Tips for Teaching and Organizing Community Health Practice/Clinical Courses

Practical Tips for Instructors, Administrators, and Organizers of Innovative/Non-Traditional Community Health Clinical Experiences

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September 2014 – March 2015
University of Lethbridge

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We cannot solve our problems
with the same thinking we used
when we created them.

Albert Einstein

Preamble

Schools of nursing need to continually find new and sustainable ways to engage students in community health practice. Despite the fact that service learning is widely used in nursing education, and despite some excellent reports on the use of this delivery model in Canada, extant literature provides little insight or prescriptive guidance in the following areas: the nature of foundational knowledge in community health nursing; faculty workload associated with a service learning model in community health clinical education; whether service learning in community *health* style projects prepare students for community *based* nursing practice; logistical issues in structuring service learning experiences in community health nursing clinical education; the shortcomings of service learning for clinical education; and how to bridge the theory/practice gap in non-traditional clinical experiences. While answering these questions is beyond the scope of this document, the tips offered herein should provide community health clinical instructors some tools to begin to address the theory-to-practice gap.

The Canadian Association of Schools of Nursing (CASN) Sub-Committee on Public Health has published a set of guidelines for undergraduate community health experiences (2010). These guidelines, which are readily available online for schools of nursing to utilize in the development of community health practice experiences, should provide the basis of all baccalaureate nursing education for community health practice. **The tips in this document expand on CASN's Guidelines, are derived from the literature, my own teaching experience, my research into community health clinical experiences, and discussions with faculty across Canada who teach community health clinical practice courses**.

Acknowledgements

Thank you to Dr. Chris Hosgood, Dean of the Faculty of Health Sciences at the University of Lethbridge, who permitted and provided resources for a review of current practice and development of potential solutions. Thank you also to my outstanding community health nursing colleagues at the University of Lethbridge, and my esteemed colleagues in community health nursing across Canada. Thank you to my PhD supervisory committee—Dr. Sylvia Barton, Dr. Jill Konkin, and Dr. Olu Awosoga—for their support in my research into this topic. Thank you to the Western Northwestern Region of the Canadian Association of Schools of Nursing for partially funding my research through the graduate research award.

Community Health Nursing Identity

- ❑ Develop, with your community health clinical education team, a statement that describes the role of the community health clinical instructor, particularly as it relates to the roles of project manager and learning experience facilitator.
- ❑ Ensure students have access to community health role models that are registered nurses, through shadow shifts and preceptor arrangements to promote both socialization into community health nursing and appreciation of its unique role responsibilities.
- ❑ Incorporate strong community health case studies that require prioritization of care and case management, in which students can integrate specialized nursing knowledge and skills.
- ❑ Create an orientation toolkit for new instructors that includes key documents and recommended tips for organizing the learning experience.
- ❑ Have regular meetings with teaching faculty to shape the learning experiences and problem solve clinical issues as a team.
- ❑ Engage with community health practice areas to stay involved and maintain relationships in the practice area.
- ❑ Find ways to enable students to experience a variety of community health nursing activities and populations. Ensure students are exposed to the two biggest areas of community health nursing: home care and public health.
- ❑ Facilitate the placement of clinical instructors into areas about which they are interested, passionate, proficient, knowledgeable and, if possible, experienced (Collier, 2010), to make the learning richer and more relevant for students. Capitalizing on faculty expertise and interests reduces workload and

Community Health Nursing Identity

ESSENTIAL:

- Faculty advisor/clinical instructor has knowledge of the Canadian Community Health Nursing Standards of Practice, primary health care principles, public health sciences and nursing science.
- Faculty advisor/clinical instructor is able to translate the community placement experience so that students can understand the community health nursing role.

PREFERRED:

- Faculty advisor/clinical instructor has current community health nursing practice experience.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 2)

stress, ignites students' passion and interest, and builds bridges with the agencies.

COMMUNITY HEALTH NURSING SCOPE OF PRACTICE

- ❑ Reconsider the length and duration of the clinical experience required for students to meet the course objectives and for entry-to-practice competence (CNA, 2005). Reconsider mandated clinical hours (Manchester, 2006). Reducing required hours may increase student opportunities as more preceptors will be available.

- ❑ Consider a competency-based approach to clinical learning. The traditional approach to practice education through clinical rotations is time-based and relies on the 'tea steeping' effect. It is premised on the assumption that any student placed in a clinical setting for a set number of hours should have learned enough by the end of the rotation. Rotation-based learning is not competency-based (Holmboe, Ginsburg, & Bernabeo, 2011; Saucier, Paré, Côté, & Baillargeon, 2012). A competency-based approach may reduce the number of student-hours in the clinical site, thus making room for more students to be exposed to community health practice roles and role models. Additionally, when students *are* in actual community health practice areas, their learning is more directly relevant to developing competencies for practice.

- ❑ Facilitate ways students can observe the role of the public health nurse and home care nurse. If direct observational experiences are not available, a video documentary project should be considered, similar to the ground-breaking documentary on street nursing, *Bevel Up*, a perennial favorite of nursing students (Wild, 2006). Similar videos could be made highlighting the role of the public health nurse and home care nurse for use in classrooms.

- ❑ Consider a curricular change that would make community health into a combined 6-credit theory and clinical course that weaves together both experiences. If clinical experiences lack direct contact with community health nurses, foundational concepts such as population health and the community health nursing process may make greater sense as part of the theory

Community Health Nursing Scope of Practice

ESSENTIAL:

- There is potential for students to work with clients at group and/or community levels.
- There is potential for exposure to broad determinants of health, citizen engagement, population health, and primary health care principles.
- There is exposure to multiple community health nursing strategies (e.g. building healthy public policy; developing personal skills; strengthening community action; creating supportive environments; reorienting health services).
- There are opportunities for practical experience where students can see the results of their actions and move toward independent practice.
- There are opportunities to develop collaborative relationships/partnerships.

PREFERRED:

- There are opportunities for the student to engage in practice with community as client.
- Students will experience being part of an interprofessional and potentially intersectoral team.
- Rural, remote and international placements are available.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 2)

course, not existing as a separate, time-intensive clinical course.

- ❑ Review Canadian nursing curricula in light of health care system realities. Consider the degree to which undergraduates should be prepared for community health roles as proportional to the percentage of graduates actually working in these areas directly after graduation.

- ❑ Review Canadian nursing curricula in light of the shift to the NCLEX-RN.

- ❑ Maximize faculty expertise, such as the possibility of rotating students through multiple experiences with different instructors teaching in their area of expertise, to broaden the students' exposure to community health practice roles and role models.

- ❑ Find ways to enable students to experience a variety of community health nursing activities and populations. Arrange job-shadowing events if possible. Ensure students are exposed to the two biggest areas of community health nursing: home care and public health.

- ❑ Balance community *health* nursing with community *based* nursing competencies and the need to prepare students for practice in the community, including the use of specialized nursing knowledge and skills. Incorporate these opportunities into the service learning experience to ensure that students have exposure to both general and specific competencies for community health practice.

- ❑ Ensure students participate in annual and pandemic (as they arise) immunization clinics. Training by faculty and/or the health authority is valuable for student learning and extra hands-on-deck can be helpful for the clinics. These opportunities must be coordinated with the relevant health authority.

- ❑ Utilize skills and simulation labs that relate to the public health and home care. Students and practicing nurses place a high value on hands-on skills, which can act as a springboard to deeper learning. Employ OSCEs where appropriate to ensure students are skilled and knowledgeable for competent, safe patient care. Simulation has been shown to greatly enhance the clinical capabilities and clinical

reasoning abilities of nursing and health professions students (Berragan, 2013; Cook, Brydges, Zendejas, Hamstra, & Hatala, 2013; Katowa-Mukwato et al., 2014; Shin, Park, & Kim, 2015).

- ❑ Arrange opportunities for direct nursing care, if possible (health assessment, foot care, immunization clinics, fall prevention and assessment, etc.). Explore opportunities with housing agencies, seniors' homes, seniors' centres, homeless shelters, non-profit groups, and so on, so that students can acquire and utilize uniquely nursing knowledge and skills and develop both general and specific competencies for nursing practice.

- ❑ Create public health opportunities that follow from an obstetric or pediatric rotation. Create home care opportunities that follow from a medical or surgical rotation. Use of "field visits, "hub and spoke" or "targeted clinical home community settings" methods of creating experiences for students in the community (Cummins et al., 2010; Farasat & Hewitt-Taylor, 2007; Williams-Barnard, Sweatt, Harkness, & DiNapoli, 2004). Alternately, conducting heart failure patient follow-ups in the community, based on a medical surgical rotation, can provide a meaningful experience for both students and patients (Wheeler & Plowfield, 2004).

COMPETENT WELL-PREPARED PRECEPTOR

- ❑ Establish a common language and understanding of terms and concepts regarding community health, standards of practice, general and specific competencies, preparation for practice, and service learning among community health clinical (and theory) instructors and community partners.

- ❑ Develop a statement of intent for both the community health theory course and community health clinical course. Articulate the goal of the clinical course in terms of preparation for practice and methods, community-based nursing versus community health nursing, how this is a valuable experience, and how specific public health and home care competencies will be met. This statement could be included in the course outline. Delineate the general and specific competencies students will have opportunity to obtain during the experience. As well, the university calendar description for the clinical course should reflect what the clinical experience actually offers.

- ❑ Align the theory and clinical courses. Consider a concept map assignment as a tool to bridge theory and practice. Consider secondary assessment data or project portfolio as possible assignments for the theory course.

- ❑ Find ways to make preceptorship work in community health by re-opening discussions with practice areas. Practice areas face numerous barriers to preceptoring, including invisibility, dual roles, mandated preceptoring, and workload. However, preceptoring remains an important role in developing students into community health professionals. A climate of preceptorship should be fostered by health authorities and well-supported by educational institutions despite current challenges (Hjälmhult, Haaland, & Litland, 2012).

- ❑ Promote education-practice collaborations such as undergraduate nurse positions, which foster

Competent Well-Prepared Preceptor

ESSENTIAL:
- There are organizational supports to precept, especially in the form of time to effectively support students.
- The preceptor has a positive attitude toward preceptorship and life-long learning.
- The preceptor has experience working in and/or with communities.
- The preceptor has the ability to help students apply theory into practice.

PREFERRED:
- Formal preceptor orientation is provided collaboratively by the community organization and the academic institution, e.g. preceptor workshop or module.
- The preceptor is a nurse with community health nursing experience and knowledge of the Canadian Community Health Nursing Standards of Practice, primary health care principles, public health sciences and nursing science.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 2)

socialization into the RN role and a strong clinical background.

- ❑ Where resources are scarce, reserve community health placements for students who actually want to be there.

Supportive Environment for Student Learning

Structuring the Experience

- ❑ Define both the objectives and structure of the clinical experience to support student learning (CNA, 2005). Determine appropriate learner outcomes and competencies (general and specific), and design service learning to meet those outcomes so that the service learning experience fosters achievement of objectives and competencies.

- ❑ Ensure there is sufficient structure to the learning experience and not an excess of discovery learning. Increased structure makes students feel safe and can be accomplished through scheduled clinical conferences, structured group meetings led by the instructor, intentional facilitation of learning using established tools and documents, and clearly describing the students role in concrete terms. The Canadian Association of Schools of Nursing is compiling a resource of teaching tools for public health nursing.

- ❑ Ensure community health clinical experiences are strongly related to nursing roles and that when they resemble teaching roles, that students are provided with the skills to do so and are able to develop and use uniquely nursing knowledge. Increase students' opportunities to build the foundations of nursing practice through the development of general and specific competencies for professional practice and opportunities to participate in nurses' work.

- ❑ Reframe service learning as first and foremost a learning experience for students, not product development for the agency. Reconsider the nature of deliverables and how complete or 'polished' deliverables should be. Ensure the agency is clear on the parameters and have the agency sign off on expectations.

- ❑ Consider the use of both project/alternative placements and preceptor experiences, as both have

Supportive Environment for Student Learning

ESSENTIAL:
- In a preceptored learning situation, there is ongoing, regular communication between faculty, preceptors and students, with at least one verbal contact.
- The community placement setting has a caring and welcoming attitude towards student mentoring.
- Student orientation to the placement setting is provided.
- Attention is paid to student safety.

PREFERRED:
- In a preceptored learning situation, there is verbal communication at least at the beginning, middle and end of the experience involving faculty, preceptors and students.
- Student preference in placement choice should be given consideration.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 2)

something unique to offer student learning. One method of having both approaches is to divide the rotation into two parts with a switch at midpoint.

- Define, delineate and articulate the parameters of a 'good service learning experience' to guide the negotiation and pursuit of opportunities (Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010). Review entry-to-practice competencies, national community health competencies, and community health nurse practice requirements to create guiding criteria for clinical experiences. Match the curriculum and course outcomes.

- Balance abstract and concrete components, population health and individual health, and population health with contact with the population. Nursing students are primarily concrete learners who appreciate the opportunity to do 'real things with real people' and who work their way from concrete tasks to the bigger picture (D'Amore, James, & Mitchell, 2012; Hauer, Straub, & Wolf, 2005; Shinnick & Woo, 2015).

- Examine and alter the parameters for structuring the experience (location, number of students in a team, amount of computer/desk work, degree of structure, nature of group work, etc.) to foster sustainability—from both the instructor workload perspective and the agency point of view. Find agencies and experiences that can accommodate greater numbers of students so that team size can be increased and/or the entire group accommodated at 1 or 2 geographic locations or clinical sites. For example, for a clinical group of 12, consider:
  - 4 teams of 3 students each, all in one clinical agency
  - 4 teams of 3 students each, 2 teams in one agency and 2 in another related/nearby agency

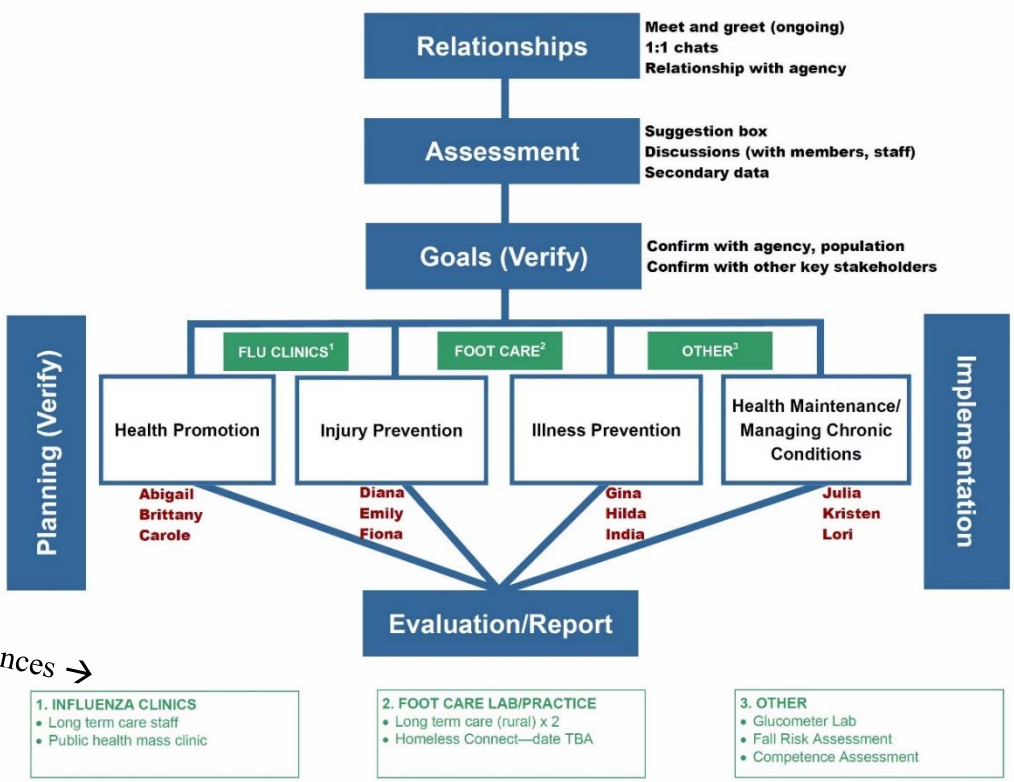
  By having all students at one location, structured clinical conferences or built-in teaching time are easy to have as standing appointments during which students reflect on past work, plan future work, and weave in theoretical concepts into their work, guided by the instructor.

  If clinical groups have more than 8 students, consider reducing the number of students (optimal number is 7 or 8), so it is analogous to acute care clinical group size. This reduction will directly reduce workload, which tends to

become unwieldy at higher numbers. It will also increase the amount of attention students get and increase the serendipitous learning opportunities.

- Organize students to optimize learning and manageability. I find this works best if I have my whole clinical group (n=12) at one site. (Or at most, have two different but related sites i.e. serving the same population.) Ideally, the agency will have a meeting room/working space for the entire group. The benefits?
    - Less driving for the instructor
    - More opportunities for direct supervision of students
    - More instructor engagement with student learning
    - Facilitates regular built-in teaching time to consolidate learning
    - Students' work is interrelated with each other's, so everyone can contribute to rich ideas
    - Implementation of common learning activities and related discussions
    - Easy sharing of resources and ideas between students
    - Greater focus on the population, the nursing process, and collaboration, instead of individuals working separately
    - The focus of the experience is on learning, not on product development
    - Enables face-to-face planning and reporting, instead of written reporting (which need to be read and marked outside of clinical time)

  For example, a clinical group might be at a senior citizens organization. Divide the group by levels of prevention and organize the experience along the lines of the community health nursing process.



- ❑ Find ways to make this non-traditional clinical experience a satisfying learning experience, not just a way to keep students busy for eight hours. Maximize the opportunities for students to develop specific and general competencies for community health nursing practice.

- ❑ Find ways to create a 'hook' in projects to get students' interest and to connect with students' concrete needs to create accessible points of connection with the experience.

- ❑ Incorporate specific nursing knowledge, concrete nursing skills, and patient contact to enhance students' connection with and appreciation of the learning experience, and to maximize opportunities for students to develop specific and general competencies for nursing practice.

- ❑ Keep health as a central and obvious theme in chosen projects. While it is often 'the process' students are learning through these experiences, students' interest and motivation is piqued when the experience/project has obvious connections to nursing and requires them to use specialized nursing knowledge that is distinct from social work, education, and other disciplines. Students seem to struggle

more and require more morale boosting and coaching (which is time-intensive and emotionally draining) for experiences with less obvious health links and minimal patient contact.

- ❑ Scale down the scope of student projects to make room for consolidating learning and structured reflection and planning, either through less intense deliverables or through a decreased focus on community development and capacity building.

- ❑ Establish, via a collaborative process among community health clinical faculty, consistent parameters to be implemented in every clinical group within a given nursing program. The following items should be consistent and standardized across all concurrent sections of the course: all forms and evaluation processes; level of supervision to be utilized; accountability process; number of required clinical hours and how those hours are to be reported by students to faculty; how time is to be used in clinical groups (such as not completing class work during clinical time, the use of pre/post conferences, etc.); and the degree of appeal and diversity of experiences.

- ❑ Make student orientation to the experience relevant. During the first two or three clinical days, strategically orient students in the clinical group to the experience, so team building and pre-contemplation can begin and so orientation is specific to the agency at which they are stationed. Include in orientation to the components that will actively prepare students for working with the agency and for having positive interactions with agency staff despite their personal feelings and thoughts. Include direct guidance, practice and coaching on the effective use of both verbal and email communications. Include opportunities to pre-contemplate issues that may arise with the agency. Include cultural inculcation whenever possible (such as sweat lodges, listening to elders, meet and greets with the population, etc.).

- ❑ Utilize the nursing program's standard clinical performance evaluation tool to evaluate student performance. Increase the alignment of community health clinical objectives with required competencies for community health; align these items with the nursing program's standardized evaluation tool. Clearly articulate what is required for a passing grade

(performance, product or deliverable quality, completion of required elements, completion of required hours, etc.). To make competency statements observable and measurable, consider implementing *entrustable professional activities* as demonstrations of competence (ten Cate, 2014; ten Cate & Scheele, 2007; ten Cate & Young, 2012) .

- ❑ Consider the nature of the outcome or deliverables in light of, first and foremost, learning potential for students. Limit the scope of deliverables, if they are required. Limit end-of-project reports to a set number of pages, and only if they are absolutely required. Otherwise, reduce closure documents to a single-page letter explaining what was done and what was learned by the students.

- ❑ Consider outcomes research to assess the consequences of service learning, community health and/or community-based nursing education on clinical competence, critical thinking skills, socialization into nursing, team functioning, and ability to function fully in the work setting.

- ❑ Standardize the experience across the program so that every student has a similar experience and broad exposure to community health nursing. Minimize disparities across experiences within a program.

- ❑ Examine the undergraduate nursing/pre-registration curriculum to ensure community health content is adequately and proportionally represented. Content such as pathophysiology, assessment, case management, and epidemiology are foundational to basic nursing practice in the community and an important aspect of community health. Opportunities and time to integrate specialized nursing knowledge and skills are also important. Examine the clinical assignments to ensure students are getting the skills and knowledge they need. Provide multiple intentional opportunities for students to make the connections between theory, clinical and practice, and to develop general and specific competencies for nursing practice.

- ❑ Utilize sites and target population groups not formally served by traditional health care services. This utilization enhances care for all.

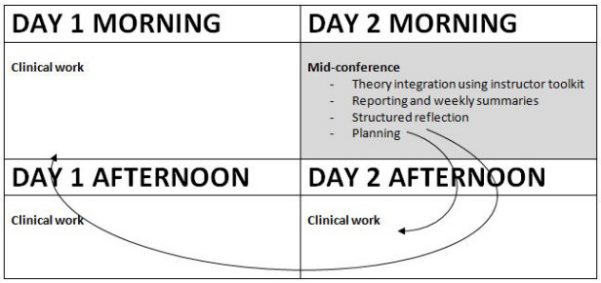
- ❑ Examine the undergraduate nursing/pre-registration curriculum and consider a curriculum that considers workplace realities. Consider possibilities such as a final residency or internship (Reagor, 2010) as an option for students, or additional courses for students interested in community health nursing to equip them with the specialized nursing knowledge and skills required for actual practice.

- ❑ Continually evaluate what we do as educators, why we do it, and whether it is effective for student learning, student engagement, student competence, and practice-readiness.

INCORPORATE BUILT-IN TEACHING TIME

- ❑ Foster strong and intentional pedagogy in community health courses so that students are better able to make links between theory, clinical, and RN practice. Good pedagogy should be shared with colleagues. The Canadian Association of Schools of Nursing is currently coordinating the development of a national resource of teaching strategies for public health.

- ❑ Enhance the learning experience through regularly scheduled teaching time in the form of clinical conferences. For example, in a 13-week clinical rotation, with 2 days per week, regularly schedule a 'mid-conference' on the morning of the second day. This time is used to:
  - Enable students' structured reflection and reporting on what they accomplished on the previous week's Day 2 afternoon and current week's Day 1.
  - Enable students' structured planning and reporting on what they will accomplish on Day 2 afternoon and Day 1 of the following week.
  - Help students integrate community health concepts into their clinical experience.
  - Utilize structured learning activities in an otherwise fairly unstructured clinical learning environment.
  - Enable real-time reporting, planning and idea-sharing between students, enhancing learning for all.
  - Facilitate real-time reflection, thus eliminating time the instructor spends outside of clinical time marking journals, reflections and planning documents.



- Enable students to peer-review each other's work and have input into the planning of their peers, strengthening learning for all. Students who are preparing workshops, teaching sessions, interventions, or presentations can present their work to peers, during a structured teaching/learning time, via laptop and data projector. The rest of the group can give their input. (Not only does this help everyone learn together and test ideas in a safe place, it means the instructor doesn't have to mark these items outside of clinical time.)
- Use a program-specific conference toolkit for clinical instructors to facilitate learning activities during the structured teaching time. Advance preparation maximizes the ability of the faculty advisor to capitalize on teachable moments. (Note: Teaching time is not for giving students more theory content. This time should not require instructor preparation, aside from standard items in the toolkit; the toolkit is a collection of strategies to help students pull the theoretical learning into their clinical work.)
- Facilitate verbal reflection through prompting questions or structured activities. Examples include: reflective questions; questions to guide future actions; games, speakers or activities relevant to community experience; and a review of objectives and Community Health Nursing Standards of Practice and competencies, with application to how students are implementing them in the clinical experience.
- Provide opportunity for students to reflect upon and complete a clinical evaluation tool, as it reflects their own practice and learning needs.

❑ Consider the weekly project summary (Diem & Moyer, 2005) as a teaching/learning tool and balance its use in light of the amount of faculty feedback required. Consider verbal reports during weekly mid-conferences instead of written reports, which require extensive time for students to prepare and for faculty to mark (outside of clinical time). Consider asking students these questions in real-time:

- What did you accomplish this week? Describe what you did, how long it took, what was involved, and what each team member did. Did you accomplish what you intended to? Why or why not? Are you on track with your timeline?

- What is your plan for next week? What activities do you anticipate? How much time will this take? Who is involved and how?
- What community health concepts are you utilizing in your practice? What concepts are you seeing 'in action' (e.g. determinants of health, intersectoral collaboration, primary health care, levels of prevention, etc.)?
- What community health nursing competencies are you using? How is it demonstrated in your practice?
- What are key future dates of which I (the instructor) need to be aware?
- What were some memorable moments this week? Frustrations?
- How is your group process and team work? What are the challenges, and how are you addressing them?
- What do you need from me at this point?

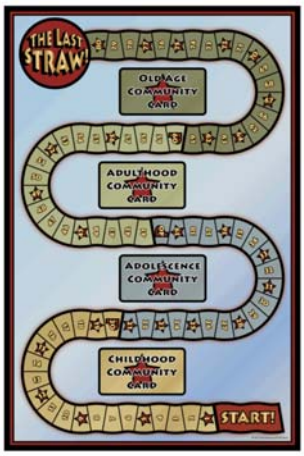
- ❑ Instead of disparaging students' focus on skills and tasks, try building on it by giving them the skills and opportunities to practice, so they can be unencumbered to attend to the patient in the clinical encounter, so that they are able to contribute meaningfully using specialized nursing knowledge and skills, and so that they get a sense of being different than teachers, social workers and event planners—roles that students often feel they are engaging in during non-traditional community health clinical. This skills-first type of developmental approach would foster students' growth from concrete to more abstract and integrative and will enable them to feel they are giving effectual nursing care at the individual level. Students with skill mastery are more likely to be competent, which will enhance their confidence, and increase their sense of belonging on the nursing unit due to their enhanced ability to participate meaningfully in the nursing work of the unit (Katowa-Mukwato et al., 2014; Levett-Jones & Lathlean, 2009).

- ❑ Consider the use of the skills laboratory for teaching psychomotor skills associated with public health and home care (and perhaps advanced practice nursing). Rotate faculty through these teaching positions so each faculty person can teach in their area of knowledge and teach the same content area to different cohorts. This may require a change with the nursing program's provincial regulatory body. Possible topics include: immunization (including

influenza), wound care, foot care, well baby assessment, maternal assessment, home care assessment and fall risk assessment. Consider aligning these components with the theory course timeline. Simulation has been shown to greatly enhance the clinical capabilities and clinical reasoning abilities of nursing and health professions students (Berragan, 2013; Cook et al., 2013; Shin et al., 2015). Employ OSCEs where appropriate to ensure students are skilled and knowledgeable for competent, safe patient care.

- ❑ Integrate concepts related to the determinants of health, problem solving, and levels of prevention into all clinical placements.

- ❑ Use *The Last Straw*, the Canadian board game on the social determinants of health (http://www.thelaststraw.ca/). It's a great learning tool for orientation to the community health practice rotation. This game is helpful to promote discussion about the social determinants of health; to help players build empathy with marginalized people and gain an awareness of players' own social location; and to encourage learning in a fun and supportive environment. The instructor follows a guidebook and observes and facilitates the game. Groups of up to 12 students can play very meaningfully. The game promotes watershed learning moments.



- ❑ Print and cut out on colored paper the course objectives or competencies for community health. Have students in pairs each blindly draw one or two out of an envelope. In pairs, have them discuss three ways that they have each been enacting that objective or competency and what they could do to further accomplish that objective. Then, have each pair share aloud with the group. Specific points include: How are you achieving this objective? How is it evident (that you are achieving this)? How do you know you are being successful? What are the challenges? What are the rewards? How does the population benefit? (See Appendix A.)

- ❑ Create a bingo game that aligns level of action (individual, family, community, sector/system and society) against the level of prevention (health promotion, primary prevention, etc.). The community health nurses' actions can be filled in by students for each square. (See Appendix B.)

- Align the students' learning with the community health nursing process (Diem & Moyer, 2005) by making intentional connections and by structuring the clinical experience to follow this process.

- Discuss with colleagues the buzzwords like *critical thinking* and how their development is best fostered. The term *clinical reasoning* reflects the integrative nature of knowledge, skills and experience required in practice (Cerullo & da Cruz, 2010). Clinical reasoning embodies critical thinking along with the application of knowledge and expertise to clinical practice (Banning, 2008). Victor-Chmil (2013) describes critical thinking as "the cognitive processes used for analyzing knowledge"; clinical reasoning as "the cognitive and metacognitive processes used for analyzing knowledge relative to a clinical situation"; and clinical nursing judgment as "the cognitive, psychomotor, and affective processes demonstrated through action and behaviours" (p. 34). By distinguishing these commonly conflated terms, instructors can have a clearer vision for what they are trying to accomplish through assignments and clinical activities.

- Utilize Bloom's Taxonomy in the development of activities and questions.

LOGISTICAL ISSUES

- Consider ways to resolve the unique challenges surrounding the use of remote placements. For example, have one whole clinical group at one location, with one day spent remote and one day on campus to prepare for the following (remote) day.

- Ensure students understand their role in the clinical placement in concrete terms.

- Restrict the clinical experience to the designated days and times. Be strict about not allowing students to do clinical work on non-clinical days, because when they're 'on,' you're 'on.' For example, for a Monday/Tuesday clinical group, have a strict 0830-1630h policy, no exceptions. Sometimes the agency will want to meet on non-clinical days for a board meeting. Have the students prepare a

written or video submission instead. Maintain these boundaries and make sure instructors model them.

- ❑ Encourage instructors to maintain boundaries around cell phone use, texting, email response time, agency contact time, and activities that occur on non-clinical days.

- ❑ Gain program-level support for community health clinical faculty through the provision of funds, technology (iPhones, data projectors, laptops, etc.), and funded annual debriefing and planning workshops.

- ❑ Establish an annual workshop at year end for instructors to debrief, problem solve, and plan future clinical experiences. Review and further develop course processes and documents. Discuss what worked and what didn't work and solve problems as a team.

- ❑ Create a community health clinical placement facilitator role to organize and secure the community health clinical rotation/sites. Periodically evaluate the job description and time requirements for this role to see if they have evolved and if either requires amendment to accommodate new roles or parameters. If instructors must go out and secure their own placements, the workload is magnified significantly (especially in rural communities) and site competition and learner collision will become an issue. Ensure this community health clinical placement facilitator is familiar with community health nursing in current and future role capacities and is able to secure opportunities that allow students to develop general and specific competencies for community health nursing practice.

- ❑ At the level of the school of nursing, ensure a centralized web-based clinical placement inventory database is in place to help identify and track clinical placement in community sites.

- ❑ Allow faculty to return to the agencies with which they are familiar. This supports the relationship-building process, which can take years, and enables a degree of familiarity from semester to semester.

- ❑ Develop a statement on the level of supervision in community health clinical, one that fosters accountability and independence in students, and that equally fosters manageability of faculty workload. As needed, coach faculty on the implementation of a supervision model that is sustainable.

- ❑ As a community health clinical team, develop a code of conduct that includes channels of communication, roles and responsibilities, and methods of fostering a positive team atmosphere.

- ❑ Discuss end-of-course evaluations specific to the clinical rotation to better understand student experiences and to find ways to enhance experiences while also managing faculty workload.

- ❑ Ensure that clinical evaluation methods and tools are sufficient to determining competence (Levett-Jones, Gersbach, Arthur, & Roche, 2011). Challenges such as the nebulousness of experiences and the absence of the instructor present considerable challenges that must be addressed. Medical education is finding ways to bridge the gap between theory and clinical practice through the delineation of *entrustable professional activities* (ten Cate, 2005; ten Cate & Scheele, 2007; ten Cate & Young, 2012).

- ❑ Avoid clinical experiences or projects that require ethics approval.

- ❑ Clarify guidelines and limitations for students through formal documents that outline expectations for professional behavior, safety issues, and so on. Students could be required to sign this document (Seifer & Connors, 2007, p. 28). Concomitant with this set of expectations, consider increasing student independence and accountability (particularly for time usage), through the use of log sheets for time accountability; the need for this monitoring may decrease over time.

- ❑ Have a community health clinical experience fund that instructors can access for clinical supplies used by students. Sometimes it helps if the instructor does the purchasing, as bills can be submitted directly and no money changes hands with students, which is cumbersome. Articulate, in writing,

the parameters for its use by clinical instructors so it is not used for classroom products and activities.

- ❑ Ensure placements are sustainable in terms of workload for faculty, pressures on host agencies, and opportunities for student learning. Host sites may be overloaded. Ensure the host site is assessed for impact of the student placement.

- ❑ Ensure there is consistency across sections regarding the type of work the students will be doing, the supervision level and the time requirements.

- ❑ Encourage faculty advisors to work smarter with Smartphones. For example, an iPhone can share applications and data with a desktop so no information is ever lost if the iPhone goes missing. (Make sure the iPhone is password protected with a 1-minute lockout.) The following features are very useful for clinical teaching:
    - **Camera**. (1) On the first day of clinical, take students' photos while they hold up a sign with their name on it. You can use these photos to learn their names. Also, you can use the photo in your Outlook contact for the student, so when s/he phones, texts or emails you, you have a visual of the student. (2) Throughout the clinical rotation, take photos of student work for your teaching dossier and annual professional activities report.
    - **Dropbox**. This online file repository can be accessed from any computer by logging in. With the Dropbox app on both your desktop and iPhone, you can access your files readily from either desktop or iPhone. For example, if you have a useful document a student can use, email it directly from your iPhone to the student without leaving your seat.
    - **Write2**. This app lets you take notes. You can use it to record mileage (dates and miles and destination), keep a student absence record, record policies and procedures, and myriad other tasks. It synchronizes wirelessly and automatically with Dropbox so nothing can ever be lost.
    - **Calendar**. Your Outlook calendar is based on your university's server but can be viewed on your desktop or iPhone. Schedule in your clinical days by copying and pasting as appointments (I schedule a morning and afternoon separately on all clinical days), and then, under the 'notes' section of each

'appointment', put in notes about what you want to help students with or what they're doing on a given day.

- **Outlook**: On your desktop, set up an Outlook contact profile for each student with their contact information, photo and other relevant information. Put a prefix before the student's name that tells you what term or section the student is in. For example: "**F13b Sally Waters**" would be a student in Fall, 2013, Section B (if you have more than one section). This way, you can easily text the entire clinical group by searching for F13 and selecting respondents. Also, if students phone or text, you know which group they're in and who they are. At the end of the semester, you just need to go to your collection of "F13s" and delete them all.

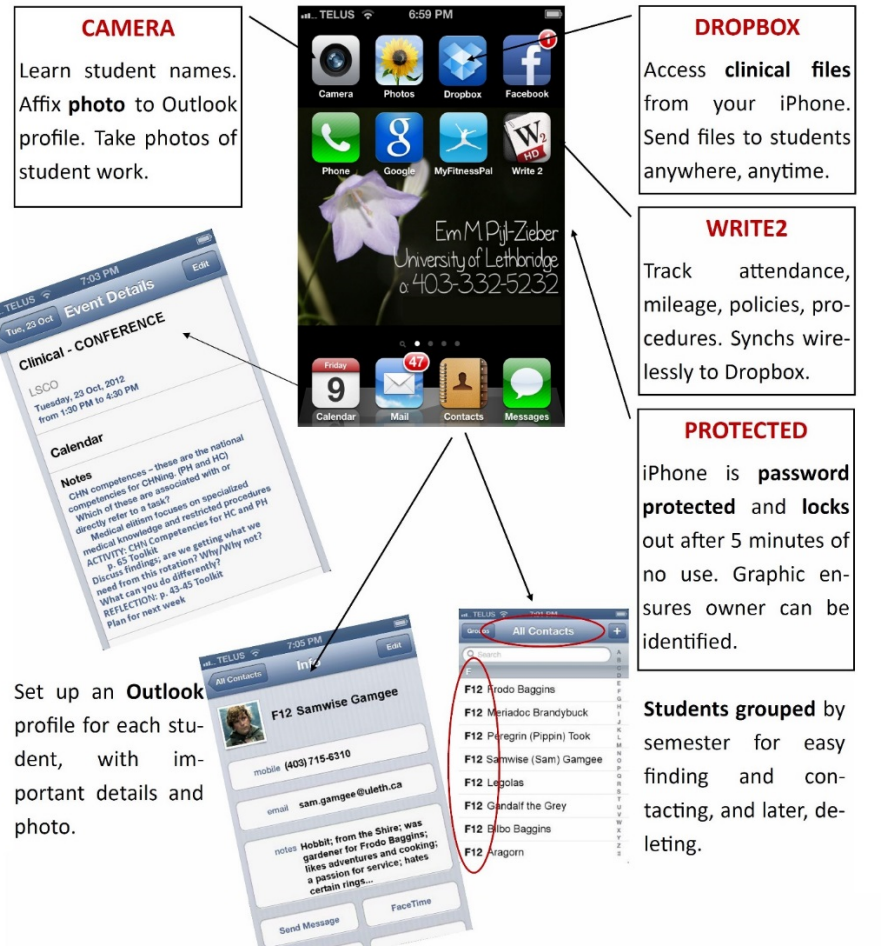


Figure: Example of using an iPhone in community clinical teaching.

- Participate in provincial and national forums pertaining to community health clinical practice placements and experiences. For example, at the Community Health Nurses of Canada annual conference, a clinical educators' forum is held to discuss issues related to clinical teaching in community health.

- Consider the development of clinical learning units (CLUs). A CLU is a collaboration of students, faculty, and health care team members that are actively involved in bridging the gap between academic and practice roles in a health care setting by working together to achieve learning objectives (BC Academic Health Council, 2007). Eggertson (2013) argues that schools of nursing often fail to utilize highly competent direct-care practitioners, who could be instrumental in helping bridge the theory-to-practice gap.

COMMUNITY-ACADEMIC PARTNERSHIP

- Engage in joint problem solving regarding clinical placements with health region, community agencies, and the University. Smith et al. (2007), in their report on clinical placements for CASN, stated that "Strong relationships and good-will between educational institutions and clinical sites, and clinical placements committees and consortiums were the most common enablers for clinical placements" (p. 5). Specifically discuss with health authorities how students can be prepared for practice and establish the health authorities' role in that process. Find ways to ensure students get exposure to nursing-specific community health knowledge and skills. Find ways to enable students to at least observe several of the community health/public health nursing roles.

- Enable faculty practice through joint appointments (Darbyshire, 2010; Rahnavard, Nodeh, & Hosseini, 2013) and a faculty practice model (Aquadro & Bailey, 2014; Barzansky & Kenagy, 2010; Dobalian et al., 2014) so that faculty remain in touch with practice and trust is re-built and relationships maintained with the units.

- Advocate for a re-integration of education and practice areas to rebuild the trust and collaborative relationship that was once there. Collaborations between academe and practice have been shown to ease graduates' transition to practice (Burns & Poster, 2008).

- Promote discussion with the health authority about ways to enable faculty competence in community health areas so that faculty can participate in the work of the unit.

- Engage the health authority in discussions about ways to allow nursing students and instructors to participate in nurses' work in community health practice rotations.

- Participate in regional, provincial or national web-based forums for discussing clinical experiences, challenges and solutions (Smith et al., 2007).

- Articulate a set of fundamental assumptions regarding the clinical experience, including: that University faculty are not responsible for final products of learning; that University

Community-Academic Partnership

ESSENTIAL:
- Formalized agreements (e.g. MOU, signed contract) exist between the community organization and the academic institution.
- Clearly defined roles and expectations are agreed to by the community organization and the academic institution.
- Formal recognition of preceptor contribution is provided.

PREFERRED:
- Formalized cross-appointments exist between the community organization and the academic institution.

(Canadian Association of Schools of Nursing Sub-Committee on Public Health, 2010, p. 3)

faculty may not be expert practitioners in the area in which students are having their rotation; and, that this is primarily a learning experience, not a product development service or consultant service. In the negotiation process, preserve and promote the ultimate goal, which is student learning.

- ❑ Clearly define, in writing, the roles and responsibilities of agency partners, particularly as they related to the role they will play in facilitating student learning. Ensure budgetary considerations and deliverable parameters are clearly stipulated in the project outline. Ensure clear guidelines and parameters exist that include the importance of having only *one* mentor or preceptor who is the point person to whom students go for input into their work.

- ❑ Evaluate community partnerships using the 'partnership assessment tool' (Seifer & Connors, 2007, pp. 35-41).

- ❑ Establish boundaries with the host agencies regarding: the private nature of the learning experience (and thus the confidentiality of the learning management system forums and the weekly project summaries, which are un-sanitized learning tools). Establish ways of engaging in joint learning with the agency via face-to-face meetings between students and the agency during pre-arranged meeting times during the clinical day. Clearly articulate, in writing, the contact parameters for faculty and students and the limits for the hours and days at the agency.

- ❑ Ensure support for the agency in meeting their needs and students' learning needs. Provide the same supports for both nursing and non-nursing mentors/preceptors. Consider ways the nursing program can express gratitude for the partnerships.

- ❑ Create stronger links with agencies, such as through evaluation, orientation and information sessions, and end-of-year luncheons.

- ❑ Ensure all University-developed documents are free of esoteric language or academic vernacular, to promote connection and understanding.

- ❑ Increase involvement with schools, in terms of teaching the health curriculum and the sexual health curriculum and screening. Deliverables are small and ongoing, and teachers

are generally happy to offload this content, which students are very adept at delivering.

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APPENDIX A: Competencies Activity

HOME HEALTH COMPETENCIES **a) Assessment, Monitoring and Clinical Decision Making** The home health nurse is able to… i. conduct comprehensive autonomous and /or collaborative health assessments to determine the health status, functional and psychosocial need and competence of clients and their families within the context of their environment and social supports	HOME HEALTH COMPETENCIES **a) Assessment, Monitoring and Clinical Decision Making** The home health nurse is able to… i. apply critical thinking skills and creative problem-solving analysis when making clinical decisions
HOME HEALTH COMPETENCIES **b) Care Planning and Care Coordination** The home health nurse is able to… i. plan and prioritize visits to meet the health and scheduling needs of clients	HOME HEALTH COMPETENCIES **c) Health Maintenance, Restoration & Palliation** The home health nurse is able to… i. understand and/or educate clients, their families/caregivers and colleagues in the safe and appropriate use and maintenance of various types of equipment, technology and treatments to maintain health and assist clients and families to integrate them into their everyday life/routine
HOME HEALTH COMPETENCIES **h) Building Capacity** The home health nurse is able to**…** i. mobilize clients, families and others to take action to address health needs, deficits and gaps accessing and using available resources	PUBLIC HEALTH COMPETENCIES **1 - PUBLIC HEALTH and NURSING SCIENCES** A public health nurse is able to… 1.1 Apply knowledge about the following concepts: the health status of populations; inequities in health; the determinants of health and illness; social justice; principles of primary health care; strategies for health promotion; disease and injury prevention; health protection, as well as the factors that influence the delivery and use of health services.
PUBLIC HEALTH COMPETENCIES **2 - ASSESSMENT AND ANALYSIS** A public health nurse is able to… 2.2Identify relevant and appropriate sources of information, including community assets, resources and values in collaboration with individuals, families, groups, communities and stakeholders.	PUBLIC HEALTH COMPETENCIES **3(A) - POLICY DEVELOPMENT** A public health nurse is able to… 3A.2 Describe the implications of each policy option, especially as they apply to the determinants of health and recommend or decide on a course of action.
PUBLIC HEALTH COMPETENCIES **3(B) - PROGRAM PLANNING** A public health nurse is able to… 3B.1 Describe selected program options to address a specific public health issue.	PUBLIC HEALTH COMPETENCIES **3(B) - PROGRAM PLANNING** A public health nurse is able to… 3B.2 Describe the implications of each option, especially as they apply to the determinants of health and recommend or decide on a course of action.

APPENDIX B: Levels of Prevention BING☺

Primary Prevention		**Secondary Prevention**		**Tertiary Prevention**
Health Promotion	Specific Protection	Early Diagnosis and Prompt Treatment	Disability Limitation	Rehabilitation

Replacing pop machines in elementary schools with water machines	Childhood immunization	Pap tests	Treatment for cervical cancer	Drug rehabilitation after crystal meth addiction
Instead of handing out Halloween candy, giving out swimming passes	Protecting the water supply of your community	Screening diners at a restaurant who may have been exposed to Hepatitis A	Treatment for Hepatitis A	Living well with Hepatitis C from drug using
Advocating for low income and affordable housing	Disaster preparedness	Regular physical exam	Lumpectomy	Learning how to use an oxygen tank, now that you have COPD from smoking
Regular exercise because it's super fun and makes you feel awesome	Harm reduction for injection drug users such as using clean needles	Regular breast exam	Treatment for breast cancer	Gradual return to work after radical mastectomy
Advocating for walking trails and recreation areas	Taking a back care program at work (teaching you how to move patients)	H1N1 screening clinic for people who had symptoms	Coronary artery bypass graft surgery to re-route circulation to the heart muscle	Cardiac rehabilitation (exercise and education)
Healthy and safe activities for youth	Blood and body fluid policy at work	Vascular risk assessment	Surgery to stabilize spinal cord injury	Helping quadriplegics learn how to live with new limitations