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PERSONAL REFLECTION

Valuing tacit nursing knowledge during the COVID-19 pandemic

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Abstract

Public health nurses in Ontario, Canada, support the healthy growth and development of children across the province through a variety of programs including home visits for pregnant individuals and families with young children. During the COVID-19 global pandemic the needs of families increased while access to health and social services decreased. During this time, home visiting teams closely involved in supporting families also experienced staff redeployment to support pandemic efforts (e.g., case and contact management, vaccinations) and changes to the nature of home visiting work, including shifts to remote or virtual service delivery. To support nursing practice in this new and evolving context, a framework for capturing and sharing the tacit or *how-to* knowledge of public health nurses was developed. A valuing of this type of knowledge for informing future public health nursing practice – well beyond the pandemic response – was recognized as a pandemic silver lining when reflecting on two years of supporting home visiting teams in our province.

KEYWORDS
community health nursing, COVID-19, evidence-based practice, home visits, nursing practice, professional knowledge, public health nursing, public health

1 | INTRODUCTION

Since the late 1800s, Canadian public health nurses (PHNs) have provided home visits to families with young children to support healthy growth and development as well as improve socio-economic outcomes (Byrd, 1995; Hanks & Smith, 1999; MacDonald & Jakubec, 2021). In the context of Ontario, Canada, there are two home visiting programs delivered through the province's public health units: (1) Healthy Babies Healthy Children (HBHC) – a program delivered by all 34 health units for pregnant individuals and families with young children from birth to school entry with both universal (e.g., postpartum screening for risk factors for entire provincial birth cohort) and targeted services (e.g., blended home visiting program delivered by PHNs and para-professionals for those screening with risk) (Ministry of Health and Long-Term Care [MOHLTC], 2018); and (2) Nurse-Family Partnership® (NFP) (implemented by five public health units) – a program, which provides frequent PHN visits to young, first-time mothers experiencing social and economic disadvantage – starting early in pregnancy (<28 weeks gestation) and continuing until a child's second birthday (Olds, 2006).

During the COVID-19 global pandemic as public health measures were implemented to minimize transmission of the SARS-Cov-2 virus, there were observed increases in the needs of families across the province of Ontario. For example, the closure of schools and daycares

led to lost income as parents and caregivers were required to stay home with young children which led to greater food insecurity for some families. This was combined with decreases in the availability of and access to a range of health and social services. At the same time, home visiting teams typically involved in supporting young families in their communities were experiencing extensive workforce redeployment and broad changes to service delivery. These transitions required home visiting teams to rapidly make sense of how to do their work in this new and evolving context.

Early in the pandemic response, the Public Health Nursing Practice, Research, and Education Program [PHN-PREP] was established by a team of researchers at McMaster University (Hamilton, Ontario, Canada) in collaboration with public health nursing partners to advance public health nurses' knowledge, skills, and agency to deliver services to pregnant individuals and families with young children enrolled in home visitation programs. From this team's unique position collaborating with and supporting the province's home visiting nurses, this article will describe (a) the pandemic impact on home visiting in Ontario, Canada and (b) how this context led to the valuing of tacit or *how-to* knowledge – when traditional evidence to guide practice in new and evolving care contexts simply did not exist. A framework for capturing and sharing this type of knowledge is also described.

2 | PANDEMIC IMPACT ON HOME VISITING IN ONTARIO, CANADA

2.1 | Increasing complexity of families

A significant trend noted by home visiting teams from early in the initial pandemic response and throughout the "waves" that followed was the increased complexity among the families enrolled in the HBHC and NFP programs as well as the broader communities they served. Complexity was described as increased mental health concerns among parents and caregivers, greater food insecurity, increased substance use, and increased risk of violence in the home. Many of these complexities observed by home visiting teams were corroborated by findings from a survey conducted by researchers at the Offord Centre for Child Studies (offordcrentre.com) of over 7000 parents/caregivers, representing over 14,000 children across Ontario, during the first wave lockdown (Gonzalez & MacMillan, 2020). The survey reported negative impacts on parent/caregiver mental health, children's behaviors and wellbeing, family functioning, and access to resources such as food and necessary supplies, money for rent/mortgage, and access to usual healthcare. A second survey conducted exactly one year after the first and representing the third wave of the pandemic in Ontario reported continued negative impacts on parent/caregiver mental health, child mental health, family functioning, and access to resources, as well as high proportions of weight gain among parents/caregivers and children and concerns about the lasting impact of COVID-19 on learning and education (Gonzalez & MacMillan, 2021).

2.2 | Impact on home visiting workforce

In Ontario, the COVID-19 pandemic and associated public health measures implemented to limit virus transmission resulted in closures of schools and daycares as well as a broad range of businesses and services. For PHNs, the impact was seen in changes to how health promotion and disease prevention services were delivered (e.g., pivoting to remote or virtual telehealth mechanisms) as well as significant shifts from regular program delivery to pandemic response activities (e.g., case and contact management, mass vaccination, etc.). Findings from an environmental scan of Ontario's 34 HBHC and five NFP programs conducted during the first and second waves of the pandemic (March-November 2020) indicated most teams experienced greater than 50% of PHN workforce redeployment from home visiting duties to support COVID-19 efforts (Jack et al., 2021). This change in the number of PHNs available to support local home visiting programs resulted in a decreased capacity to complete in-depth assessments to identify risk and create family service plan goals (e.g., effective management of addiction/dependency, improve financial stability, positive parenting strategies, etc.) and an overall decrease in services delivered by home visiting teams. Additionally, PHNs who remained in home visiting program delivery had to transition to offering services in a rapidly changing "home visiting" landscape that included reduced in-person visits, adoption of technologies such as virtual videoconferencing, and decreased availability of and access to supplementary health and social services.

3 | PRACTICE-INFORMED GUIDANCE FOR HOME VISITING

3.1 | Need for tacit knowledge sharing to support service delivery

Evidence-based public health, with its focus on using the best available peer-reviewed evidence to guide decision making, is a cornerstone of public health nursing practice (Brownson et al., 2009). However, during an exceptional world event such as a global pandemic that led to unprecedented responses at all levels of society to protect the health and wellbeing of populations, explicit knowledge to guide actions was scarce or emerging at best. Consequently, to respond to the evolving needs of families, accommodate for PHN home visiting workforce challenges, and integrate the changes required across the home visiting landscape, tacit knowledge – or the nursing knowledge garnered from professional experiences (i.e., practice-informed), community contextual knowledge, and the knowledge of others (Kothari et al., 2011) – became an important evidence source to guide PHN practice in Ontario's home visiting programs.

In May 2020, a team of researchers, nurses, and public health collaborators from academic settings, public health units, and Public Health Ontario (the PHN-PREP project team) was established. Among the goals of this team, and a priority in the immediate pandemic response period, was eliciting, documenting, and disseminating the tacit knowledge of PHNs on home visiting teams. To this aim, a framework

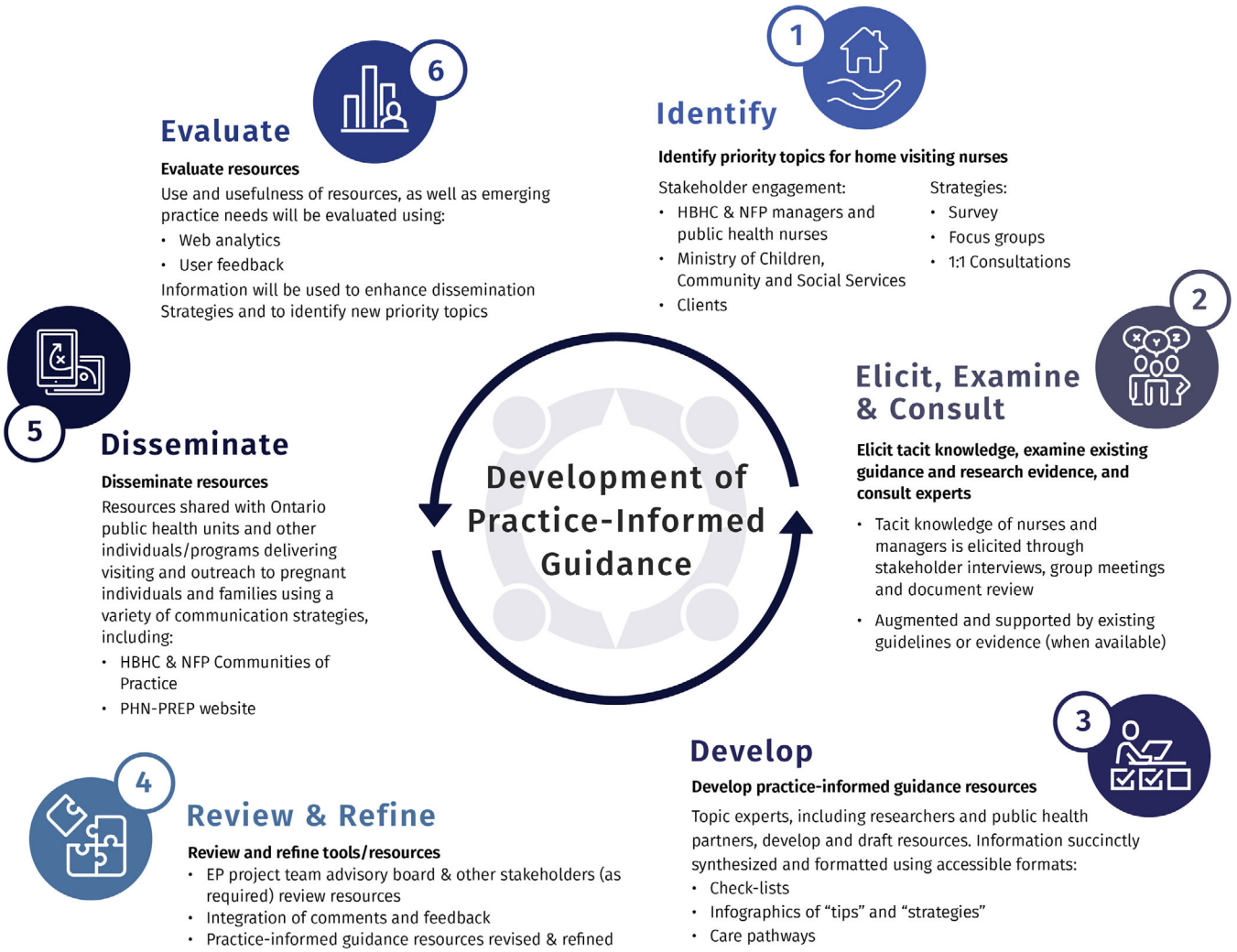

FIGURE 1 The PHN-PREP practice-informed guidance development and dissemination framework [Color figure can be viewed at wileyonlinelibrary.com]

was created for developing and sharing resources based on tacit or practice-informed knowledge, existing guidelines and/or research evidence (when available), and in consultation with content experts (see Figure 1).

The six-step framework includes: (1) identifying priority topics for home visiting nurses – a process that involves consultation with PHNs working in the field and other relevant stakeholders; (2) eliciting tacit knowledge (through PHN interviews and focus groups), examining existing guidance and research evidence, and consulting experts; (3) developing practice-informed guidance resources; (4) reviewing and refining resources – including consultation and review by a PHN advisory group; (5) disseminating resources; and (6) evaluating resources (adapted from: ECHO, 2019).

Priority topics to address emerging practice needs were identified through a PHN-PREP community of practice and through direct requests from nurses, nurse supervisors, and managers. For example, when indoor home visits were being limited to respect physical distancing measures, the topic of safely conducting in-person visits outdoors was raised by PHN stakeholders. The tacit knowledge of PHNs with experience conducting outdoor or "walking" visits was elicited during PHN stakeholder focus groups and summarized into a "how-to" style guidance document including considerations for weather, privacy, and infection-prevention (Campbell et al., 2021). Additional benefits of outdoor visits, including benefits to client mental health, were also documented. A critical component to the process of developing these resources was the input received by the PHN-PREP Advisory Board. This experienced group of PHNs and managers volunteered to provide additional feedback on how to contextualize the guidance to nursing practice standards and local contexts. Once reviewed and disseminated across the PHN-PREP network, public health units and PHNs had guidance to help inform decisions – such as, in this case, about incorporating outdoor visiting into their service delivery.

3.2 | Valuing tacit knowledge beyond times of crisis

The contextual changes to home visiting programs brought about by the pandemic, and the need to continue to support families with increasingly complex health and social needs, created an environment

where the tacit or practice knowledge of PHNs was a valuable resource for guiding home visiting practice. Moreover, as our team has reflected on the past two years supporting home visiting programs and through feedback from our PHN partners as well as general interest in and uptake of the guidance documents produced by PHN-PREP, we have realized that the valuing of this type of knowledge to inform public health nursing practice should continue beyond the pandemic recovery period. And while born out of pandemic necessity, it is our hope that our framework for the development of practice-informed guidance, including the pragmatic use of qualitative methods to harness or capture nursing "know-how" and the subsequent sharing of practice-informed guidance (e.g., through evidence networks or communities of practice) can continue to increase efficiencies across home visiting teams in a time where health and social care systems are over-burdened, yet the conditions are suited for change and innovation.

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DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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