen by many participants as a good thing. When coupled with devolution of the Department of Health away from direct services this was perceived as a painful “dance” as Public Health was receiving less than two percent of health funding dollars. Public Health was expected to play a key role in the population health agenda and anticipated a lead role in primary health care renewal.

.....  
*While we see acute care make progressive change in their understanding of Public Health, there is still no acknowledgement that there is a resource in their area that has already been working on that for eons. So this is the dance. (Management )*

Many participants felt the Department of Health's decision to keep Public Health funding as non-portable has offered some stability and protection to Public Health programs and services

.....  
*One policy that went in during decentralisation was that the Public Health budget would be non-portable. This protected Public Health nursing and all Public Health. Otherwise it would have just disintegrated and would have wound up doing secondary prevention. (Management)*

## **PHN COMMUNICATION WITH PEERS AND MANAGEMENT**

### **Peers**

A majority of PHNs stated that they receive the greatest support for their work from their PHN colleagues. This support was rooted in a shared philosophy, shared knowledge and skills as well as the ability to support each other through collaborative work, and sharing the workload. They emphasised that this support gave them strength, enthusiasm, and incentive.

Although several PHNs noted that there was good team work across shared districts with other PHNs and Public Health staff, most PHNs explained that the greatest regret in restructuring to DHAs was losing the opportunities to link with other PHNs across districts and across Nova Scotia. Some nurses described sporadic collaboration, others stated that they had almost no connection with other PHNs. This was seen as a significant barrier to their work

.....  
*You feel a bit fragmented. You feel more isolated, more self-centred. We used to have programs where we shared information with all Public Health nurses in the province. And that was great, 'cause you had a connection with other people in other communities. But really, that fracturing of connection, by changing us from being provincial employees to being municipal employees and from being*

*generic nurses to being speciality nurses or focus nurses – there aren't the connections among us anymore. (Nurse)*

### **Management**

Many PHNs identified support from their managers and Directors as a contribution to their work and satisfaction in Public Health. They described respectful relationships with managers, who were supportive of their autonomy and sympathetic to their need to balance home and workload demands.

.....  
*Our management is very supportive of our independent practice. We don't have time and we don't have money. Big hurdles! But I do feel that I have their trust and support. For example, if I need time to do research around a particular issue for a particular family and I'm at a stumbling block, I don't feel I need to go ask, I can just go and do. I mean, that's a given, but in reality it isn't always the situation. (Nurse)*

*So however many of us that are on the team you have these very strong-minded, independent women and so while we all have our own style perhaps, we are of like mind, and that makes it easy. And when I say of like mind I mean we all do want to empower our clients and we all do want the best for our clients and for them to achieve their own personal goals. So that's a support for me in that I know that I don't have to come in and educate another nurse about my philosophy.*

(Nurse)

# Findings

Several PHNs stated that management's understanding of a population health promotion approach made their work easier. Directors and managers were valued as mentors and problem solvers, helping PHNs navigate organisational changes. Some PHNs regretted having so little time with their managers, sometimes as little as twice a year. Manager workload was seen as the main reason for the limited contact.

However, several PHNs stated that they did not feel respected for their expertise and not given sufficient opportunities to give input into program planning. Some expressed concern with the hiring of non-nursing management staff who might not understand PHN practice; and identified lack of leadership from management in giving clear direction, being too cautious, and suppressing new or divergent ideas.

*Because nursing has become so complex, we looked at nursing expertise and then divided public health nurses into core service areas. This has had a lot of benefits. It was getting very difficult for everyone to know everything. The thing is, we just didn't have enough nurses to go around to do everything.*

(Management)

However, some PHNs described inconsistencies in how the programs were delivered between DHAs and these undermined the equality of Public Health Services.

*It would make a big difference if everybody was doing exactly the same thing. I don't know how CDC is being done elsewhere, but I do think it would make a difference as far as fostering citizen participation, if it were being done exactly the same everywhere. We need to clarify our role so that the public knows what we do. (Nurse)*

## Models of Practice

While several PHNs felt the change to focus program model of practice has been positive, the majority of PHNs felt that the greatest benefits still lie in the generalist model of practice with its inherent holistic approach to health. PHNs with experience in both generalist and focus practice felt that a generalist practice is unique in giving them a capacity to develop ongoing relationships with individuals in the community that enhances promotion and prevention. They believed that PHNs in generalist practice become known to the community and developed a broad knowledge of the community by working with a wide range of age groups, settings and health issues. PHNs in a generalist practice have a "totally different relationship with the community" and a "better sense of the community." A positive feature of generalist practice that was identified is the connection with vulnerable populations who might not seek help if there was not a strong relationship with the PHN.

*A general practice allows you to practice primary health care much more easily than if you're focused. If we're looking at the community, it's much easier to get a picture of the needs in the whole community as opposed to just "a school." I believe the quality of my work is much more satisfying to me and probably to the community because I am generic. (Nurse)*

The benefits of focus nursing were described as: allowing the PHN to develop expertise and confidence in one area, preventing burnout from trying to "do everything" in generalist practice; and allowing a "little bit more time" for at-risk clients.

**Programs and Standards**  
PHNs and management participants agreed that one of the most positive things achieved in recent years was the formulation of provincial standards for Public Health in 1997. The standards have been a key factor in facilitating nurses' capacity to deliver programs that address health promotion and prevention, and the determinants of health.

.....  
*Doing a good job gives nurses a sense of satisfaction in their work. One nurse commented, “I feel good about the service I provide on a day to day basis, because I feel good with the information I have, and quite knowledgeable about it. (Nurse)*

Disadvantages of focus nursing were described as: a loss of connection with the community; a lack of overview of the whole community; less PHN visibility in the community; the creation of gaps in services to some client groups; the creation of silos between program areas; and fostering a task orientation.

It was explained that the lack of staff resources and funding to deliver programs through generalist practice was the main impetus for shifting to specialised or focused practice.

## **WORKFORCE CAPACITY AND COMPETENCY**

### **Professional Development**

Several PHNs spoke of the support that they received from Public Health Services for professional development. Some PHNs acknowledged that they had opportunities to share information with other professionals in provincial committees. However, the majority of PHNs reported that lack of funding and work overload have made it difficult to take the time for professional development. Restructuring has increased the challenge to keep up-to-date. Inequity of distribution of professional development funds among Public Health staff, as well as between DHAs was identified as an issue. PHNs’ training sessions and regular meetings with other Public Health staff was described as being very important: to share information, communicate best practices, and alert one another to problems or areas where there was avoidable duplication of services. These opportunities are seriously lacking. This situation has left many PHNs feeling isolated and dissatisfied.

### **Evidence-based Practice**

Several PHNs identified that there is a greater emphasis on evidence-based decision-making and practice. They are excited about this opportunity. However, PHNs generally expressed concern that there needed to be more evidence-based decision making with program development. Evaluation of current programs was seen as necessary.

*It’s not just the meeting time. There’s a lot of reading and responding to things, and now there’s been sub committees that we are on. I guess that’s the downside with Public Health. We’ve never had a float pool. When you are off a day, or you’re off a couple of days, or if you take on a committee, it’s not just you, it’s your whole team taking it on because they’re going to have less of you to go out to the school and work.*

*(Nurse)*

Alternative models for capturing the difference their work makes in the health of individuals and the community need to be developed. Several PHNs thought that proper results-based or outcomes evaluation could assist to increase visibility of the less tangible aspects of their work. The greatest challenge is to develop evaluation tools that can capture, document, and measure quantitative and qualitative aspects of the PHNs’ practice.

.....  
*The commitment and the investment in that program is phenomenal and I just hope that the voices of the nurses are heard so we can get the bodies we need to do what they want us to do. But to get the results you need to invest in the evaluation material. If you don’t, it’s not going to work. (Nurse)*

## **PUBLIC HEALTH SERVICES INFRASTRUCTURE SUPPORT**

### **Staffing**

All participants expressed concern with the lack of human resources that are needed to effectively meet the core Public Health functions in Nova Scotia in a comprehensive way. Most PHNs identified the lack of both PHN and administrative

*The priorities that the government is setting are things like – it's the law – reporting notifiable diseases and events. But because of our four hundred thousand-population group and six or seven staff, when you look at sheer numbers of what we get to do that, occupies our whole time. So the other initiatives that we think would go hand-in-hand with this perhaps, it's difficult sometimes to get done.*

*(Nurse)*

support staff as a major constraint to their practice. The majority of PHNs reported that they do not have time and resources to meet the core program demands, community development and partnership work required.

Several PHNs identified that they were doing their own administrative work, which took them away from the community and increased their workload. Several PHNs across the province identified the lack of a casual and float pool of nurses to relieve nurses if they participated on a committee or took vacation.

It was noted that different levels of staffing, and variations in client populations and settings created great variations in terms of workload and the PHNs' sense of satisfaction in their work.

.....  
*The major difference between districts is population and we're supposed to work the same. . . . We have 4500 births, so it's a bit exasperating. There are so many things happening and such a lack of understanding. (Nurse)*

Public Health management identified that at the time when policy rhetoric pointed to the need for increased prevention and population health activities, Public Health lost both dollars and staffing positions. PHNs and Public Health management were unanimous in noting that the constant lack of adequate PHN staffing has had a significant impact on the visibility and viability of PHNs to practice within their population and primary health care focus. Uncertainty and tension are prevalent among Public Health staff, as well as concern among some for job security, program integrity, and equity.

#### **Time and Workload**

Many PHNs identified lack of time as one of the biggest challenges to accessibility. They stated that time, like money, is a limited and valuable resource. "Less time" takes many forms. PHNs referred to less time in the context of having increased workloads, increased documenting work, more time to travel greater geographic distances to reach clients, facing heavier administrative workloads, and needing more time, especially for at risk clients, to do referrals. Many PHNs described their work as a juggling act, in which they continually felt stretched and as though they are scrambling to accomplish the basics.

#### **Physical Resources**

Many PHNs stated they had good physical resources such as computers, videos and cell phones, while other PHNs said they lacked these resources. At the time of the study, one district had twenty PHNs sharing one computer. PHNs stated that not having up-to-date videos or computerised immunisation records limited their preventive work.

#### **Office Location**

Several PHNs identified office location as compromising accessibility for clients. Geographical location and/or monetary constraints were noted. Some PHNs expressed concern that there was a lack of private office space to conduct confidential discussions.

*Public health nurses'* capacity to provide services is contingent upon the public and other professionals having a clear understanding of their role. The PHNs acknowledged that their visibility derives from their ongoing relationships with individuals, families, community partners, and other stakeholders. Once PHNs are visible, known, and trusted, clients feel more at ease in participating in programs and services.

### **STRATEGIES AND FACTORS THAT CONTRIBUTE TO VISIBILITY**

Strategies were cited that contribute to their visibility and access to target populations:

- establishing a supportive and regular presence in the community with clients and partners
- developing trusting relationships and continuity doing tangible work

*Immunisation is a concrete way for you to have access to the school and parents. You may talk about an immunisation thing, and you get onto other issues that you would never otherwise have access to. And I know we often say, well, the immunisation clinic interferes with our chance to do this, but it gives you so much of a chance, too, because you are visible and it's concrete and it's something that they see you doing. (Nurse)*

### **ORGANISATIONAL FACTORS THAT ENCOURAGE VISIBILITY**

Organisational factors that foster their visibility in the community include:

- collaborating with community partners
- working in a geographically distinct area
- having a clear and unique role
- utilising organisational change opportunities
- having current and relevant health promotional materials to distribute

*One of the events in town was the campaign to go one hundred per cent smoke-free, so we ended up providing a lot of information to the citizens there. We had the information and the by-law was successfully passed. We spend time doing this kind of thing because it's important. You find yourself there as a presence, as a supportive presence. (Nurse)*

Despite the numerous factors and strategies that contribute to the PHNs' visibility in the community, the PHNs perceived they had lost visibility as a result of many factors.

### **Loss of Connection and Continuity with the Community**

By far the most troubling aspect of invisibility for the nurses is their diminished presence in the community. They believed that their diminished presence in communities gives the public and their community partners the misconception that they are no longer there. The loss of specific geographic areas for their practice, in some cases through the move to focus nursing, was seen as severing connection with many of the PHNs' long term relationships with community partners and clients.

*It's an identity thing. When we had our geographic area it was a wonderful thing. I would see women on the street, and that made a difference. I would go to the school and I would see the kids that I had visited when they were babies. And their mothers would come with them to the registration and would say, "Oh, I remember you." But we don't have that sense of continuity now. It's just, you go and see a baby. We fragmented it, that idea of families knowing a public health nurse.*

*(Nurse)*

*I find we're invisible.  
People don't know who  
Public Health is anymore.  
And in this area we're  
even more invisible  
because we've got nurses  
from the hospital going  
into the community.  
When we call, people  
think we're a nurse  
from the hospital.*

*(Nurse)*

PHN contact with some communities and client populations. The net effect is greater fragmentation of Public Health Services, less opportunity to make a difference, and greater invisibility.

#### **LACK OF SUFFICIENT FUNDING AND STAFFING**

Invisibility is further accentuated by lack of sufficient funding of Public Health Services. Short term and limited funding does not accommodate the health promotion and prevention programs that show evidence results over the long term. Consequently, the PHNs saw their ability to affect change being eroded. Reduced PHN staffing and fragmentation into nine DHAs further diluted the nurses' capacity to deliver programs and to protect the integrity of their practice.

*To do the job better, we need higher visibility maintained, not just as an organisation but what it is that we truly do. But look at our sheer numbers! Look at our sheer numbers!*  
*(Nurse)*

#### **HISTORICAL EMBEDDEDNESS OF THE ILLNESS MODEL**

Shifting of responsibilities and mandates between health, other government departments and health agencies has blurred the lines between what PHNs and acute care nurses,

#### **LACK OF UNDERSTANDING OF AND SUPPORT FOR THE PHN ROLE**

The PHNs named the government at various levels and its agencies as constraining factors. Generally, politicians are seen as not being well informed about the role of the PHN. Constant health

care organisational change has resulted in confusion among service users, health professionals and other community partners, and PHNs themselves, regarding their role. This has precipitated loss of the quality and frequency of

health and community professionals do. The PHNs contended that the illness model dominates the health care system and diminishes the PHNs' value with their peers.

*I don't think we're valued by the rest of the health care system, which is really sad because I know when I sat on the DHA I always said that what happens out in the community, it happens long before they ever get to the hospital doors. There's still an attitude out in the public that people think that health care has to do with the institution of the hospital. And that's the medical model and those old attitudes are so hard to change because they are historically ingrained. (Nurse)*

Most of the PHNs found the lack of awareness and devaluing attitudes among their hospital partners a strain on partnerships. They felt their professional credibility was undermined at times to the extent that they were limited from collaborative activities where their expertise could contribute.

#### **THE PUBLIC'S LACK OF UNDERSTANDING OF PUBLIC HEALTH NURSING**

The PHNs remarked that the role of the PHN is not well understood by much of the public. It is difficult to demonstrate the inherent value of their work because the tools to measure the effectiveness of these programs are lacking. This lack of awareness is accentuated by the media, which is generally disinterested in reporting Public Health news.

*I think it's vitally important to make citizens aware. To do that we have to be out in the community. But how can I get out and meet with the public and look at my key partners and say, you know, "This is who I am. This is what we have to offer. What do you think? What are your needs," that type of thing. (Nurse)*

#### **LACK OF A PROMOTIONAL CAMPAIGN**

The PHNs' lacked the time and skills to carry out the kind of promotional campaign they thought was needed to increase the public's awareness and dispel their misconceptions. They emphasised that while they do not want promotion that is self-serving, they do want to be visible to Nova Scotians so they can promote community health.



### **PROFESSIONAL PRACTICE**

- PHNs hold that professional autonomy and the flexibility to build individual/community capacity is of primary importance.
- PHNs are experiencing ethical dilemmas related to an increasing sense of conflicted loyalties and obligations in being true to their professional code of ethics, standards for public health nursing, and integrity as a PHN, while working under growing constraints in their everyday work environment.

### **MAKING A DIFFERENCE**

- Federal and Provincial policy structures with a greater emphasis on health promotion and prevention, population health, and primary health care fundamentally validate Public Health and the PHNs' practice.
- PHNs make a difference in building individual/community capacity by working collaboratively to promote accessibility and citizen participation.
- PHNs facilitate planned change by acting on the determinants of health and implementing multiple strategies to achieve intermediate and/or long term health outcomes.
- PHNs' social justice vision of primary health care locates them as linking agents between clients and a broad range of services, especially for vulnerable populations.
- PHNs act as initiators, community planners, collaborators, enablers, educators, advocates, and "champions."
- Collaboration and building networks are part of the PHNs' daily work.
- PHNs exercise a leadership role in collaborative activities that develop personal skills; create supportive environments, strengthen community action, re-orient health services, and build healthy public policy.
- PHNs and Public Health management demonstrate impressive resiliency in striving to make a difference in the midst of significant challenges.

### **ORGANISATIONAL CONTEXT**

- PHNs are increasingly constrained in their primary health care practice by factors internal and external to their work place.
- Some federal policies and funding initiatives, accompanied by provincial restructuring, particularly decentralisation, and insufficient funding of Public Health have resulted in fragmentation of Public Health and public health nursing.

### **VISIBILITY**

- PHNs' capacity to provide programs and services is contingent upon the public, other professionals, government officials, and policy makers having a clear understanding of their scope of practice.
- PHNs have lost visibility and viability as a result of loss of connection and continuity with the community; lack of understanding of and support for the PHNs' role; lack of sufficient funding and staffing; and historical embeddedness of the illness model.

# recommendations

## Strengthening Public Health Nurses' Contribution to Primary Health Care Renewal

The PHNs' experiential learning collectively constitutes a valuable pool of knowledge that enhances Public Health capacity for primary health care renewal while meeting the population health goals for Nova Scotia. As part of our research protocol, PHNs and Public Health management participants were asked "What would enhance the PHNs' practice in fostering citizen participation and collaborative practice?" The following strategies are based foremost on the PHNs' explicit suggestions for change, supported by Public Health management, and expanded by the researchers' interpretation.

### PRACTICE

- Create more opportunities for innovative practice.
- Enhance connections and opportunities for PHN peer communication between focus programs, within the DHA "shared service" areas, and across the DHAs in Nova Scotia, such as the establishment of a PHN practice council with equitable representation from across DHAs.
- Explore opportunities to integrate collaborative practice in the primary health care framework.
- Continue to use innovative approaches to address the needs of vulnerable populations.
- Adopt mechanisms to integrate the Canadian Standards of Community Health Nursing Practice in Public Health Services in Nova Scotia.
- Establish strong support for nursing practice such as Public Health CNS positions.

### EDUCATION

- Mobilise funding and other organisational mechanisms to support partnerships between university health profession programs, the Department of Health, and the DHAs for the integration of PHNs and other health professionals in primary health care restructuring.
- Enhance opportunities for formal and "on-the-job" continuing education.

- Assess the question of awareness of Public Health and public health nursing among the public, other professionals, government officials, politicians, and policy makers.
- Develop strategies to address areas of misunderstanding.

### RESEARCH

- Continue to develop PHN practice within frameworks of research and evaluation for "Best Practices."
- Explore funding mechanisms to support partnerships between university researchers, the Department of Health, the DHAs, and Public Health Services.
- The Department of Health and Public Health management and staff in DHAs develop mechanisms to ensure that all programs are developed, implemented, and evaluated using evidence-based decision making.
- Establish strong research-based practice and practice-based research support through establishment of CNS positions.

### POLICY

- Enhance organisational structures and opportunities that empower PHNs and promote work effectiveness and health outcomes.
- In DHAs where there is not a consistent commitment to PHN staff involvement in program planning and evaluation, this needs to be assessed through staff and partner involvement.
- Enhance information management systems.
- In partnership with the DHAs, the Department of Health, university nursing programs, and the Nursing Strategy investigate the adoption of the core competencies for community health nurses in Canada for Nova Scotia.
- Explore funding mechanisms and other strategies to ensure the competencies are met and sustained.

# References

- Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Dorna, D., Kerr, M., Hall, L., Vezina, M., Butt, M., & Ryan, L. (2003). *Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system.—A policy synthesis*. Ottawa: Canadian Health Services Research Foundation. Ottawa.
- Canadian Nurses Association (CNA). (2002). *Code of ethics for registered nurses*. Ottawa: Author.
- Community Health Nurses Association of Canada (CHNAC) (2003). *Canadian community health nursing standards of practice*. Toronto: Author.
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. London: Sage.
- Miles, M., & Huberman, A. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.
- Naylor, D. (2003). *Learning from SARS: Renewal of public health in Canada*. Ottawa: Health Canada.
- Richards, T., & Richards, L. (1991). The NUD\*IST qualitative data analysis system. *Qualitative Sociology*, 14(4), 307-324.
- Sandelowski, M. (1995). Focus on qualitative methods: Qualitative analysis—What is it and how to begin. *Research in Nursing and Health*, 18, 371-375.
- Stevens, P. E. (1993). Marginalised women's access to health care: A feminist narrative analysis. *Advances in Nursing Science*, 16(2), 39-56.
- Underwood, J. (2003). *The value of nurses in the community*. Ottawa: Canadian Nurses Association.
- World Health Organisation. (1978). *Primary health care: Report of the international conference on primary health care*. Alma-Ata, USSR. Geneva, Switzerland: Author.
- Yeo, M., & Ford, A. (1996). Integrity. In M. Yeo & A. Moorehouse (Eds.), *Concepts and cases in nursing ethics* (pp. 267-280). Toronto: Broadview Press.

