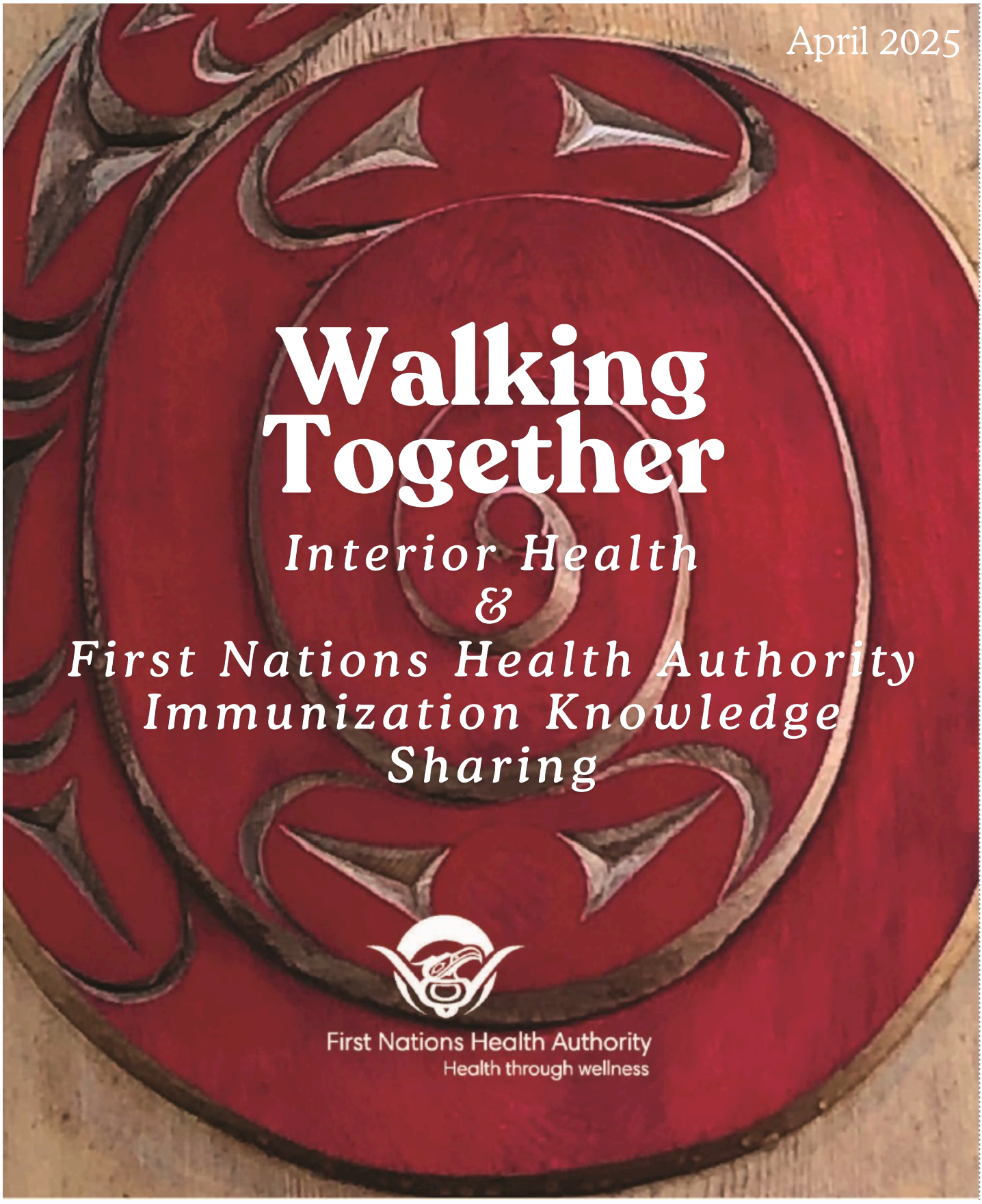

April 2025

Walking Together

Interior Health & First Nations Health Authority Immunization Knowledge Sharing

First Nations Health Authority
Health through wellness

Authors: Hermandeep Deo and Kara Bennett

Acknowledgements

We begin by acknowledging that the work of this project spanned across the traditional, ancestral and unceded territories of multiple First Nations within British Columbia (BC). This includes the territories of the Musqueam (xʷməθkʷəy̓əm), Tseil-watuth ((Stó:lō and Sə́lílwətaʔ/Selilwitulh), and Squamish (Sḵwx̱wú7mesh) Nations, where the work of First Nations Health Authority (FNHA) is centrally located. We thank the communities involved in the project: the Splatsin First Nation, who are the sourthernmost tribe of the Secwépemc Nation; the Syilx Okanagan Nation, including the Okanagan Indian Band and Lower Similkameen (Smelqmix) Indian Band. Our project gathering took place on the lands of the Syilx Okanagan Nation and the Westbank First Nation. We extend our gratitude to the Syilx Elder/Knowledge Keepers Pamela and Wilfred Barnes for warmly welcoming us to the land and generously sharing their knowledge and wisdom.

We recognize and express gratitude to the many Community Health Nurses (CHNs) and other nursing staff who shared their stories and experiences as part of the engagement and evaluation for this project. We recognize that CHNs play a vital and multifaceted role in delivering health services within the communities they serve—including, but not limited to, immunizations. It was evident through our many conversations with CHNs that they are passionate about their role; CHNs approach their work with the underpinnings of cultural humility, prioritizing relationship, mutual respect and trust as the overall framing of providing culturally safe care. To the CHNs who participated in this important work, we extend our sincere thanks for your enthusiastic engagement—without your contributions and the generous sharing of your experiences, we would not have the deeply informed and thoughtfully developed process that has shaped the success of this project. We also thank and acknowledge the Health Directors and managers from the Splatsin First Nation, Lower Similkameen (Smelqmix) Indian Band, and the Okanagan Indian Band for approving and providing support of their respective community's CHNs to participate in this project. Your support for CHNs and the project overall are deeply appreciated.

Acknowledgements continued

We express gratitude to the FNHA Skills Checklist Assessors working within the Interior Region who shared their experiences providing skills checklist sign-off for CHNs. Through rich conversations, we gained invaluable insight into the historical and current considerations of this crucial role. We extend our appreciation for the continued effort assessors invest in this work, often beyond their regular responsibilities, and recognize that this support is provided alongside already demanding workloads.

Our hands are raised to the Public Health Nurses (PHNs) and operations staff working in Interior Health (IH) for the work that took place through this pilot project in the various public health units across the Interior region. Their enthusiastic participation and support provided to CHNs was crucial to the success of this work. We sincerely thank the PHNs, Operations Staff, and CHNs for their leadership in piloting and shaping draft pathways and workflows that will pave the way for future practice.

A large part of this project involved cross-organizational collaboration. We thank our various partners who were heavily invested in the project: FNHA, including those on the Communicable Disease Population and Public Health Team and the FNHA Interior Regional Team; the IH Authority, particularly representatives from the Communicable Disease Prevention and Control Immunizations & Informatics program; and the Public Health Association of BC (PHABC).

We are grateful for Sam Bradd and Annalee Kornelsen from Drawing Change Consulting who graciously worked with us to capture the story of this project in beautiful illustrations.

The photograph on the cover is from Karl J. Robathan Photography, located on Dollarton Highway, North Vancouver. The spiral depicted in the image symbolizes self-awareness and the outward expansion of that awareness, representing a recognized symbol of the spiritual journey. This photo was used in the reports that came before this project, and we are honoured to include it here.

Finally, we want to thank the BC Immunization Committee (BCIC) for believing in and providing funding for this project.

Executive Summary

The IH and FNHA Immunization Knowledge Sharing Walking Together project represents a significant step forward in strengthening immunization service delivery for First Nations communities. Built upon previous BCIC-funded initiatives, in this pilot project we aimed to enhance mentorship opportunities for nurses by developing and testing a formalized workflow and agreement for collaboration between IH and FNHA. Through this work, we sought to support immunization competency, foster meaningful relationships between First Nations CHNs and IH Public Health, and address structural challenges that can contribute to immunization delays.

A key achievement of this project is the development of a Memorandum of Understanding (MOU, see Appendix 1), which formalizes collaboration between two health organizations built upon distinct worldviews—Indigenous and Western—yet united in their shared goal of achieving health equity and supporting nurses. This MOU is a tangible demonstration of reconciliation in action, moving beyond discussion to meaningful implementation. It serves as both a guiding framework and a commitment to strengthening relationships between health professionals and the communities they serve. IH and FNHA have signed an MOU for this mentorship model, and discussions with other health authorities across the province regarding MOUs are underway.

Public health initiatives like this one are often difficult to measure in terms of immediate outcomes, as they focus on prevention and long-term systems change. While the efficacy of a vaccine can be evaluated through clinical trials and coverage rates, assessing the broader impact of an immunization-focused mentorship program is more complex. In the context of rising nursing burnout and turnover across the province, a collaborative approach to supporting nurses in immunization delivery is both timely and necessary. The mentorship model that we describe in this report plays a crucial role in this shift, helping nurses build the skills, confidence, and connections needed to provide immunizations effectively and sustainably.

Despite the complexity of measuring systems change, this project has already shown immediate and tangible benefits. Piloting the mentorship has directly enabled additional CHNs in First Nations communities to begin providing immunizations—an important step toward improving equitable access to routine vaccines and strengthening community-based care. While it is too early to measure long-term impacts on nurse retention, the mentorship model is expected to contribute positively by increasing support, reducing professional isolation, and improving job satisfaction. Additionally, providing mentorship opportunities within communities reduces the need for rural and remote nurses to travel long distances for training, resulting in cost savings and a smaller environmental footprint.

Executive Summary continued

This project also created important opportunities for PHNs working in IH to engage more directly with First Nations communities, deepening their understanding of local context, history, and priorities. These experiences contribute to broader efforts to eradicate Indigenous-specific racism in health care by fostering respect, cultural humility, and relationship-based care. Beyond these measurable and anticipated outcomes, the IH and FNHA Walking Together initiative illustrates how strengthening the systems around immunization delivery is just as important as the vaccine itself. By addressing long-standing barriers and fostering sustainable mentorship models, we are not only improving health outcomes but also advancing equity in care.

The success of IH and FNHA Walking Together highlights the critical value of regional funding opportunities, such as the BCIC grant, that enable health organizations to implement quality improvement initiatives tailored to their specific contexts. This project demonstrates that mentorship models and collaborative approaches to immunization competency are feasible, impactful, and sustainable. However, sustaining and expanding this work requires ongoing investment. Continued funding opportunities are essential to ensure that mentorship and relationship-building efforts can grow, ultimately advancing health equity and fostering long-term, meaningful partnerships between health systems and Indigenous communities.

This project has been a major step forward, not only in improving immunization services but in strengthening relationships within our shared communities. We are immensely proud of the dedication, collaboration, and commitment demonstrated by everyone involved. The work accomplished here represents the long game in public health: bridging historical divides, building toward a new future, and ensuring that reconciliation is not just spoken about but actively realized.

We call on partners and decision-makers to join us in supporting collaborative nursing models that advance health equity in First Nations communities. Lasting change is possible when we walk together.

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Purpose

The purpose of this report is two-fold: to provide clarity and accountability for the work that was undertaken, and to offer a roadmap for organizations engaging in collaborative, cross-organizational efforts to improve the quality of health care services delivered in partnership with Indigenous communities. This report is intended for those committed to fostering an inclusive and equitable health care system—one that uplifts Indigenous communities by addressing and dismantling systemic barriers. It is a call to action to help shape a future where culturally safe and respectful care is not an aspiration, but the standard.

Within these pages, we describe the development and implementation of a mentorship model rooted in the belief that relationships are built on togetherness, team building, capacity building, nurturing, sharing, strength, love, and mutual accountability and reciprocity (FNHA, n.d.). While the focus of this knowledge-sharing journey is immunization practice, the principles and pathways described are relevant and transferable across many areas of health care provision.

Introduction

While our work impacts Indigenous communities and populations, we acknowledge that we are not Indigenous to the land on which we carry out this work. We gratefully accept the responsibilities and privilege of critical self-reflection, ethical engagement, and learning from Indigenous Elders, Knowledge Keepers, Speakers, Authors, Health Care Providers, and Individuals that have shared their knowledge for us to access along our collective journey.

The Interior Health and First Nations Health Authority Immunization Knowledge Sharing Walking Together project builds upon previous BCIC-funded initiatives aimed at improving immunization service delivery for Indigenous Peoples. In this pilot project, we set out to enhance mentorship opportunities for nurses by developing and testing a formalized workflow document and agreement that fosters collaboration between FNHA and IH Authority. Our goal was to support immunization competency by strengthening the meaningful connections between First Nations Community Health Service Providers and local Public Health teams.

By formalizing a collaborative workflow, this project addresses existing challenges that can lead to delays in routine immunizations, thus leaving communities vulnerable to vaccine-preventable diseases. A key focus of IH and FNHA's Walking Together initiative is recognizing and reinforcing the equal role of CHNs and PHNs in the delivery of immunization services. Ensuring CHNs working in First Nations Communities receive the same level of support as PHNs employed through regional health authorities is essential to achieving equity in care provision. Strengthening these professional relationships and creating clear, structured guidance for collaboration will contribute to a more effective and sustainable immunization program for Indigenous Communities.

The IH and FNHA Immunization Knowledge Sharing Walking Together project aligns with three key priorities of Immunize BC's Strategic Framework, specifically:

1. Improve access to immunization services
2. Ensure an adequate supply of knowledgeable, trained, service providers
3. Establish an immunization research agenda that includes the socio-cultural aspects of vaccine delivery and uptake (BC Ministry of Health, 2007, p. 23).

In this report, we outline the methods undertaken, the project goals, the co-creation of supporting documents, the implementation of a mentorship model in a pilot project, the evaluation of mentorship activities, and recommendations for organizations looking to undertake similar initiatives. It also provides guidance on organizational and systemic support and outlines next steps following the pilot's completion.

Background

As part of a previous BCIC-funded project, a literature review conducted by O'Connor et al. (2021) established short- and long-term recommendations to improve the provision of vaccine delivery in First Nations communities across BC through the exploration of alternate mechanisms of assessing of immunization competency among nurses. The long-term recommendation informing this project is: "Collaboration between FNHA and the [regional health authorities] for employee mentorship opportunities" (O'Connor et al., 2021, p. 25). For the full report including a scoping review, detailed evidence, and subsequent recommendations, please see O'Connor et al. (2021).

The 2024/2025 FNHA Summary Service Plan "Paddling Together: FNHA Health and Wellness Plan" invites partners to sit in the canoe with us to support FNHA's vision and tackle the waterway challenges it may face. Through the Walking Together initiative, a strong partnership has been forged. Moreover, this work aligns with strategic goals, specifically: Goal 2: "enhance access to quality health and wellness services" with an accompanying operational priority of "continue immunization education, competency registration, renewal and certification for Registered Nurses [RNs], Licensed Practical Nurses [LPNs] and student nurses across the province in First Nation communities" (p. 34). Goal 5: "drive health and wellness innovation together with First Nations and other partners" by "leverag[ing] innovative partnerships to advance creative and health and wellness initiatives" (FNHA, 2024, p .7).

To ensure a sustainable model for partnerships, FNHA began with one regional health authority (Interior Health), with the aim to expand to all the regional health authorities in the province following careful engagement and evaluation of the Walking Together initiative. In BC, there are five regional health authorities (Northern Health Authority, Interior Health Authority, Fraser Health Authority, Vancouver Coastal Health Authority, and Island Health Authority) with two province wide health authorities (Provincial Services Health Authority and First Nations Health Authority). Provincial Services Health Authority works in partnership with the province's health authorities and health care professionals to ensure that BC residents have access to a coordinated provincial network of high-quality specialized health care services. FNHA supports First Nations communities throughout the province while the regional health authorities are responsible for health care service delivery to all populations within their specific geographical boundaries.

Background continued

Through the "Indigenous Health and Wellness Strategy 2022-2026" IH (2022) has committed to: "Enhanc[ing] community relationships and engagement opportunities" (p. 28) and "support[ing] First Nations-led primary care projects in partnership with Nations, FNHA, and the Ministry of Health" (p. 32). In alignment with this commitment, PHNs, Educators, and Managers from IH have been key partners in this project work. The Public Health Agency of BC (PHABC, 2019) is an organization committed to promoting health equity through collaboration and engagement, and provided consultation throughout the project. The CHNs that participated in this pilot project are employed through First Nations communities directly (through First Nations Health Service Organizations or FNHSOs), with FNHA providing a supportive role in upholding the right of self-determination. The involvement of the CHNs was approved and welcomed by the Health Directors of their communities; a role held by a person that is appointed by the Nation's Council to prioritize the health needs of the community. Accordingly, this model of care is supported by the United Nations Declaration on the Rights of Indigenous Peoples Act (2021). The work described in this report would not have been possible without the cross-organizational efforts of all partners involved.

Background: Immunization Provision in BC

The Public Health Agency of Canada has established national immunization competency standards for health professionals, which have been adapted for the provincial context by the BC Centre for Disease Control (BCCDC, n.d.). These standards form the foundation of what is considered the gold standard for immunization education in BC. The BCCDC Immunization Competency Course, recommended for all nurses administering immunizations in BC, consists of two parts. The first is an online course and exam, Immunization Competency for BC Health Professionals, available through the Provincial Health Services Authority's LearningHub. The second component is the completion of the Immunization Skills Checklist (see Appendix 2), a tool used to assess practical immunization skills. The Immunization Skills Checklist involves direct observation of the immunizer by a designated assessor to confirm that they can demonstrate the competencies outlined in the checklist. This portion of the training requires employer support to coordinate supervision and sign-off. The Immunization Competency Course is intended for practitioners new to immunizing and is to be renewed every three years to ensure continued proficiency. Regional health authorities across the province have internal processes in place to support their employed nurses in completing the supervised checklist component of the training.

Background: FNHA Immunization Competency Support

CHNs working in First Nations communities are invited to participate in the FNHA Immunization Competency Program, which is overseen by a centralized FNHA Immunization Team. It's important to note that FNHA is not the direct employer of all nurses working in First Nations communities; while some CHNs are employed directly by FNHA, many others are employed by individual First Nations. In this context, FNHA offers an optional but widely utilized supportive role, providing guidance and resources to promote safe, effective, and culturally safe immunization practices. This clinical and administrative support is delivered through a small, dedicated team.

As part of the internal FNHA Immunization Competency Program, CHNs typically complete the BCCDC Immunization Competency Course, along with FNHA-specific education tailored to the unique needs and contexts of First Nations communities. Both RNs and LPNs are authorized to administer immunizations in BC, with differing scopes of practice. The FNHA Immunization Competency Program supports both roles, recognizing LPNs' ability to immunize autonomously within their scope.

To support competency development, FNHA has implemented an internal Skills Checklist Assessor program that is used across the province. The program offers training through virtual or in-person workshops (typically 3–4 days in length, depending on the format) and is intended for RNs with 3–5 years of immunization experience who are confident and proficient in their practice. These nurses are equipped to mentor and assess both RNs and LPNs completing the Immunization Skills Checklist. Upon successful completion of the workshop, participants are designated as FNHA Skills Checklist Assessors and added to an internal FNHA registry.

BCCDC guidance outlines that employer support is essential for nurses to complete the Immunization Skills Checklist. In situations where CHNs may not have access to this support directly through their employer, such as when local capacity or resources are limited, FNHA steps in to provide that support wherever possible. This is done in collaboration with, and in support of, First Nations employers (Health Directors) and is intended to complement local efforts, not replace them.

Background: FNHA Immunization Competency Support continued

Currently, CHNs participating in the FNHA Immunization Competency Program, whether completing the BCCDC course for the first time or renewing every three years, typically work with an FNHA-designated Skills Checklist Assessor to complete the Immunization Skills Checklist. These Assessors are not the CHNs' direct employers, and in many cases they are CHNs employed by other First Nations communities. In this way, communities are also supporting each other.

The success of the Skills Checklist Assessor program depends on experienced nurse immunizers who are supported by their managers or Health Directors to take on this mentorship role. However, FNHA does not have the capacity to meet all current needs alone. We invite other organizations to join us in providing this optional but impactful support—ensuring nurses across all communities have equitable access to the mentorship and guidance needed to deliver safe, community-based immunization services.

Background: IH Immunization Competency Support

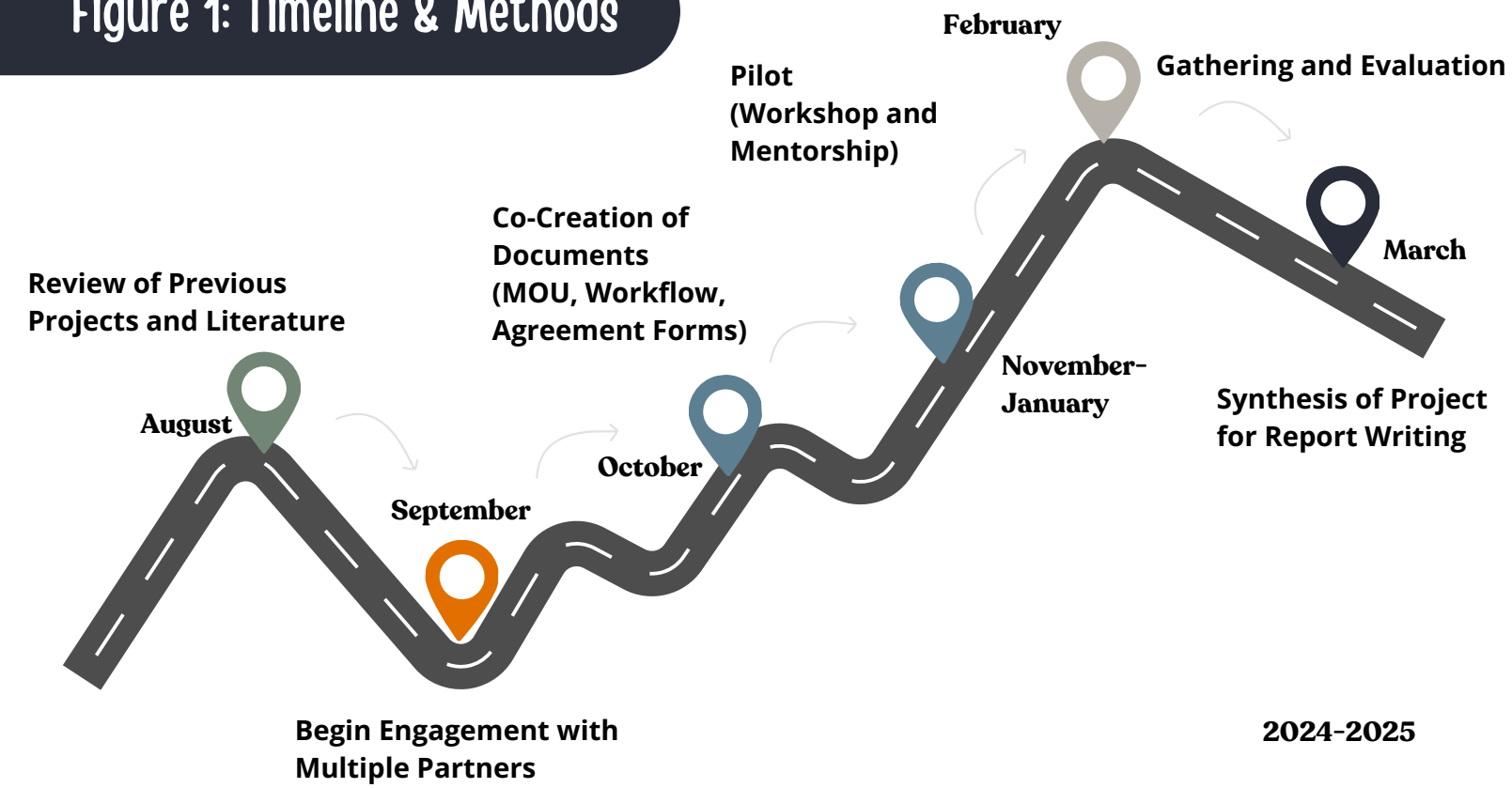
IH has a large and well-established public health infrastructure that holds a wealth of immunization knowledge and is positioned to support CHNs in their region. With established mechanisms to mentor PHNs, IH shares FNHA's goal of strong immunization programs for the whole region. In IH, the Immunization Skills Checklist sign-off of RNs occurs with support and assessment from the education/leadership team of the local public health unit. At the time of this report, LPNs do not work within IH public health in the role of immunization delivery.

For the organizational structures of FNHA and IH, please see Appendix 3.

Methods

Throughout the IH and FNHA Walking Together initiative, knowledge sharing, collaboration, and integration were embedded into the methods undertaken. A visual representation is provided in Figure 1.

Figure 1: Timeline & Methods



Biweekly meetings involving partners across organizations were held throughout the duration of the project. These meetings included partners from within FNHA in various roles including project coordinators, Communicable Disease Population and Public Health Manager, Interior Region Director of Health Emergency Management, Regional Nurse Managers, Clinical Nurse Specialists, and Community Health Practice Consultants. There were representatives from IH and PHABC in attendance at each of those meetings as well. Additionally, presentations and discussions about the project took place in various meetings with other teams, including the IH leadership team, FNHA immunization leadership team, and the Indigenous Services Canada Immunization Networking group.

Methods continued

As project coordinators, we adopted a “soft moccasin” approach. Jull et al. (2018) describes “the soft moccasin approach is about building relationships and bridging cultural differences. This approach has no room for a person of authority, only people who want to work in partnership” (p. 7). At the project's outset, we issued a call for discussions with project coordinators, inviting participation from CHNs and Skills Checklist Assessors employed by First Nations communities or FNHA-directly. In total, 10 discussions were held with RNs, some of whom had transitioned from the CHN role into positions such as Manager or Community Health Practice Consultant. Although the Skills Checklist Assessor role is intended for CHNs, due to a lack of available CHNs to provide this support, these individuals have continued to take on assessor responsibilities in addition to their new job duties. Simultaneously, we conducted a literature review to contextualize our findings within existing knowledge from various perspectives and locations. Insights from Indigenous Services Canada Immunization Networking group further provided a national perspective.

Collaboration across organizations was key to co-creating documents for use both during and after the pilot project. The pilot phase took place between November and January 2025. In February, we conducted an evaluation of the pilot using a variety of methods, including online surveys and in-person group discussions. The in-person gathering served as an opportunity to bring partners together to celebrate and assess the work completed. Following this gathering, the data and stories were synthesized into this report with recommendations for next steps.

Table 1 provides an overview of our engagement with partners, including the goals of each collaboration, while Appendix 4 offers a more detailed description of these interactions.

Methods continued
Table 1: Partner Engagement Overview

Group	Goal
Advisory Group	To facilitate efficient and timely cross-organizational collaboration for monitoring project progress and outcomes by regularly bringing together FNHA internal partners (e.g. Project Coordinators, Managers, Clinical Nurse Specialists, and Community Health Practice Consultants), IH leadership (e.g. Manager, Immunization Specialist), and PHABC representatives.
IH Operations Leads	Share knowledge of project goals, consider implications of project work, and gain insights from key partners applicable to the project.
FNHA Immunization Working Group	Share knowledge of project goals, consider implications of project work, and gain insights from key partners applicable to the project.
Indigenous Services Canada Immunization Networking Group	Share knowledge of project and gain insights from colleagues providing immunization support to nurses working in Indigenous communities in other jurisdictions nationally.
Community Health Nurses (CHNs)	To understand the perspectives and experiences of CHNs.
Skills Checklist Assessors	To understand the perspectives and experiences of FNHA-designated Skills Checklist Assessors.
Community Health Practice Consultants and Regional Nurse Manager	To understand the perspectives and experiences of FNHA staff providing immunization & general practice support to CHNs working in First Nations communities.
Partnership Accord Technical Table	To provide space for any questions, concerns, or dialogue from Nation Representatives.
FHNA and IH Teams: Clinical Informatics Systems	To determine best clinical informatics system option for documentation of immunizations during FNHA/IH Mentorship and Sign-Off pathway.

Methods: Methodology

The IH and FNHA Walking Together Initiative has drawn on Indigenous and integrative knowledge translation (iKT) approaches to quality improvement. To guide us through the cartography of this project work, we drew on four frameworks. The combination of these methodologies and frameworks have formed the path of this journey:

1. Two-Eyed Seeing
2. Ethical Space
3. Untying Colonial Knots (Figure 2)
4. First Nations Perspective on Health and Wellness (Figure 3)

The philosophy of *Etuaptmumk* (Two-Eyed Seeing), proposed by Mi'kmaq Elders Albert and Murdena Marshall, is a way of seeing the world through a shared respect and valuing of both Indigenous and Western systems of knowledge (as cited in Sinclaire et al., 2021). *Etuaptmumk* is an invitation to all involved to consider the ways we can use multiple ways of knowing to strengthen the work that we do through acknowledgment and shared respect (Sinclaire et al., 2021).

Cree scholar, Willie Ermine (2007) states:

> The "ethical space" is formed when two societies, with disparate worldviews, are poised to engage each other. It is the thought about diverse societies and the space in between them that contributes to the development of a framework for dialogue between human communities. The ethical space of engagement proposes a framework as a way of examining the diversity and positioning of Indigenous peoples and Western society in the pursuit of a relevant discussion on Indigenous legal issues and particularly to the fragile intersection of Indigenous law and Canadian legal systems (p. 193).

The ethical space framework is critically necessary in matters of health care as the inequities currently present within our health care system is the direct result of historical legal practices used against Indigenous populations. We cannot move towards reconciliation unless we are walking within an ethical space.

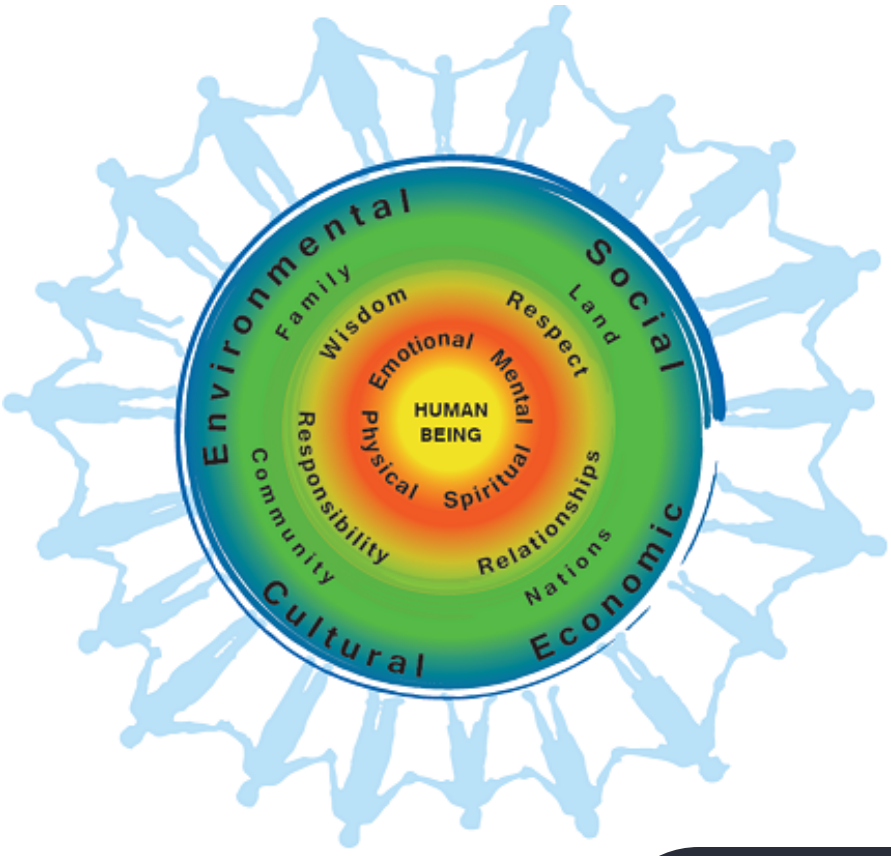
Methods: Methodology continued

Figure 2: Settler-Colonial Net Metaphor
(Jongbloed et al., 2023)

Jongbloed et al. (2023) provide a net metaphor as a tool for untying colonial knots for "Canadian health leaders who are bringing their hands, hearts, and minds to the complex and messy work of arresting White supremacy, Indigenous-specific racism, and settler-colonial harm" (p. 228). In this metaphor, there is a settler-colonial net made up of hundreds of thousands of "colonial knots" that need to be carefully untied. As settlers, we have a responsibility to untie the knots within our sphere of influence one-by-one so that the net can be safely and fully dismantled without causing further harm or creating new knots (Jongbloed et al., 2023).

We ground our work within *Etuaptmumk* (Two-Eyed Seeing) and Ethical Space to "shed light on ways to disrupt health researchers' attraction to a singular worldview which continues to privilege Western perspectives" (Sinclaire et al., 2021, p. 57). As non-Indigenous nurses working within an Indigenous organization coordinating this project, we must be very careful to not privilege the Western worldview, in which we were raised and previously worked within, through constant vigilance and critical self-reflection. Beginning with Indigenous teachings to inform our work is essential, otherwise we risk participating in 'innocent colonialism' which Seppälä et al. (2021) describe as work that is undertaken by Western scholars for their own interests that do not represent the needs of the community or those impacted by the work. "In Indigenous societies, the source of power is the sacred network of interconnectedness of all elements of the universe, swirling around in a dance of perpetual change and transformation — or the flux" (Hickey, 2020, p. 21). We recognize the power we hold in the flux of coordinating this project, and to responsibly use this power, we have taken an approach that has required constant collaboration and integration of knowledge from partners throughout every step of this work. One way of describing this methodology is iKT, however we recognize that "in Indigenous contexts, knowledge is almost always inextricably linked to action both philosophically and practicality" (Smylie et al., 2014, p. 17). In other words, while iKT is considered a methodology in the Western sense, Indigenous approaches have always included translation of knowledge into action. iKT involves integrating knowledge from various sources and partners throughout the entire project, from determining goals to evaluating the outcomes. Using iKT approaches can guide researchers to integrate Indigenous ways of knowing in a respectful manner to mainstream health research and improve overall health systems (Jull et al., 2018).

Methods: Methodology continued



Throughout this report we cite various Indigenous works and worldviews, but that is not to claim there is a singular Indigenous worldview that encompasses all Indigenous Nations across regions, instead we understand that while there is difference, there are also shared commonalities among Indigenous perspectives (Wilson-Raybould, 2022).

Figure 3: First Nations Perspective on Health and Wellness
(FNHA, n.d.)

The First Nations Perspective on Health and Wellness Tool (FNHA, n.d.) provides foundational understandings of key concepts operationalized in this project. Based upon this tool, the concept of relationship is described as:

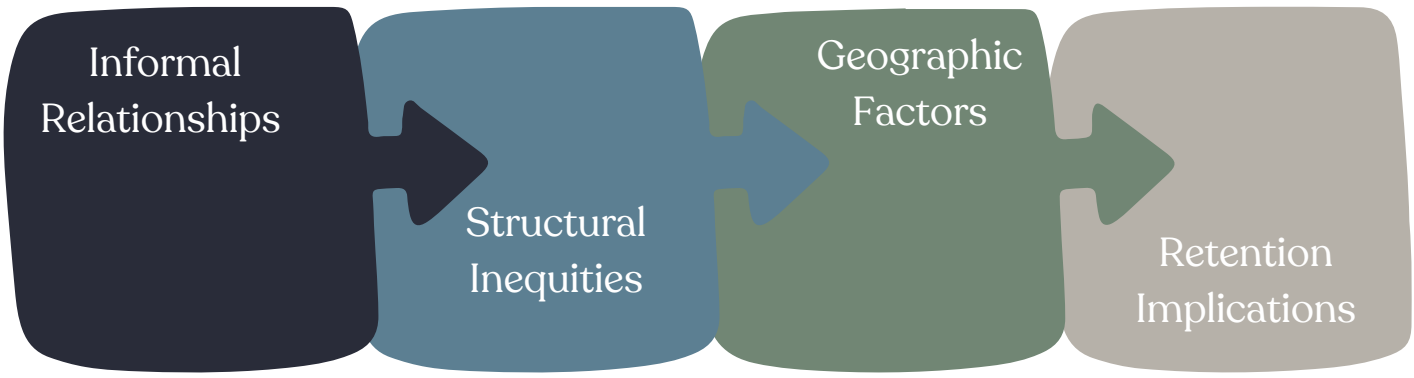
> Relationships sustain us.
> Relationships and responsibility go hand in hand. Like responsibility, relationships involve mutual accountability and reciprocity.
> Relationships are about togetherness, team-building, capacity building, nurturing, sharing, strength and love.
> Relationships must be maintained both within oneself and with those around us (FNHA, n.d.).

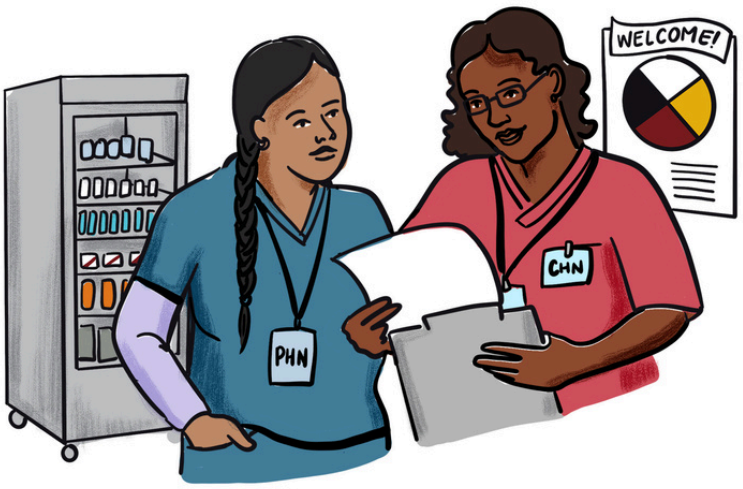
Reciprocity is operationalized as a form of shared benefit for all parties involved, with capacity being built through a mutual path of knowledge sharing in both directions (Smylie et al., 2014).

Pilot Pre-Engagement

During the pilot pre-engagement period, we met with multiple internal and external partners to determine the project goals based upon the needs of the affected population. The CHNs working in First Nations communities were consulted about their experiences, including CHNs who had not completed their mentorship and BCCDC Immunization sign-off, as well as those with varying years of experience. The nurses in supportive roles such as FNHA Skills Checklist Assessors and Community Health Practice Consultants were also consulted to capture their vantage point of support provided and the challenges they have experienced. The leadership and administrative team involved in immunization provision within FNHA was also consulted to consider potential rippling effects of workflow or process changes. At a national level, the Indigenous Services Canada Immunization Networking group provided knowledge of similar processes in other regions, including challenges, strengths, and the implementation of creative solutions. This level of engagement was undertaken to remain grounded in the principles of walking together along the journey of knowledge sharing for the good of the community. Additionally, this approach promotes the sustainability and longevity of the work done by involving partners at all stages of development rather than engagement after the work is completed. See Table 1 for a summary of partner engagement conducted throughout the project.

Despite the diversity of individuals consulted, similar threads were common amongst the areas and roles. These themes were compared with the knowledge gathered through meetings with the regional health authority and in the literature. Key themes that emerged from the pilot pre-engagement period included the value of informal relationships, structural inequities affecting nurses' access to support across communities, geographic factors necessitating unique considerations, and the implications for nurse retention.





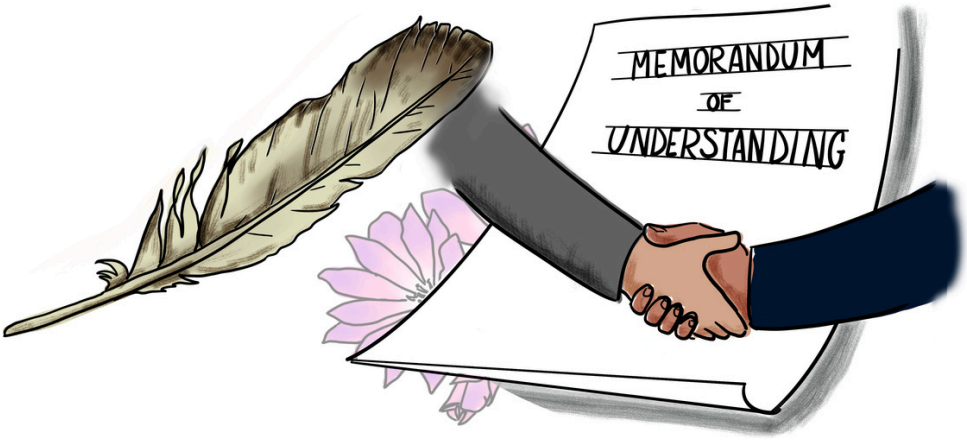
Pilot Pre-Engagement: Informal Relationships

Informal mentorship has been a foundational, and taken-for-granted, aspect of nursing practice for decades (Thorne, 2023). However, the evolution of our health care system among the backdrop of global nursing shortages and a changing model of care has resulted in mentorship being only available in limited formal capacities (Thorne, 2023). Thorne (2023) warns that "the disruption of nursing mentorship systems [i]s a serious threat to societal health writ large" (p. 1). This sentiment was echoed in the conversations with Nurses describing the relationships they formed throughout their practice within their communities, including those in their local contexts, across the province, and from within and external to their own organizations. For nurses who have worked in First Nations communities in rural and remote areas for many years, they described collaborating with the PHNs from the regional health authority as common practice, for example, reaching out with questions about immunization practice or referring clients from the community to baby groups for shared support. They also shared that they could contact nurses from other First Nations communities across the province with practice questions. All of this was informal, meaning there was no specific written agreement or process; rather, the nurses established these relationships on their own. While this was not happening in every community, it was frequently mentioned in our conversations, particularly by nurses who had transitioned into leadership roles from a CHN role. As these connections are informal, new CHNs may not know how to form these valuable relationships if they are not orientated by an experienced CHN. CHNs viewed these informal relationships as a significant strength and an essential aspect of their practice, enabling them to provide high-quality care to their communities. For many CHNs, educational opportunities such as workshops or conferences provided by FNHA, potentially virtual but especially in-person, often facilitated an informal network of support. This network, crucial for CHNs working in rural or remote areas, helps combat the challenges of professional isolation.

Pilot Pre-Engagement: Informal Relationships continued

The importance of relationships was also evident in the literature. One study conducted by Rohatinsky and colleagues (2020) in Western Canada explored the experiences of RN mentors and mentees from rural communities. The researchers found that connection, communication, and support were key facilitators of strong relationships, which has been proposed as an effective strategy of recruiting and retaining nurses in rural settings. Mentorship between the RNs through an interpersonal process was important, however organizational support from leadership was needed to support development, facilitation, and sustainment in mentorships in rural settings. The results from the study suggested that "rural-specific mentorships are effective in terms of supporting mentorships, easing workplace transition, strengthening community connections, and encouraging recruitment and retention of Registered Nurses in rural health care" (Rohatinsky et al., 2020, p.2) The researchers concluded that:

> The responsibility for mentorship resides with not only the mentor and mentee but also health organizations and rural communities. Members from all groups need to be committed and contribute to mentorship for rural mentorship programs to be successful and sustainable. Rural residents are often underserved due to insufficient numbers of healthcare professionals working in rural areas along with a limited number of services offered. The greater the numbers of healthcare professionals that can be recruited and retained within rural communities, the greater the likelihood the community residents will have timely and appropriate access to quality health services (p. 2).



Pilot Pre-Engagement: Structural Inequities

Conversations revealed that there were differences in access and support across regions. From the National Collaborating Centre for Indigenous Health, Loppie and Wien (2022) describe Indigenous health inequities through a social determinants model using a tree metaphor:

> Like the roots of a tree, structural determinants are deeply embedded ideological and political foundations, which shape all other determinants. The integrity of these foundations also determines health equity and thus the wellness of entire societies. Core determinants represent infrastructure as well as systems – of education, health, justice, social welfare, and others, responsible for the allocation of resources and supports, as well as the engagement of individuals and communities. Within these environments, in/equity is demonstrated in policies, practices, and representation, as well as how barriers to access are addressed. Stem determinants are those which have a more direct impact on the health of individuals and include, but are not limited to, education/training, employment (and therefore income and social status), social supports, and resources (individual, family, and community – human and other) (p. 12).

With a core determinant of Indigenous health being health infrastructure and allocation of resources and supports, the availability of nurse immunizers in First Nations communities is a key enabler of health equity. However, some nurses reported significant challenges in obtaining in-person support and training for their immunization practice. The model of Skills Checklist Assessors to assess immunization skills of CHNs worked well in some areas and was considered a major facilitator of practice readiness. However, the program was not as easily accessible in some areas. Some nurses reported major challenges spanning months to find a Skills Checklist Assessor to provide assessment and support with some nurses having to travel long distances for this in-person support. Figure 4 shows a map of the Interior Region highlighting the current locations of Skills Checklist Assessors. The map illustrates inequitable access across communities, and it's important to note that availability frequently changes due to nursing turnover or leaves. As such, this map represents only a snapshot in time.

Additionally, skills checklist assessors work in varied roles with differing levels of availability, creating significant challenges for new nurses seeking sign-off. It is important to note that skills checklist assessors do not receive additional support (e.g. financial reimbursement for time, costs associated with travel) to provide this service; instead, they take on the role on top of their existing workload. Employer support is required, with the understanding that being a skills checklist assessor may involve time and travel away from the CHNs own community to provide Immunization Skills Checklist to CHNs in surrounding communities.

Pilot Pre-Engagement: Structural Inequities continued

Another key component of immunization training and support is the requirement for shadowing and mentorship prior to sign-off. However, some communities have limited access to in-person support, including a lack of informal partnerships with other First Nations communities or access to regional health authority nurses for shadowing. These inequities were also evident across different regions of the country. Skills Checklist Assessors shared that their roles typically went beyond that of providing assessment of the immunization skills checklist. Often, CHNs required extended mentorship including the review of questions related to vaccine delivery. The Skills Checklist Assessors stated that while they saw the importance of providing ongoing mentorship, the time required for this support was not available due to their workload.

Competing priorities present significant challenges for CHNs in First Nations communities, where some are required to fulfill dual roles in both public health and home health due to being the only nurse in the area. This often means that more urgent, higher-priority acute care situations take precedence over immunization education and training. Further complicating the issue, some First Nations communities have smaller populations with a lower number of births per year compared to urban settings, resulting in fewer opportunities to observe and practice routine immunization for the 0- to 5-year-old population. In First Nations communities, nurses must take on additional administrative responsibilities of setting up their own clinics (e.g. ordering and maintaining supplies and biologicals, booking clients, and preparing the clinic environment). One nurse we spoke with described this as a “cart-before-the-horse” situation—where learners, often working in isolated settings and not yet fully aware of what they need to know, are expected to organize a complex process without the necessary experience or guidance.. This is in sharp contrast to nurses employed by regional health authorities, where multiple layers of support are in place, allowing nurses to focus solely on developing their immunization skills

Given that structural determinants are rooted in deeply embedded ideological and political foundations, some conversations revealed concerns raised by nurses from First Nations communities about the proposed CHN–PHN partnership. While many shared that they had positive relationships with nurses from regional health authorities, they also expressed concerns that systemic racism and bias could negatively affect nurses from First Nations communities. As the In Plain Sight report identified, Indigenous-specific racism and discrimination is a major issue in the BC health care system (Turpel-Lafond, 2020). The racism was not limited to patients, but also identified systemic racism faced by Indigenous employees.

Pilot Pre-Engagement: Structural Inequities continued

Additionally, some nurses that were not Indigenous shared they were concerned that employees of regional health authorities may have negative assumptions about the abilities of nurses who have chosen to work in Indigenous organizations or First Nations communities. This knowledge informed our project work in a major way. We focused on a strengths-based perspective and were mindful with the language used to ensure we did not inadvertently cause harm by further perpetuating negative biases of nurses working in First Nations communities. We also provided reassurance to the nurses that this process is not to replace the existing Skills Checklist Assessor model within FNHA, instead it is an optional pathway if the internal FNHA Skills Checklist Assessor process is not available. A long-term goal of this process is to build internal capacity over time for experienced CHNs to provide increased Skills Checklist Assessor support and decrease reliance on regional health authorities to provide sign-off long term. For the evaluation portion of the pilot project, we included questions regarding cultural safety to ensure that the nurses participating felt safe and to also gain knowledge on how cultural safety can be better fostered in future.

Pilot Pre-Engagement: Geographic Considerations

Geographic considerations represented either facilitators or barriers for CHNs. With many First Nations communities being in rural and remote areas, the geographic considerations varied. Nurses seeking immunization skills checklist sign-off from an FNHA designated assessor encountered increased geographic complexities due to the major limitation of large sections across regions that did not have an available FNHA Skills Checklist Assessor. Figure 4 shows a snapshot of Skills Checklist Assessor locations in the Interior region as of February 2025. Of note, this distribution changes often as nurses leave positions or change locations.

Pilot Pre-Engagement: Geographic Considerations continued

Figure 4: Map of FNHA-designated Skills Checklist Assessors (February 2025)

Access to regional health authority public health units, also scattered throughout Interior Region, are a valuable resource and support for many CHNs who work in isolation. CHNs who reported having a regional health authority public health unit in close proximity also reported easier collaborations. In these situations, some nurses recalled times of walking over with questions or attending appointments with First Nations clients at the public health units for support. Conversely, some nurses reported the closest regional health authority public health units as over an hour drive away, which may include travelling on difficult to navigate logging roads. These challenges were worsened depending on the seasons, with increased difficulty over the winter months. Increasing climate emergencies such as wildfires will likely also contribute to barriers in the future. While virtual support options were appreciated by nurses, in-person support is essential for those who are new to immunization and/or have limited experience working with the 0–5-year age group. For CHNs that do not have a regional health authority public health unit within their immediate vicinity, opportunities for formal partnerships to introduce nurses and support relationships is especially beneficial.

Pilot Pre-Engagement: Retention Implications

Retention of CHNs in First Nations communities is a major concern. The urgency of timely support for nurses hired in First Nations communities was expressed as a priority for retaining nurses. With high turnover rates for all areas of nursing and a limited supply of experienced nurses across the country, more and more CHNs are being hired with little to no public health experience, as well as hiring newly graduated nurses. Anecdotes of limited in-person mentorship opportunities increased feelings of anxiety and contributed to burnout and moral distress. More experienced nurses shared stories of high-turnover of newer CHNs that they supported within in their limited capacities and attributed the challenges of in-person immunization mentorship and difficulties with immunization skills checklist sign-off as being related to nurses leaving positions.

The issue of low retention across rural and remote communities aligns with the evidence provided by the WHO (2010), noting that "lack of access to quality health-care providers is one of the primary root causes of health inequity and is disproportionately experienced by people living in remote and rural communities," with the recommendation that "allocating available resources in a way that contributes to the reduction of avoidable inequalities in health" as being forefront in effective retention strategies (p .13). Identifying strategies to retain CHNs in First Nations communities is urgent. As Ruby E. Morgan, a Gitxsan woman of the Gitwangak Ganeda working to promote health among Gitxsan communities on the Laxyip (Territory) shares, "although we have begun to educate and train, many health professionals do not stay very long, and we begin this education again with the new health professional a few months later" (Morgan & Johnson, 2023, p. 83). This repeated education is especially challenging as most health care providers in First Nations communities in BC are non-First Nations, lacking the lived experience required to quickly integrate and work alongside the community they are entering (Morgan & Johnson, 2023). With different outsiders coming into First Nations communities, sometimes multiple different nurses per year due to attrition, efforts to build trust within health services as part of reconciliation are further challenged.

Factors influencing health care providers' decisions to work in rural and remote communities includes "access to continuing education opportunities, supervision, professional development courses/workshops" (WHO, 2010, p. 14). A scoping review of nurses working in rural and remote areas identified mentorship as a key component of being attracted to or remaining in practice positions, especially highlighting the need for a "buddy" system during the orientation period; this suggests "that retention would improve if ongoing mentoring, peer supports and professional mentors were facilitated or encouraged by organizations and management" (Holland et al., 2024, p. 7). Formal mentorship opportunities are also listed as a retention strategy in the Canadian Nursing Retention Toolkit (Health Canada, 2024).

Project Goals

After the pre-pilot engagement period, the goals of the pilot project were defined as:

1 Support
immunization knowledge sharing between nurses in FNHA and IH

2 Provide
opportunities for CHNs working in First Nations communities to shadow, practice, and complete Immunization Skills Checklist sign-off within IH immunization clinics

3 Co-create
formal documents as the foundations of agreed upon mentorship activities to be used in future collaborations

4 Integrate
principles of cultural safety throughout all project activities

Pilot Phase

The pilot phase of the project took place over three months. Table 2 provides an overview of the activities conducted during this period.

Recruitment for CHNs to participate in the mentorship program was conducted through Community Health Practice Consultants, who identified newly hired CHNs seeking immunization support. Participation in the pilot was optional and required the support of each community's Health Director.

The challenges reported by the CHNs who were identified and participated in the project reflected many of the difficulties previously shared. Most of the CHNs were new to rural practice, the CHN role, or RN practice in general. In addition to immunization training, CHNs were also responsible for orientating to multiple other components of their role. Some worked limited hours or were the only CHN in the community. This meant that they often had to prioritize more urgent care tasks, pulling them away from scheduled mentorship shifts. Participants also varied in terms of location and travel distances.

Facilitating factors to participation included CHNs who had existing informal relationships with regional health authority PHNs in their region, as well as those with more availability to schedule shifts. Additionally, CHNs who had the opportunity to complete and review the orientation materials provided by FNHA prior to the mentorship were better prepared. A total of two nurses completed the full mentorship and Immunization Skills Checklist, with 10 mentorship shifts each. One additional nurse began her mentorship and will continue to receive support beyond the pilot phase.

In the early stages of the pilot, workflows (Appendix 5), request and agreement forms (Appendices 6 and 7), and a frequently asked questions document (Appendix 8) were developed. However, these resources were distributed after the mentorship had already begun. While they were made available as optional reference materials, CHNs and PHNs were not expected to complete or review all documents. Instead, they were offered as optional reference materials, and both CHNs and PHNs were invited to provide feedback, with the intent of improving these tools for future mentorship use.

As part of the pilot phase, three members of the education team from IH attended a Skills Checklist Assessment workshop. IH is now exploring the development of a similar internal process to support immunization assessors in public health.

Pilot Phase continued
Table 2: Pilot Project Activities

Activity	Purpose
Co-creation of Memorandum of Understanding (MOU)	• Establish a collaborative process to support CHNs working in First Nations communities in accessing local IH public immunization operations. • Promote opportunities for CHNs to gain experience, build competence, and complete sign-off as approved immunization providers. • Demonstrate a joint commitment by FNHA and IH to strengthen collaboration and improve CHN connection with local IH public health staff. • Increase access to immunization services for First Nations clients within their own communities. • Reflect shared leadership and accountability, with the MOU drafted and reviewed by FNHA and IH leadership and legal departments.

Co-creation of a Mentorship and Sign-Off Pathway (Workflow)	• Develop a workflow document to guide CHNs in identifying the most appropriate route for immunization support.
	• Depicts the flow of work between FNHA and IH to support CHNs with mentorship and immunization sign-off at IH public health units.
	• Two-page workflow structure:
	  ◦ Page 1: Outlines CHN learning needs (e.g., initial mentorship and sign-off, renewal, or mentorship only) and the supports available, including when the FNHA/IH Mentorship and Sign-Off Pathway is appropriate.
	  ◦ Page 2: Illustrates the step-by-step workflow between organizations when the FNHA/IH Mentorship and Sign-Off Pathway is used.

Co-creation of a Request Form	• Designed for CHNs to formally request access to the FNHA/IH Mentorship and Sign-Off Pathway. • Captures key information needed to support the request, including details of the CHN's learning need and confirmation of employer support.
Co-creation of a Frequently Asked Questions Document	• Provides background and context to the FNHA/IH Mentorship and Sign-Off Pathway.
Shared Learning Space: Skills Checklist Assessor Workshop	• FNHA's Skills Checklist Assessor virtual workshop was opened to IH Operations staff as a pilot cross-organizational learning opportunity. • Three IH staff members participated in part or all of the workshop, sharing space with CHNs from across the province. • Promoted shared understanding of the assessment process and relationship-building between FNHA and IH staff.
Mentorship and Sign-off Shifts	• CHNs were booked for mentorship and sign-off shifts within IH Public Health Units, supporting the operationalization of the FNHA/IH Mentorship and Sign-Off Pathway.

Gathering

Attendees of the IH & FNHA Immunization Knowledge Sharing Walking Together Event

In February 2025, all individuals involved in the project were invited to attend an in-person gathering to celebrate and evaluate the collaborative work of the IH and FNHA Immunization Knowledge Sharing Walking Together project. The event was held on the traditional, ancestral, and unceded lands of the of the Syilx Okanagan Nation and Westbank First Nation, which is colonially known as Kelowna, BC.

The purpose of the gathering was to honour the work accomplished, weave together the story of the project, amplify the voices of those involved, and celebrate the relationships built throughout the initiative. Attendees included members of the project Advisory Group (including representatives from various levels of FNHA, IH, and PHABC) as well as IH Operations staff, IH PHN mentors, CHNs, and Health Directors directly involved in the project. While not all invitees were able to attend, participants were warmly welcomed by Syilx Elder/Knowledge Keepers Pamela and Wilfred Barnes, who opened the day with teachings and knowledge sharing.

Gathering continued

The event featured presentations from organizational leads, including an overview of previous BCIC-funded projects that provided context for the Walking Together initiative. Project coordinators shared a summary of the work completed and highlighted key outcomes to date.

The remainder of the day focused on evaluation and feedback, providing space for all participants to share their reflections through guided discussion and collaborative group work. A structured session allowed PHNs and CHNs to respond to pre-shared reflection questions, offering valuable insight into the impact of the mentorship experience and the Immunization Skills Checklist process.

Following this, small group discussions, facilitated by table leads and documented by recorders, focused on four key themes:

1. Processes
2. People
3. Resources & Support
4. Cultural Safety & Humility

Syilx Elder/Knowledge Keepers Pamela and Wilfred Barnes participated in some discussions, graciously offering wisdom and teachings to help close the day in a respectful and meaningful way.

> We are honored to be a part of the "Walking Together Event" to facilitate a better way forward for all of our collective children, grandchildren and great grandchildren.
> Limlemt syilx Elder/Knowledge Keepers Pamela and Wilfred Barnes

Illustrating the Path

Sharing the knowledge from the IH and FNHA Immunization Knowledge Sharing Walking Together project is being done in several ways, including this written report, presentations with community partners, conference presentations, and most importantly, through storytelling with the communities and partners involved in the pilot. As we celebrate the work done, we remember that the relationships established and supported through this work is what sustains us beyond the individual outputs of documents or specific statistics of the number of mentorship shifts completed in the pilot project. Drawing from the knowledge shared by Ruby E. Morgan of what researcher Dr. Leslie Main Johnson has learned from many years of work within First Nations Communities:

> She has learned what is important; it is not research projects and deliverables so much as research relationships, at least in working with and for our communities. We work together to define and move toward goals that are set in conversation, supporting each other, as we each bring our skills, interests, and histories to this conversation (Morgan & Johnson, 2023).

To share the story of this project, we collaborated with a graphic illustrator to visually represent both the individual and collective journeys taken, as well as the continued path we walk together. A systematic review of knowledge translation (KT) approaches and practices in Indigenous health research found that many KT methods often involved a combination of imagery with text, which “highlights the importance and value of using KT methods beyond common Euro-Western academic forms of KT, such as text-heavy and jargon-filled reports, presentations, and papers” (Morton Ninomiya et al., 2022). Additionally, Morton Ninomiya et al. (2022) encourage researchers to consider more accessible mediums to communicate KT.

The illustration (Figure 4) was developed through consultation with the individuals involved in this work, with a final review at the gathering to ensure the full story was authentically captured. This visual storytelling of the IH and FNHA Immunization Knowledge Sharing Walking Together project serves as an intentional and integral form of knowledge translation, contextualizing and mobilizing the work detailed in this report.

Illustrating the Path continued

Figure 4: A visual representation of the IH & FNHA Walking Together Initiative

There are two stories to accompany the above illustration, reflecting both personal and shared experiences within the project. The first story, meant for nurses, is available in Appendix 9. This second story, paired with the graphic, has not been written yet. Once created, it will be offered to the communities involved in the pilot project and future collaborations, with the intention of displaying it in public spaces such as Community Health Centres and Public Health Units.

Illustrating the Path continued

The bitterroot flower, featured throughout this report, symbolizes gratitude for the lands where the nurses involved in the pilot project live and work. While not tied to a specific location, its presence pays homage to the pilot communities and reflects that these shared paths can be taken in diverse regions across the country.

Traditionally significant to many First Nations in the BC Interior, bitterroot represents a sacred connection to place, resilience, and the wholistic vision of health—balancing physical, mental, emotional, and spiritual well-being. As it appears in the visual storytelling of this project, bitterroot offers a reminder of the interconnectedness between people, land, and knowledge systems.

Evaluation

The evaluation process captured success stories, challenges, and key facilitators and barriers. We also explored how cultural safety was integrated into the pilot, assessed the effectiveness of supporting documents, and gathered insights to inform the development of a more sustainable mentorship pathway moving forward. A combination of online surveys, in-person discussions, and guided group activities was used to evaluate the pilot project. Table 3 summarizes feedback received from participants of the Skills Checklist Assessor Workshop. The next section presents the feedback from CHNs, PHNs, and operations staff involved in the mentorship, and partners that attended the in-person gathering. This feedback is organized into key themes, each followed by corresponding recommendations.

Evaluation continued
Table 3: Skills Checklist Assessor Workshop Feedback

Theme	Feedback
Sharing Space	• Participants felt honored to be invited and take part in the workshop. • There was a strong sense of gratitude and appreciation for the opportunity to share knowledge and experiences. • The welcoming and friendly environment fostered meaningful connections, with a noticeable difference in pace that allowed more time for relationship-building, introductions, and deeper discussions. • Interactions were respectful, creating a space for open and thoughtful discussion. • The opportunity to hear diverse perspectives from nurses across organizations was highly valued. • Participants engaged in reciprocal learning, exchanging insights and experiences. • All participants recommended this shared learning approach between organizations.
Benefits	• Gaining diverse perspectives and approaches enriched clinical practice. • Sharing experiences and information enhanced the depth of learning. • Increased awareness and respect for how FNHA and CHNs support communities. • Recognized value of this education for all Immunization Skills Checklist Assessors, including regional health authority staff conducting Immunization Skills Checklist sign-off. • Strengthened relationships and expanded networking opportunities across organizations.
Organizational Knowledge	• Skills Checklist Assessors from both organizations follow the same standards to evaluate immunizers and face similar challenges with Immunization Skills Checklist. • Discussing different approaches to overcoming challenges was valuable (e.g. virtual vs. in-person processes and planning considerations).
Cultural Safety and Humility	• Provided an opportunity to observe and learn new ways of engaging in various interactions (e.g. within gatherings, with other health professionals, and with clients). • Increased awareness of culturally safe resources. • Sharing space with practitioners from different organizations allowed for practical insights on embedding culturally safe practices in immunization appointments.

> “You don't know what you don't know, but when you know better you do better. I feel I learned ways of doing better through this experience.”

- Regional health authority participant (in response to a question about cross-organizational learning and cultural safety)

Evaluation continued
Benefits of Implementing Mentorship

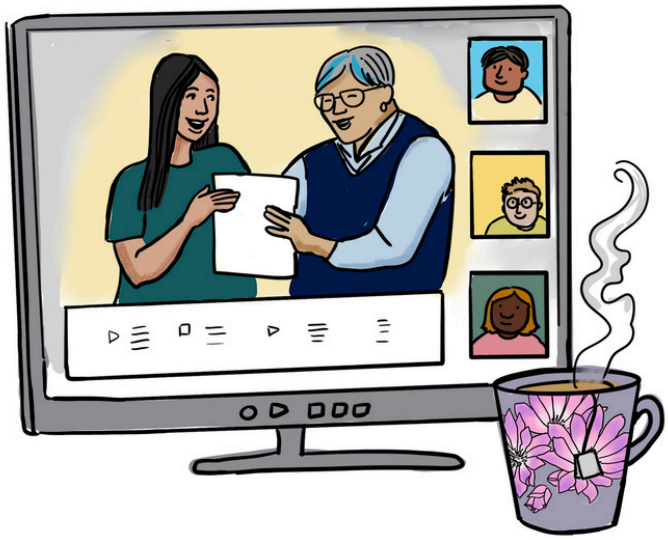
- Reciprocal learning – All participants who completed the mentorship expressed gaining valuable knowledge through mutual learning.
- Critical support for CHNs – CHNs viewed the mentorship as a “lifeline” and as necessary to the development of their immunization practice.
- Valuable experience for PHNs – PHNs found mentorship to be a meaningful and beneficial experience.
- Strengthened collaboration – Created opportunities for CHNs and PHNs to work together to better support communities.
- Improved cross-organizational understanding – IH staff gained knowledge of immunization practices in First Nations communities and CHNs learned about public health services offered by IH.
- Increased community trust – Seeing CHNs and PHNs collaborate enhanced community confidence in healthcare services.

Challenges in Implementing Mentorship

- Time Commitment – Successfully implementing immunization mentorship and sign-off required significant time and coordination from CHNs, PHNs, and their respective organizations. CHNs needed at least 10 mentorship shifts, rather than the initially estimated 5, with the total time required varying based on experience, confidence, and learning needs.
- Availability of Mentorship Opportunities – The speed at which CHNs could complete mentorship shifts was impacted by site-specific factors, such as the frequency of immunization clinics at the health center and PHN capacity to support observation.
- Scheduling Conflicts – CHNs faced competing priorities, including urgent community needs that sometimes required them to be pulled away from scheduled mentorship shifts. Clinic schedules and CHN availability did not always align, creating further barriers to completing the process.
- Increased PHN Workload – Participating in mentorship added workload pressure for PHNs, as some clients had to be shifted to other PHNs during clinics to allow dedicated mentor-mentee learning time. The mentorship was meant to also include time at the Community Heath Centres in addition to the IH Public Health Units, however minimum staffing levels and workload requirements made this difficult to organize. Additionally, the coordination of staff, mentors, and educators required significant time.

Evaluation continued
Facilitators of Implementing Mentorship

- Flexible Scheduling – Approaching scheduling with flexibility and understanding helped ensure learning outcomes were still achieved despite challenges.
- Clear Resources & Expectations – Existing tools, such as Agreement Forms and FAQs, were useful in articulating information and expectations, though additional structured educational tools could further enhance consistency.
- Strong Commitment – The dedication of all individuals involved was key to the success of the mentorship.
- Pre-Established Relationships – CHNs and PHNs who had existing informal relationships before the mentorship found it easier to collaborate and engage in the learning process.



Barriers in Implementing Mentorship

- Inconsistent Documentation Systems – Differences in documentation systems between organizations created barriers to workflow alignment and created challenges for PHNs and CHNs to complete record reviews and documentation in a timely manner. Expanded Immunization eForms were unavailable at times, requiring CHNs and PHNs to follow downtime procedures. This process involved CHNs recording immunizations on downtime forms, which PHNs then transcribed into Panorama, adding extra steps and workload.
- Restricted Virtual Communication – Some platforms (e.g., Microsoft Teams) were not universally accessible, limiting cross-organizational meetings and quick check-ins between CHNs and PHNs.

Evaluation continued Feasibility

The IH and FNHA Immunization Knowledge Sharing Walking Together project was funded through a BCIC grant, but the overall costs exceeded the expected amount, and the funding provided. The grant covered only one part-time project lead at 0.5 FTE, while the project required two part-time leads working collaboratively to fulfill a full-time role. The salary for the second project lead was provided as in-kind support from FNHA, demonstrating the additional resources needed beyond the original funding allocation.

Significant in-kind support was also required from various members from FNHA. Additionally, IH, as a partner organization, contributed substantial in-kind support by covering a significant portion of the immunization specialist's time, as well as involvement from other members of the leadership and education teams. Support for project planning and evaluation was also provided in-kind by PHABC, reflecting the multi-organizational effort required to sustain the initiative.

The cost of the in-person gathering was covered using funds from FNHA that had originally been allocated for a separate project focused on immunization uptake. This highlights the critical need for dedicated funding to support relationship-building opportunities, which are essential for cross-organizational collaboration and long-term program sustainability.

Beyond immediate implementation costs, investing in mentorship has a significant economic impact by improving retention and reducing turnover-related expenses. High turnover results in substantial costs for recruiting, onboarding, and training new nurses. By supporting CHNs through structured mentorship, organizations can enhance job satisfaction, build capacity, and increase retention, ultimately reducing long-term workforce replacement costs.

While the mentorship model used in the IH and FNHA Immunization Knowledge Sharing Walking Together project has proven to be feasible, its long-term success depends on appropriate financial investment to cover staffing, operational costs, and in-person collaboration opportunities. Adequate funding is necessary to fully implement and sustain the mentorship framework, ensuring that all partners have the resources needed to support workflow development and maintain mentorship opportunities for CHNs.

Evaluation continued Key Takeaways

The IH and FNHA Immunization Knowledge Sharing Walking Together initiative demonstrated the critical role of collaboration between CHNs and PHNs in strengthening cultural safety and clinical support of public health programming. By fostering reciprocal knowledge-sharing, mentorship not only enhanced CHN skill development but also improved access to immunization services for First Nations communities. The relationships built through this process created stronger referral pathways and reinforced the importance of working together to provide care where clients feel safest.

While the pilot focused on immunization, feedback indicated that broadening mentorship to include other public health areas—such as maternal-child health, tuberculosis screening, and traditional healing practices—could further strengthen CHN capacity and increase access to equitable health care delivery. Additionally, unexpected benefits, including PHNs gaining cultural learning opportunities through community participation, highlight the transformative potential of mentorship beyond technical training.

To ensure sustainability and scalability, mentorship must be embedded within ongoing organizational support, leadership commitment, and structured training pathways. While the FNHA Skills Checklist Assessor program plays an important role in assessing immunization competency, it is not intended to provide sustained mentorship. The current system depends largely on the voluntary participation of experienced nurses, many of whom are employed by other First Nations communities and are already balancing full workloads and employer expectations. A purposeful mentorship model is needed to provide fulsome support. Addressing systemic barriers, such as documentation challenges and access to virtual communication channels, will be essential for enhancing mentorship efficiency and integration across health organizations. Furthermore, higher-level systemic support is needed to align policies, improve cross-organizational data sharing, and provide equitable working conditions for nurses in First Nations communities.

Ultimately, this mentorship initiative illustrates that relationship-building is just as important as skill development in delivering culturally safe and effective health care. Investing in long-term collaboration, structured training and organizational support will not only improve CHN retention and confidence but also contribute to stronger public health outcomes for First Nations communities.

Recommendations

The following recommendations emerged from the evaluation of the IH and FNHA Immunization Knowledge Sharing Walking Together pilot project. They are presented in two distinct categories to reflect both the practical insights gained from implementation and the broader systemic considerations that surfaced through participant feedback and project learnings.

The first category (Table 4) includes actionable recommendations for strengthening the mentorship model piloted in this project. These recommendations are grounded in the lived experiences of CHNs, PHNs, and organizational staff, and offer clear strategies to improve the structure, delivery, and sustainability of the mentorship approach.

The second category identifies areas where larger system-wide, provincial-level support is needed. These recommendations are framed as questions rather than solutions, recognizing the complexity of cross-organizational structures and the need for continued dialogue, collaboration, and partnership to address them. They are intended to prompt further discussion and encourage multi-level engagement in developing equitable, sustainable pathways that support nurses working in First Nations communities.

Recommendations continued
Table 4: Strengthening the Mentorship Model

Recommendation	Strategy	Rationale
Increase Mentorship Duration	Schedule a minimum of 10 shifts for nurses new to immunization practice	Ensures adequate time for skill development and confidence-building
Adopt a Team-Based Mentorship Model	Pair CHNs with multiple PHN mentors	Distributes mentor workload and offers varied learning experiences
Enhance Organizational Collaboration	Display MOU and Partnership Accord; engage Health Directors and community leaders in mentorship discussions	Reinforces shared commitment and promotes CHN retention through visible leadership support
Build Flexibility into Scheduling	Adapt mentorship schedules based on CHN availability and competing responsibilities	Accommodates workload demands and improves feasibility of participation
Foster Relationship-Building Before Assessments	Encourage introductions and informal connection-building before skills checklist assessments	Reduces anxiety and promotes a psychologically safe, supportive learning environment
Prioritize Long-Term Trust-Building	Frame mentorship as a relationship-focused initiative	Strengthens organizational-community partnerships and supports reconciliation goals
Expand Beyond Immunization Training	Incorporate public health topics (e.g., maternal-child health, TB screening) into mentorship	Builds CHN capacity and supports comprehensive service delivery
Enhance Cross-Organizational Learning	Offer regular shared learning opportunities and joint training sessions	Encourages mutual understanding, role clarity, and cross-organizational cohesion
Secure Early Organizational Buy-In	Communicate mentorship value at all organizational levels, including leadership	Early engagement improves participation, resource allocation, and program prioritization
Develop Structured Educational Supports	Create webinars, orientation sessions, and step-by-step mentorship modules	Standardizes onboarding and supports consistency in mentorship delivery
Share Resources	Facilitate access to shared training and Indigenous-specific education materials	Promotes equity in access to culturally safe education and strengthens cross-organizational practice alignment

Recommendations continued Provincial-Level Support

While mentorship and training initiatives have demonstrated success at the organizational level, there are systemic challenges that require broader provincial-wide support to ensure equitable, sustainable support for nurses working in First Nations communities. These challenges extend beyond the scope of individual organizations, raising important questions about how broader collaboration and policy alignment can be achieved.

1. How can nurses (both RNs and LPNs) working in First Nations communities be supported at the same level as nurses employed by regional health authorities? There is a clear discrepancy in the level of organizational and structural support provided to CHNs compared to their regional health authority counterparts. Given the expectations placed on CHNs, what can be done at the provincial level to improve working conditions, enhance retention, and ensure equitable access to training, mentorship and resources?
2. How can Electronic Medical Record systems be streamlined across organizations to minimize documentation barriers while maintaining compliance with data governance and privacy laws? Inconsistent documentation platforms create inefficiencies and increase administrative burdens for nurses working across different systems. A more integrated approach could improve workflow, mentorship experiences and continuity of care.
3. Can a standardized process be established to ensure all CHNs working within a regional health authority's geographic boundaries have access to the regional health authority's public health information system and internal communication tools (e.g., Microsoft Teams)? Currently, CHNs face limitations in communication, which impacts their ability to coordinate care and participate in mentorship. Developing a clear, structured process for system access would support CHNs in delivering more cohesive and efficient services.
4. How can we support in-person training and support in communities that face additional barriers to full mentorship participation, such as geographic isolation or limited access to PHN mentors? In some settings, mentorship pathways may not be feasible, requiring alternative training and assessment approaches to ensure CHNs can still complete their immunization competency sign-off.
5. Is there a need for a renewed provincial immunization strategy or coordinated direction that explicitly addresses mentorship, workforce equity, and cross-organizational collaboration? A formalized strategy could provide the consistency and leadership required to move this work forward across all regions, while ensuring alignment with both Indigenous-led health initiatives and public health goals.

These questions highlight the critical need for provincial engagement and policy alignment to address ongoing systemic gaps. Without these higher-level supports, individual organizations will continue to face barriers in effectively integrating mentorship pathways for all communities.

Limitations

While the pilot project successfully demonstrated the value of mentorship and collaboration, several limitations influenced its implementation and outcomes.

- CHN Capacity: Many CHNs are currently experiencing burnout and overwhelm due to the demanding workload of their role, making participation in the pilot difficult. This mentorship initiative represents only a small part of the broader challenges of short staffing and the health care crisis, highlighting the need for more systemic support.

- Organizational Processes: Another challenge was the variation in organizational processes, which prevented CHNs from completing all portions of the Skills Checklist with the regional health authority. To address this, some components, such as reviewing the protocol for a needle stick injury, were left to be completed virtually with a Skills Checklist Assessor. However, this added an extra step to the process.

- Limited to RNs: This pilot project included only those immunizers trained as RNs; this choice was made as IH is still working on guidance to support the inclusion of LPNs in public health immunization services. While some First Nations communities do have LPNs who also require immunization support, the differences in roles and scope of practice created challenges in developing a standardized mentorship approach. Due to these inconsistencies and the need to align with existing regional health authority policies, LPNs were not included in this pilot. However, their need for support remains an important consideration for future mentorship initiatives.

- Demand of other Prioritized Activities: Scheduling constraints also posed difficulties, as the pilot took place between November and January, a period impacted by winter travel conditions and holiday schedules. Staff turnover further affected continuity, with one participant going on leave and another leaving their position entirely. Additionally, the pilot occurred during the period of the year where service demand for public health activities is at its peak. In addition to regular public health programs, public health also was also in the midst of the annual respiratory illness immunization campaign and delivering the first round of clinics of the year as part of the BC school-based immunization program in the November to January time period.

Limitations continued

- Technology: Technology-related barriers, such as differences in documentation systems and delays in training, also presented logistical challenges.

- Budget: Budget limitations were another key factor, as the grant funding only covered the salary of one part-time co-lead, leaving gaps in funding needed to support the full scope of project work. The limited timeline required significant effort to coordinate mentorship, logistics, and evaluation within a short period, making implementation more challenging.

Despite these limitations, the IH and FNHA Immunization Knowledge Sharing Walking Together project was a success due to the commitment and collaboration of all involved. Nurses, mentors, and partners worked together to navigate obstacles, ensuring that mentorship opportunities were meaningful and impactful. The experience gained from this pilot provides valuable insights for future iterations of mentorship models in similar settings.

Next Steps:
FNHA & Regional Health Authorities

1 Formalize
agreements and workflows across the province.

2 Finalize
internal processes for sustainable mentorship implementation.

3 Develop
a plan to include LPNs in mentorship opportunities. If LPNs are not currently involved in routine public health immunization service delivery within your health authority, consider how involvement of LPNs working in CHN roles could be supported and integrated in the future.

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MEMORANDUM OF UNDERSTANDING

Between

Interior Health Authority ("IH")

And

First Nations Health Authority ("FNHA")

(Individually a "Party" and collectively the "Parties")

Guiding Principles for Immunization Skills Checklist Assessors

in First Nations Communities

Purpose:

1. The purpose of this Memorandum of Understanding (MOU) is to establish a collaborative process and promote the opportunity for Community Health Nurses (CHN), who work in First Nations communities, to access local IH public immunization operations to gain experience and become competent and approved immunization providers.
2. The FNHA and IH are committed to working together to support CHNs to improve connection with local IH public health staff, and become approved and competent immunization providers. This will increase the opportunity for First Nations clients to access immunization services in their communities.

Background:

3. CHNs who work in some First Nations communities have specific and unique challenges as they often do not have any colleagues on-site and work in isolation in the community.
4. Improved connection with the closest IH public health team provides CHNs working alone in First Nations Communities a support structure and can facilitate having CHNs approved as competent immunization providers.

Term:

5. The term of this MOU will commence on November 1, 2024 and will end on October 31, 2029 (Term).
6. The Term of this MOU may be extended if the Parties agree to an extension in writing.

Current Process:

7. Currently, for CHNs to become an immunization provider, they must:

   a. register with the FNHA immunization team, who are part of the Community and Public Health Department of the Office of the Chief Nursing Operator (OCNO);
   b. sign up and successfully complete the online immunization course offered by the British Columbia Centre of Disease Control (BCCDC); and
   c. following successful completion of the above course, the FNHA immunization team will provide a copy of the Skills Checklist Assessors (SCA) to the CHN, who will then contact a SCA to arrange approval sign-off. SCAs are experienced nurses who either: work for FNHA as practice consultants; nurses with significant immunization experience who work in First Nations health service organizations or collectives; or who are FNHA-trained SCA CHNs (currently FNHA has 40 SCA CHN).

8. Due to various reasons, the above process may be unable to provide a CHN with timely approval to become an immunization provider in community. While these situations are rare, it is for this reason that the FNHA and IH are working together to formalize an alternative approval process in this MOU.

Alternative Process:

9. If a CHN is unable to follow the current process, outlined above, to become an approved immunization provider for First Nations communities, then the CHN will contact the FNHA immunization team, who will work with the CHN and FNHA regional nursing team, to determine next steps, and if needed, begin the process of engaging with Interior Health.
10. All requests for immunization skills checklist sign-off from FNHA, will be directed to the IH Population and Public Health Immunization Program. Prior to assessment, the CHN seeking immunization skills checklist sign-off will:

    a. have registered with FNHA, and have successfully completed the BCCDC immunization course, with a score of 100%;
    b. have reviewed the SCA with the practice consultant (or appropriate Lead/SCA via a virtual meeting), will have indicated their own competency, and will have indicated the competency assessed by the practice Consultant/appropriate Lead/ SCA where possible;
    c. have reviewed the BCCDC information and videos on informed consent;
    d. where possible, have attended the FNHA Fundamentals of Immunization workshop;

e. where possible, will have observed the provision of a variety of routine child and adult immunizations with an experienced immunization certified registered nurse;
f. have practiced their immunization skills for a range of ages as it pertains to:
    i. determining the appropriate immunization schedule for patients using the BCCDC Communicable Disease Control Manual, Chapter 2 Immunization;
    ii. providing patients appropriate and current education and information related to immunization and vaccines;
    iii. obtaining and documenting informed consent for patient immunization;
    iv. land-marking the immunization injection site;
    v. administering immunizations to patients under supervision; and
    vi. discussing management and mandatory reporting of anaphylaxis following immunization of a patient.

    Note: This practice must occur in the CHNs place of employment prior to the skills assessment, unless otherwise agreed to, in writing, by the CHN, FNHA and IH; and
g. communicate any checklist components (see Appendix A) requiring additional observation/practice to the IH "skills list assessor", usually a public health Community Integration Care Coordinator (CICC), prior to arranging the assessment date and time.

11. The immunization skills assessment will occur at an IH worksite normally supported by an IH CICC performing the assessment, unless otherwise agreed to, in writing, by the CHN, FNHA and IH Immunization program manager.

12. The immunization SCA performing the skills checklist for the CHN will:

a. be trained and experienced in performing an immunization skills assessment;
b. work with the requesting CHN and IH to arrange a mutually convenient date/time for the assessment to occur (note: priority will be given to IH requiring training and immunization skills checklist sign-off);
c. provide feedback to the CHN regarding strengths and areas requiring additional practice;
d. provide a hard copy of the completed immunization skills checklist to the CHN and their supervisor. Note: if additional practice is required and the skills list cannot be signed off, this feedback will be provided to the CHN and their supervisor in writing; and
e. remind the CHN to send a copy of the completed immunization skills checklist to the FNHA immunization team, who will then provide a certificate of successful completion to the CHN.

13. The following areas of the immunization skills checklist cannot be completed by a IH PHRN SCA:

a. an assessment of documentation of immunizations in non-IH related charting systems; and
b. ensuring proper clinic set-up in the home First Nations community of the CHN.

Confidentiality and Privacy:

14. The Parties agree that all personal information, personal health information and all other information shared between the Parties for the purpose of providing approval for CHNs to be approved as competent immunizers will be kept strictly confidential (Confidential Information).

15. The Parties agree that neither will collect, disclose, share, publish or otherwise report on any of the Confidential Information, without the express written consent of the other Party or as otherwise required by law. If disclosure is required by law, the disclosing Party will promptly notify the other Party of such required disclosure in writing.

Termination:

16. This MOU may be terminated by either Party in writing, upon 180 days notice.

Amendment:

17. This MOU may be amended from time to time, by either Party, with the written consent of all Parties.

Non-Binding:

18. This MOU is a non-legally binding statement of the Parties' mutual understanding and commitments over the Term of this MOU. This MOU is not intended to create any legally enforceable rights or obligations in respect of any Party and no legal rights or contractual obligations are created between the Parties by the execution of this MOU.

Governing Law:

19. This MOU will be governed exclusively by the laws of BC and the laws of Canada as applicable in BC.

Counterparts:

20. This MOU may be signed in counterparts and a signed copy may be delivered to the other Party by electronic transmission.

Notices:

21. Each Party agrees to notify the other Party as soon as possible of any significant or material change that may impact a Party's ability to meet its commitments under this MOU. Any notices under this MOU must be in writing and delivered by electronic transmission, addressed to the attention of the other Party:

First Nations Health Authority

Attention: Brittany Deeter, Director CDPPH,

OCNO, FNHA

Email: brittany.deeter@fnha.ca

Interior Health Authority

Attention: Manager, Immunization Program

Email: ImmunizationProgram@InteriorHealth.ca

This MOU is executed by the duly authorised signatories of each Party:

Dr. Martin Lavoie Chief Medical Health Officer Interior Health	March 14, 2025 DATE
Karen Littleton Director, Population and Public Health Interior Health	February 25, 2025 DATE
Monica McAlduff Chief Nursing Officer First Nations Health Authority	December 20, 2024 DATE
Lisa Montgomery Reid Vice-President, Interior Region First Nation Health Authority	January 9, 2025 DATE

Appendix 2: BCCDC Immunization Skills Checklist

Print Reset

BC Centre for Disease Control

Immunization Competency
Immunization Skills Checklist
January 2023

IMMUNIZATION SKILLS CHECKLIST

The Immunization Skills Checklist is based on the Immunization Competencies for BC Health Professionals and has incorporated aspects of the Indigenous Cultural Safety, Cultural Humility, and Anti-Racism Practice Standard outlined by certain BC health profession regulatory colleges. Immunizers can utilize the Immunization Skills Checklist to self-assess and create a plan for improvement as needed. The checklist includes columns that indicate **C** for Competent and **N** for Needs Improvement/Review. Complete the checklist with an immunization-competent assessor.

Note for Assessors: Selecting '**N**' in the Assessor column indicates sign-off is incomplete and the immunizer should formulate a learning plan and arrange a follow-up assessment.

For immunizer to complete:

Immunizer Name & Designation (e.g., RN, RPN, LPN, Pharmacist, ND):
Date exam completed: _____ ◯ Basic or ◯ Renewal

For assessor to complete:

Assessment type:	◯ In-person – Site: _____ ◯ Virtual (refer to organizational policies)

	Self-assessment		Assessor	
Clinic Setup and Vaccine Management	**C**	**N**	**C**	**N**
• Ensures anaphylaxis kit is complete and accessible. Ensures the epinephrine vials are not expired and are protected from light. Demonstrates awareness of process to replenish kit contents as needed.	◯	◯	◯	◯
• Demonstrates appropriate knowledge of the management of anaphylaxis and describes emergency plan to manage anaphylactic event or fainting episode	◯	◯	◯	◯
• Sets up clinic space, supplies and equipment to promote proper body mechanics for client and immunizer safety	◯	◯	◯	◯
• Aware of protocol for managing and reporting a needle stick injury	◯	◯	◯	◯
• Communicates considerations for delivering immunizations outside of traditional clinic settings (e.g. mass clinic or outreach clinic)	◯	◯	◯	◯
• Demonstrates appropriate knowledge of provincial guidelines for cold chain management for receiving, storing, handling, or transporting vaccines and demonstrates appropriate packing of vaccine in a cooler	◯	◯	◯	◯
• Demonstrates appropriate knowledge for Cold Chain Incident reporting process	◯	◯	◯	◯
Assessor Comments:				

	Self-assessment		Assessor	
Performs Appropriate Client Assessment Prior to Immunization	**C**	**N**	**C**	**N**
• Introduces self, welcomes client and establishes rapport. Respectfully engages with the client to identify, understand, and address the client's health and wellness goal for the appointment.	◯	◯	◯	◯
• Identifies any language or literacy barriers and makes appropriate accommodations. Welcomes support person *(e.g. family member or interpreter)*, if available.	◯	◯	◯	◯
• Assesses whether the client is comfortable in the environment or whether adjustments are needed (light, sound, etc.)	◯	◯	◯	◯
• Obtains permission from client for pre-vaccination assessment	◯	◯	◯	◯
• Assesses client health status and health history	◯	◯	◯	◯
• Assesses client's previous experience with vaccines, if any (e.g., what has worked well in the past to improve the immunization experience). Makes appropriate accommodations.	◯	◯	◯	◯

Appendix 2: BCCDC Immunization Skills Checklist

• Assesses client's immunization record for vaccine history, alerts, deferrals, precautions, exemptions, contraindications and adverse event history	○	○	○	○
• Assesses whether client received vaccines that may not have been recorded in the Provincial Immunization Registry (PIR) (e.g., Outside of BC or at a site that doesn't transfer into PIR)	○	○	○	○
• Recognizes and responds to the unique immunization needs of certain population groups. Determines whether client is eligible for additional vaccines based on age, health status, or other factors.	○	○	○	○
• Explains extra protection available with non-publicly funded vaccines that are recommended by NACI and how the client may access these vaccines	○	○	○	○
• LPNs only - Identifies process to consult/collaborate with or refer clients to an appropriate care provider before administering immunizations for clients requiring non-routine or off-schedule vaccines and/or clients not in stable and predictable states of health	○	○	○	○
Assessor Comments:				

	Self-assessment		Assessor	
Obtains Informed Consent	**C**	**N**	**C**	**N**
• Discusses the implications of the individual's rights, confidentiality, privacy, informed consent and informed refusal	○	○	○	○
• Describes the vaccination process and what the client may experience during the appointment	○	○	○	○
• Follows the seven steps for obtaining informed consent:	○	○	○	○
○ Step 1: Determine Authority to Provide Informed Consent	○	○	○	○
○ Step 2: Assess Capability to Give Informed Consent	○	○	○	○
○ Step 3: Provide Standard Information in a way that the client can understand: 1. Consent is obtained for a vaccine or a vaccine series 2. Consent is valid unless otherwise specified by the client, until revoked or as per health authority guidelines 3. Vaccine information contained in HealthLinkBC Files or other provincial resources if applicable: • Benefits of vaccination (personal, community) • Risk of not getting vaccinated (possibility of getting the disease) • Eligibility for the vaccine(s) • Common and expected adverse events • Possible serious or severe adverse events and their frequency • Contraindications and precautions • Disease(s) being prevented	○	○	○	○
○ Step 4: Confirm Understanding of Standard Information	○	○	○	○
○ Step 5: Welcomes questions and ensures the client has ample opportunity to ask any questions	○	○	○	○
○ Step 6: Confirms consent, determines if client is comfortable with process and that immunization may proceed	○	○	○	○
○ Step 7: Document Consent or Refusal	○	○	○	○
• Advises client/family to remain under supervision for at least 15 minutes after immunization (or 30 minutes if concern regarding allergic reactions)	○	○	○	○
• Provides aftercare instructions and explains how client can seek appropriate health care provider assistance for any adverse events	○	○	○	○
Assessor Comments:				

Appendix 2: BCCDC Immunization Skills Checklist

BC Centre for Disease Control

Immunization Competency
Immunization Skills Checklist
January 2023

Vaccine(s) to be administered	Self-assessment C	Self-assessment N	Assessor C	Assessor N
• Demonstrates utilization of the BC Immunization Manual to determine vaccine(s) to be administered according to guidelines of the BCCDC Immunization Program and the limits and conditions of their respective scope of practice	○	○	○	○
Assessor Comments:				

Prepares Vaccine Correctly	Self-assessment C	Self-assessment N	Assessor C	Assessor N
• Cleanses hands	○	○	○	○
• Maintains sterile and aseptic technique when preparing vaccine	○	○	○	○
• Selects correct vaccine, checks vaccine, expiry date, and dosage X 3 prior to administration	○	○	○	○
• Demonstrates appropriate use of multi-dose vials. Checks punctured multi-dose vials for expiry labels. Labels multi-dose vials with expiry date once punctured.	○	○	○	○
• Reconstitutes vaccine appropriately, if required	○	○	○	○
• Chooses correct needle length and gauge for the age and size of the client	○	○	○	○
• Demonstrates when more than one product will be administered to an individual, each product is labelled or placed on a tray that clearly identifies each vaccine	○	○	○	○
Assessor Comments:				

Demonstrates Correct Vaccine Administration	Self-assessment C	Self-assessment N	Assessor C	Assessor N
• Discusses and/or demonstrates age-appropriate strategies for reducing immunization injection pain and anxiety	○	○	○	○
• Instructs proper positioning either by showing parent to position and hold child appropriately or by instructing adult to sit and relax site of injection	○	○	○	○
• Demonstrates and/or explains accurate and age appropriate administration technique and site location	○	○	○	○
○ Intradermal	○	○	○	○
○ Intranasal	○	○	○	○
○ Oral	○	○	○	○
○ Subcutaneous	○	○	○	○
○ Intramuscular	○	○	○	○
• Safely handles and disposes of syringe	○	○	○	○
• Assists parent to comfort child as needed (if applicable)	○	○	○	○
Assessor Comments:				

Appendix 2: BCCDC Immunization Skills Checklist

BC Centre for Disease Control

Immunization Competency
Immunization Skills Checklist
January 2023

Documentation	Self-assessment C	Self-assessment N	Assessor C	Assessor N
• Documents consent or refusal for immunization	○	○	○	○
• Documents contraindications, if applicable	○	○	○	○
• Records the immunization encounter and relevant supplementary information within the appropriate documentation system accurately and completely	○	○	○	○
• Records the reason for and planned follow-up action when a scheduled immunization is not given	○	○	○	○
• Demonstrates appropriate knowledge of the process for reporting an adverse event following immunization (AEFI)	○	○	○	○
• Provides immunization record to client and explains process to access immunization records when necessary	○	○	○	○
Assessor Comments:				

Client Reminders	Self-assessment C	Self-assessment N	Assessor C	Assessor N
• Communicates to patient when next immunizations are due and how to schedule an appointment	○	○	○	○
• Reminds client to report possible serious adverse events. Provides appropriate contact information for reporting adverse events.	○	○	○	○
• Provides opportunity for any questions before completing the appointment (regarding appointment booking, aftercare, immunization records etc.)	○	○	○	○
Assessor Comments:				

	(Name)	(Signature)	(Date)
Immunizer:			
Skills Checklist Assessor(s):			
	(Name)	(Signature)	(Date)
	(Name)	(Signature)	(Date)

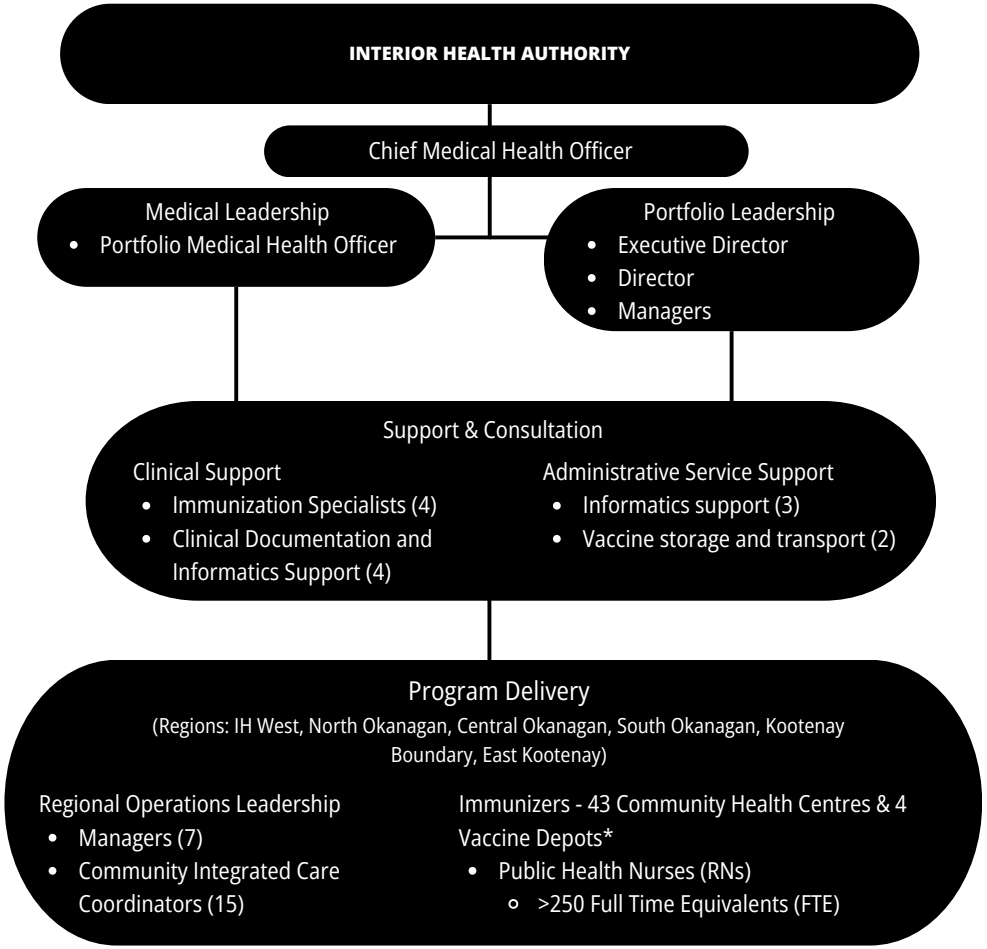
This version of the Immunization Skills Checklist has been revised in collaboration with the First Nations Health Authority to incorporate the Indigenous Cultural Safety, Cultural Humility, and Anti-Racism Practice Standard (BC College of Nurses and Midwives, College of Naturopathic Physicians of BC, College of Pharmacists of BC).

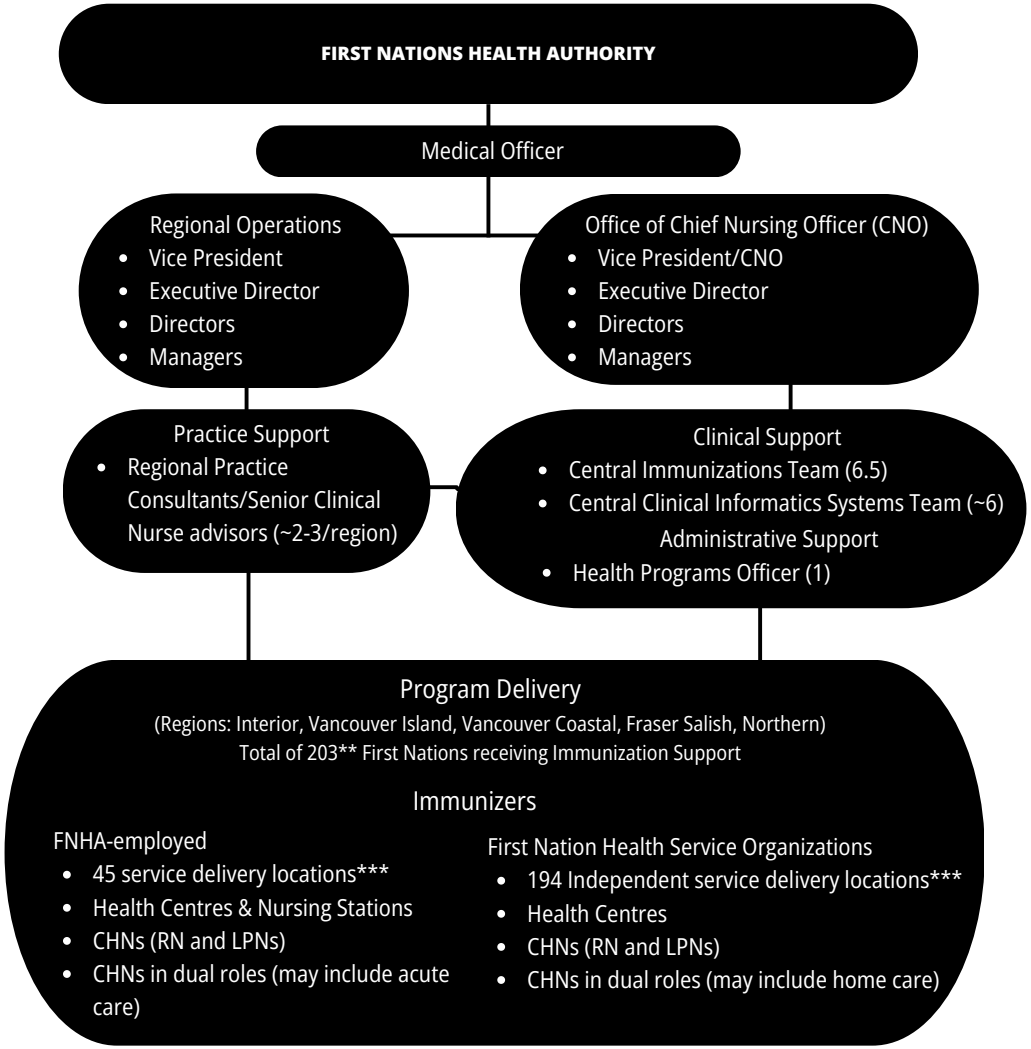
4 of 4

Source: http://www.bccdc.ca/health-professionals/education-development/immunization-courses/immunization-competency-course

Appendix 3: Organizational Structures of FNHA and IH

Note: This structure is presented solely for the purposes of the Walking Together report. It reflects a snapshot in time and is intended only to support comparison between organizations in the context of immunization services during the pilot project. Roles, structures, and processes are subject to change and should not be used or referenced beyond this context.





*Distributed facilities located in each region of IH that act as central hubs for biologic product storage and allow for transport to health centres and communities when they are needed. The depot model allows for just-in-time vaccine supply to communities and minimizes the amount of vaccine that is stored in health centres without back up power and other safe-guards due to site limitations.

**May have >1 location

***May have <1 FTE nurse per location

For further information about the Interior Region geography and First Nation communities, see https://www.fnha.ca/about/regions/interior

Appendix 4: Partner Engagement Details

Group	Goal	Function

Advisory Group (Included Project Coordinators, Managers, Clinical Nurse Specialists and Practice Consultants)	To facilitate efficient and timely cross-organizational collaboration for monitoring project progress and outcomes.	• Virtual biweekly meetings
		• Representatives from:
		  ◦ FNHA Provincial CDPPH Team
		  ◦ FNHA Interior Regional Team
		  ◦ Interior Health
		  ◦ Public Health Agency of BC

IH Operations Leads	Share knowledge of project goals, consider implications of project work, and gain insights from key partners applicable to the project.	• Understanding differences and similarities in organizational structures and processes. • Collaborating to ensure success of pilot project and sustainability of partnerships. • Trouble-shooting implementation of mentorship and sign-off pathways from an operational lens.
FNHA Immunization Working Group (Included Health Programs Officer)	Share knowledge of project goals, consider implications of project work, and gain insights from key partners applicable to the project.	• Sharing updates and soliciting feedback. • Being aware of potential overlap of work.
Indigenous Services Canada Immunization Networking Group	Share knowledge of project and gain insights from colleagues providing immunization support to nurses working in Indigenous communities in other jurisdictions nationally.	• Capturing a macro view of the training and support processes across the country. • Considering ways to support each other towards shared goals considering similar challenges.

Appendix 4: Partner Engagement Details

Group	Goal	Details

Community Health Nurses	To understand the perspectives and experiences of CHNs.	• Interviews were conducted with five CHNs who work in First Nations communities in the Interior Region and had recently completed the FNHA Immunization Competency Program to inform the goals of the pilot project.
		• Explored current role, previous nursing experience, experience with the FNHA Immunization Competency Program including the immunization skills checklist sign-off or renewal process.
		  ◦ Challenges and strengths were discussed.
		  ◦ Opportunity to provide suggestions for improvement.
		• Interviews were transcribed, coded for themes and compared to other perspectives and literature to inform project work.

Skills Checklist Assessors	To understand the perspectives and experiences of FNHA-designated Skills Checklist Assessors.	• Interviews conducted with six FNHA-designated Skills Checklist Assessors who provide Immunization Skills Checklist sign-off for CHNs in the Interior Region.
		• Current role, previous nursing experience with FNHA Skills Checklist Assessor training & support, experience providing Skills Checklist Assessor support to CHNs were reviewed.
		  ◦ Challenges and strengths were discussed.
		  ◦ Opportunity to provide feedback about the Skills Checklist Assessor role, training and support.
		• Interviews were transcribed, coded for themes, compared to other perspectives and literature to inform project work.

Community Health Practice Consultants and Regional Nurse Manager	To understand the perspectives and experiences of FNHA staff providing immunization & general practice support to CHNs working in First Nations communities.	• Interviews were conducted with 3 FNHA Community Health Practice Consultants (providing support to First Nations Health Service Organization employed CHNS) and 1 Regional Nurse Manager (providing support to FNHA employed CHNs). • Explored their experience with providing practice support to new-to-immunizing nurses and those renewing immunization competency. • Interviews were transcribed, coded for themes, compared to other perspectives and literature to inform project work.

Appendix 4: Partner Engagement Details

Group	Goal	Details
Partnership Accord Technical Table (PATT)	To provide space for any questions, concerns, or dialogue from Nation Representatives.	• Interior Region Director of Health Emergency Management engaged with Partnership Accord Technical Table in alignment with regional engagement pathways. • The project background and MOU were shared with the PATT on January 9, 2025, to highlight how this work aligns with Directive 1 (Community-driven, Nation-based) and ensure space for any questions, concerns, or dialogue from Nation Reps were incorporated into the regional perspective. • The feedback from the Nations was overwhelmingly positive, with consensus that these types of partnerships are instrumental in both building capacity for First Nations and FNHSO nurses, as well as showing how the health system can work in partnership to address systemic barriers.

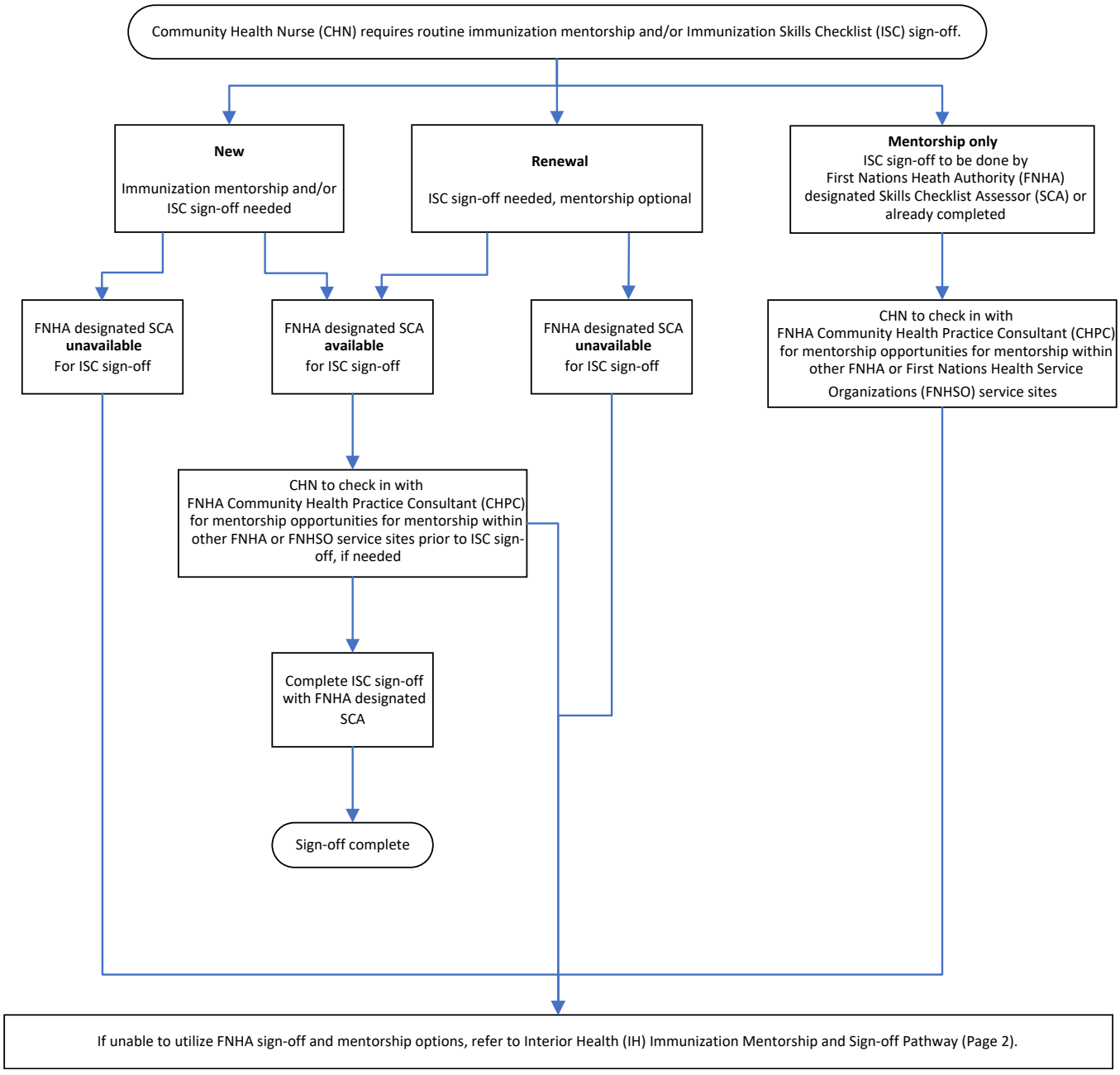
FHNA and IH Teams: Clinical Informatics Systems	To determine best clinical informatics system option for documentation of immunizations during FNHA/IH Mentorship and Sign-Off pathway.	• Clinical applications to document immunizations vary between organizations.
		• All immunizations must be documented in a manner that feed into the Provincial Immunization Registry. Panorama is BC's central repository for immunization records.
		• IH uses Panorama to document immunizations.
		• Access to clinical applications varies between First Nations communities.
		• Privacy considerations between organizations is complex.
		• The use of Expanded Immunization eForm was determined to be the best option for immunization documentation for the Mentorship Pathway and Sign-Off pathway for the following reasons:
		  ◦ Data flows into Panorama in near-real time.
		  ◦ Relatively quick turnaround time for account provisioning.
		  ◦ No VPN/TWINGATE required for access. Nurse must have work computer, BC Service Card App and access to Wifi.
		  ◦ Easy platform to learn and use.
		  ◦ Displays immunization data as seen in Panorama including: Immunization history, Immunization forecaster, AEFI, and Risk Factors* required for immunization provision best practice.
		  ◦ Allows for direct documentation of ALL immunizations administered and associated consent.
		  ◦ Downtime forms can be utilized for charting supplemental information as required.
		  ◦ Downtime forms can also be used to chart immunizations if system is unavailable.

Appendix 5: Mentorship Workflow

First Nations Health Authority
Health through wellness

First Nations Health Authority and Interior Health Immunization Mentorship and Sign-Off Pathway

Interior Health

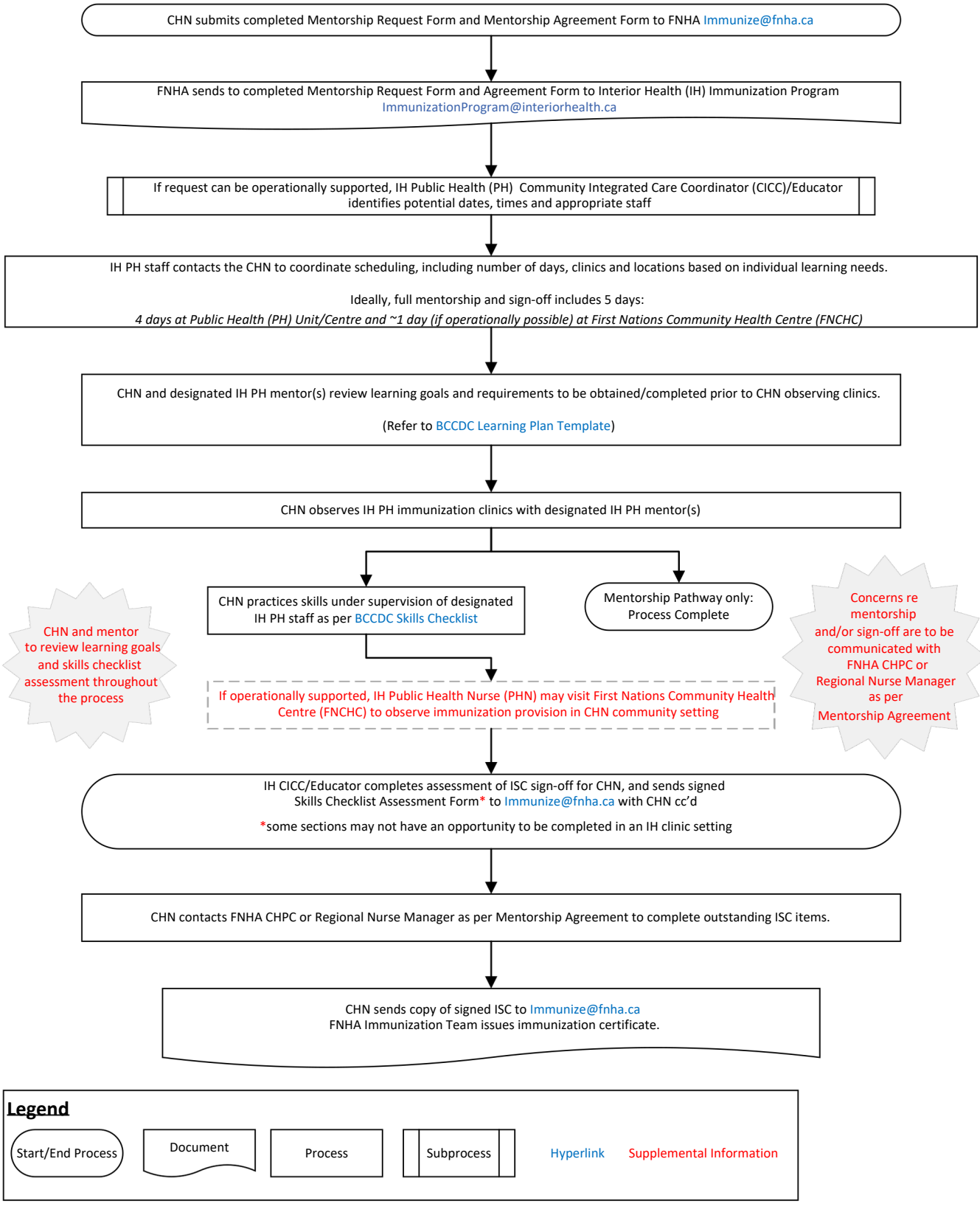


Legend

Start/End Process | Process | Supplemental Information

Appendix 5: Mentorship Workflow

First Nations Health Authority and Interior Health
Immunization Mentorship and Sign-Off Pathway



Appendix 6: Mentorship Request Form

First Nations Health Authority
Health through wellness

First Nations Health Authority and Interior Health Authority
Immunization Mentorship and Sign-Off
Request Form

***Purpose:** To request participation in the Regional Health Authority Mentorship and Sign-Off Pathway as part of the FNHA Immunization Competency program.*				
INSTRUCTIONS: Community Health Nurse (CHN) to complete WHITE SECTIONS of this form and return to Immunize@fnha.ca				
CHN *Must be a Registered Nurse to be eligible for this pathway (currently)	**Name:**		**Designation**	
	Email:		**Job Title**	
	Phone:		**Region**	
	☐ **Full-time** ☐ **Part-time** **Days of work:**		**Experience**	**Years of nursing experience:** **Years of immunizing experience:**
Heath Centre			**Does CHN have access to a work laptop?** ☐ Yes ☐ No	**Who should be contacted with concerns about mentorship and/or sign-off?** ☐ Health Director ☐ CHPC ☐ RNM ☐ Other (Indicate Name, Phone and Email below)
Community				

Mentorship and Sign-Off Pathway request:

☐ New Immunization Competency requiring **both** Mentorship and Sign Off ☐ New Immunization Competency requiring Mentorship

☐ Renewal of Immunization Competency requiring **both** Mentorship and Sign Off ☐ Renewal of Immunization Competency requiring Sign-Off **only** ☐ Mentorship **only**

"Mentorship" is defined as observation and practice opportunities for immunization practice with ongoing relationship building between CHNs and RHA staff	**"Sign-off"** includes assessment and completion of the BCCDC Immunization Skills Checklist and is based on the Immunization Competencies for BC Health Professionals

Please review the Immunization Mentorship and Sign-Off Pathway and Q&A with your Health Director or Manager.
To confirm their support for your participation, have them complete and sign the section below:

Title	**Health Director or Manager (CHN's supervisor)**	**FNHA CDPPH Manager** *(will be signed once sent to immunize@fnha.ca)*	**IH Public Health Manager**	**IH Public Health Community Integrated Care Coordinator (CICC)**	**Community Health Practice Consultant (CHPC) or Regional Nurse Manager (RNM)**
Name					
Email					
Phone					
Signature					*(no signature required)*
Date					

FNHA Immunize@fnha.ca will review information on completed form and send to IH. If request is operationally feasible, IH will connect directly with CHN.

First Nations Health Authority
Health through wellness

First Nations Health Authority (FNHA) and Interior Health Authority (IH)
Immunization Mentorship and Sign-Off
Agreement Form

Purpose: *This form will serve as the official agreement of all parties involved in the (FNHA/IH) Memorandum of Understanding, where immunization observation and practice opportunities take place in IH and/or Community Health Nurse (CHN) work sites. It outlines the requirements for CHNs before, during, and after completing the Immunization Mentorship and Sign-Off Pathway.*

Please note: Mentorship and Sign-off with IH may not fully include all CHN-specific immunization programming requirements.

CHN to complete white sections		*IH to complete grey sections*	
Name of CHN		**Signature**	
Job Title		**Region**	
Designation Registered Nurses eligible only (currently)		**CHN Contact**	**Email:** **Phone:**
Health Centre		**Community**	

☐ **CHN to review the Mentorship and Sign-Off Pathway and FAQ with Health Director or Manager.**

**Health Director or Manager must acknowledge support by signing this form below*

Title	Health Director or Manager (CHN's supervisor)	FNHA CDPPH Manager *(will be signed once sent to immunize@fnha.ca)*	IH Public Health Manager	IH Public Health Community Integrated Care Coordinator (CICC)	Community Health Practice Consultant (CHPC) or Regional Nurse Manager (RNM)
Name					
Phone					
Email					
Signature					*(no signature required)*
Date signed					

Mentorship and Sign-Off Pathway request:

☐ New Immunization Competency requiring **both** Mentorship and Sign-Off
☐ Renewal of Immunization Competency requiring **both** Mentorship and Sign-Off
☐ New Immunization Competency requiring Mentorship **only**
☐ Renewal of Immunization Competency requiring Sign-Off **only**
☐ Mentorship **only**

	Pre-Requisites for CHN: Before Mentorship and Sign-Off	Date completed
☐	Send Immunization Competency Program Registration Form to immunize@fnha.ca	
☐	FOR CHNS NEW TO COMPLETING IMMUNIZATION COMPETENCY: • Complete the BCCDC Immunization Competency Course and Exam and obtain100% (Course # 20112, found on the PHSA website: LearningHub) FOR CHNS RENEWING IMMUNIZATION COMPETENCY *(required every 3 years)* • Complete the BCCDC Immunization RENEWAL Exam and obtain 100% (Course # 20801, PHSA website LearningHub)	
☐	Immunization Communication *(*not required for CHNs renewing competency - review as needed)* ☐ Immunization Communication Module (Learning Hub) ☐ BCCDC Immunization Communication Tool	
☐	Informed Consent *(*not required for CHNs renewing competency - review as needed)* ☐ BCCDC information and videos on informed consent	
☐	Cold Chain: Vaccine Handling and Storage: *(*not required for CHNs renewing competency - review as needed)* ☐ BCCDC Vaccine Storage and Handling Course ☐ Vaccine Storage and Handling Quick Reference Guide ☐ Cold Chain Checklist ☐ Handle Vaccines with Care	
☐	Review BCCDC Blood and Body Fluid Exposure (BBFE) Management guideline and any site specific policy / procedure for BBFE *(*not required for CHNs renewing competency - review as needed)*	
☐	Complete the FNHA RISE Course: Immunization Programming - Where Do I Begin *(*not required for CHNs renewing competency - review as needed)*	
☐	Review FNHA Where Do I Start guide (A toolkit for developing immunization programs in First Nations communities in BC) *(*not required for CHNs renewing competency - review as needed)*	
☐	Review CHN Action Checklist to review considerations for setting up an immunization program *(*not required for CHNs renewing competency - review as needed)*	
☐	Review the Administrative Considerations Checklist and review with Health Director *(*not required for CHNs renewing competency - review as needed)*	
☐	Clinical applications and Documentation: *Due to cross-organizational work, CHNs will be charting immunizations administered within IH clinics in the Expanded Immunization eForm clinical application.* ☐ Set up Immunization Expanded eForms account by emailing: immsbc@fnha.ca ☐ Have access to a work lap top that can be taken to and used within IH clinic setting ☐ Take the Immunization eForm Training Course in RISE (15 min)	

	CHNs can chart consent and immunizations administered directly into Expanded Immunization eForms, but will have to chart dissent, deferrals, special considerations, risk factors and adverse events following immunization (AEFIs) using Panorama downtime forms, which will be given to the IH mentor for back-data entry into Panorama. ☐ Refer to the PHSA website here for Panorama Downtime Forms for use as per bullet above and/or in case of eForms outage. ☐ Contact immsbc@fnha.ca with any eForm access issues	
☐	Confidentiality and Privacy: ☐ The Parties agree that all personal information, personal health information and all other information shared between the Parties for the purpose of providing approval for CHNs to be approved as competent immunizers will be kept strictly confidential (Confidential Information). ☐ The Parties agree that neither will collect, disclose, share, publish or otherwise report on any of the Confidential Information, without the express written consent of the other Party or as otherwise required by law. If disclosure is required by law, the disclosing Party will promptly notify the other Party of such required disclosure in writing.	
☐	Review the Immunization Skills Checklist for familiarity and complete self-assessment	
☐	Review Immunization Skills Checklist with CHPC/RNM via virtual (or in-person) meeting to discuss any concerns and local considerations. Connect to FNHA Immunization team if CHPC/RNM not available (immunize@fnha.ca)	
☐	Review specific sections of the Immunization Skills Checklist that may have local considerations (refer to Where Do I Start guide). Be prepared to demonstrate knowledge verbally of the **local process/protocol** to mentor(s) regarding the following sections:	
	☐ Clinic Setup and Vaccine Management • Obtaining and maintaining anaphylaxis kit • Management of anaphylaxis and emergency plan to manage anaphylactic event or fainting episode • Local clinic space set up considerations • Managing and reporting a needle stick injury (blood and body fluid exposure management) • Cold chain management including receiving, storing, handling, or transporting vaccines • Cold chain incident reporting process	
	☐ Incidents and reporting • Process for Incident Reporting (ie. vaccine error)	
	☐ Adverse Events Following Immunization (AEFI) • Process for reporting and documenting an adverse event following immunization (AEFI)	
	☐ Documentation • Process to access immunization records when necessary	
☐	Reviewed and filled out the BCCDC Learning Plan Template to outline personal learning goals	
☐	Print copy of Immunization Skills Checklist and BCCDC Learning Plan Template and bring to RHA public health unit for RHA mentor to review and fill out	
☐	Send completed Immunization Mentorship AGREEMENT form and Immunization Mentorship and Sign-Off Request form to immunize@fnha.ca	

	Ideal but Not Required: Before Mentorship and Sign-Off	Date completed
☐	Receive basic orientation to CHN role with Community Health Practice Consultant (CHPC) or Regional Nurse Manager (RNM) either in-person or virtually	
☐	Review BCCDC Learning Plan Template with CHPC/RNM to review learning goals	
☐	Attend FNHA Immunization Fundamentals Workshop If **not** completed: 1. Date of next workshop: Does participant plan to attend the next workshop offered? ☐ Yes ☐ No	
	Either Before or During Mentorship and Sign-Off	**Date completed**
☐	**CHN has opportunity to OBSERVE** provision of a variety of routine child and adult immunization with an experienced immunization competent Registered Nurse. *If done **before** mentorship: discuss previous observation with mentor(s) to help identify learning goals during mentorship (e.g. age range of infants/children/adults, number of appointments observed, location of observation, type of practitioner observed, etc.)	
☐	**CHN has opportunity to PRACTICE** immunization skills with a variety of routine child and adult immunization. i. Determining the appropriate immunization schedule for patients using the BCCDC Communicable Disease Control Manual, Chapter 2 Immunization ii. Providing patients with appropriate and current education and information related to immunization and vaccines using standard information (ex. HealthLinkBC Files) iii. Obtaining and documenting informed consent for patient immunization iv. Land-marking the immunization injection site v. Administering immunizations to patients under supervision of IH mentor(s) who are Registered Nurses who work in Public Health vi. Discussing management and mandatory reporting of anaphylaxis following immunization of a patient	
	During Mentorship and Sign-Off	
	Beginning of Mentorship Period: Review BCCDC Learning Plan Template with mentor(s) to identify goals for learning and mentorship time period. Determine plan for observation and practice to ensure BCCDC Immunization Skills Checklist requirements are met as completely as possible.	
	Ongoing Mentorship Period: Use BCCDC Immunization Skills Checklist throughout mentorship to self-assess practice and adapt learning plan as needed.	

End of Mentorship Period: BCCDC Immunization Skills Checklist assessment of CHN is completed with Regional Health Authority (RHA) designated assessor. CHN to connect with FNHA CHPC/RNM for any items that cannot be completed on the BCCDC Immunization Skills Checklist with the RHA .

Nurse Mentor(s) and/or Educator			
Name			
Contact Information			

	If Operationally Feasible *(ideal but not required for CHN to complete sign-off)*	**Date completed**
☐	Connect with the public health unit Prevention Services Assistant (PSA) to discuss vaccine management, including process for ordering vaccine (particularly if this is the local health unit in which the CHN will be placing biological orders in future)	
☐	Observe and practice intradermal injections (TSTs)	
	After Mentorship and Sign-Off	**Date completed**
☐	CHN to notify CHPC/RNM that mentorship and/or Immunization Skills Checklist completed **if Immunization Skills Checklist incomplete, see note in green box below*	
☐	CHN to send completed Mentorship Agreement Form to immunize@fnha.ca for tracking purposes	
☐	CHN to send completed Mentorship Agreement Form to immunize@fnha.ca for tracking purposes	

***NOTE:** If Immunization Skills Checklist incomplete, CHN to connect with CHPC and/or FNHA Immunization Team (immunize@fnha.ca) to follow up on next steps to complete sign-off.

- Completed Immunization Skills Checklist may have signatures from both IH AND FNHA designated SCA at the bottom of the checklist
- If more than one person is completing final sign off with CHN, additional person(s) writes name and designation in "Assessor Comment" box for incomplete sections AND signs name to bottom of Immunization Skills Checklist form to complete sign-off

Appendix 8: Mentorship Frequently Asked Questions

Frequently Asked Questions (FAQ)

Walking Together: Immunization Knowledge Sharing

Appendix 8: Mentorship Frequently Asked Questions

1. What is happening?

Interior Health Authority (IHA) and First Nations Health Authority (FNHA) are collaborating in a pilot project to build mentorship pathways and relationships between Public Health Nurses (PHNs) and Community Health Nurses (CHNs) with hopes of expanding the process across the province.

2. Why is this happening?

As the landscape of health care has changed globally, we are working within the existing and escalating challenges exacerbated by the COVID-19 pandemic. Nursing staffing shortages and geographical limitations have presented a unique challenge in our existing immunization skills checklist sign-off model for CHNs. Some areas across the province are now experiencing shortages in the availability of experienced nurses to provide mentorship and BCCDC Immunization Skills Checklist (ISC) sign-off for CHNs that have limited experience in providing immunizations or who require renewal of their BCCDC skills assessment.

3. What is the role (scope) of a Community Health Nurse (CHN)?

For the scope and context of this project/document, Community Health Nurses (CHNs) are Registered Nurses who work in First Nations communities in an expanded Public Health Nurse role and are either employed directly by the First Nations community (referred to as First Nations Health Service Organizations/FNHSO's), or directly by FNHA.

CHNs hold generalist roles, and their programming covers Communicable Disease prevention and control (including Tuberculosis, STBBI, Immunizations, Communicable Diseases, and Communicable Disease Emergency preparedness planning), Maternal Child Health, and Health Promotion and Prevention programming (School Health, Harm Reduction, Chronic Disease prevention and management, Injury Prevention, Mental Wellness, Women's and Men's health).

Most CHNs also hold the administrative duties that come with programming, including reporting, vaccine fridge monitoring and maintenance schedules, ordering of vaccines, ordering supplies and equipment and reconciling purchase orders. Some CHNs also hold certified practice and offer programming related to their designation (such as OAT prescribing and STI screening and treatment). Sometimes CHNs hold a dual Nursing role where they also provide Home Care Nursing. Cultural safety and Community Engagement are guiding principles in the population health promotion work of a CHN.

4. What is the role (scope) of a Public Health Nurse (PHN)?

Public Health Nurses (PHNs) are Registered Nurses who work within Interior Health. In accordance with established vision and values of the organization, the PHN, as an integral member of the Public Health Services team, provides nursing services within the

framework of the Population Health/Health Promotion Model. Inherent in the role are knowledge, skills and abilities specific to health promotion and education, epidemiology, communicable disease prevention and control, community development, primary health care, social determinants of health and illness, and disease and injury prevention. Public Health Nurses translate knowledge from the health and social sciences to support health enhancing behaviours to diverse individuals, families, and population groups through universal and targeted interventions, programs and advocacy. Services are offered in communities, schools, homes and outreach locations to individuals, families and communities.

5. What does the term "mentorship" mean in this context?

The definition of mentorship for the purposes of the project: *observation and practice opportunities with ongoing relationship building*.

6. Why does the workflow have some CHNs partaking in mentorship only?

Some CHNs may have already had their Immunization Skills Checklist Sign-off completed, which is the minimum requirement to provide immunizations. However, due to the limited number of childhood immunizations needed in the Communities in which they work, they may not have had opportunities to administer vaccines regularly enough to feel confident in their practice and may benefit from a refresher. This process is designed to be adaptable and focus on individual learner needs.

7. What is expected of CHNs?

CHNs are expected to complete their regular orientation and the BCCDC Competency exam before completing their Immunization Skills Checklist Assessment. In addition, CHNs are expected to follow the guidance on the Request and Agreement Forms. The CHN will have opportunity to share with public health staff about working in First Nations communities, including relational, culturally safe approaches to care.

8. What is expected of PHNs?

PHNs are expected to provide opportunities for CHNs to observe and practice immunization skills, as well as provide feedback for the CHNs as agreed upon in the learning goals. Ideally these opportunities will include a variety of age groups in Child Health Clinics (CHCs) and other immunization clinics. PHNs will have opportunity to learn from the CHN about working in First Nations communities and about the CHN role.

9. What does this relationship look like?

Currently, we are focusing on the shared immunization practice between PHNs and CHNs. This begins with providing immunization mentorship opportunities for CHNs who work in First Nations Communities to build their immunization practice with support of PHNs. This initial mentorship relationship is a launching pad for building a community of support

among nurses to provide equitable, culturally safe care for all the members of their shared communities.

10. Who completes the BCCDC Immunization Skills Checklist Sign-off for CHNs?

For this pilot, if the sign-off pathway is selected, the Community Integrated Care Coordinator (CICC) or Educator at the IH clinic will assess the CHN's practice. For future implementation, if a CICC or Educator is unavailable to assess the CHNs practice, CHNs may be assessed by an IH-designated competent PHN to complete this in leu of the CICC or Educator.

11. What is a FNHA-designated Skills Checklist Assessor (SCA)?

SCAs are experienced immunizing nurses working within FNHA or First Nations Communities that have received additional training to provide immunization skills checklist assessments for CHNs working in First Nations Communities. To become an SCA, a CHN must be an RN with a current BCCNM license and have at least three (3) years of immunization experience in BC and have completed the Renewal Exam for Nurses working in Public Health. They must possess the skill, ability, and interest in assessing nursing practice and providing mentorship, as well as have support from their supervisor to travel (within reason) to provide the Immunization Skills Checklist assessments for nurses in First Nations Communities. SCAs go above and beyond to provide this service to support nurses working in First Nations Communities, as they voluntarily take the training (typically an in-person or virtual workshop provided by FNHA) and agree to have their name on a list of FNHA-designated SCAs. CHNs seeking immunization skills checklist sign-Off contact an SCA on the FNHA designated SCA list to arrange for sign-off (which is typically done in the CHN's community, unless arranged otherwise). The SCA role is similar to the CICC or Educator role, who provide the BCCDC skills checklist sign-off within IH. However, SCAs typically are not in a formal leadership role.

12. What is the role of the Community Health Practice Consultant (CHPC)?

CHPCs provide consultation, peer support and guidance to nursing practice for nurses employed by First Nations. They provide general orientation and support to nurses and health directors for community health and home care nursing programs, as well as education and clinical resources for CHNs.

13. What is the role of the FNHA Immunization Team?

The FNHA Immunization Team:

Offers training and workshops such as:
- Immunization Fundamentals Workshop – for all new immunizers or new to BC immunizers

    - o Skills Checklist Assessor (SCA) training workshops---to support assessors to provide skills checklist support to new and renewing immunizers.
- Supports activities that inform, educate, and create awareness on vaccine-preventable diseases and immunization through mechanisms such as workshops, promotion resources, teleconferences, and social marketing campaigns.
- Provides direct clinical support to nurses offering immunization programs in First Nations Communities (i.e. scheduling consults, incident report clinical guidance, practice guideline updates, etc)
- Advocates for current practice and new developments in immunization programing and population and public health prevention programs to be delivered with a First Nations focus (ex. BCIC projects, participation on various federal, provincial, and regional tables)

The FNHA Immunization Team also oversees the Immunization Competency Program (ICP) to support all First Nations in BC, including FNHA direct-service sites and Communities with transferred health services.

14. What is the FNHA Immunization Competency Program (ICP)?

The intention of the ICP program is to ensure that all CHNs working in First Nations Communities across BC who are providing autonomous immunization programming have:

- The tools they need to deliver essential public health immunization programs and services.
- Clinical support to fulfill the immunization competencies as per the British Columbia Centre for Disease Control (BCCDC) immunization manual (Decision Support Tool or DST) and within the scope and practice of a Registered Nurse or Licensed Practical Nurse.
- Support to deliver an immunization program with the goal of ensuring basic immunization services in First Nations are comparable to those delivered by regional health authorities.

15. Are there differences in practice that nurses should be aware of?

Yes, although there are similarities, there are some processes that differ. For example, CHCs are structured differently than immunization appointments in First Nations Communities. CHNs may not have the capacity to schedule back-to-back appointments or may schedule them based on the availability of the family or within other appointments. The population size varies in First Nations communities which means appointments may be structured differently or the CHN may be providing vaccines to a mix of age groups in any given clinic.

CHNs often have broader responsibilities for immunization programming in First Nations Communities, which could include being responsible for booking appointments, ordering

immunization supplies and biologicals, ensuring cold-chain maintenance and ordering & maintaining supplies for anaphylaxis kits. IH clinics often have clerical support and systems to organize and book clinics, as well as designated roles for supplies & biological ordering and maintenance.

There are also differences related to reporting for needle stick injuries, incidents, or adverse events.
During the mentorship period, CHNs and PHNs are encouraged to talk about the similarities and differences they notice and varied approaches to health promotion and prevention practices for mutual learning and knowledge sharing.

16. The Child Health Clinics involve more than immunizations, how does that fit?

Although the developmental assessments and health promotion done in CHCs are not the focus of the mentorship in the pilot project, these are valuable areas worthy of reviewing. Observation of these areas are helpful for CHNs as they may be applied in their own practice setting. Additionally, CHNs can provide context to PHNs about how these assessments and health promotion activities may be conducted differently in First Nations Communities, with a lens to cultural safety.

17. What about ordering biologicals and cold-chain maintenance learning opportunities?

CHNs are typically responsible for ordering vaccine from their local health unit and maintaining cold-chain status of vaccines in Community. During mentorship and sign-off shifts, it would be beneficial if the CHN had the opportunity to connect with the prevention services assistant (PSA) to discuss the IH process for ordering vaccine and to learn tips & tricks for biological monitoring and cold chain maintenance.

18. Why are e-Forms used for documentation?

Due to cross-organizational data sharing considerations, CHNs will be using Expanded Immunization eForms to view and document vaccine administration in IH clinic settings.

19. How will CHNs use e-Forms to view and document immunization during IH

CHNs will bring a work laptop to the IH clinic site. The IH CICC or Educator will provide the CHN with instructions on how to access wifi onsite, if available. Prior to arriving onsite, CHNs will have the Expanded Immunization e-Forms account set up by FNHA and will complete self-directed training on how to document in e-Forms.
CHNs will be able to view client immunization history, forecaster, risk factors, special considerations as well as any recommendations for documented adverse events following immunization.

CHNs will be able to document consent and vaccine administration in real-time directly after immunization provision within the clinic setting.

Any supplemental information (dissent, risk factors, special considerations, AEFIs, etc) will need to be charted on a downtime form. The IH PHN mentor will document the supplemental information into Panorama. Ideally, per best practice, this should happen in the clinic setting where the CHN can verify the information in Panorama.

20. Will there be travel involved?

Yes, this could include travel to and from local health units and/or First Nations Community Health Centres for mentorship. Time and travel related to mentorship opportunities are to be covered by the Nurse's employer.

21. After the mentorship and/or sign-off pathway is completed, is there a continued expectation for IH in the CHN's immunization practice?

No, once the process is completed, IH staff are not responsible for anything beyond the expectations on the agreement form. FNHA has an internal process for CHN support in their immunization practice and clinical immunization questions/consults.

22. The workflow includes a note about "if operationally supported." What happens if the request cannot be operationally supported?

Every effort will be made to accommodate requests through this pathway. However, there may be instances where the request cannot be accommodated at that time. Both IHA and FNHA have a shared responsibility to communicate with each other at a future time regarding request accommodation feasibility or if CHN support via the Mentorship and Immunization Competency Pathway is still needed.

23. What does the ongoing relationship mean beyond the mentorship period and/or sign-off?

The First Nations Perspective on Health and Wellness Tool describes relationships as being about togetherness, team-building, capacity building, nurturing, sharing, strength and love, involving mutual accountability and reciprocity. The relationships built in the mentorship and/or sign-off pathway are meant to be starting points, with the IH team sharing specific information related to their immunization clinics and CHNs sharing information about their practice in First Nations Communities. By walking together, PHNs and CHNs have the capacity to build a community of knowledge from their collective practices. These initial connections can be made stronger through understanding of the individuals and organizations providing health services, which may be called upon in future when collaboration is needed.

24. Does the ongoing relationship include consultations for immunization-specific situations?

No, CHNs should refer to their internal FNHA-designated supports for consultations after completing the mentorship and/or sign-off pathway.

25. Is there a tracking system to determine how often the FNHA/IHA Mentorship and Sign Off Pathway is being utilized?

Yes, FNHA has internal evaluation processes to track the usage of this pathway.

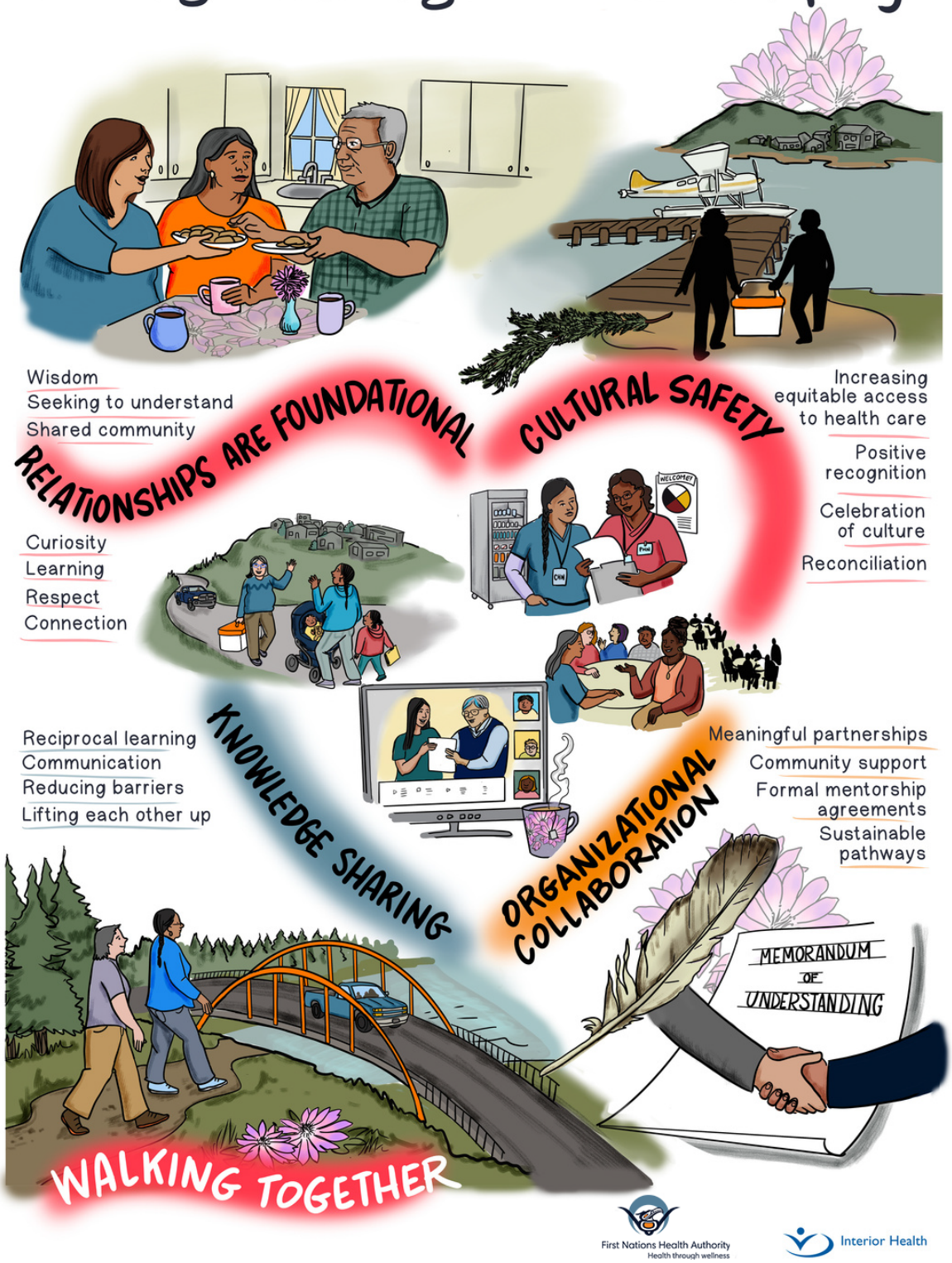
26. What is the evaluation process?

The project coordinators within FNHA have been gathering feedback throughout the project, from initial stages of planning in an ongoing process. Interviews with CHNs and Practice Consultants within FNHA informed the project planning. After their mentorship shifts, CHNs will have an opportunity to share their experiences as part of the evaluation process and are also welcome to provide feedback to the project coordinators throughout the project. IH staff involved in the project (e.g., PHNs, CICCs, Educators) will also have an opportunity to share formal feedback through a process co-developed with their leadership.

27. What is the long-term plan for this project?

Currently, we are piloting this process in the Interior region. Upon completion of the project, we will be collating the work (background, workflows, lessons learned, recommendations for future) into a detailed report that will be presented to the British Columbia Immunization Committee (BCIC). After the evaluation of the project, we hope to roll out the completed workflows across the province for relationships with all the health authorities in BC. Over time, capacity will increase with more CHNs experiencing mentorship and gaining confidence in their practice, which will increase capacity within FNHA to provide mentorship internally.

Supporting Nurses Walking Together: Sharing Knowledge for Health Equity



First Nations Health Authority
Health through wellness

Interior Health

Walking Together

Illustrating the Path

In 2024, Interior Health (IH) and the First Nations Health Authority (FNHA) set out on a journey together to support nurses working in First Nations communities with immunization competency skills. What began as a focused effort to strengthen clinical practice grew into something deeper—a collaborative process grounded in relationships, cultural safety, and shared learning. This document shares the story of that journey. Through visual storytelling, it highlights the values, connections, and community partnerships that have shaped the IH and FNHA Immunization Knowledge Sharing Walking Together project, offering both reflection and inspiration for nursing practice rooted in equity and respect.

Through this partnership, Community Health Nurses from First Nations communities worked with Public Health Nurses and educators from IH to gain immunization competency skills through a mentorship model. For the full report, see Deo & Bennett (2025).

Nursing has never been a solo endeavor. While we may have individual patient assignments, conduct home visits, or work independently in small clinics, our practice does not exist in isolation. Collaboration, mentorship, and shared learning are fundamental to nursing. From the start of our journeys in nursing school, we learn the importance of interdependence—how we must rely on and support one another. As circumstances, resources, and evidence evolve, we must remain adaptable, ensuring our practice is evidence-informed. To do this, we turn to one another—to seek guidance, stay up to date, and provide the best possible care.

Collaboration is essential for meeting our Practice Standards, which include professional responsibility and accountability, knowledge-based practice, client-focused service provision, and ethical practice (British Columbia College of Nurses & Midwives [BCCNM], n.d.). This knowledge strengthens our ability to walk together, sharing paths that have been supported by the many individuals involved in this project—each contributing to the broader goal of advancing health equity.

Guided by the wisdom shared with us on our journey of Two-Eyed Seeing within an ethical space, we have sought to weave Indigenous traditions and Ways of Knowing throughout this illustration. The essence of the IH and FNHA Immunization Knowledge Sharing Walking Together project is captured in this strategic visual storytelling, intertwining key elements that support nurses in meeting professional standards, which includes working collaboratively to address health equity. Through reciprocal knowledge sharing, foundational relationships have been established, fostering trust in shared communities and contributing to reconciliation and the reduction of health inequities. The intentional ambiguity in the overall image encourages individuals to interpret its meaning through their own worldviews, while specificity is found in the details of the illustrations.

In this project, we initially set out on a path with immunization as a central focus. However, as different individuals joined us on this journey, the path expanded, revealing a broader story of improving health equity. Drawing from Indigenous Ways of Knowing, where sustainable management practices are fundamental to cultivating and maintaining health, we have sought to create lasting pathways that prioritize health equity as the foundation for optimal immunization provision.

Rather than explicitly depicting immunization with images of needles or vaccine administration, we have acknowledged the historical and contextual understanding of health and wellness to take a culturally respectful approach that aligns with the values and preferences of First Nations communities. We have used recognizable images, such as a vaccine cooler, that link the larger illustration to the focus on immunizations. This project has successfully fostered deeper collaborative relationships between nurses in First Nations communities and Interior Health Public Health staff in the Interior region, extending beyond immunization practices.

We highlight four key themes in this illustration as guideposts: cultural safety, organizational collaboration, knowledge sharing, and relationships are foundational. Each theme is accompanied by supporting text and graphics that underpin the conceptual framework of supporting nurses to walk together. While individual interpretations of the images and words may vary, the central message remains clear: relationships are foundational to walking these paths in a good way. With a good heart, we walk together, supporting nurses in sharing knowledge and working towards health equity within their communities.

The images of bitterroot flowers represent gratitude for the lands where the nurses involved in the pilot project live and work. While the overall image is not rooted in a single specific location, these flowers acknowledge and pay homage to the location of the pilot. At the same time, they symbolize that these paths can be taken in other regions throughout the country in different ways, adapting to diverse contexts while maintaining the core values of the project.

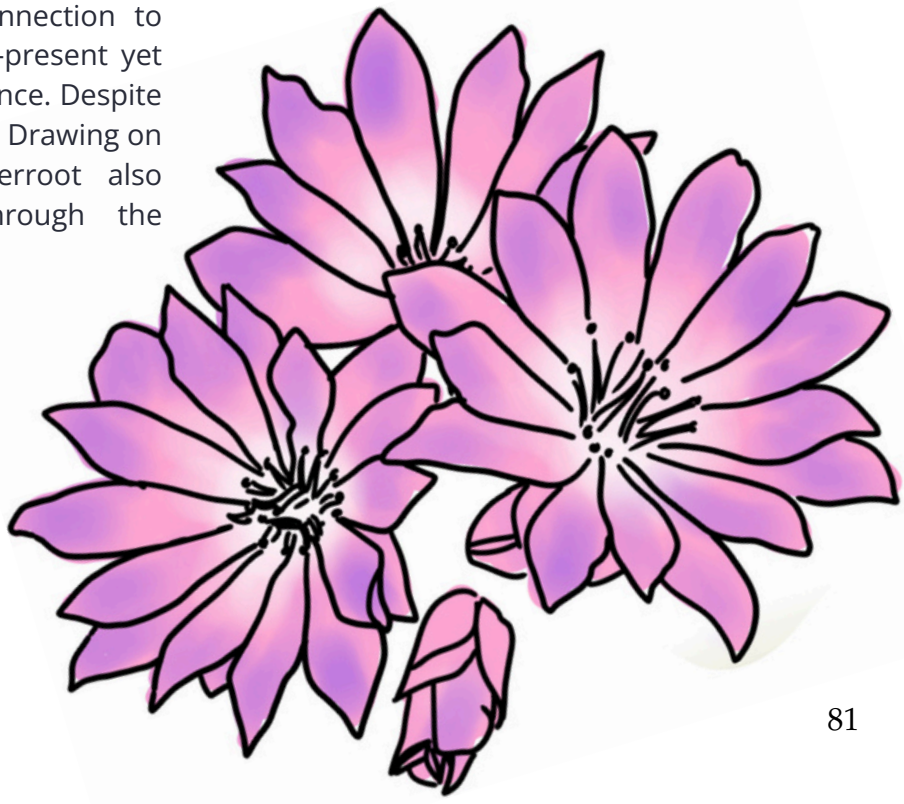
Throughout this visual story, the bitterroot flower appears in various forms, whether as tea on the kitchen table or growing on the lands where nurses walk together. As described by the First Nations Education Steering Committee and First Nations Schools Association (2016), bitterroot is traditionally significant as a plant species growing in the driest regions of the BC Interior.

The Nlaka'pmx refer to the bitterroot plant as ɬ'qwepn; Secwepemc refer to it as sp'itɬ'm (eastern dialect) or ɬ'ek'wpin (western dialect).

For the Okanagan, sp'itɬ'm is known as "the Chief for things under the ground." For thousands of years, First Nations People have harvested bitterroot, following sustainable management practices. In many communities, a special ceremony marks the beginning of the bitterroot harvest, just before the flowering stage. While protocols vary by community, they often include words and songs of respect, offering thanks to the plant for sharing itself with the people. However, changes over time have significantly disrupted the sustainable harvesting of bitterroot, such as commercial farming, overgrazing, and livestock trampling have diminished its abundance.

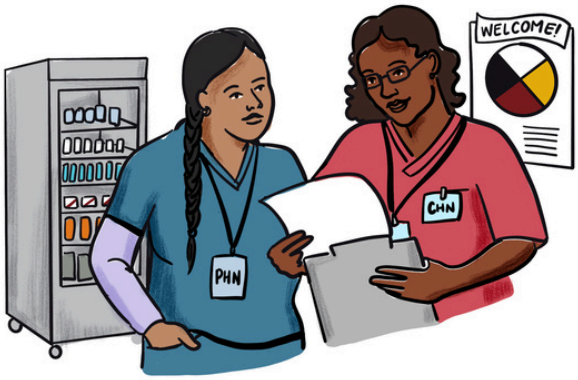
In this story, bitterroot serves as a visual reminder of the necessary balance and sacred connection to place. It exists in the background, ever-present yet maintaining its space, symbolizing resilience. Despite disruption, the plant continues to bloom. Drawing on traditional ecological knowledge, bitterroot also represents health and wellness through the nourishment it provides.

It reminds the onlooker of the wholistic vision of health and well-being that balances the physical, mental, emotional and spiritual aspects of a being, while also emphasizing the interconnectedness of individuals, families, communities, and the land.



BCCNM (2022) expects nurses to meet a practice standard of Indigenous Cultural Safety, Cultural Humility, and Anti-Racism through six core concepts:

- Self-reflective practice (it starts with me)
- Building knowledge through education
- Anti-racist practice (taking action)
- Creating safe healthcare experiences
- Person-led care (relational care)
- Strengths-based and trauma-informed practice (looking below the surface) (p. 7).



Nurses collaborating to increase equitable access to health care are actively contributing to reconciliation. Positive recognition of the unique and dynamic role of community health nurses is essential across organizations. As an extension of public health work, these nurses bring healing by providing services within communities; they are champions of cultural safety. Cross-organizational nurse partnerships play a vital role in fostering recognition and celebration of culture, creating safer and more inclusive spaces for care.

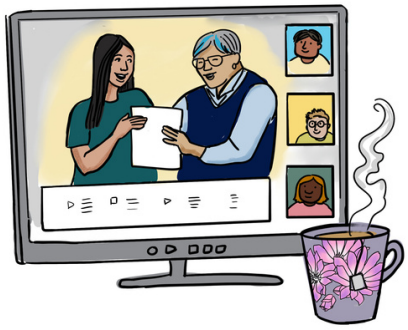
The illustration depicts a Public Health Nurse and Community Health Nurse reviewing a client chart together, with a vaccine biological fridge in the background, symbolizing how the integration of Western and Indigenous Ways of Knowing, or Two-Eyed Seeing, embeds culturally safe care through knowledge sharing. A medicine wheel, visible in the background of the clinic setting, represents the importance of balance, wellness, and wholeness. Despite geographic challenges, collaboration and resource-sharing can help create more inclusive and accessible health care. This dedication is exemplified by nurses carrying a vaccine cooler to a float plane - a powerful demonstration of their commitment to expanding equitable health care access.

Ensuring culturally safe and equitable health care access for First Nations communities requires organizational collaboration that is rooted in cultural humility, relational practice, and shared accountability. Upholding the priorities of the BCCNM Professional Standards and the BC Government's commitment to cultural safety and humility, this work must be guided by Indigenous self-determination and sustained through reciprocal relationships.

Listening to partners—seeking insight, feedback, and evaluation throughout each stage of the work—demonstrates respect, humility, and a commitment to decolonizing health systems. The creation of a Memorandum of Understanding, depicted in the illustration, formalizes relationships and affirms the commitment of key partners, signaling that this work is both supported and valued at the systemic level.

As we walk this path together, formal mentorship agreements and sustainable pathways—built through meaningful partnerships between regional health authorities, FNHA, and First Nations communities—serve as the pillars that uphold this journey. These collaborative efforts align with the BCCNM's Professional Standards, particularly the commitment to culturally safe, client-centered care that is accountable to Indigenous communities. By fostering relational trust and shared learning, these relationships strengthen the foundation for long-term systemic change, ensuring that the path toward health equity, reconciliation, and decolonization remains strong and enduring.

Appendix 9: Illustrating the Path



Bringing partners together for reciprocal learning, education, networking, and celebration is essential to fostering knowledge sharing and ensuring meaningful learning takes place. The illustration highlights nurses engaging in communication and exchanging educational experiences across organizations, demonstrating that this can occur both virtually and in-person.

Creating opportunities to lift each other up strengthens relationships and maintains positive connections that extend beyond the provision of care. Supporting participation in cultural events and spending time on the land deepens connections, to culture, to one another, and to the work itself. By reducing barriers to these shared experiences, we cultivate spaces where knowledge is exchanged in a way that is both meaningful and sustaining.

Through seeking to understand, curiosity, and a practice of humility, relationships become meaningful and enduring. The illustration depicts a Community Health Nurse investing in relationships by sharing tea and food with community members around a kitchen table, an act that reflects the value of gathering, listening, and learning from one another. In another scene, a nurse carrying a vaccine cooler greets a parent and her children as their paths cross. These moments of connection reinforce the presence of Community Health Nurses as familiar and trusted figures, fostering wisdom-sharing and learning that extend beyond clinical care.

Relationships are not just one aspect of this journey; they are the very structure that holds it together. By walking together in community, we create space for trust, reciprocity, and client-led, relational care, ensuring that the path toward health equity is not only traveled but strengthened with every step.

This visual storytelling piece beautifully captures the spirit of the IH and FNHA Immunization Knowledge Sharing Walking Together initiative, a shared journey rooted in respect, connection and a commitment to learning from one another. It serves as a testament to our dedication to walking respectfully - honoring Indigenous Knowledge, fostering meaningful collaboration and building bridges that strengthen communities. At its heart, this piece reflects our vision of creating sustainable, inclusive pathways that uplift voices, celebrate cultural wisdom and inspire lasting, positive change for generations to come.

Acknowledgements

This story is the result of many hands, voices, and hearts coming together. It reflects the collaboration, wisdom, and dedication of individuals and groups who contributed in various ways—through story-sharing, insight, editing, illustration, and reflection.

We gratefully acknowledge the contributions of Community Health Nurses and Public Health Nurses, for sharing the on-the-ground experiences, knowledge, and commitment that shaped the heart of this work. We thank FNHA, including members of the Communicable Disease Population and Public Health Team and the FNHA Interior Regional Team, for their ongoing guidance and support. From Interior Health, we thank representatives from the Communicable Disease Prevention and Control Immunizations program for their partnership throughout this journey. Our thanks also go to the Public Health Association of BC for highlighting the importance of connecting this story to the broader role of nurses in public health.

Deep gratitude is extended to Syilx Elder/Knowledge Keepers Pamela and Wilfred Barnes for generously sharing their wisdom and reflections, helping us understand the deeper meaning held within the illustration.

We extend a special thank you to Sam Bradd and Annalee Kornelsen from Drawing Change Consulting, who graciously worked with us to bring the story of this project to life through beautiful and thoughtful illustrations. The writing was carried out by Hermandeep Deo and Kara Bennett, with many others supporting through editing, feedback, and helping shape the meaning of both words and images.

To everyone who walked alongside us in this process, your contributions made this story possible.

To the nurses reading this, we invite you to walk with us: to reflect, to connect, and to continue this shared journey of learning, relationship, and working together in a good way.

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