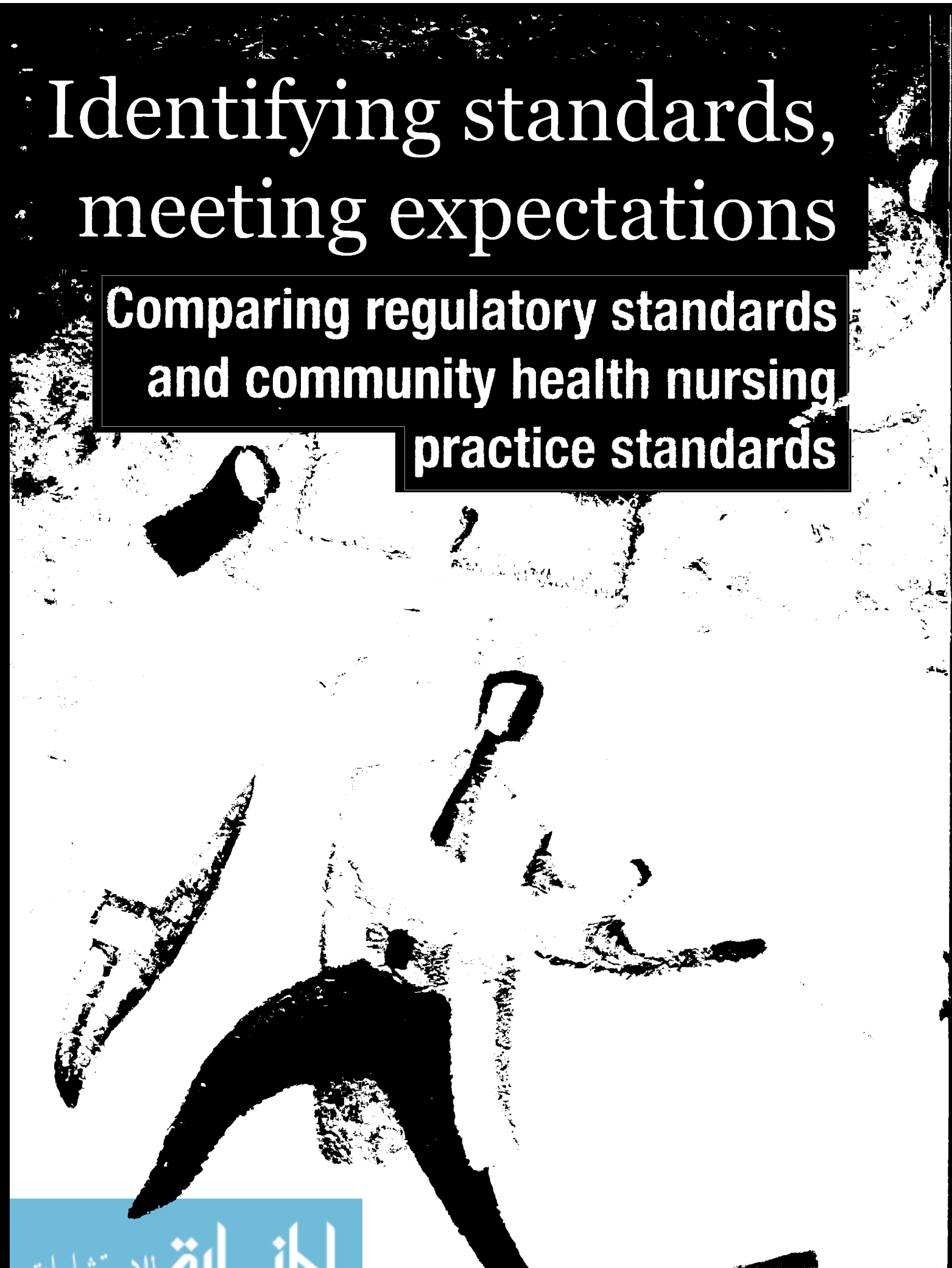
Identifying standards, meeting expectations

Comparing regulatory standards and community health nursing practice standards



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ABSTRACT

In Canada, standards from regulatory and professional bodies provide a framework for nursing practice. In a research study, the authors compared the national standards of practice developed for community health nurses by the Community Health Nurses Association of Canada (CHNAC) with those in the standards of practice developed by provincial/territorial regulatory bodies. The results of the study revealed that of 210 separate ideas, or categories of ideas, the authors identified in all 13 documents, only 58 appeared in both the regulatory and CHNAC documents; 122 were unique to the regulatory standards; 30 were unique to the CHNAC standards. These results suggest a need for associations and specialty groups, notably national ones, to integrate regulatory standards into their own documents and build upon them to reflect the dimensions of specialty practice.

Registered nurses, like other health-care professionals, are regulated in order to protect the public and ensure the delivery of quality care. In Canada, the regulatory body in the province or territory in which the nurse is employed is mandated with this responsibility. Each regulatory body has created a set of standards that represent performance criteria for nurses and reflect the various settings and diverse environments in which they practise (Gilmour, Kelner, & Wellman, 2002).

Community health nursing is one of many specialty areas of practice. The Community Health Nurses Association of Canada (CHNAC) has developed core competencies and discipline-specific standards of practice for community health nurses (CHNs). These standards "expand upon generic nursing practice expectations and articulate the practice principles and variations specific to community health nursing practice" (2003, p. 2). With more nurses moving into the community to deliver care, it is important that the standards of practice for community health nursing accurately reflect the demands on nurses working in this specialty area.

To our knowledge, there had not been an examination of the various standards documents to explore differences and commonalities. Accordingly, we conducted a research study that compared the standards of practice developed by CHNAC with the standards of practice from each regulatory nursing body in Canada.

Our purpose was to assess the similarity or dissimilarity of frameworks in the context of community care to further our understanding of the expectations of practice with the shift from hospital to community settings. Our first step was to create an aggregate of items from the regulatory nursing standards documents to have a common text for comparison. For the purposes of our research study, *item* referred to an idea or a category of ideas. We reviewed all of the standards documents to explore themes and categories.

We adapted White and Marsh's (2006) process for qualitative content analysis: formulate research questions, sample text, code text and analyze coded data. The documents were obtained from the websites of the regulatory bodies or via direct contact. The standards were imported into NVivo software to facilitate categorization of data and organization of the

items found in each statement of the regulatory standards. The items were categorized under 11 broad themes — knowledge application, responsibility/accountability, knowledge, continuing competence, ethics, communication, provision of service to the public, leadership, relationships, self-regulation and professional relationships — based on the various text headings. Two researchers completed the thematic coding of all documents by analyzing each statement. We collected, analyzed and cross-checked data from multiple sources to increase the reliability of the study; each document was compared individually with the CHNAC standards of practice to determine consistency between the standards.

The second step was to identify the items in the CHNAC document and code them using the NVivo coder. If we identified an item that was not already in the coder, we labelled the section of data and kept it in a separate list. The software allowed us to identify similar items and make some comparisons between the documents.

In the third step, categorization of the unique items found in the CHNAC document was further validated.

> ...each document was compared individually with the CHNAC standards of practice to determine consistency between the standards.

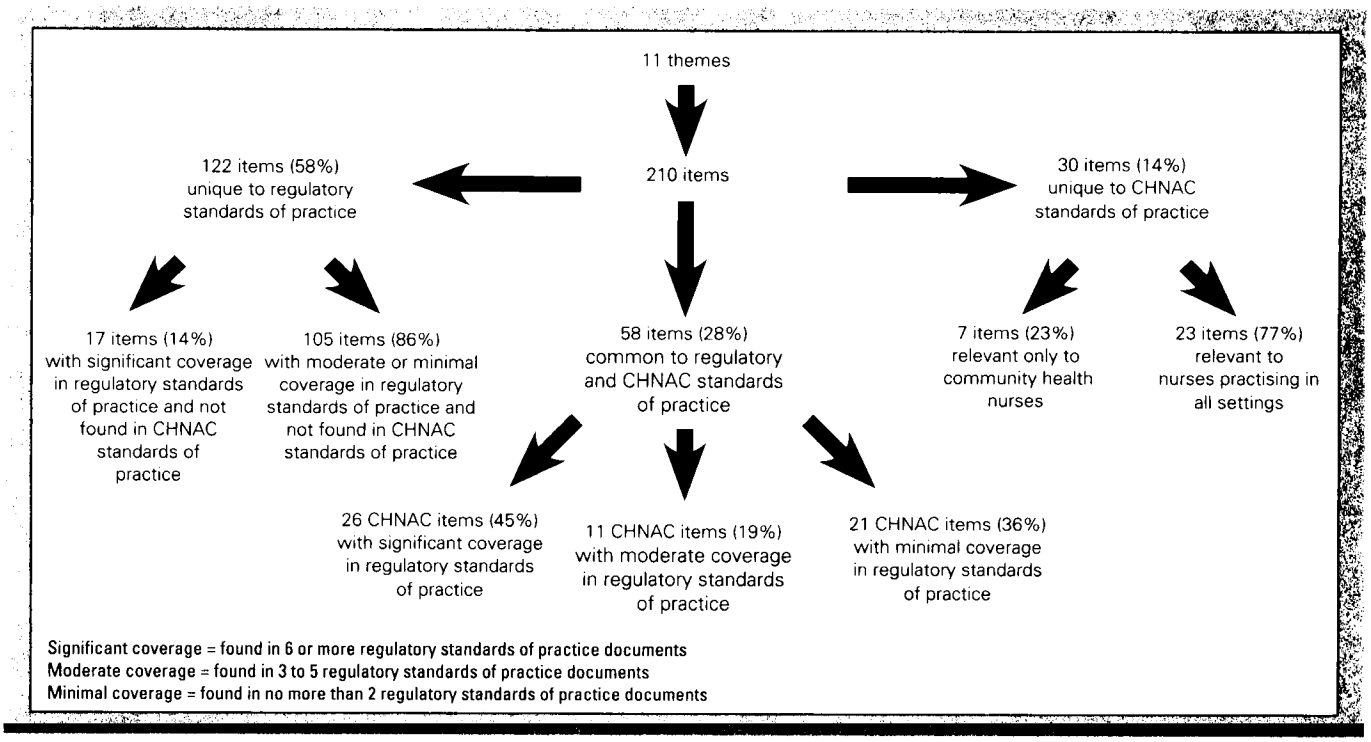
The items were organized into two categories: those relevant to community health nurses only and those relevant to nurses practising in any setting. Content validity testing was carried out with seven community health nursing experts (five from public health and two from home health care), who verified and approved the categorization of the items. References in the standards documents made to other papers and texts, such as the *Code of Ethics for Registered Nurses*, were noted but were not coded.

Therefore, it is possible that items we identified as unique to the CHNAC standards may appear in documents referenced in the regulatory standards.

A total of 210 items were identified and categorized (see box). Fifty-eight items (28%) were common to both the regulatory and CHNAC standards; 122 (58%) were unique to the regulatory standards documents; 30 (14%) were unique to CHNAC standards, including such items as *harm reduction principles, media advocacy strategies, determinants of health,* and *epidemiological principles* (see Figure 1).

It is possible that although the creators of the documents did not use common terms, they intended to convey similar messages. However, if this is the case, these commonalities were not evident to the coders and would not likely be clear to nurses, employers, educators and policy-makers. For example, in addressing knowledge application the College of Nurses of Ontario standards state, "a nurse demonstrates the standard by identifying/

Figure 1: Division of items coded in 13 standards of practice documents



ITEMS UNIQUE TO REGULATORY STANDARDS OF PRACTICE

abuse
abusive situations
activities of daily living
adjust to new self image
adjustment to environment
analyzes assessment data
anticipates potential client health problems
anticipates safety concerns
attentiveness
best practice guidelines
challenges questionable decisions
client education
client rights
client's best interest
client uniqueness
code of ethics
collects information
competence
concerns
confidentiality
conflict resolution
consultation
continuing education
continuity of care
coordinates care
critical appraisal
critical thinking
culturally safe care
culturally safe practice environment
culture of safety
current registration
decision making process
delegation
delegated acts
delegated tasks
developmental transitions
develops support networks
educational strategies
emergency preparedness
ethical principles
ethical values
evidence-based
facilitates knowledge acquisition
family participation
functional rehabilitation
guidance
health care agencies
health care data
health care system
healthy environment
healthy society
identifies learning needs
identifies self by name and designation
information relevancy
information systems
informed decisions
initiates diagnostic procedures
innovation
judgment
knowledge acquisition
knowledge application
knows course of disease
leadership
learning environment
learning plan
limitations
manage resources
maximize potential and autonomy
medication administration
mourning or loss reaction
nursing diagnosis
nursing profession
nursing role
organization
organizational culture
participates in correcting policies
personal ethical distress
personal health
personal values
philosophy
policy development
population health principles
practice review
practice setting consultation program
prenatal, delivery, and postpartum care
prevents errors
prioritization
primary health care principles
professionalism
professional regulatory bodies
promotion
protects clients from unsafe practice
provision of service to the public
public participation
quality improvement framework
quality of life
recognizes limitations
regulated acts
resolution
resource
respect
responsibility/accountability
restraint measures
return to equilibrium
role model
roles
safety
scope of practice
sexual abuse
shares information
spiritual beliefs
standards
supervision
support professional development
support professional efforts
teamwork
technology
therapeutic process
time management skills
trust
utilizes systems approach
wound care

ITEMS COMMON TO REGULATORY AND CHNAC STANDARDS OF PRACTICE

advocacy
assessment
assistance
autonomy
boundaries
change
client care
client needs
collaboration
committee involvement
communication
community resources
continuing competence
coordinates resources
cultural competence
decision making
diversity
documentation
emergency and crisis intervention
ethics
evaluation
facilitates client involvement
feedback
follow-up
health care team
health promotion
health services
identifies resources
information communication technology
information seeking skills
information utilization
interventions
knowledge
legislation
mentorship
nursing practice
nursing students
outcomes
planning
policy
practice environment
prevention and health protection
problem solving
professional development
professional committees
professional issues
quality assurance
quality improvement
reflection
relationships
reports unsafe practice
research
resource utilization
seeks assistance
social justice
theory
therapeutic relationship
vulnerable populations

ITEMS UNIQUE TO CHNAC STANDARDS OF PRACTICE

adapts practice to setting
alternate health care options
aware of community characteristics
building capacity
community development principles
community partners
determinants of health
epidemiological principles
facilitates action
harm reduction principles
health maintenance, restoration, and palliation
identify appropriate programs
identify client's health values
identify health risks
identify needs and strengths
identify root cause of illness
individual versus societal good
intersectoral collaboration
Jakarta declaration
media advocacy strategies
novice practitioner
outreach strategies
protect client from unsafe circumstances
risk factors
self-awareness
societal change supporting health
supports community action
takes action to address service gaps
upholds greater good of population
utilize mix of population based strategies

recognizing abnormal or unexpected client responses and taking action appropriately" whereas the Yukon Registered Nurses Association standards state, a nurse "identifies, analyzes and uses relevant and valid information when making decisions about client status and reporting client outcomes." The College and Association of Registered Nurses of Alberta standards address knowledge-based practice more broadly: "the registered nurse demonstrates critical thinking in collecting and interpreting data, planning, implementing and evaluating all aspects of nursing care."

The relatively low number of common items was not surprising to us; however, further analysis demonstrated that only 45 per cent of these items were included in at least six regulatory documents. *Cultural competence* and *health promotion*, for example, appear in just two of the regulatory standards documents.

The number of differences we found in these documents has implications for nurses, employers and educators: CHNs should refer to the standards of their specialty area in addition to those of their regulatory body to support their practice; employers should ensure they consult both the respective provincial/territorial standards and the CHNAC standards when developing orientation programs for CHNs; educators need to be aware of the items in the CHNAC standards not found in the regulatory standards so they can adequately prepare nursing students for practice in all settings.

We had anticipated that most of the regulatory standards would have been incorporated into the CHNAC standards and built upon to reflect the unique aspects of community health nursing. However, it became clear to us that guidelines for the provision of safe, ethical and quality care could only truly be met by combining two sets of standards. The results of our study suggest a need for associations and specialty groups, notably those that are national in focus, to integrate the regulatory standards into documents they create.

The lack of consistency in standards of practice documents creates challenges for nurses and health-care stakeholders. Of utmost importance is that nurses whose practice shifts from hospital to the community receive comprehensive orientation programs to adequately prepare them. ■

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