



CANADIAN
NURSES
ASSOCIATION

Optimizing the Role of Nursing in Home Health

May 30, 2013

cna-aiic.ca

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© Canadian Nurses Association
50 Driveway
Ottawa, ON K2P 1E2

Tel.: 613-237-2133 or 1-800-361-8404

Fax: 613-237-3520

Website: cna-aiic.ca

ISBN 978-1-55119-403-5

05 2013

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KEY MESSAGES

- ❖ People want to be at home and to direct their care, even when their health is compromised.
- ❖ The convergence of an aging population, with concomitant chronic disease, our rising health-system costs and the demand for high-quality, responsive health care places a greater emphasis on the provision of home care programs in Canada.
- ❖ Nowhere is there more opportunity for change than in home care. Keeping people at home is the key to a sustainable health system and pivotal to seamless care across the continuum.
- ❖ Home care is truly conducive to a client-centred approach, which puts clients at the centre of care and supports them through the care continuum, rather than having providers and organizations working independently. Since care happens best where the person lives, partnerships involving home care can ensure more effective care.
- ❖ Nursing is a specialized area of practice and is the most used professional resource in home care. Home health nurses are highly skilled, they've got strong interpersonal skills that support a client-centred approach and they've had proven positive outcomes, especially in older adult, wound and end-of-life care.
- ❖ The optimization of home health nursing is enabled by the following:
 - ❖ Leadership that creates supportive workplaces and strives for change in policy and funding
 - ❖ Health systems that are aligned and work for the common goal of providing care closer to home
 - ❖ Nursing proficiency (through education and practice standards) that helps maintain competency and professional confidence in home health
 - ❖ Interprofessional respect within team relationships and supportive communities
 - ❖ Technology that supports clinicians and clients in more efficient care and timely communication
- ❖ The current policy shift to community health has generated greater awareness about home care as well as further study seeking to assess its impact and learn how it can best be leveraged (strategies to demonstrate outcomes specific to client populations were identified in British Columbia, Saskatchewan, Ontario and Nova Scotia). Opportunities exist for nurses to be members of the care team, to practise holistically, to be accountable for best practice and to realize clinical and quality-of-life outcomes.
- ❖ A number of barriers prevent home health nurses from practising to full scope, and these are likely indicative of the transitional period in which home health nursing currently operates. Barriers to practice are evident at individual (client and nurse) and organizational (employer, association and academic institution) levels and derive from a range of limitations, from the provision of supplies and nurse demographics to funding and professional guidelines.
- ❖ The lack of role clarity in home health nursing has led to its underutilization, to an emphasis on tasks and to performance that is measured by process indicators.

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- ❖ The current strong demand for home health nursing will only increase, and the profession is solidly positioned to evolve by means of enhanced education and supports.
 - ❖ The health system is at a point of change, and home health nursing, specifically, is critical for bringing about a successful transformation. The profession's optimism and strong leadership can and must be drawn upon as we work with clients and families, other disciplines, academia, policy-makers and key stakeholders to design a system that connects people to the health and wellness care they want and deserve.

EXECUTIVE SUMMARY

Nursing in home care

Nurses are critical to the health-care system and can be found in every sector. Indeed, nurses are “globally acknowledged as the linchpin of the healthcare system” (Alameddine et al. 2009, p. 67). Home health nurses are one of seven groups who use the community nurse title (Underwood et al., 2009), and they are guided by the *Canadian Community Health Nursing Standards of Practice*. Home health nurses are committed to providing accessible, responsive and timely care that allows people to stay in their homes with safety and dignity (Community Health Nurses of Canada [CHNC] (2010).

Because home care is vital to a new approach in health care, the existing demand for home care nursing is expected to increase dramatically. A report from the Canadian Nurses Association (CNA) predicts that, by 2020, two-thirds of Canadian nurses will be working in the community, compared to 30 per cent today (Villeneuve & MacDonald, 2006). This shift will have profound implications on the way nurses are educated and supported to practise as members of integrated health-care teams.

Home health nursing is a specialized area of nursing practice that provides care in the client’s home, at school, in the workplace or in other community settings (Ontario Home Care Association [OHCA], 2011). It is a unique nursing field that focuses on care to acute, chronically ill and healthy clients of all ages. Home health nursing integrates community-health nursing principles that promote health while emphasizing the environmental, psychosocial, economic, cultural and personal health factors affecting an individual’s and a family’s health status (Humphrey & Milone-Nuzzo, 1996).

With the shift of the health-care system to the community, we need to understand the nursing aspect of home health. We must also ensure that policies and practices support home health nurses to practise to their full scope. Accordingly, CNA has initiated work to identify issues and options for optimizing the role of registered nurses (RNs) and nurse practitioners (NPs) in the new home care paradigm.

The escalation of home care

Home care is broadly accepted as a vital component of the health-care system, and today every jurisdiction in Canada provides publicly funded home care to its constituents. Services range from basic supportive care to complex care with highly specialized clinical interventions.

The convergence of an aging population with concomitant chronic disease, our rising health-system costs and the demand for high-quality, responsive health care places a greater emphasis on the provision of home care programs in Canada. While many situations exist in which home care would be invaluable for children and younger adults, the vast majority of home care recipients are still seniors. As the number of elderly people grows, so too will age-related chronic conditions that can jeopardize an individual’s ability to live independently in the community (Carrière, 2006). Currently, four in five seniors living at home have at least one diagnosed chronic condition (compared to one in ten of those between the ages of 25 and 54), increasing the likelihood of receiving home care (Rotermann, 2005).

Home care, as part of an integrated health-care system, can save money and improve quality of life for people who would otherwise be cared for in an institutional setting (Hollander, Miller, MacAdam,

Chappell, & Pedlar, 2009). It is vital to understand and support the optimization of the nursing role to enable people to remain at home and avoid premature placement in a facility or inappropriate use of the emergency room.

Optimization of home health nursing

Optimizing the nursing workforce will enable the best client outcomes (individual, family, group or community) while ensuring the most effective and appropriate use of human resources in the health system (Lipskie, 2012).¹ To understand the extent to which nursing is practised to full scope in the home, and to help CNA position its action plan for the better use of nurses across the care continuum, we conducted a literature review of home health nursing care (including outcomes) and a consultation process (survey and interviews). The response rate was excellent, and respondents were generous with their time and insights.

The findings from these initiatives suggest potential for improved nursing practice, passion for the home care agenda and concern for the magnitude of change required at the funding, policy, and academic levels (despite examples of excellence in practice). While the data on numbers of home health nurses in Canada is limited, in 2010, RNs employed in home care represented 2.8 per cent of the workforce while licensed practical nurses (LPNs) or registered practical nurses (RPNs) represented 0.5 per cent. More often, LPNs/RPNs are described as practising to full scope and as better prepared to deliver care in the community. Responses were mixed regarding the extent to which RNs optimize their practice: some believe the ability to do so is a key factor in attracting nurses to the sector, while others are concerned that home health nursing is now broken down by task. None of the respondents could comment on NP practice, as this role is limited within home care. Yet all saw the potential for an expanded NP role in home care — particularly as a link to primary care for homebound and orphan patients and as support for home health nurses.

A number of barriers to practising to full scope were identified, at individual (client and nurse), organizational (employer, association and academic institution) and systemic levels, which likely reflect the transitional period in which home health nursing currently operates. The issues include the following:

- Changing patient and nurse demographics
- Challenges related to the working environment (which changes with every home visited)
- Gaps between education and the realities of practice
- Challenges for ongoing professional development, which must address the diversity and increasing complexity of client need (for a mobile workforce dispersed across the community)
- Lagging recognition of the need to fund development and support programs to help new nursing graduates meet this clinically demanding role and to adequately sustain existing staff levels
- Limits on funding models for comprehensive home nursing practice and both basic and innovative technologies to deliver care and communicate with team members

¹ Personal communication from C. Lipskie, policy analyst for the Ontario Ministry of Health and Long-Term Care's optimization of nursing workforce working group, December 18, 2012.

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- Ramifications for clients and the health-care system due to outdated perceptions about the capacity of home care (generally and specifically) and the role and expertise of the home health nurse

Notwithstanding the challenges for enabling home health nurses to practise to full scope, a number of jurisdictions respect home care and home health nursing and promote adherence to the *Canadian Community Health Nursing Standards of Practice*. Work is being done to identify nursing-sensitive outcomes, as one way of highlighting the very important contribution of home health nurses to the health and well-being of Canadians.

Conclusions and recommendations

The optimization of home health nursing is enabled by the following:

- Leadership that creates supportive workplaces and strive for change in policy and funding
- Health systems that are aligned and work for the common goal of providing care closer to home
- Nursing proficiency (through education and practice standards) that helps maintain competency and professional confidence in home health
- Interprofessional respect within team relationships and supportive communities
- Technology that supports clinicians and clients in more efficient care and timely communication

Since work in these critical areas will help enhance home health nursing practice, the recommendations in this paper are built on these themes.

The recommendations should be considered as a whole, as it will take a concentrated and broad effort to achieve the necessary changes to support the maturation of home health nursing. Through their implementation, however, home health nursing will be coveted as a preferred practice in Canada.

Leadership

- ❖ Nursing organizations need to establish transformational leadership competency at all levels of home care nursing (individual nurses, organizations and systems) to facilitate advocacy, policy and infrastructure development as well as coaching and change in practice.

Aligned health systems

- ❖ Governments need to shift their funding and policy emphases to new community-based, integrated models of health care. In order that Canadians can remain at home, the new models must include connections with primary care and be sufficiently resourced and equipped to provide state-of-the-art home care.

Nursing proficiency

- ❖ Governments and nursing organizations need to clearly articulate the full scope of practice for home health care nursing to enable a successful health-system transformation into client-centred community care.

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- ❖ Universities and colleges across the country need to establish a portable, core-nursing curriculum that includes standards, competencies and clinical placements for home health nursing in Canada.
 - ❖ Orientation, preceptorships and other supports are needed for new employees.

Interprofessional respect

- ❖ CNA to lead the establishment of a national home health coalition of employers, educators, researchers and nursing organizations from across Canada, which champions and promotes home health nursing and celebrates and honours the contributions of all team members.

Technology

- ❖ Governments need to provide incentives that will increase the use of technology in home care. Doing so will enable better client education and self-management, remote-client monitoring by the care team, point-of-care electronic documentation, improved communication and more effective use of technology by all health-care team members.

The health system is at a point of change, and home health nursing, specifically, is critical for bringing about a successful transformation. The profession's optimism and strong leadership can and must be drawn upon as we work with clients and families, as well as with other disciplines, academia, policy-makers and key stakeholders to design a system that connects people to the health and wellness care they want and deserve.

OVERVIEW

CNA recognizes home care as an integral part of medicare, believing that all Canadians, regardless of where they live, should receive the care and support they need in their homes and communities. In 2012, CNA published *A Nursing Call to Action: The Health of Our Nation, the Future of Our Health System*, a report that recommends ways to transform the health system so that more care delivery occurs at home and in the community than in institutions.

This paper identifies issues and options for optimizing the role of RNs and NPs within home care. It examines the current practice setting and the value proposition of home health nurses (including related outcomes), while offering a discussion and recommendations on moving forward. The paper positions CNA as the developer of objectives, activities and indicators for optimizing the role of the home health nurse.

CNA describes the optimization of a given nursing practice as a process of determining how competencies can be used to best advantage. Optimization includes breaking down divisions within nursing, as well as barriers with other professions, in order to facilitate collaborative interprofessional practice. This process will enable the best client outcomes (individual, family, group or community) and bring about the most effective and appropriate use of human resources in the health system (Lipskie, 2012).

APPROACH

The Canadian Home Care Association (CHCA) and Saint Elizabeth (SE) jointly undertook the development of this paper to support CNA's leadership in contributing to a more robust home care delivery system.

Over a six-week period, we targeted 46 key informants across Canada, who represented a range of nursing and/or home care leaders and researchers identified by the project partners. The informants were asked to spend about an hour for an online survey and/or interview. Thirty-eight individuals participated in the survey (an 83 per cent response rate); sixteen in the interview (by phone).

Respondents were assured anonymity and told that the information gathered would be reported in the aggregate. The authors are grateful to the participants for their time and candour in discussing the issues and opportunities facing nursing today.

BACKGROUND

Home care is a vital component of the health-care system, providing short-term, post-acute interventions as well as long-term care for individuals with a vast array of needs. Care ranges from basic support to complex care requiring highly specialized clinical interventions. Home care in Canada is now being driven by the aging population, increased health-system costs and a growing demand for high quality, responsive health care.

New partnerships are emerging between primary care, hospital, community and long-term care that seek to address the needs and preferences of Canadians remaining at home. Because home care is vital to a new approach to health care, current demand for home health nursing will only increase. A CNA report estimates that the existing one-third of nurses working in Canadian communities will rise to two-thirds by 2020 (Villeneuve & MacDonald, 2006) — a shift with profound implications for the way nurses are educated and supported to practise as members of integrated health-care teams.

The Community Health Nurses Association of Canada (CHNAC) has adopted a leadership role in the development of competencies and standards for community nursing, including home health. The extent to which home health nurses practise to full scope is a result of many factors being explored in this paper.

Home Care in Canada

The Canadian Home Care Association (CHCA) defines home care as “an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the family caregiver” (2008, p. 1). This definition is reflected in most federal, provincial and territorial home care programs across Canada.

The first publicly funded home care program was established in 1970 in Ontario. Others have since evolved distinctly within each provincial, territorial and federal jurisdiction. Because home care does not fall under the 1984 *Canada Health Act*, the principles of health insurance do not apply. However, every province and territory relies on home care as an important program to supplement the health-care system and the efforts of individuals to care for themselves with the assistance of family, friends and community.

Home Care Clients

The majority of home care clients (between 60 and 70 per cent) are aged 65 and over. Twenty to thirty per cent are over 21 years of age, and children represent about 10 per cent of home care clients. These statistics vary in Nunavut and in First Nations and Inuit home and community care programs, where populations are much younger (CHCA, 2008).

Home care programs across Canada provide a comprehensive range of coordinated health-care services for individuals of all ages that promote, maintain or restore health within the context of daily life. Home care services help people with acute, chronic, palliative or rehabilitative health-care needs to be as independent as possible. These services also ensure the coordination and management of admissions to facility care

when living in the community is no longer viable (CHCA, 2008). Home care is increasingly acknowledged as integral to the health system, yet because it is outside of the *Canada Health Act* its services and programs, levels of coverage, funding and eligibility criteria vary across the country. Examples of publicly funded home care include professional nursing; rehabilitation; pharmacy and respiratory therapy; personal and home support; and access to resources, such as medical equipment, supplies and medication (although some of these services may be limited in certain regions or not provided at all).

Home care nursing is provided in every jurisdiction in a case-management capacity and for individuals with short-term acute needs (CHCA, 2007).

Overwhelmingly, Canadians want to remain at home, even when support is limited (Canadian Institute for Health Information [CIHI], 2011). While most with life-threatening illnesses would prefer to die at home, two-thirds (67 per cent) of Canadian deaths still occur in hospitals (Statistics Canada [StatsCan], 2008). This gap between preference and practice remains despite provincial and territorial commitments in 2004 to provide first-dollar coverage for case management, nursing, personal support and palliative-specific medications in their palliative home care programs (Health Canada, 2004). Without adequate home care, families lose their ability to cope, client care needs are compromised and individuals may be unnecessarily hospitalized or placed in institutional care.

Canadian Population

According to StatsCan (2012), “life expectancy in Canada is one of the highest in the world” and is expected to grow, making the aging population a key driver of health-system reform. By 2036, seniors in Canada will comprise 25 per cent of the population (CIHI, 2011). Currently, those age 80 and higher are one of the fastest growing segments of the population, and by 2056 about one in ten Canadians will be 80 years and over, compared with about one in 30 in 2005 (Bélanger, Martel, & Caron-Malenfant, 2005).

Today, 93 per cent of seniors live at home with some formal and/or family caregiving support (CIHI, 2011). Functional limitations associated with aging and/or chronic disease contribute to reduced activity and social engagement for seniors living at home. Social isolation can contribute to a decline in health and well-being, and the risk of fall-related injuries (which are more serious) increases as people age (CNA, 2012a). In fact, an estimated 40 per cent of admissions to long term care occur after an older person falls (CNA, 2012b).

Surveillance Nurse

As part of an initiative to shift care to the home, this nursing position was created in the B.C. Fraser Health Region to assume responsibility for clients with stable care plans. The home health nursing intervention is designed to proactively ensure client well-being at home through regular contact, followup and intervention prior to the onset of an acute episode (CHCA, 2012).

While seniors are typically healthy as they age, chronic health conditions are on the rise. In Canada 41 per cent of seniors have two or more chronic conditions like diabetes, respiratory issues, heart disease and depression (10 to 15 per cent of seniors; NEC, 2012), and many experience a decline in physical and/or cognitive functioning (Health Council of Canada, 2010). Chronic conditions are expected to increase with the population's changing age composition. The total number of Canadians with a disability is expected to grow from 4.5 million in 2006 to between 6.4 and 7.1 million in 2031. According to recent projections, most of this growth will occur among seniors 70 years and older (Human Resources and Skills Development Canada, n.d.). These demographic shifts are informing the need for an expanded role for home care within a transformed health system.

Between 2003 and 2009, the prevalence of diabetes and high blood pressure in seniors has risen — from 13.5 per cent to 18.1 per cent for diabetes and from 42.8 per cent to 48.9 per cent for high blood pressure (as cited in CIHI, 2011).

Canadian Community Health Survey: Healthy Aging, 2008-2009

Current State

Several interview participants identified the exciting opportunities for change in the current home care environment and noted that other sectors are now recognizing the central role of home and community care to the health-care system. Canadians value their home care programs and services and want the option to be cared for and/or to die at home. Collaboration between home care and primary care has been shown to improve access to care and treatment, regardless of age and condition (Markle-Reid et al., 2003, 2008). In addition to providing home visits to deliver prescribed care, home care has proven to be effective in providing proactive followup (Markle-Reid et al., 2003, 2008; Hollander & Chappell, 2002; Hollander, Chappell, Prince & Shapiro, 2007) to support improved client and health outcomes. Home and community care require a team approach to care — by physicians, rehabilitation therapists, community pharmacists, unregulated staff and home health nurses — to realize optimal health outcomes.

HOME HEALTH NURSING

Home health nursing is a specialized area of nursing practice that provides care in the client's home, school, workplace or other community settings (OHCA, 2011). It is a unique nursing field that focuses on care to acute, chronically ill and well clients of all ages. Home health nursing integrates community-health nursing principles that promote health while emphasizing the environmental, psychosocial, economic, cultural and personal health factors affecting an individual's and family's health status (Humphrey & Milone-Nuzzo, 1996).

As one of seven groups using the community nurse title (Underwood et al., 2009), a home health nurse combines knowledge from primary health care (including the determinants of health), nursing science and the social sciences, and has a nursing diploma (applicable to RPN, RN) or baccalaureate degree in nursing (CHNAC, 2008). The role is based on the *Canadian Community Health Nursing Standards of Practice* and consists of the following five interrelated standards:

1. Promoting health — health promotion; prevention and health protection; health maintenance, restoration and palliation
2. Building individual and community capacity
3. Building relationships
4. Facilitating access and equity
5. Demonstrating professional responsibility and accountability (CHNAC, 2008)

These standards apply to community health nurses working in practice, education, administration or research; they act as a benchmark for new community health nurses and become basic practice expectations after two years of experience (CHNAC, 2008). Accordingly, home health nurses bring a comprehensive lens to

- assessment, monitoring and clinical decision-making;
- care planning and coordination;
- health maintenance, restoration and palliation;
- identifying and meeting gaps in knowledge and care;
- teaching and education;
- communication, especially listening; and
- building capacity and client engagement (CHNC, 2010).

The home health nurse is someone who enjoys the new challenges and variability within each home environment. Consulting with colleagues and revisiting clients may be hours or days apart, and in some jurisdictions the nurse must act through telephone and/or remote monitoring access only. Therefore, the home health nurse must be able to apply policies with maturity, self-confidence, flexibility and resourcefulness to ensure personal and client safety (Ontario Community Support Association & Ontario

Home Care Association, 2008). Home health nurses have a developed understanding of their client's rights, how to direct their care and how to live at risk. They must be skilled at engaging in therapeutic relationships with clients and supporting their self-care. Some interview respondents suggested that home health nurses also need to be politically wise (in presenting issues and/or negotiating on behalf of their clients in relation to the family, the health care team or the broader community) and be clinically astute, confident and comfortable in autonomous practice.

When asked to compare this description with their understanding of the current role, 79 per cent of survey respondents replied favourably. Yet others said they were case managers and/or members of an interprofessional team, that health promotion only happened in the context of the client's current illness and that home health nurses often oversee the work of unregulated staff. Additional key elements of the role were said to include applying best practice guidelines, working with family and facilitating safety in the home.

Registered Nurses

In 2010, 77.9 per cent of RNs were employed as staff nurses/community health nurses and 7,362 RNs were employed in home care, which represented 2.8 per cent of the total nursing workforce (a drop of 0.7 per cent from the previous year) (CIHI, 2010). The average age was 47.4 years (CIHI, 2010), higher than nurses working in other sectors.

Percentage of RNs in Community Health ¹ in 2010									
BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
12.5%	14.0%	18.1%	17.7%	16.3%	10.4%	11.6%	10.2%	3.1%	12.6%
Percentage of RNs in Other Places of Work ² in 2010 ³									
8.6%	13.5%	12.9%	11.1%	10.1%	20.7%	11.2%	12.1%	24.0%	11.1%

¹ Includes data from community health centres, home care agencies, nursing stations (outpost or clinic) and public health department/units.

² Includes data from business/industry/occupational health offices, private nursing agencies/private duty, self-employed, physician's office/family practice units, educational institutions, association/government and others.

³ In the territories, a significant portion of RNs work in health centres, home care agencies or nursing stations (outpost or clinic) and public health departments/units (41.2 per cent).

In 2003, the Canadian Home Care Human Resources Study projected that the ratio of home care nurses to home care clients will change from one caregiver for every 37 clients in 2001 to one caregiver for every 100 clients in 2046 (Home Care Sector Study Corporation, 2003).

Licensed Practical Nurses/Registered Practical Nurses (2)

In 2010, 1,710 LPNs (0.5 per cent of the total nursing workforce) were employed in home care, a growth of 5.4 per cent.

Percentage of LPNs in Community Health ¹ in 2010									
BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
5.7%	25.9%	9.2%	10.4%	11.5%	1.9%	4.0%	14.5%		3.4%
Percentage of RNs in Other Places of Work ² in 2010 ³									
6.6%	9.2%	2.8%	6.0%	6.2%	11.8%	3.0%	2.6%		1.6%

¹ Includes data from community health centres, home care agencies, nursing stations (outpost or clinic) and public health department/units.

² Includes data from business/industry/occupational health offices, private nursing agency/private duty, self-employed, physician's office/family practice units, educational institutions, association/government and other.

³ In the territories, a significant portion of LPNs work in hospitals (45.0 per cent) and nursing homes (39.6 per cent).

Nursing Outcomes in Home Care

The value of care delivered by the nurses identified above is difficult to demonstrate. Recently, however, Doran, Mildon and Clark (2011) reported that valid nursing-sensitive indicators now exist that are feasible to collect and use in both safety and quality outcomes for clients. Nursing-sensitive outcomes are “relevant, based on nurses’ scope and domain of practice, and [possess] empirical evidence linking nursing inputs and interventions to the outcome” (Doran, 2003, p. vii) and are identified from the structure, process and outcomes of nursing care (Doran & Pringle, 2011). Over the last ten years, nursing has moved to capture nursing-sensitive outcomes in the community. Health Outcomes for Better Information and Care (HOBIC and C-HOBIC) have also taken a broader perspective to include outcomes such as functional status, symptoms and therapeutic self-care. In addition, interview participants mentioned the importance of the RAI-HC,² and many saw the use of assessment data and the identification of outcomes both as an improvement for nursing and as a promising area for future work, especially in home care.

The HOBIC initiative is a project funded by the Ontario Ministry of Health and Long-Term Care. It involves the collection of standardized information about nursing in acute care, complex continuing care, long term care and home care settings across Ontario (Institute for Clinical Evaluative Sciences [ICES], 2012). The HOBIC database is housed at ICES, which enables an understanding of practice across sectors.

² The Resident Assessment Instrument — Home Care (RAI-HC) is a standardized, multi-dimensional assessment system for determining client needs, which includes quality indicators, client assessment protocols, outcome measurement scales and a case mix system.

However limited, there is evidence that by providing health assessment, support and access to resources through regular home visits, home health nurses can play a major role in individualized health promotion and preventive care for older people (Byles, 2000; Elkan et al., 2001). A Markle-Reid study (2006), for example, suggests that a diversity of home visit interventions by home health nurses can favourably affect health and functional status while reducing mortality rates and depression. Recent studies in Ontario demonstrated that, with no additional expense, home health nursing resulted in enhanced quality of life for older adults in connection with early identification and the management of risks for adverse events (i.e., falls, polypharmacy, depression, caregiver stress) (Markle-Reid et al., 2003). Several randomized trials of mental-health interventions with medical patients over the age of 75 also showed that those in the home intervention group had improved physical function and fewer readmissions to hospital and nursing homes (Burns, Denning, & Baldwin, 2001).

In addition, there is evidence that home health nursing has a positive impact on clients with chronic disease. The researchers found that, as clients received more nursing time, they demonstrated an increase in the “uses pacing activity to manage dyspnea” outcome indicator (Adams & Short, 1997, p. 57). A study by Rogers, Perlic and Madigan (2007) reinforces these results, noting that dyspnea patients receiving a higher number of nursing visits were seven times more likely to improve or stabilize than patients who received fewer nursing visits.

Interview participants also reported a number of activities underway to demonstrate the impact of home care nursing. While not yet published, the evidence suggests that home care nurses practising with best practice guidelines (BPGs) for falls, pressure ulcers, dyspnea and pain achieve better outcomes.³ A more knowledgeable worker can often detect issues earlier and address care more holistically for improved client outcomes.

Example: Decline in rates of dialysis through home health nursing and nephrology collaboration

The diabetes risk evaluation and microalbuminuria project (DREAM) at the Battleford Tribal Council Indian Health Services home care program showed that using a home care nurse to implement a treatment strategy for blood pressure control was more effective in lowering diastolic pressure than was home care visits for blood pressure monitoring alone, even when there was followup treatment by a family physician (Tobe et al., 2006).

To date, research on the impact of home health nursing on system outcomes has been limited and mixed. A retrospective record review aimed at identifying reasons for hospitalization, falls or death within 60 days of home health care referral found no significant differences in the number of home visits (all disciplines combined) with patients who experienced a fall, compared to those who did not (Taft, Pierce, & Gallo, 2005). However, there is evidence that deploying nurses in home care saves health-care costs; for example: having nurses provide leading practices in home wound care; integrating nurse-led models of care to reduce high hospital readmissions by 10 per cent for those with chronic conditions; providing 25 per cent of palliative care in the home rather than acute hospital settings; providing community care for

³ Personal communication from Diane Doran.

patients in hospital who are designated as needing an alternative level of care; and providing proactive community care and patient self-management for those with congestive heart failure and other chronic conditions (Browne, Birch, & Thabane, 2012).

Nurse Practitioners Working in Home Care

A relatively new addition to home care nursing is the nurse practitioner (NP) role. NPs are RNs with additional educational preparation and experience who can order and interpret diagnostic tests; prescribe pharmaceuticals, medical devices and other therapies; and perform procedures (CIHI, 2010). NPs are currently licensed in all provinces and territories except the Yukon (CIHI, 2010); however, in 2009 the Yukon government approved the inclusion of NPs in the *Yukon Registered Nurses Profession Act* and, after working closely with the Yukon Registered Nurses Association to develop NP regulations, has recently (October 2012) tabled legislation to include NPs among the province's health-care providers (Yukon Health and Social Services, 2012).

In 2010, of the 486 NPs employed in Canada, seven worked in home care and 199 in community health (CIHI, 2010). While, in Alberta, NPs function as consultants, conducting in-home assessments and directing care (Tung, Kaufmann, & Tanner, 2012), Ontario NPs are used (when access to a family physician is restricted) to provide home-based palliative care services and advice on care management issues. More recently in Ontario, 38 NPs have been identified as working in the home care sector (community care access centres) (College of Nurses of Ontario, 2012). Because of their limited use, little has been written about the role and benefit of home care NPs. Nevertheless, Neal (2004) reported that RNs and other home care professionals value the NP role. Neal further contends that NPs could reduce the fragmentation of care for patients discharged from acute-care sites such that, with NP support, these patients might go directly home rather than to extended-care facilities. Survey respondents agreed, suggesting that better use of NPs could improve access to primary care for homebound clients (extending the reach of the family physician), serve as experts in specific clinical areas and provide support to RNs in the community.

Nurse Practitioners in Home Care and Outcomes

Because of NPs' limited use in home care, most studies examining their impact are based on anecdotal evidence and subjective data from descriptive studies. Yet, in one study, 36 NPs in Boston reported that they improved patients' quality of life and prevented medication errors, falls, emergency department (ED) visits, hospitalizations and death (Dick & Frazier, 2006). As well, it has been suggested that home-based primary care provided by NPs in the United States can be associated with improvements in chronic illness management, illness and injury prevention, and quality of life (Auer & Nirenberg, 2008). NPs may also reduce hospitalizations, reduce caregiver burnout by eliminating transporting the client to the doctor's office (Auer & Nirenberg, 2008) and reduce ED visits (Counsell et al., 2007).

A small pilot study (Tung et al., 2012) in Canada also examined the effect of a home care NP on ED visits for homebound older adult patients. The authors compared ED visits in home care clients followed by NPs with those receiving usual care and not followed by NPs. The number of ED visits was reduced in the intervention group and no significant difference occurred in death rates between the two groups. Currently, research is underway to examine other system impacts on primary care and admission to long term care.

Home Health Nurses?

Whether or not there are enough home health nurses in Canada is difficult to answer. Many believe there are opportunities to better use the abilities of all providers and to enhance interprofessional, team-based care (CNA, 2012a). Yet, as several interview participants indicated, if nurses are not practising to full scope, projections (which are based on current utilization) are misleading. And in the same way that nursing continues to try to identify and communicate the benefits it brings to the health-care system, so too is the role of home health nurses (the primary professional providers of home care) underutilized because it is often not recognized (Doran et al., 2012).

ENABLERS TO NURSING PRACTICE IN HOME CARE

To more effectively meet the needs of our aging population and benefit from the care and contributions of home care nurses, it is important to understand the current enablers and barriers that affect their working to full scope.

A national study of community nurses (Underwood et al., 2010) found four factors that enable nursing practice: professional confidence, supportive workplaces, supportive communities and good team relationships. These factors, combined with several additional themes identified by interview participants, can be further aligned with the following five key enablers:

1. Nursing Proficiency (education, professional confidence)
2. Interprofessional Respect (team relationships, supportive communities)
3. Leadership (supportive workplaces, policy and funding)
4. Aligned Health System Goals (increased care closer to home)
5. Technology (support for clinicians and clients)

Nursing Proficiency

While it is important that nurses have enough time to perform the activities necessary to meet client needs (Institute of Medicine, 2003), quality nursing care is very much a function of the nursing proficiency that arises from the education, subsequent knowledge, skills and experience nurses bring to their roles. This is certainly true of home health nursing, where basic nursing knowledge is coupled with on-the-job mentorship and experience and, in some organizations, access to continuing education to maintain competencies and confidence in professional roles and responsibilities (Underwood et al., 2010). Proficiency is often linked to what some see as the particular strength and confidence of home health nurses (Underwood et al., 2010), and interview participants suggested that most community nurses feel sufficiently confident to practise autonomously, communicate decisions to managers and advocate for change.

Interprofessional Respect

Working to full scope of practice is also enabled by the belief of most community nurses (including home health nurses) that their education prepares them to work with other providers (Change Foundation, 2011), although some nurses feel they do not often have strong relationships with physicians (Underwood et al., 2010). Generally speaking, nurses value teamwork, feel respected and want to be active participants in decision-making (Doran et al., 2012).

When home health nurses are an integral part of a team, they are valued for their skills in holistic nursing assessment, which includes the physical, social, emotional and cultural aspects of care. This holistic framework facilitates an appreciation of the social determinants of health and nurses' contributions to population health, which ultimately leads to better care and more frequent health promotion for people experiencing illness, crisis or life transitions (Besner, 2004).

In several jurisdictions across the country, home health nurses are partnering with family physicians to better coordinate and integrate care. CHCA's national partnership project (2006) showed that home care contributes to effective chronic disease management through secondary and primary care intervention. Because the project was able to demonstrate improved clinical outcomes, higher patient and provider satisfaction and lower inappropriate system use, the partnership model has been replicated in several communities across the country.

The introduction of home care nurses in emergency departments has also resulted in better collaboration, awareness and respect across health-care sectors; better use of resources; and most importantly, improved care for clients (CHCA, 2007). For example, interview and survey respondents spoke of medication management programs involving collaboration between a community pharmacist, physician and home health nurse that helped reconcile client medications and avoid confusion and errors.

Example: In Vancouver, a quick-response team ensures that home health nurses see clients in a timely way before regular home care services are initiated.

In Quebec, the program of research to integrate the services for the maintenance of autonomy (PRISMA) uses an integrated service-delivery model to help assess, coordinate, maintain and evaluate the full range of home care services delivered by medical practitioners, public service providers and volunteer organizations. Results on the efficacy of this model showed a decreased incidence of functional decline, a decreased burden for caregivers and a smaller proportion of older people wishing to enter institutions (CHCA, 2012).

Leadership

Several interview participants said that the presence of nursing leaders — both in local delivery organizations and at provincial and national levels — is an important enabler to home health nursing and full scope. Leaders have the knowledge and skills in home health nursing and are able to work with outside organizations to establish partnerships and appreciation for nursing skills and knowledge. Most interview participants mentioned the importance of continued leadership at a national level, through such organizations as CNA and CHNAC, so that advocating for certification and recognition for a home health nursing specialty continues. Also important for participants was that key nurse executives and other organizational leaders actively ensure that home health nurses within their organizations have the knowledge, skills and support they need, and that external bodies, such as colleges and universities, can effectively help students and new graduates move into the practice setting.

Aligned Health System

Another enabler to full scope of practice for home health nurses is aligning their philosophy, education and current work with the overall goals of the health-care system. Nursing education focuses primarily on health and wellness, and today's health-care system is aimed at improving population health and wellness. Nurses might then be required to help individuals and communities accept greater responsibility for their health within well-coordinated and appropriate interprofessional teams whose work is aligned with other

social and economic sectors (Besner, 2004). Doing so would ensure that the right care is provided to the right people, by the most appropriate provider, in the right setting, using the most suitable and cost-effective technology (Alberta Association of Registered Nurses, 1992; Besner, 2004). Yet, as Besner (2004) points out, “health for all” is not always a concept that resonates with Canadian nurses. So, if we are going to reform health care and nursing practice, a refocus on practice needs to take place. Nurses have the necessary skills and knowledge; what is needed is a structure to promote its operationalization.

In several areas of the country, a shift is already underway to support better alignment among health systems and to enable a move from task-based nursing to interprofessional team-based care. For example, at B.C.’s Fraser Health a number of initiatives are underway to enhance the RN scope of practice, in part by blending case management into nursing practice and using a more population-based approach to care. One example, the BreatheWELL at Home program (Burnett, Fraser, & Park, 2012), focuses on coaching clients to self-manage their chronic obstructive pulmonary disease (COPD), including the initiation of treatment for disease exacerbations. Technology is provided in the home to reinforce teaching, while home health nurses work with clients to develop contingency (“flare-up”) plans, which may include antibiotics and steroids the client can self-initiate. Nurses participate through ongoing support, followup and reinforcement activities as needed.

Another example of goal alignment is the outcomes-based reimbursement (OBR) initiative in Ontario. Interview participants cited OBR as having the potential to shift the focus from “doing dressings” to comprehensive assessment and care planning that would achieve defined and shared outcomes for the client. The intent is that the home health nurse will be accountable for following best practices in specific client populations, such as diabetic foot ulcers, and will determine the care approach to achieve clinical outcomes within established benchmarks.

Alternate level of care (ALC) is a measure describing the use of a hospital bed by someone who does not require the intensity of resource/service for this care setting. The ALC rate typically refers to those in acute care; however, the rate can be used to measure other populations and care settings like palliative or chronic care. In 2009, ALC patients accounted for five per cent of hospitalizations and 14 per cent of hospital days in acute facilities (CIHI, 2011).

In other areas of the country, the effort to decrease the number of persons designated to ALC beds and to get people home has resulted in initiatives such as Home First (Ontario), Home is Best (British Columbia) and Home Again (Nova Scotia). In these models, the health-care team works collaboratively to enable the person to go home safely and in a timely way. Nurse autonomy and flexibility is encouraged so that the right nursing skill mix and timing of services are provided and nurses can support clients and their families to explore care options and determine their plan of care.

Technology

Several interview participants identified technology as an enabler for home health nursing. Currently, nurses in certain areas are using technology like smart phones and tablets to increase real-time communication and access to information through telephone, e-mail and text messaging. Some also identified work being done that uses digital photography to obtain consultations for wound care.

Example: The Capital Health Region in Alberta demonstrated the effectiveness of technology to optimize enterostomal therapy expertise (Semotiuk, 2005), using a web-based software program to extend the services of two enterostomal therapy nurses working in home care.

Interview participants suggested that there are promising technology practices to support the care of individuals with diabetes, congestive heart failure and COPD, which could be used as templates for expanded scope of nursing practice. They also suggested using other technology-based initiatives that could support home health nursing. For example, the e-shift program at the South West Community Care Access Centre in Ontario, which leverages technology to connect an enhanced-skill personal support worker (PSW) in the home with an RN through a web-enabled smartphone. This technology allows an expert pediatric RN to monitor, mentor and manage care at up to four locations simultaneously (South West Local Health Integration Network, 2012). As well, in Manitoba, technology provides the health-care team with urgent care alerts through the enhanced, home-based, community care virtual ward program.

BARRIERS TO NURSING PRACTICE IN HOME CARE

While survey respondents concurred with the definition of home care nursing, only 50 per cent believe that nursing is currently practising to full scope. More often, LPNs were described as practising to full scope and being better prepared to deliver care in the community. Respondents were mixed as to the extent to which RNs optimize their practice: some believe the ability to do so is a key factor in attracting nurses to the sector, while others expressed concern that home health nursing is now broken down by task. None of the respondents could comment on this situation in NP practice. The barriers for home health nurses practising to full scope are presented from the context of the individual (client and nurse), the organization (employer, association and academic institution) and the system.

Individual

Changing Patient Population

It is generally acknowledged that the shift from reactive episodic treatment to proactive sustained care is being driven by an aging population who would greatly benefit from having home health nurses practising to their full scope. Yet today's home care clients are much more complicated than they once were. Not only are they discharged earlier with more acute conditions, care is now being delivered in a context that includes a lack of family support, language barriers, cultural differences and low client health-literacy levels.

These complexities are further compounded by the fact that most nurses have a generalist knowledge base and skill set. Currently, nurses may not have the specialty knowledge needed for all populations, despite the fact that college standards and frameworks are the basis for their decisions about whether they can meet client needs. Because population needs are changing, several interview participants noted inconsistencies in nursing care, which may be further complicated by having multiple care providers visiting the same client.

Changing Nurse Population

Many interview participants identified a perceived disconnect for nurses between care, quality and accountability. This disconnect has developed for a number of reasons; for example, moving nurses to a task-based practice (in an attempt to serve more clients) without having adequate resources to meet the demand. Indeed, some respondents recognized this type of shortcoming as an inherent risk of program growth. As well, infrastructures are lacking that could provide nurses with the data, feedback or other mechanisms to know the outcomes of the care they deliver and their degree of accountability for improvement. Alternative theories on this disconnect range from attitudinal changes across the generations and the pervasive lack of funding in home care for education, peer mentoring, equipment and technology to models that separate care planning from the execution of specific tasks.

Organization

Healthy Work Environments

It appears that home health nurses appreciate the same supportive work environment attributes that hospital-based staff nurses value (Flynn, 2007; Flynn & Deatruck, 2003). Some authors suggest that healthy work environments are as necessary in home health settings as they are in hospital or institutional settings for advancing professional practice, nursing outcomes and fewer adverse events (Flynn, 2007; Laschinger, Almost, & Tuer-Hodes, 2003; O'Brien-Pallas et al., 2004; Tigert & Laschinger, 2004). One conceptual model of nursing organization and outcomes (Aiken et al., 2002) defines organizational support for nursing practice as a set of core attributes (modifiable by managerial decisions) within a supportive work environment that includes (a) sufficient resources, (b) nurse autonomy, (c) nurse control of the practice environment, and (d) collegial nurse-physician relationships.

The challenge — and for many the pleasure — of home care nursing is its multiple and varied working environments, which reflect the full range of social, geographic and socioeconomic settings. By working in client-controlled environments not necessarily designed for the delivery of health care, home care nurses can never be sure of what they will encounter. Therefore, they must be more aware and diligent about assessing their own health and safety than in facility-based care. Other safety issues include risks associated with driving, isolation, and lack of equipment and supplies.

In addition to supportive work environments, most community nurses would like policy and practice information and more learning opportunities (Underwood et al., 2009), although education should be tailored to their specific learning needs and accessible in the community setting. Without these criteria community nurses in some areas understandably lose interest in attending learning events.

Focus groups exploring this issue found that community nurses often feel topics are irrelevant to their practice context, and that they are excluded from the process of identifying learning needs. In settings where they were given separate learning events, they felt disconnected from the rest of the primary health care team (Cunningham & Kelly, 2008). On the other hand, respondents spoke of the effectiveness of technology-enabled access to clinical guidelines and resources made available through phones or tablets. Introducing advanced practice nurses in some jurisdictions has been instrumental in program development, relevant education and access to research to support care delivery by the nurses in the community.

Education and Practice

A barrier raised by several interview participants is the gap between nursing education and the current practice environment. While nurses receive education on the health promotion, prevention, assessment and management of health-related conditions, once they enter the health-care system, this knowledge is rarely operationalized or used as intended. In most home health-care settings, practice is based on the medical model (with its focus on disease, managing symptoms and undertaking prescribed interventions), which promotes the nurse's role as a function of task and seldom realizes their full scope of practice. In addition, it leads to (1) poor use of their knowledge and skills, (2) limited development, (3) inadequate client care, and (4) frustration and dissatisfaction for nurses.

As a result of this underutilization, nurses themselves do not really understand their scope of practice and how RN and LPN roles differ. In the past, RNs were educated at a college or diploma level. Today, LPNs receive very similar education, and, though RNs are now educated at university, the practice environment has never determined how to use this new knowledge to its full capacity. Consequently, there is an overlap and a misunderstanding regarding these two roles.

In a recent study (Doran et al., 2012), interviews with senior leaders and decision-makers in home care organizations revealed a range of criteria for allocating RN/LPN visits. Although the criteria are primarily based on matching a nurse's level of skill to patient characteristics and complexity, there appears to be some discretion and variance as to which factors are weighted most in allocation decisions.

Ongoing Education for Complex Needs

Today most nurses are educated as generalists, and in the past this preparation was sufficient to meet the needs of the client population in the community. As mentioned, however, home care requirements are changing, as many clients now have more advanced care needs. Shorter lengths on service make it difficult for nurses to be fully aware of the client's baseline health and social conditions as well as to educate clients and prepare them for discharge. Several interview participants said that many home health nurses lack the skills in chronic disease management to support clients with self-management and prevention activities. They suggested home health nurses require a different skill set, including client-centred teaching models, standardized approaches and toolkits to enable behaviour change.

While changes are occurring in the complexity of client need, there has also been a rapid expansion of clinical knowledge, drugs, medical devices and technologies. This expansion also has implications for home health nurses and their organizations, since it increases demands on nurses' time and may take them away from adequately performing some of their primary responsibilities (Institute of Medicine, 2003; Besner, 2004).

New Graduates

Several interview participants mentioned a lack of engagement among new nurse graduates. Many said that, in general, new grads are leaving the profession at an alarming rate due to a work-life imbalance, unhealthy work environments and the medical approach to care. Home care is a challenging environment for new graduates, because nursing students are not exposed to home health during their nursing education (and therefore do not consider it as a career option). Few nursing programs have a community nursing stream, and those that do quite often focus on public health nursing rather than home care. While home care programs across the country are receptive to clinical placements for nursing students and the recruitment of new grads, the need for clinical experience and robust mentorship programs cannot be underestimated.

System

Many survey respondents and interview participants suggested that barriers to optimized nursing practice in home care stem from a number of system issues, such as (1) “siloes” funding, accountability and practice; (2) the lack of coordination and management at care transition points; (3) inadequate and slow investments in technology for documentation, communication and remote monitoring; (4) limited resources for research; and (5) support for interprofessional collaboration.

Funding Models

Most interview participants identified the medical model of care as a prime barrier to the current health-care system. Because the medical model promotes a functional rather than a holistic approach to health care, the funding model that follows it offers little incentive or support for assessing and managing psychosocial factors. Although funding models for home care vary across Canada, generally, the pressures to contain costs result in narrowing nurses’ scope of practice and undervaluing nursing care (Besner, 2004). This results in home health nurses not being able to consistently address “health promotion, teaching and counseling,” and initiating, managing and evaluating resources (CHNAC, 2008, p. 8)

Since current funding models are so firmly based on containing costs and outcomes, health-care organizations are reluctant to accept changes in practice or use more innovative models. Some interview participants felt we should talk in terms of funding levels instead of funding models, since the amount of money rather than the models themselves are to blame. Whatever the root cause of the limitations on care, the reality is that health-care providers face an increased pressure to do more with less and to simply focus on the tasks at hand. Most participants feel that, from an overzealous quest for cost efficiency, there is now a dichotomy between what our aging population needs and what home health nurses and organizations are able to provide.

Most felt that, while present funding models make it difficult to use money correctly, no matter what a new model might look like, it should support collaborative practice and an interprofessional approach — and not be based on fee for service. The fee-for-service payment system has been shown as ineffective for client care, as reinforcing a focus on disease and as fragmenting care. Moreover, this approach is particularly difficult for older adults who struggle in reconciling information from multiple providers for multiple conditions while receiving multiple medications and treatments.

One interview participant said that when senior organizational leaders’ focus on “putting out fires” and the “bottom line,” they’re often trying to solve problems with unregulated workers rather than with nurses working to their full scope of practice. Enhancing nurses’ scope of practice requires a different frame of reference and model of care, and it appears that many leaders lack the insight and courage to make major changes to the current system.

Lack of Resources

The economic pressures rising across the country are putting pressure on home care to do more with less. As a result, there can be a lack of human resources, supplies, and equipment and community resources to which nurses can link their clients. A recent report on building and sustaining a work force in home and community care (Doran et al., 2012) suggests that we need effective strategies to address the projected nursing shortage — particularly in home care, where demand is expected to increase and disparities in supply have been greatest. To promote a stable nursing workforce in home care, we must consider nurses' needs at different stages of their careers. Although home care organizations have recently changed their hiring prerequisites to let new graduates enter home care, student placements, orientation, mentorship/preceptorship, and learning and career development should be strengthened to support home health nurse recruitment and retention.

As well, given the increasing number of nurses over the age of 50, it is vital to understand how to influence home care sector retention in the later career stage. We've paid less attention to retaining than to recruiting these nurses, and still less when it comes to older nurses (Storey, Cheater, Ford, & Leese, 2009). Clearly, distinguishing between different career stages as we develop and implement recruitment and retention strategies is essential. Like other nurses, home health nurses are interested in a good salaries, benefits and job security. Yet, based on the history of home health nursing and the funding models in some provinces, these are not always available. As a result, some nurses leave the sector for more stable conditions.

Most interview participants identified the need for an electronic health record, which would enable more information sharing and reduce duplication, but felt this was only possible with an infusion of funding. Several also recognized the need for more collaboration with key technology organizations such as Canada Health Infoway.

Lack of Communication

Effective timely communication is a particular challenge in home care where the nurse is always on the move. Because cellular telephones and personal digital assistants (PDAs) are not ubiquitous in home care, nurses have difficulty accessing clinical support, contacting team members and coordinating necessary supplies and equipment. Tablets, e-mail and text messaging are among the technologies being tested; however, interview participants reported that the home care sector lags in this area, which contributes to inefficiencies, poor interprofessional collaboration and the duplication of services and roles. Interview participants also noted the failure to link electronic home care records to other health-system data. This lack of coordination works against getting nurses' the knowledge they need and compromises their ability to synchronize with others. A related problem is the poor interface between providers working in the public system and those working through contracts with private agencies.

In a recent Change Foundation (CF) survey (2011), while respondents said their training had prepared them well to work with other providers, almost a quarter reported they did not feel part of a team. Among the reasons given were a lack of time for communicating with others; a failure to be compensated for the time required (i.e., not being paid for team meetings); and working largely in isolation (where they are not expected to communicate and coordinate with others) (CF, 2011; Besner, 2004). The lack of

communication may also be the cause of job dissatisfaction among regulated community health professionals (CF, 2011). Survey participants noted that timely access to quality information and the sharing of information among providers is central to the provision of care. Yet, many regulated health professionals were not satisfied with the information they were given for their first visit with clients. More specifically, they identified (1) insufficient information on the client's medical history; (2) difficulty getting information from family physicians; (3) the unavailability of hospital discharge summaries; (4) concerns about the usefulness and operability of client information systems; and (5) having to rely on the client to pass information on to other providers (CF, 2011).

Adding to this lack of information was having to contact other health or social service providers for client information about diagnostic test results, which almost a third of regulated health professionals said they had to do. A large percentage of respondents also indicated they were not aware when other health-care providers were involved in a client's care, had no access to other providers' plans, had to rely on the client to inform them of other providers' care or lacked the time to review care plans in the home (CF, 2011). Compounding this situation, more than 40 per cent of community RNs lack opportunities to discuss clinical or program issues or debrief with their colleagues or management (Underwood et al., 2009). Respondents spoke of ineffective hospital discharge planning and unrealistic expectations across the system. These issues create such a loss of confidence in home care that clients return to hospital instead of using the full scope of practice of the home health nurse and the rest of the primary care team.

In addition, almost two thirds of regulated health professionals reported having to ask their last client to repeat some or all of their health or care history and having to repeat an assessment or test for their clients (CF, 2011). The lack of communication during transition between sectors seems particularly challenging. Transitions were identified as an area where care is less than seamless and where poor coordination and integration of care occurred. For example, more than a quarter of respondents failed to be promptly informed about a client being moved from home to hospital (or other care facility) and about discharge plans when a client was sent home (CF, 2011).

Lack of Understanding Regarding Role

We must understand exactly what home health nurses do if we are to ensure the care they give is appropriate, of the highest quality and capable of maximizing health outcomes. A key way to optimize home health nursing may be to help clients, nurses, organizational leaders and others across the health-care system better understand their role. Clients have a poor understanding of service-provider roles, according to two recent studies, one of which focused specifically on community nurses (CF, 2011; Underwood et al., 2010). Only 55 per cent of RNs and 66 per cent of LPNs agreed that clients understood their roles or trusted nurses from their agency and worked in partnership with them to achieve good care. This response was further validated by the several interview participants who felt the lack of understanding of the role of home health nurses is a key factor in underutilization, although it might also have occurred because the role may be operationalized in different ways in different locations across Canada.

Example: In Saskatchewan a universal care model, based on the Southcentral Foundation (SCF) in Alaska, promotes integrated care emphasizing employee knowledge and skills and a multidisciplinary approach. All non-clinical work is given to medical assistants, so nurses can focus on client health-care needs, especially chronic-disease management.

The role of nurses in home care includes an ongoing oversight of clients, which we most often refer to as assessment, monitoring or evaluation. Through this practice, home care nurses can detect the potential risk of errors or adverse events and prevent avoidable health problems or complications associated with illness, injury or treatment (IOM, 2003). Yet, the staff mix changes undertaken during the past few years to meet these patient requirements (as a result of cost containment and restructuring) has contributed to role ambiguity among registered nurses and registered practical nurses (Besner, 2004).

DISCUSSION

The health system is changing. We're moving from an episodic, acute-care system serving the health requirements of a younger population to one responding to individuals with longer term chronic care needs. This shift reflects both the advances in health care, which are enabling individuals to live longer with conditions previously believed to be life-ending, and the wave of aging "boomers." While healthier than previous generations, seniors can expect to develop chronic health conditions as they age. Not only can such individuals be managed in the community, most prefer to remain at home. To support this goal, all provinces and territories provide publicly funded home care programs.

Home care is cost effective and care effective, yet moving health care to the home also means more responsibility for the clients themselves and for other family caregivers. "Family caregivers" provide care and assistance for spouses, children, parents and other extended family members and friends in need of support due to age, illness, injury or disability (Canadian Caregiver Coalition, 2008).

Our society assumes, and expects, that Canadians will shoulder this caregiver role. However, the growing number of seniors, particularly those in their eighties and nineties (a rapidly increasing group), raises questions about whether families and caregivers can provide the level of care needed to safely maintain a given population in their own homes.

Understanding the needs and preferences of care recipients and family caregivers is critical when considering the role of the health-care team — more specifically, the role the home health nurse (who respondents consider to be mainly RNs or LPNs/RPNs). Generally speaking, those involved in home care, including policy-makers and other health-care stakeholders, see an opportunity to expand the role for its value, its cost effectiveness and, more importantly, its appeal to clients, who overwhelmingly want to receive care at home.

This exploration sought to uncover the enablers and barriers that would optimize the scope of practice and enhance the capacity of nurses who practise in home care. The themes uncovered were consistent across the country — arising out of a depth of knowledge about nursing and the health-care system and from a passion for home-based care — and showed obvious opportunities for nurses to do more at the point of care. Yet, with few exceptions, most survey respondents and interview participants felt that the current underutilization of nursing is a symptom of a siloed and overburdened system too strongly focused on acute-care. We repeatedly heard concerns about increasing demands that coincided with a shortage of resources (time, people, technology and money). While home health practitioners "make do" and pride themselves on their resourcefulness, the lack of support makes it more difficult — for example, the refusal to use technologies in home care that have demonstrated compelling efficiencies and improvements in access to care, support for family caregiving and in outcomes.

The current policy shift to a community health-care strategy has generated greater awareness about home care as well as further study to assess its impact and to understand how the resource might be leveraged. The emphasis on tasks in nursing still runs across most disciplines in home care. Performance continues to be measured in terms of process indicators — for example, time spent, numbers of clients visited, average numbers of visits, length of stay on the program. However, more recently the value of home care service has drawn a new focus across the country. Here, strategies to demonstrate outcomes specific to patient populations (identified in British Columbia, Saskatchewan, Ontario and Nova Scotia) are presenting

opportunities for nurses to practise holistically as accountable members of a care team (in accordance with best practice) and to realize clinical and quality-of-life outcomes.

Nursing is a specialized area of practice and is the most used professional resource in home care. Home health nurses are highly skilled and have strong interpersonal skills that support a client-centred approach. Those respondents who indicated that their home health nurses practise to full scope all saw the nurse (RNs, LPNs/RPNs, primarily) as part of an interprofessional team working toward care objectives. Although some nurses use frameworks and decision-making models provided by regulatory bodies, it was suggested that health care organizations operationalize and clarify nursing roles to avoid confusion and reduce any fears or conflicts. A respectful, truly client-centred model of effective teamwork is one that respects the individual contributions of each team member, while seeing care delivery in terms of “how much” intervention rather than “who” provides the care.

Where nurses are seen as more task oriented, a consensus arose on the need to better understand the potential of home health nursing and, indeed, of the broader health-care team practising to full scope.

To manage the diversity of clients and the complexity of care needs in the home, nurses require support from leadership and advanced practice specialists as well as ongoing professional development. They require more skills in chronic-disease management and cultural competency. More attention must also be given to home health nursing standards and competencies to assure consistent practice. This consistency could be achieved through (1) more rigorous, home care-specific CNA certification, (2) greater data collection and analysis to inform nursing-sensitive outcomes, (3) better home care education (for nurses and other professionals) at the university and college levels, and (4) improved strategies to help nurses make the transition into the home care workforce.

Respondents from across Canada spoke positively about the importance of NPs for supporting access to homebound and orphan patients in primary care and for providing clinical support to home health nurses. Yet they spoke less favourably about separating case management from care delivery. While unique to home care, this separation creates a “disconnect” between care, quality and accountability. The population approach, in contrast, challenges nurses to apply critical thinking and take a comprehensive approach to care.

Despite research suggesting that nursing intervention correlates highly with better outcomes, many interview participants noted an increased use of unregulated staff and worried about the long-term implications for the system and clients. So long as cost is the frame of reference for our decision-making, they saw us losing the opportunity to see health-care delivery from evidence and client perspectives — any decisions made out of this framework can only provide a temporary solution to our current health-care system issues.

Overall, this is a pivotal moment for nursing in Canada. We are on the threshold of change in home health nursing, and the future is promising. We have the opportunity to promote nursing, test new ways of delivering care and engage clients and their families in a more meaningful way. As a profession, we have the basic knowledge and skills to undertake the transformation, but ultimately, these won't be enough. We also need the voice of clients and their families in the home to help us design a system that connects people to the health and wellness care they want and deserve. So we have a moral and ethical imperative to engage health-care practitioners, educators, leaders, researchers and policy-makers so they will join us in sparking, spreading and sustaining the solutions.

CONCLUSION AND RECOMMENDATIONS

The “baby boomer bump” is impacting the way we provide health care and, consequently, the significance of home care and home health nursing. Home care is becoming increasingly prevalent and important to the health-care system. The home setting is conducive to a client-centred approach to care, which not only puts clients at the centre of care, but also supports them through the care continuum, rather than having providers and organizations working independently. Since care happens best where the person lives, partnerships involving home care ensures more effective care.

As central to care, home health nurses must focus on helping clients attain and maintain optimal health, wellness and independence. These aims can be achieved by intervening on specific client concerns, directing positive influences on health and advocating for institutional and structural change (Besner, 2004). For the nurse this means using the holistic client assessment process they were educated to provide, which includes an ability to evaluate all aspects of health and to identify, interpret and relate (often to other members of the health care team) how the client’s unique circumstances, goals and aspirations may inhibit or facilitate the acceptance, capacity and/or willingness to adhere to therapy (Besner, 2004).

Just as survey respondents and interview participants were critical of the current state of home care, they were impatient for the future of home care nursing, believing it could emerge as the preferred practice setting where nurses practise to full scope and are valued for their knowledge and expertise.

The following recommendations were developed out of the consultations for this paper to enable the optimization of home health nursing. Since the recommendations and actions are not mutually exclusive they should be considered as a whole. By implementing the recommendations, home health nursing will be coveted as a preferred practice setting in Canada.

Leadership

- ❖ Nursing organizations need to develop transformational leadership competency at all levels (individual nurse, organization and system) of home care nursing to facilitate advocacy, policy and infrastructure development, as well as coaching and change in practice.

Specific actions

- Nursing organizations and health science faculties to develop a home care nursing-leadership program that recognizes the significance of leadership at all levels, the challenges of supporting a mobile clinical team dispersed across the community and the importance of working with a diverse team of caregivers.
- F/P/T governments to work with home care employers to establish health and safety policies and regulations that support the mobile health-care workforce and the multiple work environments nurses practice in.
- F/P/T governments to build funding into home care budgets to support ongoing professional development and mentoring support for home health nurses.

- Health-system employers to establish a leadership career track and secondment opportunities for nurse leaders outside the sector. These programs will promote greater understanding, knowledge and partnerships to help achieve an integrated, interprofessional approach.

Key Success Indicators:

Short Term 0 – 12 months	<ul style="list-style-type: none"> • Transformational leadership program development, with specific components related to home health nursing underway in universities across Canada • Establishment of working groups in all F/P/T jurisdictions to explore the unique health and safety considerations in home care
Long Term > 12 months	<ul style="list-style-type: none"> • One health-system employer within each F/P/T jurisdiction can document a nursing leadership program that includes opportunities for secondment • Funding formulas with money specifically earmarked for home health nursing professional development, including updates on new medication, home health interventions, new technologies

Aligned health system

- ❖ Governments need to shift the funding and policy emphasis to new community-based, integrated health-care models, that include connections with primary care and are funded and equipped to provide state-of-the-art home care so Canadians can remain at home.

Specific actions

- F/P/T governments to shift the percentage of home care funding in their health-care budgets to reflect and realize the goals of population-based care through the recruitment and retention of home health nurses.
- Colleges and universities to establish a faculty community-health leadership position to oversee the integration of a community health and wellness approach in all health profession curricula, especially initiatives that are provided in the home.
- F/P/T governments and home health organizations to identify and pilot new delivery models that support the full scope of nursing practice, integration of NPs onto the home health-care team, client-centred care and alignment of initiatives across the care continuum.
- F/P/T governments and health-care organizations to identify and pilot new ways of practice with an interprofessional team approach to care, which will enable client-centred care with all team members practising to their full scope.

Key Success Indicators:

Short Term 0 – 12 months	<ul style="list-style-type: none">• The establishment of a working group at the university level to explore a “community health leader” faculty position in universities across the country
Long Term > 12 months	<ul style="list-style-type: none">• Increase the share of the home care funding percentage within the total F/P/T health-care budget year over year• Develop care that considers the needs and risks for specific populations and involves home health nurses more in coordinating care, mitigating risks and assisting clients in navigating the system.• Provide more care in the community with home care nurses providing care for those with greater acuity and complex needs• Ensure equitable compensation and benefits across the health system

Nursing Proficiency

- ❖ Governments and nursing organizations must clearly articulate the full scope of practice for home health care nursing to help the health system shift successfully to client-centred community care.
- ❖ Universities and colleges across the country need to establish a portable, core nursing curriculum that includes standards/competencies for Canadian home health nursing.

Specific actions

- CNA to convene a meeting of provincial, territorial and national leaders and ministry staff to review, discuss and establish scope of practice guidelines for home health nursing.
- The federal government to launch pilot projects testing new, full scope of practice to optimize the role of home health nurses.
- CNA to review entry-to-practice competencies with key home health care leaders to ensure they meet the requirements of full scope of practice home health nursing.
- Colleges and universities to establish knowledgeable and skilled home health nurse experts on faculty.
- Colleges and universities to establish new community health programs with courses on effective nursing interventions that enable successful client self-management of chronic disease and support of the older adult.
- Colleges and universities to establish mandatory clinical placements in home care settings, allowing all nursing students to apply new knowledge and skills and receive ongoing mentorship and support.
- F/P/T governments and colleges and universities to supply employers with resources to enable student placements at undergraduate and graduate levels.

Key Success Indicators:

Short Term 0 – 12 months	<ul style="list-style-type: none">• CNA established working group to review scope of practice and entry-to-practice guidelines for home health nursing• A relaunch of guidelines• Develop an implementation plan to pilot test the expansion of nursing caseloads, which will include more assessment, case coordination, navigation, chronic-disease management and care of older adults
Long Term > 12 months	<ul style="list-style-type: none">• CNA established home health nurses working group to advise on education and ongoing professional development, including interprofessional approaches• New community programs at colleges and universities to include courses for nursing specific to enabling chronic disease self-management, caring for the older adult, using best practices and working with families• Mandatory home health clinical placements embedded in nursing curricula across the country• An increase in the number of nursing student placements in home health organizations• Home care employers reporting ability to support student placements• An increase in the number of nursing graduates expressing interest in home health nursing as a career choice• Provide an opportunity to obtain CNA certification in home health nursing• Greater role for home health nursing in primary care, including home visits, holistic assessment, case coordination, navigation, chronic-disease management, care of older adults and coaching, and links with other community organizations to maintain health and wellness

Interprofessional Respect

- ❖ CNA to lead the establishment of a national home health coalition of employers, educators, researchers and nursing organizations from across Canada that champions and promotes home health nursing and celebrates and honours the contributions of all team members.

Specific actions

- CNA to work in with partnership with professional organizations, such as the Canadian Medical Association, the College of Family Physicians of Canada and rehabilitation therapies, to further define full scope of practice and the intersections and synergies between home health-care providers.
- Members of the coalition to host a biannual “mega conference” focusing on excellence in collaborative practice and criteria of practice among multiple members of the care team (formal and family) in the community.
- Establish a national endowed research chair in home health nursing.
- Disseminate innovations in home health nursing through various mediums that reach and inform the public, health-care teams and the broader system.
- CNA to undertake to identify champions for home health nursing among influential leaders at the federal/provincial/territorial levels
- CNA to promote the creation of awards for nursing that honour and reward excellence in home health nursing practice.

Key Success Indicators:

Short Term 0 – 12 months	<ul style="list-style-type: none">• CNA established interprofessional working group to examine scope of practice between members of the health team• Establishment of a planning group to host first biannual interprofessional conference
Long Term > 12 months	<ul style="list-style-type: none">• CMA and other health colleges established honorary nurse award• Endowed research chair in home health nursing established for Canada• Home health nursing champions identified in each province/territory and federally• Greater clarity about the role, full scope of practice and value of the home health nurse• New delivery models that reflect greater integration across professions and sectors, including primary care, acute and long term care

Technology

- ❖ Governments need to incent the increased use of technology in home care to enable greater client education and self-management, remote client monitoring by the care team, point-of-care electronic documentation, improved communication and more effective use of all health-care team members.

Specific actions

- Create provincial/territorial technology advisory committees to provide ongoing guidance to policy-makers, partners of education, workplaces and academia on the issues, trends and factors impacting home health nursing.
- Establish an innovation fund to support the testing of technology to leverage and optimize the capacity of the home health nurse.
- F/P/T governments to develop a technology-implementation plan responsive to successfully tested innovations and the needs of home care providers/clients.
- Strengthen partnerships between technology providers and home health care to influence and guide innovation and to support the deployment of resources and their adoption across the country.

Key Success Indicators:

Short Term 0 – 12 months	<ul style="list-style-type: none">• Establishment of home health nursing technology advisory committees within each F/P/T jurisdiction• Creation of technology and home health care provider working group
Long Term > 12 months	<ul style="list-style-type: none">• Innovation fund established• Home care technology-implementation plan established• Technology established as an integral component of the home care nurse's resources, enabling more effective and efficient practice• Greater emphasis on best practice and use of data to inform care is evident at the individual and system levels through the use of technology at the point of care

APPENDIX 1

Survey Questions

- From what jurisdiction are you responding?
- Thinking about home care nurses, is the above definition of home care nursing consistent with your understanding? If no, how do you define home care nursing?
- Is the above definition consistent with what you currently see happening in practice? If no, what are the current gaps?
- Do you believe that home care nurses are working to full scope of practice? If no, what are the current gaps?
- Please describe the enablers to optimize scope of practice in home care.
- Please describe the barriers to optimal scope of practice in home care.
- Are home care nurses in your setting active members of the interprofessional care team? If no, please explain why.
- How do home care nurses contribute to the interprofessional care team?
- Do you see an increased role for nursing in home care? If yes, what role do you see emerging?
- Do you have home care NPs in your area?
- What is the role of NPs in home care in your setting?
- Do you believe that there will be an increase in demand for NPs in home care? If yes, why?
- Please describe what you believe to be a leading practice in home care nursing relating to the optimization of scope.

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