

Master's in Nursing Final Project

Defining Ourselves Through Our Stories: Building Learning Communities

for Public Health Nurses

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### Abstract

Through this project, I have explored the concepts of professional identity, communities of learning, practice stories and reflective practice. From the foundation of these concepts, I have adapted a story-based learning model for public health nursing practice. Based on constructivist and transformative learning theory, this learning strategy supports public health nurses in examining their practice through the lens of their discipline specific competencies. As public health nurses gather into communities of learning to reflect on their practice stories, they will have opportunity to develop life-long learning skills and to deepen their sense of professional identity. Story-based learning moves professional development from a training model to an education model where public health nurses can grow as persons and professionals.

## Table of Contents

Acknowledgements.....	ii
Abstract.....	ii
Table of Contents.....	iii
Introduction.....	1
The Context.....	1
Professional Identity.....	4
Professional Development.....	6
Building Communities of Learning that Support PHN Professional Development.....	9
Fostering Learning in the Workplace.....	15
Context Based Learning.....	16
Narrative Pedagogy: The Power of Story.....	19
Thinking Like a Public Health Nurse.....	26
Clinical Reasoning and Nursing Judgment.....	27
Ways of Knowing.....	30
Role of Reflection.....	31
Group Strategies to Foster Reflective Practice.....	33
Adapting Story-based Learning to Public Health Nursing.....	38
Program Components.....	41
Anticipated Outcomes.....	42
Reflections from a Pilot.....	44
Implications for PHN Continuing Education.....	44
Conclusion.....	46
References.....	47
Appendix A: Story-Based Learning Model.....	62

Appendix B: Applying the Story-Based Learning Model to Public Health Nursing Practice.....63

Appendix C: Story Template for Story Based Learning.....66

Appendix D: Story-based Learning Facilitators Workshop Lesson Plan.....68

## Introduction

Like many nurses in British Columbia, public health nurses (PHNs) are experiencing frequent and rapid changes in their work. These changes can leave the PHNs with unanswered questions. Who are we? What distinguishes us a speciality practice? What can we hang onto during these times of frequent change? How do we move into the future? One place we can find some of the answers to these questions is in our stories. Boykin and Schoenhofer (1991) believe that the ontology of nursing is discovered in the examination of practice stories. In this project I will explore the concepts of professional identity, communities of learning, contextual learning through stories, and reflective practice. From this foundation, I will develop a program that will support PHNs to critically examine their practice through a story-based learning model. With the support of a workplace culture of learning, PHNs can examine their practice from the lenses of the knowledge, skills, judgments, and attributes described in the public health nursing competencies. Through this process I anticipate that the PHNs will develop life-long learning skills and solidify their sense of professional identity.

## The Context

Public health nursing in British Columbia encompasses a wide range of nursing interventions that promote health and prevent disease. The current job description for a PHN in my health authority includes the broad statement that PHNs improve health for individuals, families, groups and communities through education and health promotion services (Fraser Health, 2008). PHNs work with individuals and groups in ways that are “innovative, creative, intuitive, and educational” (Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic & Chircop, 2006, p. 61). Aston et al. (2006) describe how the PHN role often encompasses multiple roles

such as educator, facilitator, resource person, and advocate. Public health nursing is a complex role that requires a high degree of nursing skill. In 2004 public health nursing was designated as a speciality practice by the Canadian Nurses Association (CNA) and in 2009 public health nursing became one of the 19 nursing specialities with a certification program (Aston et al. 2006, CNA, 2010).

Public health agencies have identified the need to develop the skills of the public health workforce to meet the increasing challenges facing the healthcare system (Gebbie & Hwang, 2000). To this end, in 2008 the Public Health Agency of Canada (PHAC) released the Core Competencies for Public Health in Canada (PHAC, 2007) to describe the essential knowledge, skills, and attitudes necessary for the practice of public health. The Community Health Nurses of Canada and the PHAC recognized the need for discipline specific competencies for PHNs and in 2009 released the Public Health Nursing Discipline Specific Competencies. These competencies are the “integrated knowledge, skills, judgements, and attributes required of a public health nurse to practice safely and ethically” (CHNC, 2009, p. 2). The 66 competencies encompass a wide range of knowledge and skills ranging from being able to apply public health and nursing sciences to developing advocacy skills.

In contrast to this celebration of the wide-ranging role of PHNs, the PHN role in my health authority has gradually shifted from a historical role of community based health promotion to a stronger emphasis on clinical services for individuals. This can be seen in our greatly expanded immunization program and in the introduction of both an early postpartum discharge program and structured telephone support. This change is mirrored in Saskatchewan where 70 – 90% of PHN practice is centered around health education and clinical services (Schoenfeld & MacDonald, 2002 ) and in Manitoba where nurses described a reduction in their

involvement in community-level health promotion activities with the advent of early postpartum discharge programs (Cusak, Hall, Scruby & Wong, 2008).

PHNs are caught in a professional dilemma as their employers are not able to provide the time or resources to embrace many of the activities that define public health nursing as a nursing speciality. For the PHNs who completed their CNA certification in 2009 or are in process of completing it in 2010, the contrast between the potential scope of PHN practice and the current practice is even more obvious. In contrast, the many PHNs with less than ten years experience in public health nursing have never worked in an environment that focuses on wide scale health promotion and community development and therefore may lack the vision and skills to integrate these components of public health nursing into their practice.

To add another layer of complexity to the issue of eroding public health nursing identity, there is a current introduction of Licensed Practical Nurses (LPNs) into the health unit work team. The primary focus of LPN practice in public health is on immunization tasks and skills. PHNs are concerned that this focus on tasks may signify that their knowledge, values, and competence as public health practitioners are no longer valued by the employer.

In conversations this winter, experienced PHNs described how their practice has shifted over the last few years: “We’re diminishing. They talk the talk of preventive health but there is no support”, “I feel that caring for the individual has been lost in the population health focus on immunization stats”, “I am struggling. What I know is being missed, not valued, not acknowledged by the system. The new nurses don’t get the spirit or philosophy of public health nursing; they are more skills oriented”, “I feel like a trained monkey, just giving more and more shots”. A recent research report for the Community Health Nurses of Canada described the

concerns of community health nurses as being confused about their role, devalued in the workplace, unable to apply the full scope of their practice, inadequately prepared, denied access to research funding, and unsupported by administration (Schofield, Ganann, Brooks, McGugan, Dalla Bona, Betker, et al. 2008). PHNs are struggling with knowing who they are in the context of the current healthcare environment.

### Professional Identity

Professional identity in nursing is defined as “the development within nurses of an internal representation of people-environment interactions in the exploration of human responses to actual or potential health problems” (Cook, Gilmer & Bess, 2003, p. 311) or, more simply, “having the feeling of being a person who can practice nursing with skill and responsibility” (Öhlén & Segesten, 1998, p. 721). Janzen’s (2008) study of the professional development of first-line nurses found that, although the nurses identified knowledge and skill development as important components of learning in the workplace, the most significant component was becoming a “competent, compassionate, caring and empowered professional” (p. 25).

Professional identity as a nurse in general and as a public health nurse in particular, can be linked to identifying with the competencies of the nursing profession. There has been a movement to embrace nursing competencies as a way to “design curricula, accredit licensing procedures and define speciality practice” (Nelson & Purkis, 2004, p. 247). In May 2009, the Community Health Nurses of Canada released a set of discipline specific competencies for PHNs. These competencies are based on the Public Health Agency of Canada’s Core Competencies for Public Health in Canada (PHAC, 2007) and the Community Health Nursing Standards of Practice (CHNAC, 2008), and are defined as the “integrated knowledge, skills, judgement and attributes required of a public health nurse to practice safely and ethically” (CHNC, 2009, p. 2).

Öhlén and Segesten (1998) posit that professional identity is formed in both the personal and interpersonal dimensions. Personal identity is the foundation of professional identity and is influenced by factors such as psychosocial development as well as how the individual interacts with his or her environment (Cook et al., 2003). One of the Öhlén and Segesten's study participants described professional identity as follows:

And it is about, I think, realizing one's limits and possibilities. To know what you can do and what you can't, and it is very much a question of feeling at one with one's profession, as it's sometimes formulated. I don't mean to distinguish between private life and professional life but to feel whole. (p. 722).

The interpersonal dimension of professional identity begins with nursing education. As student nurses are exposed to nursing knowledge and observe nurses in action in their clinical placements, they begin to develop a concept of what it means to be a nurse. Studies have demonstrated that students develop their sense of being a nurse over the course of their studies (Cook et al. 2003, Öhlén & Segesten, 1998). In the workplace, registered nurses continue this process through exposure to new nursing knowledge and through observing how their colleagues respond to their clients and to each other. Developing an identity as a nurse requires a degree of reflection regarding how nursing knowledge and nursing actions align with personal identities, values, and beliefs. This personal vision of what it means to be a professional nurse is strengthened when it aligns with the values and beliefs of respected colleagues (Fenwick, 2008). Because of the complexity of all the contributing factors that shape a sense of professional identity, nurses develop their identity in unique ways and at individual paces.

Wenger (1998) describes how learning in a community of practice has the potential to go beyond the acquisition of knowledge and skills to promote the development of a personal and corporate identity. The social nature of learning communities allows the members of a community of practice to start creating personal histories of becoming as they negotiate meaning together. “It is that learning – whatever form it takes – changes who we are by changing our ability to participate, to belong, to negotiate meaning. And this ability is configured socially with respect to practice, communities and economies of meaning where it shapes our identities” (Wenger, 1998, p. 226). Andrew and Ferguson (2008) emphasize that communities of practice can provide a way for nurses to articulate their roles and “build both professional identity and recognition” (p. 11).

Many factors influence how PHNs shape their professional identity. Working with clients, sharing practice stories, interacting in the workplace, and identifying with professional standards and competencies all contribute to the shaping of professional identity. Establishing communities of learning in the workplace is one way PHNs could continue this journey of self discovery. Through the process of collectively viewing practice through the lenses of public health nursing science, PHN values and beliefs, the Public Health Nursing Discipline Specific Competences (CHNC, 2009), and the Canadian Community Health Nursing Standards of Practice (2008), PHNs have an opportunity to refine their professional identity.

### Professional Development

Professional development is closely linked to the concept of professional identity. At first blush, the objective of Professional Development is to develop the knowledge, skills, and attitudes needed to improve patient care. On closer examination, Professional Development is

also about changing perspectives. Paulo Freire argues that educators must move away from a banking concept of education where teachers deposit knowledge into their students, to a liberating pedagogy that focuses on problem posing that facilitates reflection, experimentation, and developing new ways of being in the world (Eisen, 2001).

In problem-posing education, people develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as static reality, but as reality in process, in transformation (Freire, 1970, p. 83).

In her study of how professional nurses learn, Daley (1999) discovered that the development of expertise goes beyond accumulating practice experience to incorporate being able to reflect on and make meaning of professional experiences. She posits that professionals construct their working knowledge base by linking new concepts with their practice experiences (Daley, 2000). Her Model of Learning in Continuing Professional Education depicts knowledge as a “social construction of information that occurs through a process of constructivist and transformative learning” (Daley, 2000, p. 35).

Constructivists believe that knowledge is not an external entity to be discovered but that learners construct new knowledge in the context of sharing their understandings, practices, and language with each other (Powers & Knapp, 2006. pp. 27 - 28). Learners go through a process of meaning making as they integrate new knowledge into the framework of their previous learning (Young & Maxwell, 2007, p. 9). Daley (2000) summarizes constructivist learning as:

“a process of probing deeply the meaning of experiences in our lives, and developing an understanding of how these experiences shape understanding. Within a constructivist

framework, learning activities are designed to foster an integration of thinking, feeling, and acting while helping participants learn how to learn” (p. 36).

Mezirow (1990a) describes transformative learning as learning through critical self-reflection that leads to a change in perspective and a greater understanding of one’s experience. He identifies that the goal of adult education is to engage learners in a process of rational discourse and critical reflection in order to understand the meaning of their experience. The desired result of this understanding is to take action based on the insights gained through this reflection. Yorks and Sharoff (2001) maintain that a process of self-reflection can open up patterns of thinking that make room for seeing the interconnectedness of mind-body-spirit. The goal of this process is for the learners to open up their potential to think more holistically. While constructivist learning theory helps us understand how professionals acquire knowledge through their experiences in the workplace, transformative learning describes how learners change their perspectives and ways of thinking in response to this acquired knowledge (Daley, 2000).

Marsick (1990) suggests that there are new demands for learning in the workplace that require reflection on experience, linking personal meaning with the socially created meaning of the organization, and the transformation of personal frames of reference. She advocates for an action learning strategy that includes project work on real life problems and reflection seminars. She maintains that learning in the workplace often goes beyond learning specific skills to meet a particular competency, to the realm of personal development. She notes that it is frequently self-perception, entrenched beliefs, and powerful feelings that hold the learners back. Marsick enumerates the potential outcomes of action learning in the workplace as an increased understanding of problems; clarification of personal theories of action; and exposure of the assumptions, beliefs, and expectations that influence thinking and decision making.

In Daley's (2001) research on how clinical nursing practice facilitates learning, nurses indicated that their practice facilitates both personal and professional development. The nurses reported that rather than targeting psychomotor skills, the skills they learned in the workplace were largely focused on the interpersonal skills they required as they established a helping relationship with their clients. Daley argues that because of the important role clinical nursing practice plays in professional practice development, the role of continuing education providers should move towards facilitating a process of learning through reflection on clinical experiences. She states "It is through reflection on clinical experiences that nurses gain maturity and confidence in their abilities and in who they are" (p. 53).

When asked to describe positive workplace learning experiences, PHNs in my health authority identified the following themes: collaborative learning, mutual respect, atmosphere of trust, focus on reflective practice, creative learning strategies, and relevance to their work. They described professional development as primarily a personal responsibility but that the employer also carries some responsibility to create learning opportunities. They acknowledged the importance of a supportive learning environment and self motivation for life-long learning. In their view, the focus of professional development should be on building knowledge, skills, and attitudes to enhance client care (A. Whyte, personal communication, March 23, 2010).

#### Building Communities of Learning that Support PHN Professional Development

In a national Canadian survey, PHNs have identified the importance of organizational support for strong learning environments that would allow them to keep their skills and competencies current (Underwood et al., 2009). Hart & Rotem (1995) highlight the importance of six independent variables in the creation of effective learning environments in clinical

settings: autonomy and recognition, role clarity, job satisfaction, quality of supervision, peer support, and opportunities for learning. Cooper (2009) avers that organizational support is vital for the creation of a culture of professional development for nurses and that supportive infrastructure must be built into any professional development initiative. McGoldrick, Menschner, and Pollock (2001) describe the need for nurturing learning environments that “fosters creativity, risk taking and staff nurse involvement” (p. 19). Jantzen (2008) argues that “a safe and healing workplace culture is central to learning from experience” (p. 27) and that healthcare should move from punitive quality improvement programs. An innovative example of how a teaching hospital in Ontario supported staff development is the 80/20 Human Becoming Patient-centered Care Professional Development Model. In this model nurses spend 80% of their salaried time in direct patient care and 20% in professional development activities. The results of this program were decreased overtime costs, a slight increase in workload hours per patient, lower sick time, increased patient satisfaction, increased staff satisfaction, and non-existent staff turnover. There was only a slight increase in operational costs (Bournes & Ferguson-Paré, 2007).

Two recent educational experiences for PHNs in my health authority have spurred me on to explore ways to provide organizational support so that PHNs can form communities of learning in the workplace. The first story is about the 27 PHNs who obtained their CNA certification in community health nursing practice in 2009. These nurses, with some organizational support, formed weekly participant led study groups. The learners described the study groups as integral to their learning and as a very positive learning experience. They also described how this learning experience moved them to a deeper understanding of the foundations of public health nursing practice. In contrast, a recent program change in my workplace, along with its accompanying educational session, left nurses frustrated and angry. The nurses

expressed feelings of disempowerment as they were not given the opportunity to voice their ideas regarding the mandated program changes. This method of program implementation is not aligned with their conception of public health values and beliefs. One of the outcomes I have observed from this last experience is that some nurses have given up voicing their concerns and resigned themselves to passively wait for the next clinical practice guideline to be “rolled out”.

Two terms are commonly used for the description of learning communities in the workplace. The first term, Communities of Practice, has become popular in professional development and workplace learning literature as championed by Etienne Wenger. Wenger (2006) identifies the key characteristics of a community of practice as having a shared domain of interest; engaging in joint activities and discussions as a community; and possessing a shared repertoire of practice resources, experiences, stories, tools, and ways of being. He bases his ideas on a social theory of learning which holds the position that learning is fundamentally a social phenomenon. Wenger (1998) posits that learning is about creating meaning out of experience in community. His social theory of learning model describes learning as doing, belonging, becoming, and experiencing.

The second, more general term, is Communities of Learning. One description of a community of learning is “a group of colleagues who share a common educational interest, value collaborative learning environments, are goal-oriented, interested in self-learning, value connectedness, are passionate about their own learning, doing and reflecting and are willing to nurture others” (Ohio Learning Network as cited in Bassi & Polifroni, 2005, p. 105).

Communities of learning share many of the characteristics of communities of practice such as valuing the contributions of members with diverse areas of expertise, welcoming multiple perspectives, supporting individual development, advancing the collective knowledge base,

sharing learning, and solving problems collectively (Honey, Gunn & North, 2004). While it could be said that communities of practice focus on developing a common repertoire of practice resources and communities of learning focus on knowledge development, the definitions and characteristics of these two terms overlap. I will be drawing upon both of these terms in this paper.

Communities of practice can be as simple as a work team that works well together effectively and as complex as an international on-line learning community. PHNs work within a community of practice as they share practice stories, consult with each other regarding evidence-informed practice, develop local practice guidelines, and support each other in the workplace. While this conceptualization of workplace learning provides valuable insights and direction for professional development, I feel that the broader term, community of learning, is a better fit for the learning strategy I will be developing. The focus of my learning strategy is to foster a culture of learning that supports reflective practice and life-long learning skills rather than a on a particular product or outcome. I will, however, incorporate some of the qualities of communities of practice into my conceptualization of communities of learning. At present, there is limited opportunity in my health authority for PHNs to directly shape the direction of their practice but there is organizational support for workplace learning. By supporting learning in the workplace through the development of communities of learning, the scope of public health nursing practice would be validated and thus provide PHNs with a sense of identity and hope for the future.

In the workplace, communities of practice develop when groups of people who share a common concern or passion about a topic, seek to deepen their knowledge and expertise by intentionally gathering for dialogue (Andrew, Tolson & Ferguson, 2008). Wenger, McDermott, and Snyder (2002) describe communities of practice as “groups of people who share a concern, a

set of problems, or a passion about a topic, and who deepen their knowledge and expertise in the area by interacting on an ongoing basis” ( p. 4). Communities of practice in nursing are a platform for collaborative workplace learning that can lead to practice development and the creation of new knowledge, the creation of a nurturing and caring environments, and the enhancement of patient care (Andrew et al., 2008, Bassi & Polifroni, 2005).

Some of the outcomes of a community of practice are the production of a body of common knowledge, the establishment of practice norms, the promotion of personal relationships, the development of new ways of interacting, and possibly the development of a common sense of identity (Wenger, 1998). Wenger describes how the members of a community of practice become informally bound by the value that they find in learning together. In order to make a community of practice work, members must be able to engage with each other and be willing to both contribute and to respond to the contributions of others. There must also be a sense of accountability and responsibility to the enterprise. Finally, members must be able to make use of the repertoire of the practice in a meaningful way. To be a community of practice the dimensions of mutual engagement, a joint enterprise, and a shared repertoire must be present.

Issues of power in the workplace affect both communities of learning and communities of practice. Owenby (2002) contends that communities of learning are only successful if they are built on the foundation of horizontal power relations. Citing Poell, Van der Krogt, and Wildemeersch, Owenby describes the horizontal learning network as an egalitarian, problem solving community of learning that focuses on solving “complex problems by reflecting on experiences, developing joint action theories, and bringing these into practice in an investigative manner” (p. 52). Wenger et al. (2002) argue that the health of a community of practice depends on voluntary engagement and internal leadership. They propose that organizations can create the

environment in which communities of practice (COP) can thrive by valuing the learning they do, making time and resources available, encouraging participation, and removing barriers. “An effective COP offers a place of exploration where it is safe to speak the truth and ask hard questions” (Wenger et al., 2002, p. 37).

Unfortunately, workplace learning is not always situated in this safe place but can rather become a vehicle to forward the agenda of management. When learners are required to attend continuing education programs that they did not have a voice in planning and that are not related to their personal learning goals, they are left feeling “coerced and disempowered” (Owenby, 2002, p. 54). There can be some inherent areas of dissonance between organizational governance and the establishment of communities of learning. In order to actualize the benefits of a community of learning, the learners must be given the freedom to focus on areas of practice that are meaningful for them without the constraints of also trying to follow a learning agenda established by management. With this freedom for learning, the outcomes are not predictable and learners may challenge hegemonic decision making processes and cherished discourses. Drennon (2002) notes that some organizations will not support practitioners’ critical examination of practice or policies and that communities of learning may opt for ‘safe’ inquiry projects that “will not disrupt the status quo” (p. 64). He argues that there is little chance of democratic staff development initiatives to thrive unless there is organizational commitment to a democratic culture.

Despite the challenges, learning in the workplace has become a vital component of workplace culture as the growth of professional knowledge expands exponentially (Solomon, 2001). Terms such as learning organizations, knowledge translation and exchange, and corporate universities are visible in the continuing professional development literature. The need to have a

competent, skilled workforce of public health professionals is recognized by the Public Health Agency of Canada with its recent launch of Core Competencies for Public Health in Canada (PHAC, 2007) and the subsequent launch of the Public Health Nursing Discipline Specific Competences (CHNC, 2009). This follows an international move to create industry wide institutionally recognized and legitimized knowledge (Solomon, 20001).

While competencies can be used on an individual level to motivate learners and tailor learning plans to meet learner specific needs as well as on an organizational level to support institution wide learning initiatives; they can also be used as a technology of power to determine who is deemed competent and who is not (Solomon, 2001). Competencies are often used to measure if nurses are meeting standards of practice. The narrow, prescriptive nature of predetermined competencies can limit opportunities to look at innovative and alternative ways of knowing as their scope is only as wide as the vision of their creators. There is a tension between valuing identified knowledge, skills and attributes and embracing multiple and divergent ways of knowing. Through this project I will embrace both these ideas and demonstrate how PHNs can use their discipline specific competencies as a launching pad to explore and add depth to their scope of practice.

### *Fostering Learning in the Workplace*

Building a culture of learning in the workplace creates the space for members to develop life-long learning skills. Even though the CRNBC requests nurses to include peer feedback in their continuing competence learning plan, the focus of many professional development programs has been on the individual nurse. This could limit nurses' repertoire of life-long learning skills to individual learning strategies. As PHNs participate in community learning

activities, they can develop new, corporate learning skills. As Wenger (1998) elucidates, learning in the social context creates a sense of identity; the identity of the individual and the identity of the group. By encouraging a culture of learning throughout the organization, PHNs could develop a range of learning skills that would provide a vehicle to increase their professional knowledge and possibly have the added bonus of an increased sense of professional identity, both individually and as a workplace team.

### Context Based Learning

Critical thinking has been identified as a crucial skill for nursing in today's healthcare system (Forneris, 2004, Rideout et al., 2002, Ironside, 2005). Critical thinking can be fostered through contextual educational approaches such as context based learning, problem based learning, and story-based learning (Forneris & Peden-McAlpine, 2007). Contextual learning strategies move learning from a structured learning environment to "a dynamic context-based process of critical thinking in practice" (Forneris & Peden-McAlpine, 2006, p. 3). Wenger et al. (2002) explain how sharing the tacit knowledge necessary for critical thinking requires interaction and informal learning processes such as conversation and storytelling. Brookfield (1990) values using descriptions of significant events or "critical incidents" (p. 179) to foster critical thinking in the workplace.

Contextual learning is focused on "developing [the] learner's ability to discern what is relevant and meaningful given the context of the situation" (Forneris & Peden-McAlpine, 2006, p. 2). This requires the nurse to engage in a reflective process to make relevant connections to the meaning of a particular context. Forneris & Peden-McAlpine, 2006, assert that it is through open dialogue that perspectives and assumptions can be evaluated and learners can develop

situational understanding. Hartrick Doane and Varcoe (2005) highlight the importance of understanding the context of client's lives in order to provide health promoting care.

Problem Based Learning (PBL) is a contextual learning strategy that began as an alternative approach to teaching physicians at McMaster University in the late 1960's. It has since spread world-wide in medical education as well as in disciplines such as nursing, architecture, business, engineering, mathematics, occupational and physiotherapy, and science (Rideout & Carpio, 2001). PBL is a curriculum that is organized around practice problems that relate to desired learning outcomes rather than around specific topics or disciplines. Through a small group process, learners unpack the issues embedded in the problem situation, and thereby identify their learning needs. The group is then responsible to meet these learning needs through individual research which is subsequently shared with the group. Some of the learning skills that can be developed through PBL are critical thinking, information retrieval and management skills, self-evaluation and peer evaluation skills, and collaboration (Ääri, Elomaa, Ylönen & Saarikoski, 2008).

In their study of graduating baccalaureate students, Rideout et al. (2002) did not find that students from a PBL curriculum felt any more prepared for clinical practice than students from a conventional nursing program. However, they did discover that the PBL students had a sense of confidence in their ability to function effectively in novel situations based on their ability to identify their learning needs and access appropriate resources. Tiwari, Lai, So, and Yuen (2006) found that undergraduate nursing students in Hong Kong who were enrolled in a PBL curriculum demonstrated a significant level of critical thinking disposition compared to students educated through lectures. The authors concluded that active participation in learning within a reflective

group process that provides a sense of safety and peer support enhances the development of critical thinking.

Howkins and Allison (1997) evaluated an educational model for interprofessional learning based on the theoretical framework of PBL. They identified the key characteristics of a successful interprofessional program as active learning, focusing on real life problems, developing skills of enquiry, enhancing group learning, using available resources including people resources, and using the skills of a trained facilitator. White, Amos, and Kouzekanani (1999) found that PBL empowered registered nurse students to be active participants in their learning and develop critical thinking skills as they incorporated their work experience and previous knowledge to their current learning.

Similar to PBL, a case study learning approach guides students to learn through solving a practice based problem. The difference between a case study approach and PBL is that students apply their previous learning to solve the problem presented in the case rather than use the case as a springboard to explore new areas of learning. Tomey (2003) articulates the advantages of case study learning as “learning that facilitates active and reflective learning and results in the development of critical thinking and effective problem-solving skills” (p. 37). She posits that case study learning develops self-directed life-long learners.

Williams and Day (2007) emphasize that it is important for nursing practice to move beyond focusing on problems, difficulties and illnesses to include a more holistic focus on the concept of health. They suggest that Context Based Learning (CBL) is an effective strategy for nursing education. While the phases and the philosophical underpinnings of CBL, as outlined by

Williams and Day, mirror those of PBL, they also provide an important reminder to stay within a strength-based, holistic paradigm.

Contextual learning approaches, such as narrative pedagogy and storying techniques, are now being used by a variety of practice disciplines to develop critical thinking skills (Crawford, Dickinson & Leitmann, 2002). Gartner, Latham & Merritt (1996) describe how narratives reflect discipline specific knowledge and actions that “respect the story teller as an embodied knower within the cultural dialogue of that discipline” (p. 2). They explain how narrative enquiry provides an avenue to access the tacit knowledge and deeper knowledge embedded in professional disciplines. Forneris & Peden-McAlpine (2006), define contextual learning as a “process of critical reflection whereby the contextual realities of real-life situations are unveiled through reflection on narrative” (p. 5).

#### *Narrative Pedagogy: the Power of Story*

Learning through the communal practices of sharing practice stories and narratives is recognized by many authors as a valid teaching/learning approach that has the potential to foster critical thinking and thus impact patient care. Gartner, Latham & Merritt (1996) describe narratives as providing an important link between nursing practice, ontology, epistemology, and ethics. Diekelmann (2001), through her research into the shared experiences of students, teachers, and clinicians, identified Narrative Pedagogy as a way to develop “community-reflexive scholarship” (p. 68) that moves the learners forward to new ways of learning that engender community. She describes how sharing and interpreting contemporary narratives of lived experiences creates communities of learners where it is safe to question and learn. Young (2004) depicts Narrative Pedagogy as “community-reflective scholarship in which students and

teachers use the interpretations of their experiences, by putting their heads together, to bring about change” (p. 25).

The hallmark of Narrative Pedagogy is that all pedagogies can converge through open dialogue that encourages multiplicity of perspective. The learners are invited to move past positions of power, critique, and deconstruction to seek out common experiences and meaning through both communal discourse and self reflection. Ironside (2006), building on Diekelmann’s work, identifies how Narrative Pedagogy helps students to both challenge their own assumptions and use multiple perspectives to interpret clinical situations. Scheckel and Ironside (2006) describe narrative pedagogy as an approach to learning where stories are shared in a community of learning in a way that allows the perspectives of all the participants to converge to create new understandings.

Forneris and Peden-McAlpine (2007) discovered that when coached to integrate critical thinking into their practice, novice nurses were able to move to a level of competence more quickly than the 2 -3 years described by Benner (as cited in Forneris & Peden-McAlpine, 2007, p. 418), and thus become an effectual member of the healthcare team in a more timely manner. The investigators highlighted the importance of dialogue in developing a process for critical thinking in practice and saw their study as supporting the work of Diekelmann and colleagues as well as Ironside. “Our case study findings suggest that, by sharing narratives on practice experiences, novice nurses were not only able to explore their own thinking but also to gain perspective from others. This helped them engage in critical questioning focused on context” (p. 419).

Khosravani, Manoochehri and Memarian (2005) studied the effects of group-dynamic sessions in the development of critical thinking skills of the 4<sup>th</sup> year students in their community health course. Their quasi-experimental study revealed a significant increase in critical thinking skills in the experimental group, and they conclude that cooperative learning methods appear to be helpful in the clinical training of nurses.

Sandor, Clark, Campbell, Rains and Cascio (1998) evaluated critical thinking skills in a scenario-based community health course. Using the Watson-Glaser Critical Thinking appraisal (WGCTA) questionnaire, Sandor et al. saw significant improvements on the Interpretation and Evaluation subscales and on the total critical thinking scores from pre-test to post-test for students who completed the course. The course was taught using pre-developed scenarios based on complex families in the community setting, and the students met in small student led discussion groups to work through each scenario using the nursing process. This was followed by large group classes where the instructor challenged the students to expand their thinking to a higher level.

Stories have been used throughout history to make meaning of our experiences (Chartier & Lapointe, 2007, Bowles, 1995). Narrative learning can be thought of as “learning as construction of meaning from experience” (Clark & Rossiter, 2008, p. 63) and is thus integrally linked to adult learning theory as described by Dewey, Lindeman and Knowles (Clark & Rossiter, 2008). Narrative learning is the process of giving language to lived experience and in this process of story construction, meaning is created. Chartier and Lapointe (2007) posit that while teachers and trainers tend to transmit knowledge through lectures and other teacher centered approaches, continuous learning in the workplace is primarily transmitted through site specific stories.

Young (2004) and Brown, Kirkpatrick, Mangum and Avery (2008) discuss how valid knowledge is gained through reflecting individually and corporately on stories of lived experience. Story-based learning can showcase nursing values, lead to deeper insights, situate learning in current practice, and provide the emotional links between story themes and learning content that makes concepts memorable (Brown et al., 2008). Stories can also promote greater understanding amongst peers and foster the development of a culture where individual values and concerns are validated (Bowles, 1995, Brown et al., 2008).

Gartner et al. (1996) suggest that the process of story writing “invites the student to reach a deeper level of understanding by asking questions about personal beliefs and assumptions that are implicit in their narratives” (p. 9). They describe how this process can move the learners to ask further questions regarding which theories inform their practice, how the evidence supports their theories, and the origin of their values and beliefs. Examining practice stories can not only give meaning to nursing situations but also “challenge and transform habitual theories and practices” (p. 9). Shieh (2005) studied how writing the stories of their clinical experience impacted student nurses’ learning. The findings of her evaluation study revealed that the students found story-based teaching helpful in bringing the learning to a personal level, encouraging them to go deeper, and facilitating critical thinking. Shieh concludes that storytelling and analysis creates new insights for the learners which can improve their ability to think broadly and deeply.

Writing practice stories from the standpoint of the nurse, places the nurse in the middle of the story rather than on the outside looking in. Describing her lived experience as a nurse showcases her knowledge and skills as well as the assumptions and biases she brings to her practice. This is a very different perspective than working from case studies and may not always

be comfortable for the story writer or the listeners. If the nurse chooses to write the story from the standpoint of the client, the lived experience of the individual and/or family is highlighted. This perspective helps the learners explore how social and political influences are impacting health. By moving to a first person perspective, new insights and ways of knowing are opened up. The listeners or readers of the story are also invited to engage their minds, spirits, imaginations, and hearts as they respond to the story and thereby develop holistic understanding of clients' lives (Clark & Rossiter, 2008).

Brown et al. (2008) contend that story telling is a means to recover the art of nursing. Hunter (2008) challenges nurse educators to implement innovative learning strategies such as storytelling that incorporate the aesthetics of nursing. "Stories act as an important bridge between art and science which facilitate both the personal and professional reflection and growth necessary for holistic nursing practice" (Hunter, 2008, p. 4). Her research into how storytelling might facilitate student's understanding and integration of the art and science of nursing practice revealed that students were able to identify empirical, ethical, aesthetic, and personal ways of knowing in their stories. Leight (2002) asserts that nurses need to embrace two epistemologies: scientifically derived knowledge and intuitive application of knowledge. She believes that story telling is a useful strategy to develop aesthetic knowledge in nursing. Boykin and Schoenhofer (1991) maintain that it is through the study of nursing situations described in stories that the ontology of nursing is discovered.

Because stories have the power to expose the core concepts of a phenomenon of interest in the discipline of nursing, they provide an opportunity to view nursing practice through an ethical lens. Milton describes the ethical lens of nursing perspectives as "where questions emerge and surface about doing what is right or what it means to have straight thinking" (Milton, 2004,

p. 208). Bowman (1995) uses stories to reinforce ethical theory and analysis in her model of ethical knowing. Diekelmann and Diekelmann (2000) posit that Narrative Pedagogy opens up new ways to understand the study of both ethics and genetics in nursing practice.

Young (2007) developed a story-based, learner-centered pedagogical model to guide clinical decision making in nursing. Her Story-based Learning Model is a variation of Case Method Teaching and PBL and is grounded in the ethic of caring and constructivist learning theory. She describes how working with stories provides learners with “opportunities to begin transforming explicit knowledge into tacit knowledge” (p. 166). She asserts that by building on their existing knowledge and learning by interacting with each other, the learners are able to “learn how to learn, to think critically and to attend to emotions” (p. 165). Her goal is that the learners would become flexible and thoughtful professionals who are able to work as a team. She contends that by working with stories, rather than cases, learners are able to focus on the wider socioeconomic and political contexts of people’s lives.

The Story-based Learning Model (Young, 2007) is comprised of an outer circle that describes the learning processes of participatory dialogue and critical appraisal. The inner circle delineates the six phases of the learning model: attending to the story, determining what is going on in the story, identifying patterns of wholeness and disruption, envisioning nursing support, reflecting on learning and interpretations, and returning to the “new” story. The phases of the Story-based Learning Model are undergirded with the ethic of caring; caring enough about clients’ wellbeing to explore the stories of their lived experience in depth and then acquire the nursing knowledge necessary to provide holistic nursing care.

To apply this model to public health nursing, PHNs would be given the opportunity to examine their practice through their own stories. One of the strengths of this model is that it encourages the learners to attend to the emotion present as well as the socioeconomic and political factors at play. This aligns with the Public Health Nursing Discipline Specific Competences (CHNC, 2009) where PHNs are expected to include knowledge of public health sciences including the health status of populations, inequities in health, the determinants of health, social justice issues, and principles of primary healthcare in their approach to client care. Working with stories that illustrate how PHN competencies impact client care can make these competencies come to life.

Using stories written by their peers around “real” practice situations makes the learning relevant and both intellectually and emotionally engaging for the learners. Andrews, Hull and Donahue (2009) propose that “learners embedded in contextual, authentic, real world problems are more engaged, draw on more resources and transfer learning more effectively” (p. 17). With real situations, the nuances of the lived experience of clients are accessible, and there is more opportunity to view the client’s experience from a holistic standpoint. Working with stories can provide a rich learning experience that incorporates multiple ways of knowing.

Boykin and Schoenhofer (1991) describe an important difference between a story of a nursing situation and a case study. While case studies separate the learners from the situation, stories bring the nurse as a person into the nursing situation. Crawford, Dickinson and Leitmann (2002) describe how narrative approaches encourage learners to become more aware of their own knowing while “honouring the knowing of those with whom they work” (p. 175). Janzen (2008) contends that first-line nurses develop professionally as they reflect on the challenges and successes of their own practice and the practice of their colleagues in a supportive, safe, and

healing workplace culture. Sharing personal practice stories within a community of learners in the workplace also creates a space to honour each others' practice and open up to different perspectives on what is good nursing work.

The Story-based Learning Model incorporates a significant amount of time for reflection on practice. The writing of practice stories provides an opportunity for the writer to reflect on the context of her client's situation and on her nursing actions. Listening and exploring the stories through a group process provides an opportunity for the learning group to reflect on the interpretation of the story, consider potential implementation issues, and explore what they have learned through the process.

By critically examining PHN practice through story-based learning, the learners enter the emancipatory learning domain where the focus shifts from knowledge accrual to the development of self-knowledge through reflective practice (French & Cross, 1992). The emancipatory paradigm process of examining assumptions, rules, habits, and traditions of the healthcare system opens the door to address some of the institutional issues of power and control that impact nursing practice (Romyn, 2001). Story-based learning aligns with Freire's support of problem posing education, with its attending dialogue and active learning strategies that move learners to reflection and action that is based on reality (Bevis & Murray, 1990). Freire suggests that learners are then able to move forward and use the past to build the future (Freire, 1970).

### Thinking like a Public Health Nurse

Today's healthcare environment requires nurses to be able to work in environments characterized by high levels of acuity, complexity, and constant change, while at the same time

be able to respond holistically to the needs of individuals and families (Usher, Tollefson & Francis, 2001; Thorne, Reimer Kirkham & Henderson 1999). With budgetary measures limiting the amount of time nurses have to work with their patients and clients, nurses need to be able to think through complex situations in order to provide effective care. The move away from solely focusing on empirical ways of knowing to a more holistic approach requires nurses to embrace multiple ways of viewing health and illness. In public health nursing, where a caring, relational practice is one of the foundational values and beliefs (CHNC, 2008), PHNs need to “remain mindful of the larger contexts of families’ lives and their own judgments and assumptions a family’s vulnerability, risks or strengths” (Browne, Hartrick Doane, Reimer, MacLeod & McLellan, 2010, p. 33). In order to keep all these considerations in the foreground, PHNs need to be skilful in clinical reasoning and adept at self reflection.

### *Clinical Reasoning and Nursing Judgment*

Some nursing scholars have questioned the ability of the nursing process to address the complexity of the ways nurses need to think in today’s healthcare milieu. Boychuk Duchscher (1999) contends that the nursing process does not include an emphasis on building nursing interventions in collaboration with the client nor values the “phenomenological knowledge generated by nursing practice” (p. 581). She argues that the nursing process is a linear approach to problem solving that is solely based on empirical ways of knowing. Today’s nurses also need to be able to address the sociocultural, environmental, economic, and political issues affecting health. She recommends that the nursing process be augmented with the application of a critical thinking process that includes reflection, dialogue, and dialectical thinking with the goal of challenging potentially oppressive ideologies that could impact both client and nurse. Jackson

(2004) suggests that the nursing process should be considered a circular process rather than viewed as completed once the issue is resolved. Tanner (2006) also highlights the limitations of the nursing process and prefers to describe the work of nursing as involving clinical judgment. She contends that the linear problem solving approach of the nursing process fails to account for the multiple factors that nurses consider in making clinical judgments.

Tanner (2006) developed a clinical judgment model as an alternative to the nursing process. Her definition of clinical judgment is “an interpretation or conclusion about a patient’s needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient’s response.” (p. 204). She views clinical reasoning as the process nurses go through to make their clinical judgments. This process requires the nurse to understand the pathophysiological aspects of the client’s situation; how the illness experience is impacting the client; and which physical, social, and emotional strengths and coping resources they are able to bring to the situation. Tanner contends that clinical judgments are more strongly influenced by the knowledge the nurse brings to the situation than by the objective data available. She views clinical judgments as depending on knowing the patient well and that nurses’ decision making is strongly influenced by the context of care. Nurses formulate their judgments through a variety of reasoning patterns including reflection on practice.

Benner, Sutphen, Leonard and Day (2010) have broken down the ways nurses think into the subcategories of clinical reasoning; clinical imagination; and creative, critical, scientific, and formal criterial reasoning. They define clinical reasoning as the “ability to reason as a clinical situation changes, taking into account the context and concerns of the patient and family” and

clinical imagination as being able to “conjure up possibilities, resources, and constraints in the patient and family situations” (p. 85).

Critical thinking is considered an important skill to bridge the gap between theory and practice to meet the goal of improved patient outcomes (Manias & Street, 2000, Forneris & Peden-McAlpine, 2007). There is a strong emphasis on critical reflection in many nursing curricula (Yorks & Sharoff, 2001, Scheckel & Ironside, 2006) and it is a key component of many current teaching approaches such as narrative pedagogy (Scheckel & Ironside, 2006), problem-based learning (Wolff, 2007), context-based learning (Williams & Day, 2007), and story-based learning (Young, 2007).

Critical thinking in nursing can be described as a composite of abilities that includes an attitude of inquiry that seeks out knowledge, skill in determining valid knowledge, and the ability to artfully apply knowledge to specific to nursing situations (Khosravani, Manoochehri & Memarian, 2005). Forneris and Peden-McAlpine (2007) define critical thinking as “a process of reflective thinking that goes beyond logical reasoning to evaluate the rationality and justification for actions within context” (p. 411). Pesut (2001) breaks down the reasoning process into four types of logic: the logic of discerning patient care issues, the logic required to plan care that effects a positive change in the client, the logic of judgment to make meaning of evidence derived from the change in the client, and the logic associated with the conscious reflection of nursing actions. Kuiper and Pesut (2004) describe effective clinical reasoning as a combination of critical thinking and reflection. Brookfield identifies the four key components of critical thinking as identifying and challenging assumptions, recognizing the important of the context in shaping perspectives, exploring and imagining alternatives, and applying reflective scepticism

(Brookfield, 1987, as cited in Boychuk Duchscher, 1999, p. 579). These comprehensive definitions of critical thinking align with how some authors describe clinical reasoning (Murphy, 2004). While the definitions of clinical reasoning, clinical imagination, critical thinking and critical reflection overlap and have many similarities, the outcome of thinking well as a nurse are sound nursing judgments (Tanner, 2006, Pesut, 2001).

### *Ways of Knowing*

Nurses draw from a range of ways of knowing to form their nursing judgments. In 1978 Carper identified four patterns of knowing in nursing: empirical knowing, aesthetic knowing, ethical knowing, and personal knowing (Bonis, 2009). Chinn and Kramer (2008) add a fifth pattern of knowing: emancipatory knowing that identifies social, economic, and political conditions that produce health inequities. Liaschenko and Fisher (1999) describe nursing knowledge in everyday nursing language as case knowledge comprised of knowledge of pathophysiology, disease process and therapeutic protocols; patient knowledge that focuses on how the individual patient is responding to care within the context of the healthcare system; and person knowledge that describes the lived experience of the individual within the context of their life. From her analysis of the evolution of the concept of knowing in nursing, Bonis (2009) concludes that knowing in nursing “refers to a uniquely personal type of knowledge constructed of objective knowledge interfaced with the individual’s perspective on personal experience” (p. 1328). She adds that knowing in nursing derives from a process of reflection on personal and professional experiences. This reflective process results in a transformation of the nurse’s perspective. Boykin and Schoenhofer (1991) argue that nursing stories are an effective strategy

to incorporate Carper's ways of knowing and that they provide an opportunity to reflect on the richness of the lived experience in nurse-client interactions.

Daley (2000) suggests that a significant proportion of professional learning arises from the experience of dealing with practice situations. Schön describes the crisis that arises when professionals leave the clarity of their educational preparation to deal with "situations of uncertainty, instability, uniqueness and value conflict" (Schön, 1983 as cited in Daley, 2000, p. 28). He contends that it is in these very situations where tacit and intuitive knowledge develop. Mezirow (1990a) proposes that perspective transformations are often in response to a disorienting dilemma that challenges previous understandings. Benner uses the term "paradigm case" to describe clinical situations that stimulate learning and development (Benner et al., 2010). Brookfield (1990) suggests that exploring significant events or "critical incidents" (p. 179) in the learners' lives is an effective mechanism to unveil assumptions that underlie their thoughts and actions. All of these authors recognize that transformational learning often arises from the critical reflection on a significant practice situation. Daley's (2001) research supports this premise. In her study of how clinical nursing practice facilitates learning, the nurses described how they are at times confronted with cases that challenge their knowledge base, beliefs, and assumptions. These cases challenge nurses to reflect on their personal values, beliefs, and practices. Through this process of reflection they often change some element of their nursing practice in a significant way.

### *Role of Reflection*

Educational theorists such as Dewey, Habermas, Schön, Mezirow and Brookfield have all considered reflection to be an important component of the learning process (Ruth-Shad, 2003).

Ruth-Shad (2003) defines reflective practice as a “self-examination that involves looking back over what has happened in practice in an effort to improve or encourage professional growth” (p. 488). Schön believes that professionals learn in their everyday practice by reflecting during the performance of their roles and by reflecting back on their practice experiences. He describes these ways of knowing as reflecting in-action and on-action. Reflection-in-action allows for a reassessment of practice situations as they are happening with an attendant reconsideration of strategies of action and possible on-the-spot experimentation (Schön, 1987). On the other hand, Schön’s reflection-on-action is based on a review of a situation that has already happened in order to determine what, if anything, should be done differently in the future (Ruth-Shad, 2003).

Atkins and Murphy (1993) summarize the stages of the reflective process as beginning with a realization that there is a gap in understanding of a specific nursing situation. This stage is followed by a critical examination of the nurse’s feelings and her current clinical knowledge. The final stage is the development of a new understanding of the situation. Interest in reflective practice has grown in recent years as nurses have come to realize that “relying solely on technical and rational ways of knowing and competence-based practice was not enough to provide holistic, safe practice” (Ruth-Shad, 2003, p. 490).

Ruth-Shad (2003) identifies the positive outcomes of a reflective practice as the integration of theory and practice, increased learning from experience, enhanced self-esteem, acceptance of professional responsibility, enhanced critical thinking and judgment, a sense of empowerment, increased social and political emancipation, improvement of practice through greater self-awareness, and expanded clinical knowledge and skills. Usher, Tollefson and Francis (2001) suggest that the reflective process brings new understanding of action situations, the cultural milieu, taken-for-granted assumptions, safe and competent practice, and ways of

challenging the status quo. Heath (1998) posits that reflection on practice can surface the tacit knowledge that develops through nursing experience. Schön maintains that reflection on practice makes room for “criticism, testing and restructuring of understanding” (Heath, 1998, p. 1055).

The learner characteristics that support reflective practice are being flexible, mindful, willing to contribute, self-motivated, transparent, and imaginative (Ruth-Shad, 2003). Atkins and Murphy (1993) outline the cognitive and affective skills need to engage in reflection. Nurses need to develop self-awareness regarding how the practice situation is affecting their feelings, and the ability to accurately describe the key components of a nursing situation. They also need to be able to critically analyze the situation to identify existing knowledge, assumptions and alternatives; to integrate new knowledge into previous knowledge base; and to evaluate the value of the new knowledge.

#### *Group Strategies to Foster Reflective Practice*

Strategies to promote reflective practice include debriefing sessions, reflective journals, reflective essays, case histories, action learning groups, discussion groups, and clinical supervision (Cotton, 2001). Central to many of these strategies is an examination of practice stories. Kirrane (2001) evaluated an action learning strategy that incorporated reflective processes that was used in a staff development program for nurses in a neurology unit. She concludes that as the nurses share problem situations and explore alternatives as a group, they incorporate reflective processes that could lead to improved patient outcomes. Forneris and Peden-McAlpine (2007) describe how sharing narratives of real-life practice situations allowed novice nurses to explore their own thinking and gain perspective from each other. Crawford, Dickinson and Leitmann (2002) describe how a number of practice disciplines use narrative and

storying strategies to foster critical reflection that explores the interactive relationship between thinking and action.

While reflection in practice is often viewed as an individual activity, there is an important role for collective reflection in the workplace. Group processes and group dynamics have the potential to bring a greater degree of insight and understanding of complex nursing situations (Platzer, Blake & Ashford, 2000a). Heath (1998) suggests that group reflective strategies might enhance the development of reflective skills for nurses with limited knowledge of the practice situation as they begin to feel comfortable exploring practice with their colleagues. Forneris and Peden-McAlpine (2006) contend that reflection requires dialogue. They envision an interactive process where perspectives and assumptions are evaluated within the context of the real life practice situations. Nelson and Purkis (2004) express their concerns regarding the use of individual reflection to monitor nursing competence by Canadian nursing regulatory authorities. They fear that locating professional practice in the individual, versus communal understanding of what constitutes good practice, will cause nursing knowledge and skill to diminish.

There is a richness of experience and learning that is located in the group reflective process. As colleagues gather to share their multiple perspectives on their own practice, they make room for new insights. In line with Wenger's conceptualization of communities of practice, Murphy and Timmins (2009) suggest that through the development of communities of practice and frameworks for reflection, there is a mechanism to give language to tacit knowledge so that it can be shared with colleagues. Platzer, Blake and Ashford (2000a) evaluated the process and outcomes of reflective practice groups comprised of registered nurses who were continuing their education. They found that through this strategy some students made significant

growth in critical thinking ability and went on to develop a deeper sense of professionalism.

A group approach to reflective practice does present some obstacles. In their study of returning registered nurses, Platzer et al. (2000b) found that the students experienced many barriers to learning from a group reflective process. Their findings suggest that previous educational experiences prevent some learners to engage in and be open to an adult-centered learning strategy. This effect was compounded by workplace cultures where “openness to ideas, challenge to authority and subjecting one’s own actions to honest scrutiny is not encouraged” (p. 1006). These barriers affect the willingness of the learners to be vulnerable as well as their ability to take responsibility for their own learning. Jackson and Chase (2004) emphasise the importance of the organization embracing the open sharing of questions, new ideas and risk-taking from all levels. Haddock (1997) describes how action learning groups can be an effective strategy to facilitate reflective practice but can also evoke repressed anxiety and distress. She concludes that in order for reflection on potentially anxiety provoking situations to occur, group facilitators must provide a learning environment where it is safe to take risks.

Although some authors are concerned that the use of reflective guides to structure reflection may limit the outcomes, others feel that following a model could provide a degree of guidance and structure, particularly for beginning practitioners (Heath, 1998). Nielsen, Stragnell and Jester (2007) created a reflection guide based on Tanner’s Clinical Judgment Model to facilitate student reflection in a senior-level precepted clinical practicum. Forneris and Peden-McAlpine (2006) have developed a Guided Narrative Reflection Process to direct narrative reflective journaling. Based on their review the literature, Kuiper and Pesut (2004) conclude that guiding the reflective process promotes greater levels of reflectivity. They posit that “Guided reflection using self-regulated learning strategies prompts the development of meta-cognitive

insights needed to connect the cognitive skills of critical, creative and systems thinking to the clinical reasoning in specific contexts” (p. 388).

Reflective practice is not without its critics. Some researchers state that empirical evidence of the impact of reflective practice on patient outcomes is inconclusive and that strategies which promote critical thinking can actually have a detrimental effect on practitioner’s psychological well-being, if not implemented with care (Braine, 2009, Burton, 2000). Cotton (2001) contends that reflective practice has been “poorly defined, uncritically presented and enthusiastically accepted as good for nursing and nurses” (p. 512). She suggests that the discourse of reflection in nursing can become a hegemonic approach to dictate to nurses what they may think and how they are to think. She warns that strategies to promote reflective thinking such as journals and clinical stories allow the thoughts of nurses to become part of the public sphere were they are open to interpretation and judgment. Mackintosh (1998) is concerned that the emphasis on individual perspectives of events excludes the views of the multidisciplinary team, family members, and the clients themselves. Reflection as a learning strategy privileges certain learners. It could be a better fit for nurses over the age of 25 as they have been found to have the cognitive readiness and experience to execute mature critical reflection (Burton, 2000). Contemplative practitioners (Cotton, 2001) and nurses with a wealth of professional experience (Burton, 2000) may find self reflection easier than action oriented or novice nurses.

The educational program I am developing will incorporate group reflective strategies that focus on the PHNs practice stories. Young’s Story Based Learning Model (Young, 2007) integrates many of the components of clinical reasoning and reflective practice. Her model

provides a list of critical questions that encompass Carper's (Bonis, 2009) and Chinn and Kramer's (2008) ways of knowing. She invites the learners to identify their learning issues, analyze practice stories to identify patterns, explore different approaches to nursing support, and reflect on the cognitive and meta-cognitive outcomes of the activity.

In my application of Young's model, I will focus on PHNs reflecting on, writing, and sharing their own practice stories. To illustrate the power of stories to transform PHN practice I would like to share a recent experience. One of my clinical educator colleagues was coaching a newer PHN about providing telephone support to a new mother. The nurse expressed her frustration that the mother did not seem to be accepting any of the advice she was giving. In exploring the story a little deeper, the nurse was able to identify her assumption that if a client doesn't accept her advice, she feels that she is not being a successful PHN. Together, the educator and the PHN explored the idea that providing support that respects the mother's views without offering any nursing advice can also be considered good nursing care. This awareness was a transformative and freeing moment for this PHN as she revised her understanding of good PHN practice. As I reflected on this story, I recognized my own learning need to be more supportive of novice PHNs in regards to their conceptualization of the PHN role. This practice story provided a mechanism for the nurse and educator in question to reflect on the meaning of PHN practice. It also gave me, as a listener of the story, to reflect on my practice. Through my educational strategy of a reflective learning process that is embedded in practice, I anticipate that PHNs will develop an increased sense of professional identity as well as valuable learning skills.

### Adapting Story-based Learning to Public Health Nursing

My adaptation of Young's (2007) Story Based Learning (see Appendix A) to public health nursing is based on the intersection of the concepts of professional identity, PHN practice stories, communities of learning, and reflective practice. The purpose of creating this learning strategy is to foster communities of learning in the workplace that will enhance the PHNs' skills of clinical judgment through reflection on their practice stories. Through this focus on actual stories, PHNs will have the opportunity to demonstrate how they are incorporating the public health nursing core competencies into their everyday practice. By exploring their practice within the context of a community of learners that is composed of their colleagues, the PHNs will also be able to expand their concept of what it means to do good work as a public health nurse. A community of learning can provide a safe environment for PHNs to build on their existing knowledge and open themselves up to the possibility of transforming their perspectives.

Along with Young's (2007) Story Based Learning Model (SBL), I have incorporated concepts from two other models of educational design. Similar to SBL, Carpio's (2001) Conceptual Model for Student-Centered Curriculum Design is also based on a small group strategy focused on practice problems and self-directed learning. She bases her model in the context of competency-based practice, professional accountability and evidence-based practice. She envisions that the outcome of nursing education is to "prepare collaborative and reflective practitioners who are life-long learners and critical thinkers" (p. 326). The components of her model that I have incorporated into my strategy are her emphasis on competency-based practice, the development of life-long learning skills, collaborative practice, and critical reflection.

Daley (2000), in her Model of Learning in Continuing Professional Development, focuses on how professionals develop knowledge through practice. Based on her research, Daley's model illustrates how nursing knowledge is a "social construction of information that occurs through a process of constructivist and transformative learning" (p. 35). The SBL strategy incorporates both ways of knowledge generation. PHNs are invited to build on their previous knowledge as they move through phases II through IV. They are also invited to explore new perspectives as they grapple with some of the "big questions" regarding the influence of dominant ideologies on the client's experience of health and illness (Young, 2007, p. 175).

Professional identity develops as experienced nurses continually integrate the knowledge and skills gained through workplace learning with their own personal identities, values, and beliefs (Chinn & Kramer, 2008). Benner et al. (2010) posit that professional identity includes "agency, commitments, practice capacities, and identification with the profession's notions of the good as well as standards" (p. 86). The PHN competencies document some of the knowledge, skills, judgment, and attributes PHNs require to practice safely and ethically (CHNC, 2009). By mapping the PHN competencies to the SBL model, I provide PHNs with a picture of how these competencies play out in everyday practice (see Appendix B). As they work through the SBL process, PHNs can use the competencies to expand some of the areas of inquiry. For example, during phase III of the SBL process, the learners are asked to look for patterns of wholeness and disruption. By cross referencing Competency 1: Public Health and Nursing Sciences, the PHNs are encouraged to apply concepts such as knowledge of the health status of populations, inequities in health, the determinants of health and illness, and social justice to this analysis. Thus, by incorporating the PHN competencies, this learning strategy becomes situated in the specialized practice of public health nursing. As nurses see how their discipline specific

competencies are illustrated in their practice stories, they develop a stronger sense of professional identity as a PHN.

While Young (2007) invites stories from either learners or educators, my adaptation of her model is solely based on practice stories written by nurses providing direct care. I feel that the process of writing personal practice stories provides a unique opportunity for PHNs to reflect deeply on their work (Street, 2001). Listening to colleagues' practice stories will engage the listeners to reflect on both the events in the story and on their own practice. It is an opportunity for both the authors and listeners to link thinking with action (Chinn & Kramer, 2008, Crawford et al., 2002). Through this process the PHNs will become more aware of their clinical reasoning and judgment as well as honour the wisdom of their colleagues and their clients (Crawford et al. 2002).

I believe these practice stories written by peers will energize the learning process by being engaging, relevant and meaningful (Daley, 2000). One important advantage of "real" stories is that they often continue to unfold as the PHN maintains a relationship with a particular client or family. This offers further opportunity to learn from practice as the group reflects on the effectiveness of nursing actions and explores new approaches to enhance care. Working with an evolving story aligns with the circular process built into SBL. Thinking about their stories and choosing which stories to record and discuss gives the nurses control of the focus of the learning activity. I feel that giving the PHNs control of the content of learning sessions is particularly important in my work environment where most of the recent staff education has been initiated by the administration. An added benefit of recording these practice stories is that PHNs will generate a written record of their good work.

One of the goals of implementing SBL in public health nursing practice is the development of communities of learning in each health unit. By starting the process of learning with a structured approach that is fairly easy to follow, I am hoping that the PHNs will continue to value learning together. This learning strategy will give them an opportunity to explore new insights that could lead to the creation of new knowledge and new ways of knowing (Wenger, 1998). SBL is only one strategy that can be used within a community of learners to advance their practice. As PHNs engage in learning together, they may move on to other strategies to meet their learning needs. As PHNs embrace learning as part of their everyday practice, they will develop and enhance learning skills that will serve them throughout their careers.

Reflection is built into every phase of the SBL model. This learning strategy invites nurses to ask the hard questions regarding their practice. What assumptions are being made? What biases am I bringing to this situation? What ideologies are impacting the experience of health and illness for this family? PHNs need to be able to use multiple ways of thinking to deal with evolving situations, incorporate the context of care, address the concerns of the client and family, and explore possible solutions (Benner et al., 2010).

### *Program components*

The first component of this learning strategy is the implementation of the SBL model in public health nursing practice. SBL is a flexible strategy and could be used in a variety of settings; from staff or team meetings to longer educational sessions. The process could be completed in one session, or it could be divided into shorter segments. I have developed a simple guide for the application of SBL to public health nursing (see Appendix B). I have also

created some directions and a template (see Appendix C) to help nurses write their practice stories as it is often easier to tell than write our stories (Street, 1991).

The second component of my strategy is to develop a community of learners comprised of office champions and SBL facilitators. Several authors have described the value of having skilled facilitators or coordinators to support workplace learning (Wenger et al., 2002, Daley, 2000). Through my previous experience with new initiatives I have found it important to have at least one nurse in each health unit to be a champion of the project. Without this support, the new program often loses impetus and slowly disappears from daily practice. In our health authority there are 18 public health offices. My goal is to support at least one PHN from each office as well as the nine clinical nurse educators to be SBL facilitators. This support would consist of a three and a half hour facilitator workshop (see Appendix D), quarterly meetings to form a community of learners within the facilitator group and a shared website where articles, practice stories and comments from facilitators can be posted.

### *Anticipated Outcomes*

With the speed in which new knowledge is being generated in nursing practice, it is vital that nurses develop life-long learning skills in order to remain competent (Murphy 2004). Knowles (1975) uses both an individual and group orientation in his description of self directed learning skills:

Self-directed learning is a process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing and implementing

appropriate learning strategies, and evaluating learning outcomes (as cited in Crooks, Lunyk-Child, Patterson & LeGris, 2001, p. 52).

Benner et al. (2010) attest that “the skills of inquiry that nurses have as they enter practice are weak, a situation which hampers their learning over the course of their careers” (p. 31). They list skills such as conducting research, accessing databases, using resources to answer practice questions, and seeking information from colleagues from another discipline as important for nursing practice. Rideout (2001) delineates the skills necessary for self-directed learners as being able to self-assess learning gaps, self-evaluate, reflect, think critically, manage information, and work collaboratively in a group setting (p. 55). Mezirow (2003) believes that adult learners should possess the ability to be critically self-reflective and exercise reflective judgment regarding the assumptions behind their beliefs, values, and feelings. SBL provides an engaging opportunity to extend these important learning skills. As PHNs become more comfortable applying these skills to their practice, they will be able to use them in a range of learning situations.

PHNs in my health authority find themselves in the midst of conflicting ideologies. On the one hand, their practice is narrowing as the health authority focuses on measurable outcomes such as immunization and breastfeeding rates, while on the other hand national organizations are celebrating the complexity and diversity of public health nursing practice by establishing a certification process and discipline specific competencies. One way to live with this tension is to incorporate our competencies within the parameters of our daily practice. I believe that the SBL strategy is one way to do this. As PHNs view their practice through the lens of the competencies, they will begin to see how they can incorporate the knowledge, skills, judgments, and attributes that define us as PHNs into their current practice. For example, a PHN could apply her

knowledge of the determinants of health, health promotion, working with diversity, and advocacy to support a new immigrant mother who is struggling with breastfeeding. By developing their competencies in their current practice, PHN stand ready to move forward to a wider scope of practice in the future. I believe that honouring our practice through our stories will give us a greater sense of who we are as PHNs and hope for the future.

### *Reflections from a Pilot*

During a recent continuing education workshop approximately 50 PHNs worked through the SBL model using a practice story written by a colleague. The session was facilitated by an experienced educator who was very familiar with the SBL process. Although SBL was new for the PHNs, they possessed strong group skills and were able to fully engage in the process. The learners were provided with the SBL guidelines (see Appendix B), a written copy of the story and some resource materials. I observed that the nurses became very engaged in the story. While at times the PHNs tended to go directly to planning nursing care, they also spent time exploring the context of care and their own learning needs. Spending time reflecting on the learning process was new for the nurses and several commented how they could see the value of including reflection in their learning activities. As one participant noted, the SBL model provided structure to their discussions and guided them to view the practice situation more holistically. Overall, the PHNs viewed the SBL model as an effective strategy to explore their practice.

### Implications for PHN Continuing Education

It is time for PHN continuing education to move from a training model to an educational model. Daley (2000) describes how the educator role should shift from “developer of specific

program content to facilitator of learning, growth, and change in professional practice (p. 40). Reflective learning strategies based in practice such as SBL, concept maps, reflective journals, action learning groups, collaborative inquiry, and communities of learning help learners develop learning skills that “foster a constructivist-transformative approach to practice development” (Daley 2000, p. 40). As clinical nurse educators shift their practice from training to educating, they will likely meet resistance. Administrators may not understand or value this shift from the traditional training role of clinical education. PHNs may come to learning sessions with the attitude of “just give me what I need to know” and balk at the hard work of transformative learning. The educators themselves may be uneasy with the learner discomfort that transformative learning can evoke. Workshop evaluations might not be positive if the learners did not enjoy the process of learning. If clinical educators want to embrace Mezirow’s (1990b) conceptualization of adult education as assisting adults to understand the meaning of their experience by participating in reflective discourse to validate ideas and then act on these insights, they will need to push past this resistance and embrace their roles as educators.

In order to learn, learners need a safe learning environment. Communities of learning can be that safe place where PHNs can explore the tension between knowing and not knowing. It is where they can engage in the intellectual and emotional work of unlearning practices that evidence no longer supports and adopt new practices (MacDonald, 2002). As Mezirow (1990b) states, transformative learning is best experienced with others where there is multiplicity of perspectives, emotional support, feedback for interpretations, and modelling of new ways of seeing (1990). Clinical nurse educators can foster the development of communities of learning by creating opportunities for nurses to gather to learn, valuing the learning that comes out of these group activities, providing resources and support, encouraging participation, and removing

organizational barriers (Wenger et al. 2002). While it is important that participation in learning communities is voluntary and that the group sets the direction for the learning activities, clinical educators play a vital supportive role both in the group and in the larger organization.

### Conclusion

As with countless others throughout history, PHNs define who we are through stories (Boykin & Schoenhofer, 1991). It is through our practice stories that we learn what good public health nursing looks like and it is through our practice stories that we open our eyes to new ways of caring and being a nurse. SBL is one learning strategy that encourages PHNs to gather in communities of learning, to reflect on practice stories in order to learn, and to grow as persons and professionals. Through this process, PHNs will have the opportunity to develop learning skills that will enhance their work throughout their career and to develop a deeper sense of professional identity.

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Appendix A

A Story-Based Learning Model: Blending Content and Process to Learn Nursing

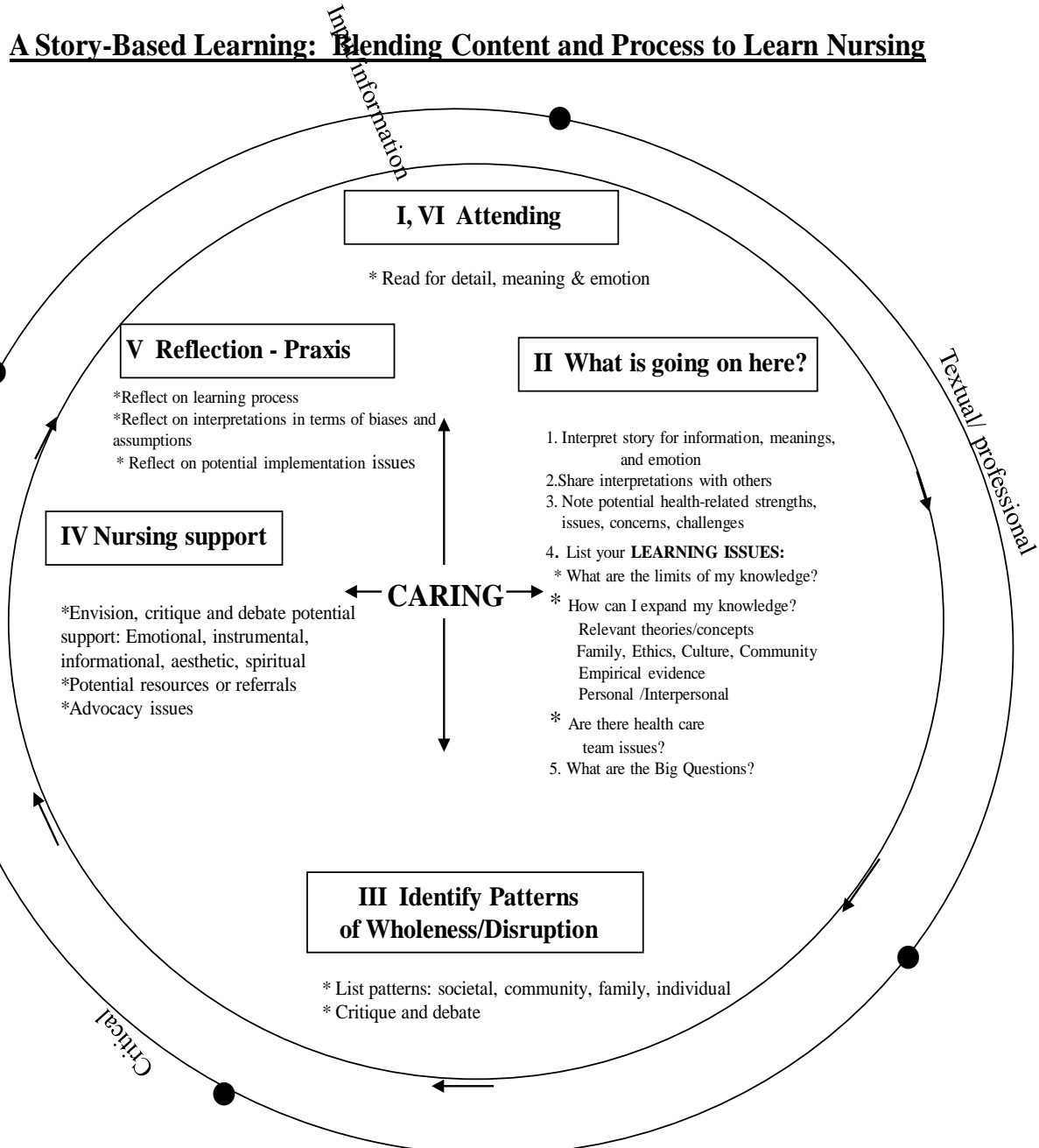


Figure 8-1

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Young, L. E. (2007). Story-based learning: Blending content and process to learn nursing. In L. E. Young, & B. L. Paterson (Eds.), *Teaching nursing: Developing a student-centered learning environment* (1st ed., pp. 164-188). Philadelphia: Lippincott Williams & Wilkins. Used with permission of the author.

## Appendix B

### **Applying the Story-Based Learning Model to Public Health Nursing Practice**

Story-Based Learning is grounded in the ethic of caring. Both the Canadian Nurses Association's Code of Ethics and the Community Health Nurses Canada's Values and Beliefs emphasize the importance of incorporating caring into nursing practice. Public Health Nurses can demonstrate their commitment to caring for their clients by acquiring the theoretical, empirical, critical, personal and interpersonal knowledge on which they base their practice. Story-Based Learning can be the vehicle that moves that learning to the next level through the critical examination of the context of clients' lives.

#### **The Story-Based Learning Model**

**The Outer Circle:** The outer circle of the model describes the process of learning. The first element is **Participatory Dialogue** where there is freedom to ask probing questions, brainstorm ideas, analyze the context of the story, and explore possibilities within the safety of a community of learners. The second element of the outer circle is **Critical Appraisal**. The learners are encouraged to examine issues such as the presence of biases, the scientific merit of the information, the practical value of the information, and issues of race, culture, gender and age.

#### **The Inner Circle:**

**Phase One: Attending to the Story.** The learners listen to the story for meanings, emotions and details.

**Phase Two: What is Going On Here?** During this phase the learners share their interpretation of the story. They identify the client's strengths, challenges, issues and concerns. During this phase learners can identify what knowledge and/or skills they require to make good decisions. What are my knowledge gaps in terms of knowledge of the client, substantive knowledge, knowledge of resources, etc? During phase two system issues may also surface. It is the time to ask the Big Questions such as: What role do the social determinants of health play in this story? What are the ethical dilemmas? Are there issues of social justice? The group may decide to adjourn at this point to seek out the knowledge needed to move forward.

**Phase Three: Identify Patterns of Wholeness and Disruption.** This phase involves the group identifying patterns that are promoting health for this client and those patterns that are disrupting health. These patterns could be personal health behaviours but can also be family and system patterns. It is from the analysis of these patterns that the learners develop their action plans.

**Phase Four: Nursing Support.** Drawing on nursing knowledge the learners develop a plan for holistic nursing support including nursing interventions, directing to resources, making referrals and becoming the client's advocate.

**Phase Five: Reflection and Praxis.** This is the time for the learners to reflect on what they have learned from this story. Were the discussions helpful and safe? Did learning happen? What helped? What got in the way? Were the sources of empirical and theoretical knowledge adequate? Did any biases or assumptions come to light?

**Phase Six: Attending to the Story.** The learners spend some time to reflecting on the story and consider if their perspective shifted through this process.

### Group Process

1. Create a story using the Story Template for Story-Based Learning.
2. Go through the first two phases of the Story-Based Learning Model. Identify group learning needs. Divide up the research tasks to individual nurses to report back at the next session.
3. Read the story aloud again and review learnings from Phase Two. Group members share their research. Are there new Big Questions?
4. Move through Phases Three through Six.

Young, L. E. (2007). Story-based learning: Blending content and process to learn nursing. In L. E. Young, & B. L. Paterson (Eds.), *Teaching nursing: Developing a student-centered learning environment* (1st ed., pp. 164-188). Philadelphia: Lippincott Williams & Wilkins.

**MAPPING**  
**The Public Health Nursing Discipline Specific Competences**  
**To**  
**A Story-Based Learning: Blending Content and Process to Learn Nursing**

<b>Story Based Learning Model</b>	<b>PHN Discipline Specific Competency</b>
Phase One: Attending To The Story (listening to the story)	
Phase Two: What is going on here?	1. Public Health & Nursing Sciences 2. Assessment and Analysis 6. Communication
Phase Three: Identify Patterns of Wholeness/Disruption	1. Public Health & Nursing Sciences 2. Assessment and Analysis 6. Communication
Phase Four: Nursing Support	3. Policy and Program Planning, Implementation and Evaluation 4. Partnerships, Collaboration and Advocacy 5. Diversity and Inclusiveness 6. Communication
Phase Five: Reflection-Praxis	8. Professional Responsibility and Accountability
Phase Six: Attending To The Story (time to reflect on the story)	
	7. Leadership: this competency is aligned with participation in all phases of the SBL process

## Appendix C

**Story Template for Story Based Learning**

Public Health Nursing practice stories are rich in their complexity. This template will assist you in crafting the different components of your stories into a written format.

***A. To start the creative process:***

**1. Finding a Story:** Think of a story from your practice that has presented you with a challenge. It could be a moral or ethical challenge or a challenge from a nursing care perspective. It does not have to be a situation that you were able to resolve, in fact, telling a story of a situation that didn't go well is often a rich source of learning for yourself and your colleagues.

**2. Shaping Your Story:** Think of a theme for your story (you can't tell everything in one page). What will be the beginning, middle and ending? Who is the main character? What were the challenges? Was there a turning point? What was the resolution, good or bad?

**3. Decide Who is Telling the Story:** Decide which standpoint you will use to tell this story. It could be from your standpoint, the client's standpoint or a family member's standpoint. If you are writing from the client's standpoint, write in the first person as if the client was speaking. You are welcome to use some creative licence when it comes to recording what they were thinking.

**4. Paint a Picture:** Use lots of detail as you write the story. Appeal to the listener/reader's five senses. Think of it as painting a picture. Consider including the physiological, social, cultural, political, relational or ethical aspects of the person's experience. Describe what is going on in terms of facts, meaning and emotion. Bring in some drama. Include the client's or family's strengths as well as their challenges.

**5. Invite the Listener to Care:** Bring in the emotions of the situation.

***B. Once you have decided on a story, you may want to start the writing process by completing the following template. Other nurses may want to just start writing and then come back to the template to determine if they have missed important details.***

Describe the setting: (Where was I? What could I see, smell, hear and/or feel?)
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<p>Who are the characters in this story? Describe each person's role.</p>
<p>What is important to include regarding the client's personal context (physiological, social, cultural, political, relational and/or ethical aspects).</p>
<p>What is the challenge in my story? What is the main point I would like to convey?</p>
<p>Describe the interaction. Who did what? Who said what? What happened next? Was there a turning point?</p>
<p>What was I thinking and feeling? What were others thinking and feeling?</p>
<p>Was there a resolution to the challenge?</p>

***C. Now that you have everything on paper, craft your ideas into a story that is at a maximum one page long.***

Appendix D

**Story-based Learning Facilitators Workshop**

**Goal:** to equip the learners with the knowledge and skills required to facilitate SBL through a 3.5 hour workshop.

**Objectives:**

- The learners will be able to describe how constructivism and transformative learning support professional development.
- The learners will be able to describe the importance of reflection in advancing PHN practice.
- The learners will be able to describe the function of communities of learning in the workplace.
- The learners will be able to apply the SBL model to a practice story.
- The learners will be able to integrate the PHN competencies into the SBL process.
- The learners will be able to identify key facilitation skills to support learners through the SBL process.

CONTENT	LEARNING ACTIVITY	TIME	OUTCOMES
1. Introductions and housekeeping	<ul style="list-style-type: none"> <li>- Introduction of facilitator, class members, agenda for session</li> <li>- Housekeeping information</li> </ul>	15 min	<ul style="list-style-type: none"> <li>- Set the tone for the session</li> </ul>
2. Learner's knowledge and experience regarding facilitating group learning	<ul style="list-style-type: none"> <li>- Pair/share activity :                             <ul style="list-style-type: none"> <li>a) Tell a story regarding personal experience of supporting learning in the workplace</li> <li>b) One thing I hope to learn today</li> </ul> </li> <li>- Report back to class</li> </ul>	15 min	<ul style="list-style-type: none"> <li>- Establish baseline of previous knowledge and learning needs</li> </ul>
3. Professional Development Model: adult learning theory, constructivism, transformative learning, reflection	<ul style="list-style-type: none"> <li>- Lecture with PowerPoint slides to cover content</li> <li>- Groups of 3-4: read practice story &amp; explore biases and assumptions</li> <li>- Individual activity: personal reflection on previous activity, journal insights</li> <li>- Group of 3-4: share insights from personal reflection</li> <li>- Large group discussion: impact of individual &amp; group reflection</li> </ul>	45 min	<ul style="list-style-type: none"> <li>- Basic understanding of adult learning theory and the role of constructivism, transformative learning, &amp; reflection in staff development</li> </ul>

4. Communities of Learning	<ul style="list-style-type: none"> <li>- Brief Introduction to Communities of Learning through PowerPoint</li> <li>- Brainstorm important attributes of COL</li> </ul>	15 min	<ul style="list-style-type: none"> <li>- Understanding of the characteristics of a COL will form foundation for implementing SBL</li> </ul>
5. Coffee Break		15 min	
6. Story Based Learning	<ul style="list-style-type: none"> <li>- Review the SBL Model through PowerPoint</li> <li>- Groups of 6: guided experience of working through the phases of SBL</li> <li>- Large group discussion: how did you see the PHN competencies integrating with the SBL process?</li> </ul>	40 min	<ul style="list-style-type: none"> <li>- Ability to integrate the SBL process with the PHN competencies</li> </ul>
7. The Facilitator's Tool Kit: organizational skills, group process skills, effective questioning, encouraging reflection, role model being expert learner	<ul style="list-style-type: none"> <li>- Groups of 3-4: remembering a story of an effective facilitator</li> <li>- Large group discussion re characteristics of effective facilitators</li> <li>- Review roles of SBL facilitator through PowerPoint</li> <li>- Groups of 3-4: review questions embedded in SBL model &amp; content from today's workshop. Create a one page listing of key questions &amp; facilitator tips to help when facilitating SBL</li> </ul>	50 min	<ul style="list-style-type: none"> <li>- Designing a one page list of key points will help learners consolidate workshop concepts</li> <li>- Workshop facilitator to compile all the lists &amp; email to class participants so they can be used as a resource</li> </ul>
8. Summary	<ul style="list-style-type: none"> <li>- Large group activity: create a group concept map of role of facilitator in SBL</li> </ul>	10 min	<ul style="list-style-type: none"> <li>- Concept mapping as a summary tool consolidates learning. The map will be part of the evaluation of learning outcomes.</li> </ul>
9. Evaluations	<ul style="list-style-type: none"> <li>- Learners asked to complete the evaluation form</li> </ul>	5 min	<ul style="list-style-type: none"> <li>- Evaluation form explores shift in knowledge</li> </ul>