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Teaching and assessment strategies for nursing self-care competencies in Ontario's nursing education programs

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A B S T R A C T

In Canada, nurses comprise half the healthcare employment sector, yet comparably, they are twice as likely to experience absenteeism due to occupational burnout. This issue is pronounced for entry-level nurses. The College of Nurses of Ontario (CNO) mandates professional practice standards and entry-level practice competencies; notably, these documents lack explicit performance expectations linked to nursing self-care. This lack of acknowledgment is reflected in what is known, which is little, about how self-care competencies are taught and assessed in nursing education programs. From a Program Director perspective, this study examined the strategies used to teach and assess self-care competencies in Ontario's nursing education programs. Survey results ($n = 8$), reported intention-action gaps highest (i.e., there is a need for increased teaching), in self-care competencies not mandated by the CNO (i.e., *relationship*, *emotional*, and *spiritual* self-care), whereas competencies mandated by the CNO (i.e., *professionalism*), were rated higher in relative teaching than importance. Given that self-care strategies (e.g. maintaining healthy interpersonal relationships and engaging in spiritual growth and mindfulness) have shown to be protective factors against workload stress, burnout, and job attrition, regulatory colleges need to consider mandating these self-care competencies within their professional practice standards and entry-level registered nurse practice guidelines.

1. Background

In Canada, nurses are the largest group of health regulated professionals. They comprise almost half of the healthcare employment sector (Canadian Institute for Health Information, [CIHI], 2018). In Ontario alone, this includes more than 140,000 registered nurses (RN), registered practical nurses (RPN), and nurse practitioners (NP), (Registered Nurses Association of Ontario, [RNAO], 2017). Compared to other employment sectors, the statistics are staggering. Nurses are twice as likely to be absent from their job due to illness or injury (Berry and Curry, 2012). In 2016, this equated to an average of 24, 600 regulated nurses, each week, who were absent from their job (RNAO, 2017). In addition to absenteeism, almost 20% of nurses employed in Ontario hospitals, resign their jobs on an annual basis (RNAO, 2017). The economic burden that absenteeism and turnover pose on the Canadian healthcare system has been approximated to two billion dollars annually (RNAO, 2017). According to the Canadian Federation of Nurses Unions ([CFNU], 2017), “Public healthcare employers paid \$989 million in 2016 for illness or disability-related absenteeism costs; the total cost of unpaid and paid nursing overtime was an additional \$968 million” (p. 1).

The reasons for the high turnover and absenteeism rates in the Canadian nursing sector have largely been attributed to excessive

workload and occupational burnout (Berry and Curry, 2012; CIHI, 2017; RNAO, 2017). It has been well documented that work overload, stress, compassion fatigue, and occupational burnout have negatively impacted the sustainability of practicing nurses in Canada (Berrios et al., 2015; Epp, 2012; Harwood et al., 2010; Wu, Singh-Carlson, Odell, Reynolds, & Su, 2016). This issue is even more pronounced for nursing students and entry-level nurses who are developing their clinical proficiency, while at the same time, learning to manage work-life balance (Babenko-Mould and Laschinger, 2014; Boamah et al., 2017; Gibbons, 2010; Hensel and Laux, 2014; Laschinger et al., 2015; Laurencelle and Scanlan, 2018; Price et al., 2018; Reyes et al., 2015).

In Ontario, RNs, RPNs, and NPs are required by the College of Nurses of Ontario (CNO) to maintain and sustain professional practice standards throughout their careers. The CNO's (2002/2009) *Professional Practice Standards* document provides an overall framework for the professional practice of nursing competencies that reflect “the professional expectations of nurses and applies to all nurses, in every area of practice” (p. 3), including nurses in the roles of administrators, educators, and researchers. The CNO's (2002/2009) *Professional Practice Standards* are currently organized into seven categories: 1) accountability, 2) continuing competence, 3) ethics, 4) knowledge, 5) knowledge application, 6) leadership, and 7) relationships. According to the CNO's continuing competence standard:

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Table 1
Nursing self-care competencies defined.

Competency	Definition
Professional	activities to help students commit to act consistently with personal and professional values
Physical	activities to help students stay fit and healthy so they have enough energy to get through their work and personal commitments
Psychological	activities to help students stay mentally healthy and to rationally engage with professional challenges found in their work and personal lives
Emotional	activities to help students identify, understand, and express emotions in healthy ways
Relationship	activities to help students maintain healthy and supportive relationships in their work and personal lives
Spiritual	activities to help students develop a sense of perspective and meaning beyond day-to-day life

Competence is the nurse's ability to use her/his knowledge, skill, judgment, attitudes, values and beliefs to perform in a given role, situation and practice setting. Continuing competence ensures that the nurse is able to perform in a changing healthcare environment. (p. 5)

Key competencies, as outlined within the CNO's (2014) *Competencies for Entry-Level Registered Nurse Practice* guideline, are used by the CNO "in the evaluation of baccalaureate nursing education programs to ensure that the curriculum prepares graduates to successfully achieve professional practice standards upon entry" (p. 3). Within Canada, some nursing colleges, such as the College of Nurses of British Columbia ([CRNBC], 2012), specifically link physical, psychological, and emotional self-care competencies to their professional practice standards and competency requirements. Within Ontario, however, this is not the case. Of the five entry-to practice RN competencies identified by the CNO (i.e., 1) professional responsibility and accountability, 2) knowledge-based practice, 3) ethical practice, 4) service to the public, and 5) self-regulation), professional responsibility/accountability and self-regulation are the two competencies most linked to self-care. The definition of these competencies and examples of what these competencies look like in practice, nonetheless, are vague. For example, as part of the CNO's professional responsibility and accountability competency, a nurse must:

Demonstrate accountability and acceptance of responsibility for one's own actions and decisions; [and] Recognize individual competence within the legislated scope of practice and seeks support and assistance as necessary. (p. 5)

As part of the CNO's self-regulation competency, a nurse:

Demonstrates continuing competence and preparedness to meet regulatory requirements by: (a) reflecting on one's practice and individual competence to identify learning needs; (b) developing a learning plan using a variety of sources (e.g. self-evaluation and peer feedback); (c) seeking and using new knowledge that may enhance, support, or influence competence in practice; [and] (d) implementing and evaluating the effectiveness of one's learning plan and developing future learning plans to maintain and enhance one's competence as a registered nurse. (p. 10)

Neither competency statement outlines performance expectations related to nursing self-care. This lack of acknowledgment of self-care may be related to assumptions that this competency has limited utility or importance in nursing and thus, in nursing education. Lack of acknowledgment of the need for self-care competency is reflected in what is known, which is little, about how self-care competencies are taught and assessed in nursing education programs in Ontario. Similarly, nursing education literature is characterized by a lack of information related to the way self-care competencies, as protective strategies against workload stress and occupational burnout, are addressed in nursing education curricula. Most research on nursing self-care education has centered on the negative outcomes of professionalism, (i.e., stress and burnout), rather than on positive ways to teach and assess it in relation to continuing competence as part of the professional nursing

role (Enns et al., 2018; Scammell, 2016).

1.1. Purpose

To help support the development and implementation of self-care curricula in Ontario's nursing education programs, this study examined, through the lens of Program Directors, the educational strategies used to teach and assess self-care competencies as part of the professional nursing professional role.

2. Method

A descriptive cross-sectional research study was designed to gather information about the way self-care competencies are taught and assessed in Ontario's nursing education programs. The data collection instrument used for this study was a 15-item online survey questionnaire. Survey questions, designed to evaluate self-care competencies, were adapted from those used by Warren et al. (2014) and Chou et al. (2008) in studies that examined the educational strategies for professionalism as part of the CanMEDS competency framework. This study explicitly focused on the educational activities and attitudes related to self-care competencies rather than overall professional competencies, which is different from the studies by Warren et al. and Chou et al.

Nine categories of self-care competencies related to nursing education and practice were used in this study. Three self-care categories were selected from the CanMEDS professional role competency framework. These included: 1) the assessment of one's personal health and well-being, 2) the resilience to cope with stressful situations, and 3) the capacity to navigate self-care resources. An additional six categories of self-care competencies (see Table 1), adapted from the *Homewood Health (2016) Self-Care Starter Kit*, were included in the survey. These were: 1) professional self-care (i.e., activities to help students commit to act consistently with personal and professional values), 2) physical self-care (i.e., activities to help students stay fit and healthy so they have enough energy to get through their work and personal commitments), 3) psychological self-care (i.e., activities to help students stay mentally healthy and to rationally engage with professional challenges found in their work and personal lives), 4) emotional self-care (i.e., activities to help students identify, understand, and express emotions in healthy ways), 5) relationship self-care (i.e., activities to help students maintain healthy and supportive relationships in their work and personal lives), and 6) spiritual self-care (i.e., activities to help students develop a sense of perspective and meaning beyond day-to-day life). Before being electronically administered, survey questions were reviewed for clarity, relevance, and ease of completion by a nursing student and nursing faculty member who were not participants in the study.

Research ethics clearance for this research was obtained from Brock University's Research Ethics Office prior to study commencement. Participant recruitment for this study followed a total sample approach. In the winter of 2018, study invitation e-mails were sent to all Program Directors (n = 38) of undergraduate nursing schools in Ontario. E-mail addresses were obtained from institutional program directories and websites. Informed consent was obtained through e-mail upon survey

commencement and emphasized that participation was voluntary and anonymous. The e-mail invitation included a link to the online survey questionnaire, which was launched through [SurveyMonkey.com](https://www.surveymonkey.com), a secure online, privacy-protected software service that specializes in survey administration. Survey reminders were sent four weeks following the initial survey e-mail invitations. Responses were received over an eight-week period.

Thirteen questions were designed to collect categorical data and two questions were designed to collect open-ended response data. The first three questions were used to collect demographic information (i.e., type of nursing program taught, the types of self-care competencies taught, and the training years in which self-care competencies are taught). The next ten questions were used to collect information about the instructional and assessment methods used to teach and evaluate self-care competencies, as well as attitude information about the satisfaction, importance, and the ease or difficulty in which self-care competencies are taught and assessed. The final two questions asked participants to describe potential barriers in teaching and/or assessing self-care competencies within their nursing education programs.

To illustrate the divergence between respondents' ratings of self-care importance (i.e., intention) versus teaching (i.e., action), an *intention-action gap* was calculated (see [Table 2](#)). Intention-action gaps were calculated using a method proposed by [Warren et al. \(2014\)](#), where the relative teaching frequencies were subtracted from the weighted importance ratings, after they were converted to relative frequencies.

3. Results

Of the eight Program Directors who responded to the survey (21% response rate), five reported that their programs were registered nursing programs, two were registered practical nursing programs, and one was a combination of both registered nursing and registered practical nursing programs. All respondents indicated that their programs taught professional self-care and six of the respondents indicated that their programs taught students about personal health and well-being in addition to resilience in coping with stressful situations. Five respondents indicated their programs taught physical self-care competency, and four respondents indicated that their programs taught students how to develop a capacity to navigate self-care resources, psychological self-care, and emotional self-care. Two respondents indicated that their programs taught relationship self-care and spiritual self-care (see [Fig. 1](#)).

When asked in what years self-care competencies were taught, all respondents indicated teaching took place during the first year, with follow-up teaching occurring in the second to fourth year. When asked how self-care competencies were taught, *formally in the classroom* was rated as the most frequent method across all nine self-care categories, followed by *informally in the classroom*. When asked what methods were used to teach self-care competencies, *student-faculty interactions* and *group discussions* were rated as the most utilized. In all cases, faculty



Fig. 1. Self-care competencies taught.**

**Note: Respondents were asked to “check all that apply”.

within the nursing program were responsible for teaching self-care practices and respondents were either *very satisfied* or *satisfied* in the way self-care practices were taught. When asked what methods were used to assess self-care competencies, *reflective journals* and *faculty feedback* were rated as the most utilized, followed by *peer feedback*. In all cases, faculty within the nursing program were responsible for assessing self-care practices, and respondents were either *very satisfied* or *satisfied* with the way self-care practices were assessed.

When asked to indicate the difficulty of teaching and assessing self-care competencies, across all nine self-care categories, respondents indicated assessment was more difficult than teaching (see [Fig. 2](#)). When asked to rate the importance of teaching self-care, respondents indicated that all nine self-care categories were *moderately to extremely important*. When the rated importance is higher than the reported teaching, the intention-action gap is positive (suggesting there is a need for more teaching). When the reported teaching is higher than the rated importance, the intention-action gap is negative (suggesting there is an over-emphasis in teaching). In this study, relationship and spiritual self-care had the highest positive intention-action gap, followed by emotional and psychological self-care. This suggests that the importance of these topics is rated higher than the actual teaching provided and therefore, more teaching is needed in these areas.

When participants were asked to describe barriers in teaching or assessing self-care practices as part of their nursing education program, two key themes emerged: 1) challenges in assessment relate to the way students enact self-care knowledge in authentic learning and practice situations and, 2) the current nursing curriculum is already content dense. These sentiments are explicitly reflected in the following statements from participants:

“In general, I think that assessing knowledge of self-care would be much easier than assessing whether or not individual students enact this

Table 2
Self-care intention-action gap (rated importance versus relative teaching).*

Self-Care Competency	Importance (Weighted Average)	Intention (Relative Importance,%)	Action (Relative Teaching, %)	Intention-Action Gap
Spiritual self-care	4.71	67.3	25.0	42.3
Relationship self-care	5.00	71.4	25.0	46.4
Emotional self-care	5.14	73.4	50.0	23.4
Psychological self-care	5.00	71.4	50.0	21.4
Capacity to navigate self-care resources	4.86	69.4	50.0	19.4
Physical self-care	4.57	65.3	62.5	2.8
Assessment of personal health & well-being	5.00	71.4	75.0	-3.6
Resilience to cope with stressful situations	5.14	73.4	75.0	-1.6
Professional self-care	5.14	73.4	100.0	-26.6

*Note: The intention–action gap is calculated by subtracting the relative percentage reporting teaching (action) from the relative percentage of rated importance (intention) for each competency category. Positive action gaps indicate a lower teaching percentage than rated importance, which suggests the need for increased teaching in those areas.



Fig. 2. Difficulty (weighted average) of teaching and assessing self-care competencies.***

***Note: Difficulty was assessed using a 4-point Likert scale, where 1.0 = very easy, 2.0 = easy, 3.0 = difficult, and 4.0 = very difficult.

knowledge. I am sure we could all identify an area of self-care that is lacking and most likely as health care providers, we already have the knowledge of what we should do ... however, are actions actually taken?" (Participant 8)

"While it [self-care] can be in the curriculum, it is not always at the right moment to address issues - it is best informally in clinical settings or when students seek advice or help individually." (Participant 4)

"The biggest barrier is the amount of content and evaluation that already needs to be done in 16 months in order to fulfill the entry to practice competencies. Although these [self-care] practices are absolutely important, they may not be as important as other content." (Participant 6)

4. Discussion

Nurses, as well as other professional healthcare practitioners, work in a reciprocally dynamic role in which their health and well-being directly impact their professional competence and vice versa (Smith, 2017). This interchange of personal self-care practice and professional competence is often understated within the legislative framework of professional practice guidelines. Nursing education programs teach and assess what their regulatory colleges mandate. We see this reflected in our study results. The topic of *professionalism*, as mandated by the CNO, is taught in all nursing education programs surveyed. Other self-care competencies, (i.e., *relationship*, *emotional*, and *spiritual* self-care) not mandated by the CNO are not necessarily being taught in the nursing education programs that were surveyed. Professionalism, as articulated in competency statements and standards, fails to explicitly include self-care and may be over-emphasized in teaching. Teaching over-emphasis was indicated by a negative intention-action gap where the importance of professionalism (i.e., intention) was rated as less than the relative teaching (i.e., action). Analysis of intention-action gaps in emotional, relationship, spiritual, and psychological self-care competencies suggests the opposite. These four areas had the highest intention-action gaps which suggest a need for more teaching. Self-care strategies such as maintaining healthy interpersonal relationships, engaging in spirituality and mindfulness, and emotionally connecting with others can lead nursing students and entry-level nurses to develop a positive nursing identity, professional nursing behaviours, and coping strategies (such as resilience), which ultimately leads to greater job satisfaction and sustainability (Cino, 2016; Hensel and Laux, 2014; Perez, 2016; Scammell, 2016). The findings of a positive intention-action gap in these self-care areas has significance for nursing education where prelicensure nurses begin to develop their nursing identity, components of which are healthy relationships and coping strategies that mitigate against stress, which can threaten the "optimal development of a professional identity during prelicensure education and as new nurses

transition to practice" (Hensel and Laux, 2014, p. 227).

In our study, all participants indicated that it is more difficult to assess self-care competencies than to teach them. Although very little research has been conducted to measure the difficulty and effectiveness of teaching self-care competencies in nursing education, results of this study are consistent with research in physician education, where self-care competencies are linked to the professional role. In general, medical educators have reported significant challenges in the ways that self-care competencies are taught and assessed (Chou et al., 2008; Holmboe et al., 2017; Jarvis-Selinger et al., 2012; Wald et al., 2015; Warren et al., 2014; Whitehead et al., 2015). In part, some of these challenges relate to the multifaceted social dynamics of professional identity formation (Cruess et al., 2015). Other challenges relate to the suitability of teaching methods and evaluation criteria reflective of this complexity (Wald et al., 2015; Warren et al., 2014). Typical teaching and assessment strategies that are used to instill and measure cognitive competencies in medical education (i.e., standardized practicums, high-fidelity simulations, knowledge tests, and in-training evaluations) do not accurately gauge successful learner self-care competency as part of professional identity formation (Holmboe et al., 2017; Wald et al., 2015; Warren et al., 2014; Whitehead et al., 2015). For example, it is easier to instruct and assess how to correctly insert a catheter than it is to teach and evaluate students' understanding and application of self-care practices. In part, this also relates closely to the ways in which nursing education is structured around task-based activities that are directed towards the patient-client as opposed to psychosocial education for nursing self-care such as practices that promote and enhance emotional, psychological, spiritual, and relationship self-care. Lack of emphasis on teaching in these areas, despite their perceived importance, as indicated in the intention-action gap analysis, may well reflect perceived difficulties in gauging acquisition of self-care competency, as well as the need to investigate further how self-care competencies can be effectively taught and evaluated.

A variety of interventions intended to increase self-care efficacy and coping, and to reduce anxiety and stress in nursing students, have included role-play, simulation, wellness courses, art therapy, and teaching of relaxation and meditation techniques (Turner & McCarthy, 2017). Most often, these interventions have been utilized in classroom and laboratory settings. Instructional strategies for anxiety and stress reduction, however, have shown to be most promising when performed in combination with cognitive reappraisal (Turner & McCarthy, 2017). In a recent study that involved Taiwanese nursing students, it was shown that the intentional inclusion of instructional workshops about resilience, paired alongside clinical preceptorship experience, was effective in helping students to identify specific sources of stress during their clinical placements (Liang, Wu, Hung, Wang, & Pen, 2019). In turn, students were able to develop increased confidence and resilience. Students also indicated that instructional strategies such as the use of reflective diaries, personal interviews, and group discussions, were most helpful in building support, communication skills, and a sense of belonging. These instructional strategies also helped to reduce students' sense of isolation and worry about their organizational skills or technical proficiency during their clinical placements.

4.1. Scope and limitations

The scope of this study applies to the educational activities and attitudes of self-care competencies in Ontario's nursing education programs, as examined through the lens of Program Directors. Due to the study design, a small number of participants were involved and the response rate was low (21%). A low participant response rate may have been affected by the online survey study design method and/or the target population (i.e., Program Directors) itself. Challenges associated with online survey research have suggested that, "reaching the target population through online methods poses certain difficulties. Email messages announcing surveys are frequently interpreted as junk mail

and are deleted without hesitation from the mailbox or automatically diverted by screening programmes” (Lefever et al., 2007, p. 576). Likewise, it should be noted, that although Program Directors have an overall understanding of the curriculum content (i.e., class format, educational expectations, and program deliverables) which uniquely positions them to inform our research topic, they also have onerous administrative and supervisory responsibilities, which may limit their time availability to participate in research. Results from this study, therefore, may be transferable, but not generalized, to other professional learning communities, especially those that require professional and regulatory licensing (e.g. medicine and the health and social services professions), where issues of capacity for self-assessment, self-care, and sustainable practice may be linked to the professional role. Participant practice locations and the social, cultural, and political characteristics of the communities in which participants work may also present confounding variables that may potentially disrupt the applicability of study results (i.e., a large urban teaching hospital versus a rural or remote distributed medical education centre).

4.2. Implications

Resilience is frequently cited as a possible buffer or protective strategy against stress in nursing students (Liang et al., 2019; Thomas and Asselin, 2018). It is thought to be enhanced by self-care practices such as proper sleep, exercise, and life-work balance between work and leisure. Also, learning to access social supports such as clinical faculty, who have a particularly important role in providing opportunities for students to debrief experiences and reflect, is thought to be another important self-care practice for nursing students (Thomas and Asselin, 2018). In an integrative review of resilience in nursing students, Thomas and Revell (2016) have suggested, that while social support is important in its development, resilience in relation to nursing students is still not well understood. Further, it is not clear whether or how specific teaching strategies, such as reflective journaling, role-play, and wellness courses for example, contribute to resilience or self-care in general. This remains an important area for future research, particularly in clinical practice, which has been identified as a particular area of stress and anxiety for nursing students (Grobeck, 2016; Liang et al., 2019; Thomas and Asselin, 2018; Turner and McCarthy, 2017).

5. Conclusion

Our study demonstrates that without explicit guidance from regulatory nursing colleges, self-care competencies that are important to nursing practice and job sustainability (i.e., *relationship*, *emotional*, and *spiritual* self-care) are not necessarily taught in nursing education programs. The relative lack of attention to self-care competencies in nursing professional practice standards and entry-to-practice competency guidelines may indeed be reflected in a gap between the perceived importance and teaching of self-care competencies within current nursing education programs. This gap may further be explained by the prioritization of other content, such as *professionalism*, that is perhaps easier to teach and assess, but less critical to the development of an identity that is able to sustain practice and professionalism through the acquisition of healthy, supportive relationships and coping strategies. The economic burden of absenteeism among the largest workgroup in Canadian healthcare and its attendant effects on patient-client care and the workplace, are critical considerations for healthcare and nursing. This may lend urgency to consideration that cognitive and psychomotor skills may no longer be sufficient training requirements for new graduates. Instead, if we believe that self-care is an important competency and that it is connected to sustainable nursing practice and the emergent professional identity of new nursing graduates, we need to consider turning intention to action through further exploration of how to teach and how to effectively assess acquisition of self-care competencies.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

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