Community Health Nursing

Competency & Skills

Institute of Primary Health & Ambulatory Care

And

Institute of Women's & Children's Health

Townsville Health Service District

Queensland Health

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Queensland Nurses Union	**Office of the Chief Nursing Officer: QLD**
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University of Tasmania	**Staff Development Unit**
Nursing Skills Checklist Advisory Committee	**Community Nursing Review Steering Committee**

The Community Nursing Skill Mix Project was proposed through the Institute of Primary Health and Ambulatory Care Workforce Plan and funded through the Townsville Health Service District Workforce Plan allocation.

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Foreword

Community health nursing is a unique area of nursing practice that extends the delivery of professional nursing care beyond the walls of hospitals to every conceivable environment in which the recipients of care may be located. Community health nurses are skilled practitioners that carry their professionalism into these sometimes challenging environments with a commitment and passion that is the hallmark of nursing. In the course of completing this project it has become evident that while the technical skills of nursing in the community differ little from the skills used in other health care settings there are significant underpinning principles, philosophies and attitudes that enable the community health nurse to function as an autonomous professional in diverse settings. These attributes are often difficult to quantify objectively. Never-the-less this project has undertaken to present a competency statement and units that describe the role of the community health nurse and provide a framework to support nurses entering this challenging but rewarding area of health care delivery.

Background

According to the 2005 Australian Institute of Health and Welfare the nursing workforce had an average age of just over 45 years, increasing to almost 47 years in community health settings. (AIHW 2005, p25-38) These figures have shown a steady increase in the years between the 2001 and the 2005 census. It is also evident that certain barriers exist to entry into community health nursing. In a 2004 review of literature by Brookes et al (2004, p197) it was noted that community health nursing is low on the list of career choices for nurses, lacks clear role definitions and has unclear and variable educational requirements. This review also noted that community health nursing in most cases requires two years clinical experience.

In contrast to the negative view from workforce statistics, the community setting offers a wealth of opportunities for professional growth and genuine job satisfaction. Community health nursing is generally associated with fewer requirements for shift work, more comprehensive involvement with clients and their families and a scope of work across preventative, curative and palliative interventions. With every increasing pressure on acute care settings and the need to enhance community based health interventions an examination of ways to reduce the barriers to nurses entering the community health nursing is appropriate.

The Institute of Primary Health & Ambulatory Care and Women's & Children's Health Institute through the Community Nursing Review Steering Committee has been working for some three years on the development of a sustainable community health nursing workforce. The work so far has resulted in three reports, and a combined action plan making recommendations on the way forward to achieve this goal. Historically nurses working in the community settings have been grade 6 (clinical nurses) or above, having had some experience in other settings prior to moving into community work. In the context of the nursing workforce challenges facing health care and community health care in particular, one strategy put forward is to consider possible inclusion of grade 4 (enrolled) and grade 5 (registered) nurses into community health nursing. This competency and skills checklists document is intended to support the transition of nurses into community health nursing by articulating the fundamentals of community health nursing and offering detailed descriptors of particular priority areas of nursing practice within this context.

In referring to grades of nursing this document has used the Queensland Health Nursing and Midwifery Classification Structure: Human Resource Policy of May 2008 (Queensland Health 2008).

Overview of Process

The combined action plan of the Community Nursing Review working parties recommended the engagement of a project officer to undertake certain elements within the plan. The specific strategies for the project to advance were objective 3.1, expansion of nursing role: inclusion of advanced EN and RN positions, and objective 3.2, the development of a competency-based framework. (THSD 2009, p12)

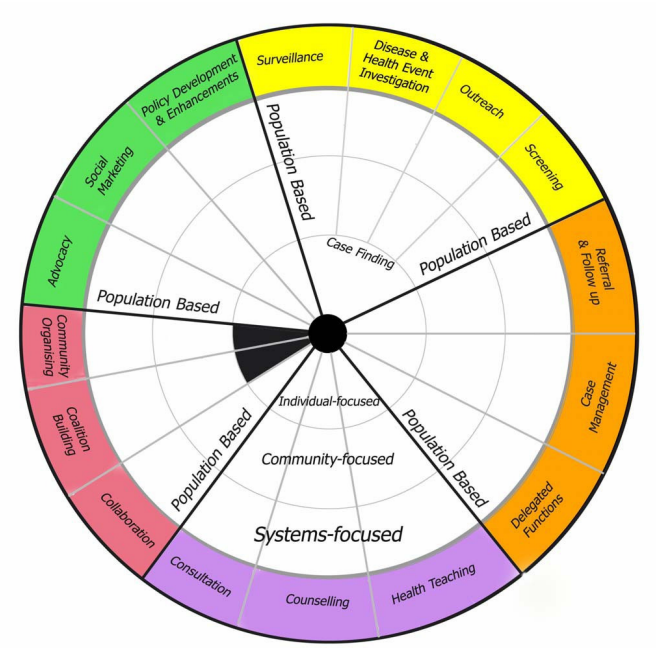
Among the key finding of the working parties one model was developed that captured the model of care for community nursing and another was identified that described the interventions that make up the core business of community nursing. Alongside these models an analysis of the community health services was undertaken to identify the distinct role requirements considered important to the delivery of each service. Eleven services formed the focus of the review. These were

- Aboriginal & Torres Strait Islander Health Program,
- Aged Care Assessment Team,
- Alcohol, Tobacco and Other Drug Service,
- BreastScreen,
- Child Youth and Family (including midwifery outreach),
- Community Health,
- Extended Acute Care (including Hospital in the Home),
- Home and Community Care,
- Integrated Health Care Partnerships,
- Mobile Women's Health Service,
- Sexual Health Services.

Through a process of categorising and summary competency, competency units and skills were generated from the data gathered in this analysis. Ongoing consultation with a reference group of nurses from the services, intermittent consultation with a broader audience and team leaders and liaison with educators, clinical nurse consultants and nursing executives within the state and across states helped to refine the list and ensure it as an accurate reflection of community nursing in the Townsville Health Service District.

Underpinning Models

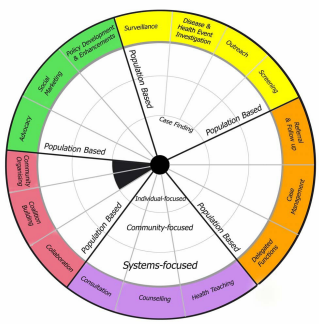
Among the key findings and recommendations of the working parties preceding this project were two models. The Core Business Working Party identified the Public Health intervention Wheel as describing the key areas of intervention in community health nursing. The Model of Care Working Party developed a model describing the key features of community health nursing. These models have been widely accepted by the three working parties and the broader community health nursing workforce in Townsville. They have been used to underpin the development of this document and are therefore presented here.



Intervention Wheel (Keller et al, 2004)

Developed by Gay Kirkham, Nursing Model of Care Working Party

Public Health Intervention Wheel



Public Health Interventions

- **Surveillance:** Describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data for the purpose of planning, implementing, and evaluating public health interventions
- **Disease and other health event investigation:** Systematically gathers and analyses data regarding threats to the health of populations, ascertains the source of the threat, identifies cases and others at risk, and determines control measures.
- **Outreach:** Locates populations-of-interest or populations-at-risk and provides information about the nature of the concern, what can be done about it, and how services can be obtained.
- **Screening:** Identifies individuals with unrecognized health risk factors or asymptomatic disease conditions in populations.
- **Case finding:** Locates individuals and families with identified risk factors and connects them with resources.
- **Referral and follow-up:** Assists individuals, families, groups, organizations, and/or communities to identify and access necessary resources in to prevent or resolve problems or concerns.
- **Case management:** Optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services.
- **Delegated functions:** Direct care tasks a registered professional nurse carries out under the authority of a health care practitioner as allowed by law. Delegated functions also include any direct care tasks a registered professional nurse judges entrusts to other appropriate personnel to perform.
- **Health teaching:** Communicates facts, ideas, and skills that change knowledge, attitudes, values, beliefs, behaviours, and practices of individuals, families, systems, and/or communities.
- **Counselling:** Establishes an interpersonal relationship with a community, a system, and family or individual intended to increase or enhance their capacity for self-care and coping. Counselling engages the community, a system, and family or individual at an emotional level.
- **Consultation:** Seeks information and generates optional solutions to perceived problems or issues through interactive problem solving with a community, system, and family or individual. The community, system, and family or individual select and act on the option best meeting the circumstances.
- **Collaboration:** Commits two or more persons or organizations to achieve a common goal through enhancing the capacity of one or more of the members to promote and protect health
- **Coalition building:** Promotes and develops alliances among organizations or constituencies for a common purpose. It builds linkages, solves problems, and/or enhances local leadership to address health concerns.
- **Community organizing:** Helps community groups to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively have set.
- **Advocacy:** Pleads someone's cause or act on someone's behalf, with a focus on developing the community, system, and individual or family's capacity to plead their own cause or act on their own behalf.
- **Social marketing:** Utilizes commercial marketing principles and technologies for programs designed to influence the knowledge, attitudes, values, beliefs, behaviours, and practices of the population-of-interest.
- **Policy development and Policy enforcement:** Places health issues on decision-makers' agendas, acquires a plan of resolution, and determines needed resources. Policy development results in laws, rules and regulation, ordinances, and policies. Compels others to comply with the laws, rules, regulations, ordinances, and policies created in conjunction with policy development.

Keller, L.O., Strohschein S., Lia-Hoagberg B., & Schaffer M.A., (2004)

Community Health Nursing Model of Care

The **model of care for nursing services** within the Institutes of Primary Health and Ambulatory Care and Women's and Children's Health is based on a firm foundation of the eight (8) Primary Health Care principles. The two (2) pillars supporting the community represent the nursing workforce and the systems that support the workforce. It is essential that both pillars are strong. The characteristics required for a quality nursing workforce are a caring attitude, willingness to advocate on behalf of others, a holistic approach to care in a supportive environment, a professional approach to duties, and respect for all cultures and each other. The systems that support the workforce, and therefore the community, are information technology designed to enhance service delivery, risk management strategies designed to protect the staff and clients and quality management strategies designed to ensure effective, researched and documented service. The wheel in the middle represents the evidence based interventions that support the community with the purpose of promoting good health and preventing ill health.

Community health nurses believe that for individuals to actualise their health potential, they must engage in the process of health. This necessitates a partnership perspective where the individual is an active participant in the decisions they make for their own health. The outcome of a healthy workforce, healthy systems, and evidence based intervention all grounded in the principles of primary health care and working in partnership with the community would result in healthier communities.

Caring: is about understanding and responding to clients needs. It requires sound knowledge based on learning and experience. It has been identified by the two working parties as a major component of the core nursing business of community health nurses. It links to the interventions of advocacy, social marketing, case management, consultation and collaboration.

Professionalism: "The critical element of professionalism is adequate control to determine how nurses do their work, determine standards and control the profession's labour market. Nurses value their work as a collective promise to serve the community in matters of responsibility in maintaining standards for safe and competent nursing and in participating in legislative and social initiatives that shape health and health care. Nurse's codes of ethics and practice signify its professionalism and its evolution since the first international code of ethics for nurses was promulgated in 1953 (Meleis 1991). Self-regulation negotiated with the state and expressed in legislation is valued by nurses and is fundamentally important for patients" (Lets Talk Nursing QNU conference, July 2006). Professionalism links to the interventions of policy development and enhancement, coalition building, disease and health event investigation, delegated functions, outreach and surveillance.

Advocacy: To plead someone's cause or act on someone's behalf, with a focus on developing the community system and individual's or family's capacity to plead their own cause or act on their own behalf. While it is an intervention in itself, it also links to health teaching, counselling and screening.

Holism: Holism is the value of nursing that respects and regards the 'whole' human person. It links to the interventions of collaboration, case management, consultation, counselling, community organising referral and follow-up.

Mentoring: "Mentorship is a process by which a mentoree experiences personal and professional growth, in line with specific goals of the mentoree (Lacey, 1999, 8). It differs from preceptorship whereby the process is directed at personal and professional growth, regardless of the roles involved." (Mentoring Program, Nursing Services, The Townsville Hospital, 2002). Mentoring links closely with professionalism and its associated interventions. Mentoring involves relationship role modelling, advocacy, and support that may be incorporated in supervision relationships (IRM 3.14/1 page 1).

Respect: Respect, both mutual and cultural, encompasses all Primary Health Care principles and core nursing interventions.

Partnership: Nurses provide total patient care within a professional partnership model of care. Nurses support each other and work "together" to provide optimal client outcomes. It is linked to advocacy, case management, professionalism, health teaching and consultation.

From Model of Care Working Party final report (2006)

The document as a framework

While every effort has been taken to create a complete and detailed set of competency units and skills it is hoped that this document will provide a framework and inspiration for ongoing review and amendment to keep it live. It is also hoped that there will be ongoing development of additional skills checklists to articulate other areas of community health nursing and other grades of nursing beyond the scope of this project. As service demands and community trends evolve is expected that this document will evolve also. It is recommended therefore that the monitoring of this document is given carriage by an appropriate committee or position within the Institute of Primary Health and Ambulatory Care Services and Women's & Children's Health Institute.

National and State Standards and Competencies

Other documents articulating competency standards for nursing exist nationally and in Queensland. In preparing this document care has been taken to avoid duplication and to enable cross referencing of these competency units to other standards. As well as competency standards at both state and national levels codes of conduct and professional standards have been drawn up to support the monitoring and regulation of nursing practice. It is also acknowledged that in some specialty areas of practice guidelines and competency standards have also been developed for advanced endorsed practice. Again this document sets out to remain generic and therefore has attempted to avoid anything that relates to specialty areas where endorsement and specific competency documents already exist. Where standards and competencies exist from national, state and organisation levels these take precedence over this competency and skills framework. This work is intended to fill a gap and add refinement to a specific area of nursing practice. Following is a list of other standards, competency and skill documents that provide a background to this work.

Australian Nursing and Midwifery Council: retrieved from www.anmc.org.au
- ANMC Code of Ethics for Nurses in Australia
- ANMC Code of Ethics for Midwives in Australia
- ANMC Code of Professional Conduct for Nurses in Australia
- ANMC Code of Professional Conduct for Midwives in Australia
- National Competency Standards for the Enrolled Nurse
- National Competency Standards for the Registered Nurse
- National Competency Standards for the Midwife
- National Competency Standards for the Nurse Practitioner

Australian Nursing Federation: retrieved from www.anf.org.au
- Competency standards for the advanced enrolled nurse
- Competency standards for the advanced registered nurse

Queensland Health
- Code of Conduct

Queensland Nursing Council
- Scope of Practice - framework for nurses and midwives

Townsville Health Service District
- Nursing Skills Development Framework and Nursing Skills Checklists

Competency and Skills Content

As described earlier a process of synthesising the valuable work of the working parties preceding this project formed the foundation of the content for this work. Where there was insufficient data from the previous work to make a statement against a particular skill area additional data was sought as to the possible role that community health nursing may have in relation to that skill. A skill element was then generated that reflected the level of knowledge, understanding or involvement that was considered appropriate and endorsement of this new data received from the reference group. The definitions from the background literature describing the public health intervention model have been included to provide some understanding to the development of each skill and as guidance to any future development. At the skill checklist level and the development of performance criteria a review of relevant literature was undertaken to support these criteria and feedback sought from community health nurses and nursing experts. The literature reviewed against each skill checklist is referenced in the clinical guidelines included as appendices to this document and as separate skill checklist documents.

Other competency and standards documents were reviewed in the preparation of this document. A special interest group within the Western Australian Department of Health, have previously put together a set of competency standards for community health nurses (Community Nurses Special Interest Group, Western Australia, 2001). These offered valuable content ideas for beginning and advanced community health nurses. Five competency units are presented each divided into several competency elements and supported with performance criteria. These competency units include professional and ethical practice, leadership and management as well as care delivery and health promotion.

The Ambulatory Care Nursing Administration and Practice Standards (American Academy of Ambulatory Care Nursing, 2007) similarly offer a range of standards that include nursing administration, ethics, leadership and staffing. The content of the standards specific to nursing practice offered ideas that help frame this work but again were limited in their direct application to the current context.

Document Structure

The structure of this competency and skills list is designed to provide some articulation with broader competency and standards documents and incorporates the areas of the public health intervention wheel developed by Keller et al (2004). These standards are developed in five levels commencing with a single competency statement for community nursing. Five competency units reflect the broad areas of the intervention wheel, seventeen skills are described using the definitions of the individual interventions of the wheel. Each skill is then divided into elements as was required to capture all the data provided by the work of the working parties and one skill in particular, that of "delegated functions" was further delineated using five phases of the nursing process some of which were further divided into parts to ensure no loss of data. Following broad consultation with community health nurses certain areas were then prioritized for further development using a skills checklist format, including the identification of performance criteria. Three priority areas were identified and separate performance criteria developed for grade 4 and 5 nurses. In summary the following illustrates the arrangement of the competency and skills presented in this document.

Competency Statement ***1 single competency statement***

1. Competency Units ***5 broad competency categories***

1.1 Skills **17 individual skills.**

Skill definition from original article by Keller et al (2004).

1.1.1 Skill Elements	27 statements adding detail to the skills.

Performance Criteria	6 sets addressing 2 nursing grades & 3 priority skills

Competency Statement and Skills List

Community Health Nurse Competency Statement

The community health nurse is a professional who delivers evidence based nursing care to individuals, families, significant others and defined communities, underpinned by the principles of primary health care and health promotion, supporting self-reliance in recovery from illness, enhancement of health or management of chronic and terminal conditions, in a setting which is optimal for the client or community.

1. *Competency Unit 1. Community Health Appraisal and Screening*

The community health nurse implements strategies to identify individuals and groups who have or are at risk of having compromised health status, to attempt to identify the causal factors for negative changes in health and to identify the resources appropriate to support optimal health outcomes.

1.1. Skill 1. Surveillance

Describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data for the purpose of planning, implementing, and evaluating public health interventions

1.1.1.	Community health nurses have a broad knowledge of the role of surveillance in informing their practice and support surveillance through the delivery of current, accurate and complete data to recognised surveillance systems.

1.2. Skill 2. Disease and other health event investigation

Systematically gathers and analyses data regarding threats to the health of populations, ascertains the source of the threat, identifies cases and others at risk, and determines control measures.

1.2.1.	Community health nurses have an understanding of the role of population health initiatives in responding to identified events and support these through their interactions with individuals and groups within the community.

1.3. Skill 3. Outreach

Locates populations-of-interest or populations-at-risk and provides information about the nature of the concern, what can be done about it, and how services can be obtained.

1.3.1.	Outreach is carried out in a planned and coordinated way to maximise the reach of services to the community where community risk or need is identified.

1.4. Skill 4. Screening

Identifies individuals with unrecognized health risk factors or asymptomatic disease conditions in populations.

1.4.1.	Screening and developmental assessments carried out using identified tools; ie Asymptomatic STI, Growth and Development, School-age Hearing.

1.5. Skill 5. Case Finding

Locates individuals and families with identified risk factors and connects them with resources.

1.5.1.	Assessment, including risk assessment, of identified at risk groups or individuals. **This skill is detailed further in the Nursing Skill Checklists appendices.** Appendix 1.A. Community Health Nursing Assessment – Nursing Officer Grade 5 Appendix 1.B Community Health Nursing Assessment – Nursing Officer Grade 4

Performance Criteria: Community Health Nursing Assessment: Nursing Officer Grade 5
Part A: DEMONSTRATES THE ABILITY TO: ***Assess clients in community settings***
• articulate the purpose and principles of client assessment in the context of community health nursing. • establish effective communication including listening and observation skills to facilitate the collection of accurate, reliable and relevant information that can be validated by the client and colleagues. • use and document a systematic approach to the collection of information about the clients health status. • collect and document data from clients own perceptions of health status, direct observations, reports from family / significant others, physical examination and documented case notes and referrals as appropriate. • apply an assessment process that seeks to identify and is orientated to clients own goals with particular reference to level of functionality and ability for self care and to accurately document this. • conduct a comprehensive assessment that identifies the health deficits and self care capacities of the client taking into account their emotional and physical characteristics and the environmental and social contexts. • ensure the inclusion of family, significant others and the capacity and accessibility of health resources in scope of assessment as potential contributors to the provision of health care as evidenced in documentation of the assessment. • apply an empowering approach, facilitating individuals and families to identify and address own health risks and deficits including the appropriate use of health care resources. • identify and utilise the available assessment tools appropriate to the specific clinical setting and consistent with service policies and procedures. • identify own scope of practice in relation to the collection and interpretation of client information and seek support and supervision to maintain quality care for each individual client and to develop own skills.
Part B: DEMONSTRATES THE ABILITY TO: ***Assess communities and populations***
• articulate the purpose and principles of community assessment from a community health nursing perspective. • articulate various sources of information relevant to developing an understanding of the family or community group. • understand the characteristics of the community context of the health service and how those characteristics may impact on health status and the use of health related resources. • identify and use appropriate avenues to disseminate relevant community information to inform the development of health care services. • identify at risk groups within populations and describe their defining characteristics. • maintain an empowering approach, facilitating community and populations to identify and address own health risks and deficits. • support and participate in broader population based surveillance programs and recognise their role in the early identification of health deficits and the processes for case finding and referral to community health services.

Performance Criteria: Community Health Nursing Assessment: Nursing Officer Grade 4
Part A: DEMONSTRATES THE ABILITY TO: ***Assess clients in community settings***
• articulate the purpose and principles of client assessment in the context of community health nursing. • establish effective communication including listening and observation skills to facilitate the collection of accurate, reliable and relevant information that can be validated by the client and colleagues. • collect and document data from the clients own perceptions of health status, direct observations, reports from family / significant others, physical examination and documented case notes and referrals as appropriate. • carry out delegated tasks that contribute to the comprehensive assessment process. • accurately document data collected for assessment purposes and ensure this is reviewed by the appropriate registered nurse. • apply an empowering approach, facilitating individuals and families to identify and address own health risks and deficits including the appropriate use of health care resources. • identify and utilise the available tools for data collection appropriate to the specific clinical setting and consistent with service policies and procedures. • identify own scope of practice in relation to the collection of client information and seek support and supervision to maintain quality care for each individual client and to develop own skills.
Part B: DEMONSTRATES THE ABILITY TO: ***Assess communities and populations***
• articulate the purpose and principles of community assessment from a community health nursing perspective. • articulate various sources of information relevant to developing an understanding of the family or community group. • understand the characteristics of the community context of the health service and how those characteristics may impact on health status and the use of health related resources. • identify and use appropriate avenues to disseminate relevant community information to inform the development of health care services. • maintain an empowering approach, facilitating community and populations to identify and address own health risks and deficits. • support and participate in broader population based surveillance programs.

2. ***Competency Unit 2. Health Care Delivery***

The community health nurse provides professional nursing care in partnership with the individual client or community group that is consistent with the scope of practice of the nurse, is based on evidence, encourages the participation of the client, draws together and coordinates the resources of multi-disciplinary teams and is focused on defined and measurable outcomes.

2.1. Skill 6. Referral and follow-up

Assists individuals, families, groups, organizations, and/or communities to identify and access necessary resources in to prevent or resolve problems or concerns.

2.1.1. Manage and organise referrals, transfers and waitlists, effectively between allied health, clinics, medical teams, non-government organizations, including appropriate report preparation and dissemination.

2.1.2. Carry out initial assessment of clients prior to service / program intervention either face to face or by phone to a) establish clients consent to intervention, b) assess risk and need, c) make arrangements for service / program contact and d) enable completion of appropriate documentation and feedback to referring practitioner or agency.

2.2. Skill 7. Case Management

Optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services.

2.2.1. Monitor ongoing needs of clients using various tools for assessment of ongoing treatment planning and evaluation appropriate to the particular service.

2.2.2. Facilitate or participate in case conferencing of clients, particularly those with complex needs and ensuring that all relevant health professionals are included.

2.2.3. Client files are prepared that contain all up-to-date documentation relevant to the client and are completed according to the established standards for nursing documentation.

This skill is detailed further in the Nursing Skill Checklists appendices.

Appendix 2.A. Community Health Nursing Case Management – Nursing Officer Grade 5

Appendix 2.B. Community Health Nursing Case Management – Nursing Officer Grade 4

Performance Criteria: Community Health Nursing Case Management Nursing Officer Grade 5
• Able to verbalise/describes the primary goal of nursing case management. • Able to describe the characteristics of clients and client groups for whom case management is an appropriate intervention strategy. • Demonstrates the ability to develop, maintain and appropriately conclude professional relationships with clients, significant others and key services providers. • Demonstrates use of appropriate communication and interpersonal skills with clients, significant others and service providers. • Identifies and documents the level of assessment and needs identification for the individual client or client group and ensures this is carried out by the appropriate health professional. • Management of referrals demonstrates adherence to service standards and processes. • Written care plans demonstrate collaborative development in consultation with the client and a clinical nurse. • Documents in the care plan all aspects of client need and the appropriate health professionals/service to meet those needs. • Demonstrates ability to initiate and/or participate in case conferencing of all clients with a clinical nurse, including other health professionals as required. • Accesses, uses and shares accurate and up-to-date information on services and facilities to maintain own knowledge in supporting individual clients and for the use of colleagues. • Provides up-to-date information to support individuals to make informed choices about the care and services they receive and provide active support and education to enable individuals to act on those choices • Able to provide documented evidence of periodic analysis and revision of expected outcomes, interventions and priorities in the clients' condition, needs or circumstances and evaluates and follows up in regard to new strategies to meet unmet needs or new needs as they arise. • Negotiates agreed timeframes and conditions for discharge from care and contingences for review and readmission if the clients' circumstances change and documents these in the client file.

Performance Criteria: Community Health Nursing Case Management Nursing Officer Grade 4
• Able to verbalise/describe the primary goal of nursing case management. • Able to describe the characteristics of clients for whom case management is an appropriate intervention strategy. • Demonstrates an ability to develop, maintain and appropriately conclude professional relationships with clients, significant others and key services providers. • Demonstrates the use of appropriate communication and interpersonal skills with clients, significant others and service providers. • Support assessment and needs identification for the individual client through carrying out delegated components of data gathering and observation and documenting findings. • Able to describe service standards and processes for management of referrals. • Able to verbalise their role in contributing to the development and implementation of collaborative care plans in consultation with the client and a registered nurse. • Able to describe the use of the care plan that includes all aspects of client need and identifies the appropriate health professionals to meet those needs. • Demonstrates an ability to participate in case conferencing of all clients with registered nursing colleagues. • Accesses, uses and shares accurate and up-to-date information on services and facilities to maintain own knowledge in supporting individual clients and for the use of colleagues. • Provides documented reports of client contact observations and interventions to support the monitoring, evaluation and revision of care.

2.3. Skill 8. Delegated Functions

Direct care tasks a registered professional nurse carries out under the authority of a health care practitioner as allowed by law. Delegated functions also include any direct care tasks a registered professional nurse judges entrusts to other appropriate personnel to perform.

2.3.1. Assessment

- Carry out comprehensive clinical bio-psycho-social assessments, including wounds assessments, collection of vital signs, family and support structures assessment, functional ability assessments.
- Clinical assessments are supported through the collection of pathology specimens, ordering of other investigations including medical imaging and referral for specialist assessment as required.

2.3.2. Nursing diagnosis

- Clinical problem solving and decision making processes are undertaken to formulate nursing diagnoses using analysis of assessment, pathology and screening tool results within scope of practice.

2.3.3. Planning

- Comprehensive nursing care plans are developed in consultation with the client and senior clinicians that demonstrate a comprehensive approach to nursing care.
- Care plans show collaboration across disciplines, adaptation to the individual client presentation and use of evidence based guidelines and include provision for review and monitoring parameters and a plan for discharge.

2.3.4. Implementation

- Deliver care in a setting that is accessible and appropriate to the clients requirements including conducting health centre based clinics, outreach clinics, and home visits.
- Implement care as described in care plans and/or clinical management pathways based on the clinical decision making and nursing diagnosis, either directly or as delegated depending on scope of practice.
- Administer, prescribe or supply medication according to scope of practice, standing orders, endorsements and immunisation and drug therapy protocols.

2.3.5. Evaluation

- Care is subject to ongoing monitoring and evaluation and adjusted as needed in response to the clients' status, including the use of relevant evaluation and assessment tools, with changes being reported to the multi-disciplinary team and case coordinator as appropriate.

3. *Competency Unit 3. Education and Support*

The community health nurse supports the self-care and self-reliance of the client or community through delivery of health education and promotion that enhances the skills of clients and significant others to carry out interventions, increases the capacity of the client or community to identify and access health related resources and encourages health enhancing and illness avoiding practices by individuals and communities.

3.1. Skill 9. Health Teaching

Communicates facts, ideas, and skills that change knowledge, attitudes, values, beliefs, behaviours, and practices of individuals, families, systems, and/or communities.

3.1.1. Community health nurses provide education on health issues specific to the needs of the individual clients, including recognition of risk factors and behaviour change strategies, management of chronic conditions, strategies for accessing resources and support.

3.1.2. Community health nurses facilitate learning through coordinating, facilitating or supporting group programs on health issues, which may include the development of programs as required or leadership of established programs according to their specified guidelines.

3.1.3. Community health nurses assist individuals in preparing for and following through of treatment programs and interventions through the provision of advise and education as to the intervention offered and the participation required from the client including consent and contractual arrangements.

3.1.4. Community health nurses deliver accurate, timely and appropriately tailored information and training on health issues to a variety of forums in the community using newsletters, public addresses, brochures and appropriate use of the media.

This skill is detailed further in the Nursing Skill Checklists appendices.

Appendix 3.A. Community Nursing Health Teaching – Nursing Officer Grade 5
Appendix 3.B. Community Nursing Health Teaching – Nursing Officer Grade 4

3.2. Skill 10. Counselling

Establishes an interpersonal relationship with a community, a system, and family or individual intended to increase or enhance their capacity for self-care and coping. Counselling engages the community, a system, and family or individual at an emotional level.

3.2.1. Community health nurses support clients, their families and groups through the provision of counselling, motivational interviewing and facilitation of self help programs.

3.3. Skill 11. Consultation

Seeks information and generates optional solutions to perceived problems or issues through interactive problem solving with a community, system, and family or individual. The community, system, and family or individual select and act on the option best meeting the circumstances.

3.3.1. Community health nurses provide clinical support options and resources to clients, their families and community groups through broad consultation with colleagues, other disciplines and organisations, developing and maintaining both formal and informal networks.

Performance Criteria: Community Health Nursing Health Promotion & Education: Nursing Officer Grade 5
• recognise and describe the formal and informal educative roles in community health nursing practice. • articulate the purposes of and differences between health teaching and health promotion in community health nursing. • describe the principles in developing, maintaining and concluding therapeutic partnerships with individuals and communities. • use effective communication skills in interactions with individuals and communities. • maintain a client / community centred focus when providing health education or health promotion. • show appropriate respect and acknowledgment of individual's prior experience and learning when preparing, delivering and evaluating health education. • use teaching skills that enhance the transfer of learning into changes in health behaviours. • adapt the health teaching or health promotion strategies to accommodate the particular needs and/or capacities of the individual or group. • monitor and evaluate the outcome of health education or promotion in terms of changes in health behaviours or status. • document health education activities as a part of client care or as evidence of community development activities.

Performance Criteria: Community Health Nursing Health Promotion & Education: Nursing Officer Grade 4
• recognise and describe the formal and informal educative roles in community health nursing practice. • articulate the purposes of and differences between health teaching and health promotion in community health nursing. • describe the principles in developing, maintaining and concluding therapeutic relationships with individuals and communities. • use effective communication skills in interactions with individuals and communities. • support a client / community centred focus when participating in the delivery of health education or health promotion. • show appropriate respect and acknowledgment of prior experience and learning when preparing and delivering education to individuals. • use teaching skills that enhance the transfer of learning into changes in health behaviours. • adapt the health teaching or health promotion strategies to accommodate the particular needs and/or capacities of the individual or group. • document health education activities as a part of client care or as evidence of community development activities.

4. *Competency Unit 4. Community Development*

The community health nurse seeks to identify and/or create community structures and networks that support healthy behaviours through active participation in community organisations and developing and maintaining networks and coalitions that collaborate in the delivery of health care.

4.1. Skill 12. Collaboration

Commits two or more persons or organizations to achieve a common goal through enhancing the capacity of one or more of the members to promote and protect health

4.1.1.	Community health nurses participate in the development of collaborative responses to health needs through liaison with and coordination of teams across disciplines and/or services and organisations.

4.2. Skill 13. Coalition building

Promotes and develops alliances among organizations or constituencies for a common purpose. It builds linkages, solves problems, and/or enhances local leadership to address health concerns.

4.2.1.	Community health nurses develop and maintain networks and coalitions between Queensland Health services and institutes, specialists, GP's, government and non-government organisations that support the provision of effective and comprehensive health care, developing memorandum's of understanding or service agreements where applicable.

4.3. Skill 14. Community Organising

Helps community groups to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively have set.

4.3.1.	Community health nurses carry out community consultation and negotiation and initiate community development strategies for enhancing health.

5. *Competency Unit 5. Political Action*

The community health nurse proactively takes action to create, enhance and protect the individuals ability to access appropriate health care choices and resources through advocating on behalf of individuals, supporting the promotion of health enhancing behaviours and actively participating in the development and enforcement of appropriate health related policies and procedures.

5.1. Skill 15. Advocacy

Pleads someone's cause or act on someone's behalf, with a focus on developing the community, system, and individual or family's capacity to plead their own cause or act on their own behalf.

5.1.1.	Individuals and communities are supported by community health nurses to exercise their rights in relation to appropriate health care and where they are unable to do so the community health nurse actively advocates on their behalf.

5.2. Skill 16. Social marketing

Utilizes commercial marketing principles and technologies for programs designed to influence the knowledge, attitudes, values, beliefs, behaviours, and practices of the population-of-interest.

5.2.1.	Community health nurses understand the principles of social marketing and seek to reinforce health behaviour choices of individuals and communities in line with the objectives of evidence-based campaign strategies.

5.3. Skill 17. Policy development and policy enforcement

Places health issues on decision-makers' agendas, acquires a plan of resolution, and determines needed resources. Policy development results in laws, rules and regulation, ordinances, and policies. Compels others to comply with the laws, rules, regulations, ordinances, and policies created in conjunction with policy development.

5.3.1.	Community health nurses ensure adherence to all relevant legislation and participate in the review, development and implementation of policies and procedures at service, state and national levels.

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Appendices: Skill Checklists; Community Health Nursing

The following set of skill checklists have been identified as the key areas of community nursing that require detailed criteria as a basis for the demonstration of competence by nurses entering the field. These have been developed using the general format for skills checklists used in the Townsville Health Service District.

For the three key areas identified Skill Checklists have been developed for grade 5 nursing officers (registered nurses) and grade 4 nursing officers (enrolled nurses).

The three areas have been included:

- Community Health Nursing Assessment
- Community Health Nursing Case Management
- Community Nursing Health Teaching

Skills Checklist - Community Nursing

EQuIP Function: Continuum of Care	
Document Custodian: Skill Mix Project	**Next Review Date**: August 2010

Appendix 1.A. Community Health Nursing Assessment: Nursing Officer Grade 5.

Target Audience: Nursing Officer Grade 5 (Registered Nurse), Community Health Settings.

Associated Policies/ Procedures: (Please list any relevant Policies &/or Procedures related to the content of this Skills Checklist. Please hyperlink where possible)

Name: …… **Payroll Num**:…….

SKILLS CHECKLIST:	Key C = Competent for Level S = Requires Supervision D = Requires Development		
Performance Criteria			
Part A: DEMONSTRATES THE ABILITY TO: ***Assess clients in community settings***	C	S	D
1. articulate the purpose and principles of client assessment in the context of community health nursing.			
2. establish effective communication including listening and observation skills to facilitate the collection of accurate, reliable and relevant information that can be validated by the client and colleagues.			
3. use and document a systematic approach to the collection of information about the clients health status.			
4. collect and document data from clients own perceptions of health status, direct observations, reports from family / significant others, physical examination and documented case notes and referrals as appropriate.			
5. apply an assessment process that seeks to identify and is orientated to clients own goals with particular reference to level of functionality and ability for self care and to accurately document this.			
6. conduct a comprehensive assessment that identifies the health deficits and self care capacities of the client taking into account their emotional and physical characteristics and the environmental and social contexts.			
7. ensure the inclusion of family, significant others and the capacity and accessibility of health resources in scope of assessment as potential contributors to the provision of health care as evidenced in documentation of the assessment.			
8. apply an empowering approach, facilitating individuals and families to identify and address own health risks and deficits including the appropriate use of health care resources.			
9. identify and utilise the available assessment tools appropriate to the specific clinical setting and consistent with service policies and procedures.			
10. identify own scope of practice in relation to the collection and interpretation of client information and seek support and supervision to maintain quality care for each individual client and to develop own skills.			

Part B: DEMONSTRATES THE ABILITY TO: *Assess communities and populations*			
1. articulate the purpose and principles of community assessment from a community health nursing perspective.			
2. articulate various sources of information relevant to developing an understanding of the family or community group.			
3. understand the characteristics of the community context of the health service and how those characteristics may impact on health status and the use of health related resources.			
4. identify and use appropriate avenues to disseminate relevant community information to inform the development of health care services.			
5. identify at risk groups within populations and describe their defining characteristics.			
6. maintain an empowering approach, facilitating community and populations to identify and address own health risks and deficits.			
7. support and participate in broader population based surveillance programs and recognise their role in the early identification of health deficits and the processes for case finding and referral to community health services.			

Towards Excellence:

Following attainment of a mandatory standard of performance against the above criteria nurses are encouraged to strive for excellence in practice. Reflective self assessment supported by peers and mentors can assist this process. The Benner model of skill acquisition is provided here as a guide to facilitate self assessment and reflection on practice on the journey to higher levels of proficiency.

Benner Skill Acquisition Model	
1. Novice	Relies on guiding principles and rules to perform within set parameters.
2. Advanced beginner	Performs routine functions; requires some assistance in complex situations/setting priorities.
3. Competent	Prioritises and completes functions independently; can adapt practice to manage complex situations.
4. Proficient	Demonstrates speed and flexibility in decision making; can predict outcomes independently and plan for contingencies.
5. Expert	Demonstrates mastery in performance; demonstrates creativity and innovation; responds intuitively.

Comments or Plan:

Date	Assessed by:	
	Name (print)	Signature
Date	Staff member being assessed:	
	Name (print)	Signature

Clinical Information Guide

Part A: DEMONSTRATES THE ABILITY TO:
Assess clients in community settings

1. articulate the purpose and principles of client assessment in the context of community health nursing.

"Assessment in nursing is the deliberate and systematic collection of information (data) about an individual, family or group (community)." (Carpenito-Moyet, 2007, p14) Assessment should be viewed as a process rather than a single point in time. Rambo (1984, p19, 20) describes two levels of assessment. Level one is the collection of information about behavioural or functional changes and identifies those that may be maladaptive. A second level of assessment seeks to identify the causes behind changes with particular focus on those that have been identified as maladaptive.

2. establish effective communication including listening and observation skills to facilitate the collection of accurate, reliable and relevant information that can be validated by the client and colleagues.

The development and use of effective communication is essential to gathering accurate and complete information from a client or their family. This is particularly so when exploring issues of values, and beliefs that are relevant to health status.

3. use and document a systematic approach to the collection of information about the clients health status.

Deliberate and systematic are characteristics of nursing assessment. The use a consistent systematic approach encourages completeness and efficiency in the assessment process. It also enables colleagues to be able to efficiently review the documented assessment information.

4. collect and document data from clients own perceptions of health status, direct observations, reports from family / significant others, physical examination and documented case notes and referrals as appropriate.

In the community health setting, where the client or significant other will be care givers in partnership with the community health nurse, their perceptions, believes and attitudes to the health issue are integral parts of the assessment process. For completeness and validation direct nursing observations, physical examination and previous history perspectives should also be collected and documented. According to the principles of documentation accurate reporting of the information and its source should be entered into the client notes.

5. apply an assessment process that seeks to identify and is orientated to clients own goals with particular reference to level of functionality and ability for self care and to accurately document this.

As a part of the empowerment approach noted in point 8, ensuring that the assessment process clearly identifies the clients' goals for health care and is orientated to these is critical in providing a foundation for planning interventions and education that supports self-care by the client. Failure to recognise and work toward the clients goals is likely to limit efficacy in the health care delivered. Konkle-Parker (2001, p64) makes the comment that "Since many health related behaviour changes are complex, a client-centred approach is critical to focus on the clients specific issues that contribute to nonadherence." Like any other client or clinical information it should be documented in accordance with the standards as articulated by the Queensland Nursing Council (2005).

6. conduct a comprehensive assessment that identifies the health deficits and self care capacities of the client taking into account their emotional and physical characteristics and the environmental and social contexts.

and

7. ensure the inclusion of family, significant others and the capacity and accessibility of health resources in scope of assessment as potential contributors to the provision of health care as evidenced in documentation of the assessment.

"Community nursing assessment … includes gaining information about and an understanding of the physical, psychological, social, family, cultural, economic and environmental factors that impinge on individuals well being." (McIntosh J. 2006, p300)

8. apply an empowering approach, facilitating individuals and families to identify and address own health risks and deficits including the appropriate use of health care resources.

Self-efficacy, the belief that one has the capacity to perform a particular task, is described by Cross et. al. (2006) has having a measurable association with better health status. Encouraging and facilitating self care by clients is beneficial to the client and to health services. The role of the community health nurse is to work in partnership with clients and their families or other care givers to ensure an optimal level of health and well being is achieved with a minimum of intrusion necessary by health services. In the context of health care the balance between self care and nursing intervention is a dynamic one subject to ongoing assessment and adjustment. Maintaining the principle of self-efficacy and empowerment will provide a clear foundation for assessment and adjustment.

9. identify and utilise the available assessment tools appropriate to the specific clinical setting and consistent with service policies and procedures.

While there is some evidence to suggest that a conversational approach to assessment may elicit a more client centred and contextual analysis of "need", the use of structured assessment tools is applied in some areas to promote consistency and efficiency in the identification and prioritization of need. (McIntosh J., 2006) The community health nurse is encouraged to identify and use assessment tools appropriate to the specific area of work and seek to engage the client in an assessment process that meets the requirements of structured assessment tools but is not confined by them.

10. identify own scope of practice in relation to the collection and interpretation of client information and seek support and supervision to maintain quality care for each individual client and to develop own skills.

The assessment process forms the foundation of sound clinical decision making leading to quality client outcomes. The practice of assessment as with many nursing skills will be enhanced with application and experience. At all level of experience the nurse is expected to acknowledge their scope of practice and seek support from colleagues and superiors to ensure that the assessment process is complete and accurate.

Part B: DEMONSTRATES THE ABILITY TO:
Assess communities and populations

1. articulate the purpose and principles of community assessment from a community health nursing perspective.

"Community needs assessment should be done to assure that the programs and services that are developed are as responsive as possible to the community." (Torrisi & Hansen-Turton, 2005, p17)

2. articulate various sources of information relevant to developing an understanding of the family or community group.

Sources of information and the depth of information sought will vary depending on the intended purpose of the community analysis. Data may be collected from personal observation of the community or group or may involve demographic data from more formal collection systems such a census data or local council data. A useful community profile and needs analysis will take into account determinants of health, including socio-economic and environmental factors. It will also consider community networks and infrastructure including health, recreational and educational facilities. St. John & Keleher (2007) provide an overview of the full range of data collectable for a give group or community.

3. understand the characteristics of the community context of the health service and how those characteristics may impact on health status and the use of health related resources.

Not all data is of equal value in supporting the delivery of health care. St. John & Keleher (2007) point out that the community's and the community nurse's judgements are important factors in prioritising need and focusing the community assessment process. In the community context need may be expressed by the community, inferred by comparison with other communities or described by analysis of objective data. Recognising the context in which need is identified and the capacity of the community in relation to need is valuable in supporting, evolving and delivering health services.

4. identify and use appropriate avenues to disseminate relevant community information to inform the development of health care services.

St. John & Keleher (2007) comment that, "Simply gathering data will not change anything". The understandings gained through data collection and analysis need to be applied to practice in some form. This may be through recommending the development of particular programs at a service level, including the data in service planning activities or adding to district or state wide data collection systems and processes. "Health agencies can create a living file that profiles the local community and their health and social issues." (St. John & Keleher, 2007 p80)

5. identify at risk groups within populations and describe their defining characteristics.

The identification and definition of at risk groups will offer valuable depth in areas that may be prioritised for the application of health interventions. Clearly articulating the characteristics of a group will assist the planning of effective health interventions and provide evidence for the application of resources.

6. maintain an empowering approach, facilitating community and populations to identify and address own health risks and deficits.

"The success of a community based program is dependant upon community member participation and the fostering of a sense of neighbourhood ownership." (Torrisi & Hansen-Turton, 2005, p18) The assessment and planning processes for any community health intervention should be based on and incorporate community participation. As for individual health care the self efficacy on the part of a community group is an important factor in achieving optimal and sustainable health outcomes.

7. support and participate in broader population based surveillance programs and recognise their role in the early identification of health deficits and the processes for case finding and referral to community health services.

"Surveillance gathers the, who, when, where and what; these elements are then used to answer why. A good surveillance system systematically collects, organises and analyses current accurate and complete data for a defined disease condition. The resulting information is promptly released to those who need it for effective planning, implementation and evaluation of disease prevention and control programs." (Stanhope & Lancaster, 2004, p907)

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Created By :	Name: Designation:	**Date**:	
Reviewed By:	Name: Designation:	**Date**:	Include all review dates in descending order

Skills Checklist - Community Nursing

EQuIP Function: Continuum of Care	
Document Custodian: Skill Mix Project	**Next Review Date**: August 2010

Appendix 1.B. Community Health Nursing Assessment: Nursing Officer Grade 4.

Target Audience: Nursing Officer Grade 4 (Enrolled Nurse), Community Health Settings.

Associated Policies/ Procedures: (Please list any relevant Policies &/or Procedures related to the content of this Skills Checklist. Please hyperlink where possible)

Name: …… **Payroll Num**:…….

SKILLS CHECKLIST:	Key C = Competent for Level S = Requires Supervision D = Requires Development		
Performance Criteria			
Part A: DEMONSTRATES THE ABILITY TO: ***Assess clients in community settings***	C	S	D
11. articulate the purpose and principles of client assessment in the context of community health nursing.			
12. establish effective communication including listening and observation skills to facilitate the collection of accurate, reliable and relevant information that can be validated by the client and colleagues.			
13. collect and document data from the clients own perceptions of health status, direct observations, reports from family / significant others, physical examination and documented case notes and referrals as appropriate.			
14. carry out delegated tasks that contribute to the comprehensive assessment process.			
15. accurately document data collected for assessment purposes and ensure this is reviewed by the appropriate registered nurse.			
16. apply an empowering approach, facilitating individuals and families to identify and address own health risks and deficits including the appropriate use of health care resources.			
17. identify and utilise the available tools for data collection appropriate to the specific clinical setting and consistent with service policies and procedures.			
18. identify own scope of practice in relation to the collection of client information and seek support and supervision to maintain quality care for each individual client and to develop own skills.			

Part B: DEMONSTRATES THE ABILITY TO: *Assess communities and populations*			
8. articulate the purpose and principles of community assessment from a community health nursing perspective.			
9. articulate various sources of information relevant to developing an understanding of the family or community group.			
10. understand the characteristics of the community context of the health service and how those characteristics may impact on health status and the use of health related resources.			
11. identify and use appropriate avenues to disseminate relevant community information to inform the development of health care services.			
12. maintain an empowering approach, facilitating community and populations to identify and address own health risks and deficits.			
13. support and participate in broader population based surveillance programs.			

Towards Excellence:

Following attainment of a mandatory standard of performance against the above criteria nurses are encouraged to strive for excellence in practice. Reflective self assessment supported by peers and mentors can assist this process. The Benner model of skill acquisition is provided here as a guide to facilitate self assessment and reflection on practice on the journey to higher levels of proficiency.

Benner Skill Acquisition Model	
6. Novice	Relies on guiding principles and rules to perform within set parameters.
7. Advanced beginner	Performs routine functions; requires some assistance in complex situations/setting priorities.
8. Competent	Prioritises and completes functions independently; can adapt practice to manage complex situations.
9. Proficient	Demonstrates speed and flexibility in decision making; can predict outcomes independently and plan for contingencies.
10. Expert	Demonstrates mastery in performance; demonstrates creativity and innovation; responds intuitively.

Comments or Plan:

Date	Assessed by:	
	Name (print)	**Signature**
Date	**Staff member being assessed:**	
	Name (print)	**Signature**

Part A: DEMONSTRATES THE ABILITY TO:
Assess clients in community settings

11. articulate the purpose and principles of client assessment in the context of community health nursing.

"Assessment in nursing is the deliberate and systematic collection of information (data) about an individual, family or group (community)." (Carpenito-Moyet, 2007, p14) Assessment should be viewed as a process rather than a single point in time.

12. establish effective communication including listening and observation skills to facilitate the collection of accurate, reliable and relevant information that can be validated by the client and colleagues.

The development and use of effective communication is essential to gathering accurate and complete information from a client or their family. This is particularly so when exploring issues of values, and beliefs that are relevant to health status.

13. collect and document data from clients own perceptions of health status, direct observations, reports from family / significant others, physical examination and documented case notes and referrals as appropriate.

In the community health setting, where the client or significant other will be care givers in partnership with the community health services, their perceptions, believes and attitudes to the health issue are integral parts of the assessment process. For completeness and validation direct nursing observations, physical examination and previous history perspectives should also be collected and documented. According to the principles of documentation accurate reporting of the information and its source should be entered into the client notes.

14. carry out delegated tasks that contribute to the comprehensive assessment process.

"Community nursing assessment … includes gaining information about and an understanding of the physical, psychological, social, family, cultural, economic and environmental factors that impinge on individuals well being." (McIntosh J., 2006, p300)

15. accurately document data collected for assessment purposes and ensure this is reviewed by the appropriate registered nurse.

Documentation is both a record of activities undertaken and a means of communication between nurses and other health professionals. All information regarding a client should be documented according to the Queensland Nursing Council Documentation Standards. (Queensland Nursing Council, 2005)

16. apply an empowering approach, facilitating individuals and families to identify and address own health risks and deficits including the appropriate use of health care resources.

Self-efficacy, the belief that one has the capacity to perform a particular task, is described by Cross et. al. (2006) has having a measurable association with better health status. Encouraging and facilitating self care by clients is beneficial to the client and to health services. The role of the community health nurse is to work in partnership with clients and their families or other care givers to ensure an optimal level of health and well being is achieved with a minimum of intrusion necessary by health services. In the context of health care the balance between self care and nursing intervention is a dynamic one subject to ongoing assessment and adjustment. Maintaining the principle of self-efficacy and empowerment will provide a clear foundation for assessment and adjustment.

17. identify and utilise the available tools for data collection appropriate to the specific clinical setting and consistent with service policies and procedures.

In many service areas structured assessment tools are available to assist the collection of relevant client data. These tools promote consistency and efficiency in the identification and prioritization of need. (McIntosh J., 2006) The community health nurse is encouraged to identify and use assessment tools appropriate to the specific area of work within their scope of practice.

18. identify own scope of practice in relation to the collection and interpretation of client information and seek support and supervision to maintain quality care for each individual client and to develop own skills.

The assessment process forms the foundation of sound clinical decision making leading to quality client outcomes. The practice of assessment as with many nursing skills will be enhanced with application and experience. At all level of experience the nurse is expected to acknowledge their scope of practice and seek support from colleagues and superiors to ensure that the assessment process is complete and accurate.

Part B: DEMONSTRATES THE ABILITY TO:
Assess communities and populations

8. articulate the purpose and principles of community assessment from a community health nursing perspective.

"Community needs assessment should be done to assure that the programs and services that are developed are as responsive as possible to the community." (Torrisi & Hansen-Turton, 2005, p17)

9. articulate various sources of information relevant to developing an understanding of the family or community group.

Sources of information and the depth of information sought will vary depending on the intended purpose of the community analysis. Data may be collected from personal observation of the community or group or may involve demographic data from more formal collection systems such a census data or local council data. A useful community profile and needs analysis will take into account determinants of health, including socio-economic and environmental factors. It will also consider community networks and infrastructure including health, recreational and educational facilities. St. John & Keleher (2007) provide an overview of the full range of data collectable for a give group or community.

10. understand the characteristics of the community context of the health service and how those characteristics may impact on health status and the use of health related resources.

Not all data is of equal value in supporting the delivery of health care. St. John & Keleher (2007) point out that the community's and the community nurse's judgements are important factors in prioritising need and focusing the community assessment process. In the community context need may be expressed by the community, inferred by comparison with other communities or described by analysis of objective data. Recognising the context in which need is identified and the capacity of the community in relation to need is valuable in supporting, evolving and delivering health services.

11. identify and use appropriate avenues to disseminate relevant community information to inform the development of health care services.

St. John & Keleher (2007) comment that, "Simply gathering data will not change anything". The understandings gained through data collection and analysis need to be applied to practice in some form. This may be through recommending the development of particular programs at a service level, including the data in service planning activities or adding to district or state wide data collection systems and processes. "Health agencies can create a living file that profiles the local community and their health and social issues." (St. John & Keleher, 2007 p80)

12. identify at risk groups within populations and describe their defining characteristics.

The identification and definition of at risk groups will offer valuable depth in areas that may be prioritised for the application of health interventions. Clearly articulating the characteristics of a group will assist the planning of effective health interventions and provide evidence for the application of resources.

13. maintain an empowering approach, facilitating community and populations to identify and address own health risks and deficits.

"The success of a community based program is dependant upon community member participation and the fostering of a sense of neighbourhood ownership." (Torrisi & Hansen-Turton, 2005, p18) The assessment and planning processes for any community health intervention should be based on and incorporate community participation. As for individual health care the self efficacy on the part of a community group is an important factor in achieving optimal and sustainable health outcomes.

14. support and participate in broader population based surveillance programs and recognise their role in the early identification of health deficits and the processes for case finding and referral to community health services.

"Surveillance gathers the, who, when, where and what; these elements are then used to answer why. A good surveillance system systematically collects, organises and analyses current accurate and complete data for a defined disease condition. The resulting information is promptly released to those who need it for effective planning, implementation and evaluation of disease prevention and control programs." (Stanhope & Lancaster, 2004, p907)

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Cross, M.J., March, L.M., Lapsley, H.M., Byrne, E. & Brooks, P.M. 2006, 'Patient self-efficacy and health locus of control: relationships with health status and arthritis related expenditure.' *Rheumatology* vol. 45, pp. 92-96.

McIntosh, J. 2006 'The evidence base for individual patient and client assessment by community nurses.' *Primary Health Care Research and Development 2006;* no. 7, pp. 299-308

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St. John, W. & Keleher, H. 2007, *Community Nursing Practice.* Allen & Unwin, Crows Nest, NSW.

Stanhope, M., & Lancaster, J. 2004, *Community and public health nursing.* Mosby.

Torrisi, D.L. & Hansen-Turton, T. 2005, *Community and nurse-managed health centers: getting them started and keeping them going.* Springer Publishing Company, New York.

Created By :	Name: Designation:	**Date**:	
Reviewed By:	Name: Designation:	**Date**:	Include all review dates in descending order

Skills Checklist - Community Health Nursing

EQuIP Function: Continuum of Care	
Document Custodian: Skill Mix Project	**Next Review Date**: August 2010

Appendix 2.A. Community Nursing Case Management: Nursing Officer Grade 5

Target Audience: Nursing Officer Grade 5 (Registered Nurse), Community Health Settings.

Associated Policies/ Procedures: (Please list any relevant Policies &/or Procedures related to the content of this Skills Checklist. Please hyperlink where possible)

Name: …… **Payroll Num**:…….

SKILLS CHECKLIST **DEMONSTRATES THE ABILITY TO:**	Key C = Competent for Level S = Requires Supervision D = Requires Development		
Performance Criteria	C	S	D
1. Able to verbalise/describes the primary goal of nursing case management.			
2. Able to describe the characteristics of clients and client groups for whom case management is an appropriate intervention strategy.			
3. Demonstrates the ability to develop, maintain and appropriately conclude professional relationships with clients, significant others and key services providers.			
4. Demonstrates use of appropriate communication and interpersonal skills with clients, significant others and service providers.			
5. Identifies and documents the level of assessment and needs identification for the individual client or client group and ensures this is carried out by the appropriate health professional.			
6. Management of referrals demonstrates adherence to service standards and processes.			
7. Written care plans demonstrate collaborative development in consultation with the client and a clinical nurse.			
8. Documents in the care plan all aspects of client need and the appropriate health professionals/service to meet those needs.			
9. Demonstrates ability to initiate and/or participate in case conferencing of all clients with a clinical nurse, including other health professionals as required.			
10. Accesses, uses and shares accurate and up-to-date information on services and facilities to maintain own knowledge in supporting individual clients and for the use of colleagues.			
11. Provides up-to-date information to support individuals to make informed choices about the care and services they receive and provide active support and education to enable individuals to act on those choices			
12. Able to provide documented evidence of periodic analysis and revision of expected outcomes, interventions and priorities in the clients' condition, needs or circumstances and evaluates and follows up in regard to new strategies to meet unmet needs or new needs as they arise.			
13. Negotiates agreed timeframes and conditions for discharge from care and contingences for review and readmission if the clients' circumstances change and documents these in the client file.			

Towards Excellence:

Following attainment of a mandatory standard of performance against the above criteria nurses are encouraged to strive for excellence in practice. Reflective self assessment supported by peers and mentors can assist this process. The Benner model of skill acquisition is provided here as a guide to facilitate self assessment and reflection on practice on the journey to higher levels of proficiency.

Benner Skill Acquisition Model	
11. Novice	Relies on guiding principles and rules to perform within set parameters.
12. Advanced beginner	Performs routine functions; requires some assistance in complex situations/setting priorities.
13. Competent	Prioritises and completes functions independently; can adapt practice to manage complex situations.
14. Proficient	Demonstrates speed and flexibility in decision making; can predict outcomes independently and plan for contingencies.
15. Expert	Demonstrates mastery in performance; demonstrates creativity and innovation; responds intuitively.

Comments or Plan:

Date	**Assessed by:**	
	Name (print)	**Signature**
Date	**Staff member being assessed:**	
	Name (print)	**Signature**

Clinical Information Guide

1. Able to verbalise/describe the primary goal of nursing case management.

"The primary goal of community nurse case management is to work in partnership with patients to change behaviours and patterns of health care utilization." Zerull (1999). Bergen (1992) refers to a model of case management that is an extension of the key worker/care coordinator function where the health partitioner role includes arranging and monitoring of care as well as their direct professional intervention. A variety of definitions are offered depending on the model used and the purpose. Most consistently however is the recognition that case management should be aimed at two main outcomes; 1) an improvement the quality of care and 2) a decrease the cost of care in both hospital and community settings (Lee et al, 1998).

2. Able to describe the characteristics of clients and client groups for who case management is an appropriate intervention strategy.

Some indicators of clients that may benefit from a case management approach include those who have recurring hospital admissions, complex and concurrent health problems, chronic conditions that impact on their ability to live independently in a community settings.

3. Demonstrates the ability to develop, maintain and appropriately conclude professional relationships with clients, significant others and key services providers.

And

4. Demonstrates use of appropriate communication and interpersonal skills with clients, significant others and service providers.

"The relationship between the nurse case manager and the client was identified as a central theme of professional practice. This relationship allows the nurse and the client to identify jointly patterns that may improve the client health and empower him of her in making healthcare decisions." Forbes A.M., (1999, p28) Clarity around the relationship and boundaries provide a number of benefits for both the case manager and the client and should be proactively negotiated. (Walsh 2000 p80) Likewise Anderson states that the "effectiveness is based on the quality of the relationship … established with the client." (Anderson 2007) For this reason the communication used is critical to building an empathic, enabling relationship that supports information and education uptake by the client and effective consultation with the health care team.

5. Identifies and documents the level of assessment and needs identification for the individual client and ensures this is carried out by the appropriate health professional.

In order to achieve the primary objectives of case management it is critical to ensure a systematic approach to assessment and the use of appropriate assessment tools. The role of the RN is to initiate assessments where appropriate to their scope of practice or to ensure that a suitably qualified professional carries out the assessment and the results of such are incorporated into the ongoing case management of the client.

6. Management of referrals demonstrates adherence to service/unit standards and processes.

This will be demonstrated by recognition of the processes specific to the area of work, and timely and accurate use of those processes to ensure client need is met.

7. Written care plans demonstrate collaborative development in consultation with the client and a clinical nurse.

8. Documents in the care plan all aspects of client need and identifies appropriate health professionals to meet those needs.

Nursing care plans are a valuable tool in ensuring comprehensive and coordinated care is provided and evaluated to meet the specific needs of the client. This is particularly so in the

community context where written documentation forms a critical link between client and nurse case manager and between the health care team, especially where face to face contact between clinicians may not occur on a regular basis. The Queensland Nursing Council provides standards for Professional Documentation that underpins these performance criteria. (Queensland Nursing Council 2005)

9. Demonstrates the ability to initiate and/or participate in case conferencing of all clients with a clinical nurse, including other health professionals as required.

The case conference is a formal coordinated communication between all members of the health care team. It enables each health care provider to see their role in relation to the particular client or target group under discussion and to establish complementary goals with other providers and the client or target group. Case conferencing is an accepted and established practice in mental health settings. In community health settings it is one means of ensuring comprehensive care while avoiding duplication or competition of services. (Davis & Thurecht 2001), (Queensland Health 2007)

10. Accesses, uses and shares accurate and up-to-date information on services and facilities to maintain own knowledge in supporting individual clients and for the use of colleagues.

And

11. Provides up-to-date information to support individuals to make informed choices about the care and services they receive and provide active support and education to enable individuals to act on those choices

Key strategies to encouraging changes in patterns of health care utilisation are the provision information and education that is simple, accurate and relevant to client. The gathering, interpretation and strategic dissemination of information on community based resources helps to provide clients with opportunities for health care they may not have considered. Likewise the provision of appropriate education alongside interventions encourages self management by the client or family / significant others thus reducing the reliance on health services. Forbes (1999, p32) describes nicely the role of the nurse case manager in "assisting both the client and the system to negotiate the relationship". Likewise Erci (2005 p37 reports that the "greatest impact of case management was on client knowledge".

12. Able to provide documented evidence of periodic analysis and revision of expected outcomes, interventions and priorities in the clients' condition, needs or circumstances and evaluates and follows up in regard to new strategies to meet unmet needs or new needs as they arise.

"Evaluation of care is a central part of case management practice." Carr D.D., (2000) As with the nursing process, review and evaluation are key phases of case management to ensure that all needs are being met to an acceptable standard and health care is being delivered efficiently. As a case manager drawing on the resources of a team of services and practitioners it is critical that periodic review and evaluation processes include documentation and dissemination of changes to needs and care to ensure coordinated adjustment of service delivery across the team.

13. Negotiates agreed timeframes and conditions for discharge from care and contingences for review and readmission if the clients' circumstances change and documents these in the client file.

In seeking to achieve "changed behaviours and patterns of health care utilization" establishing time frames appropriate to address the range and acuity of identified needs is an essential part of maintaining efficiency in service delivery. With the quality of the relationship between client and community health nurse being recognised as the basis of effectiveness in case management it is important that the end phase to the relationship is negotiate to provide an ongoing sense of empowerment for the client in their access to and reliance on health care resources.

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Created By :	Name: Designation:	**Date**:	
Reviewed By:	Name: Designation:	**Date**:	Include all review dates in descending order

Skills Checklist - Community Nursing

EQuIP Function: Continuum of Care	
Document Custodian: Skill Mix Project	**Next Review Date**: August 2010

Appendix 2.B. Community Nursing Case Management: Nursing Officer Grade 4

Target Audience: Nursing Officer Grade 4 (Enrolled Nurse Advanced Practice), Community Health Settings.

Associated Policies/ Procedures: (Please list any relevant Policies &/or Procedures related to the content of this Skills Checklist. Please hyperlink where possible)

Name: …… **Payroll Num**:…….

SKILLS CHECKLIST **DEMONSTRATES THE ABILITY TO:**	Key C = Competent for Level S = Requires Supervision D = Requires Development		
Performance Criteria	C	S	D
1. Able to verbalise/describe the primary goal of nursing case management.			
2. Able to describe the characteristics of clients for whom case management is an appropriate intervention strategy.			
3. Demonstrates an ability to develop, maintain and appropriately conclude professional relationships with clients, significant others and key services providers.			
4. Demonstrates the use of appropriate communication and interpersonal skills with clients, significant others and service providers.			
5. Support assessment and needs identification for the individual client through carrying out delegated components of data gathering and observation and documenting findings.			
6. Able to describe service standards and processes for management of referrals.			
7. Able to verbalise their role in contributing to the development and implementation of collaborative care plans in consultation with the client and a registered nurse.			
8. Able to describe the use of the care plan that includes all aspects of client need and identifies the appropriate health professionals to meet those needs.			
9. Demonstrates an ability to participate in case conferencing of all clients with registered nursing colleagues.			
10. Accesses, uses and shares accurate and up-to-date information on services and facilities to maintain own knowledge in supporting individual clients and for the use of colleagues.			
11. Provides documented reports of client contact observations and interventions to support the monitoring, evaluation and revision of care.			

Towards Excellence:

Following attainment of a mandatory standard of performance against the above criteria nurses are encouraged to strive for excellence in practice. Reflective self assessment supported by peers and mentors can assist this process. The Benner model of skill acquisition is provided here as a guide to facilitate reflection and self assessment of practice on the journey to higher levels of proficiency.

Benner Skill Acquisition Model	
16. Novice	Relies on guiding principles and rules to perform within set parameters.
17. Advanced beginner	Performs routine functions; requires some assistance in complex situations/setting priorities.
18. Competent	Prioritises and completes functions independently; can adapt practice to manage complex situations.
19. Proficient	Demonstrates speed and flexibility in decision making; can predict outcomes independently and plan for contingencies.
20. Expert	Demonstrates mastery in performance; demonstrates creativity and innovation; responds intuitively.

Comments or Plan:

Date	**Assessed by:**	
	Name (print)	**Signature**
Date	**Staff member being assessed:**	
	Name (print)	**Signature**

Clinical Information Guide

1. Able to verbalise/describe the primary goal of nursing case management.
Case management has been defined in the literature in a variety of ways depending on the model used and the purpose. The goals of case management are 1) to improve the quality of care and 2) decrease the cost of care in both hospital and community settings (Lee et al, 1998). In the context of community nursing Zerull (1999) provides this definition, "The primary goal of community nurse case management is to work in partnership with patients to change behaviours and patterns of health care utilization." Bergen (1992) refers to a model of case management that is an extension of the key worker/care coordinator function where the health partitioner role includes arranging and monitoring of care as well as their direct professional intervention.

2. Able to describe the characteristics of clients for whom case management is an appropriate intervention strategy.
Some indicators of clients that may benefit from a case management approach include those who have recurring hospital admissions, complex and concurrent health problems, chronic conditions that impact on their ability to live independently in a community settings.

3. Demonstrates an ability to develop, maintain and appropriately conclude professional relationships with clients, significant others and key services providers.
"The relationship between the nurse case manager and the client was identified as a central theme of professional practice. This relationship allows the nurse and the client to identify jointly patterns that may improve the client health and empower him of her in making healthcare decisions." Forbes A.M., (1999, p28)

4. Demonstrates the use of appropriate communication and interpersonal skills with clients, significant others and service providers.
"The relationship between the nurse case manager and the client was identified as a central theme of professional practice. This relationship allows the nurse and the client to identify jointly patterns that may improve the client health and empower him of her in making healthcare decisions." Forbes A.M., (1999, p28) Clarity around the relationship and boundaries provide a number of benefits for both the case manager and the client and should be proactively negotiated. (Walsh 2000 p80) Likewise Anderson states that the "effectiveness is based on the quality of the relationship … established with the client." (Anderson 2007) For this reason the communication used is critical to building an empathic, enabling relationship that supports information and education uptake by the client and effective consultation with the health care team.

5. Support assessment and needs identification for the individual client through carrying out delegated components of data gathering and observation and documenting findings.
In order to achieve the primary objectives of case management it is critical to ensure a systematic approach to assessment and the use of appropriate assessment tools. The role of the EN is to support assessments through collecting client data use the assessment tools where appropriate to their scope of practice according to service guidelines and standards.

6. Able to describe service standards and processes for management of referrals.
This will be demonstrated by recognition of the processes specific to the area of work, and timely and accurate use of those processes to ensure client need is met.

7. Able to verbalise their role in contributing to the development and implementation of collaborative care plans in consultation with the client and a registered nurse.

and

8. Able to describe the use of the care plan that includes all aspects of client need and identifies the appropriate health professionals to meet those needs.

Nursing care plans are a valuable tool in ensuring comprehensive and coordinated care is provided and evaluated to meet the specific needs of the client. This is particularly so in the community context where written documentation forms a critical link between client and nurse case manager and between the health care team, especially where face to face contact between clinicians may not occur on a regular basis. The Queensland Nursing Council provides standards for Professional Documentation that underpins these performance criteria. (Queensland Nursing Council 2005)

9. Demonstrates an ability to participate in case conferencing of all clients with registered nursing colleagues.

The case conference is a formal coordinated communication between all members of the health care team. It enables each health care provider to see their role in relation to the particular client or target group under discussion and to establish complementary goals with other providers and the client or target group. Case conferencing is an accepted and established practice in mental health settings. In community health settings it is one means of ensuring comprehensive care while avoiding duplication or competition of services. (Davis & Thurecht 2001), (Queensland Health 2007)

10. Accesses, uses and shares accurate and up-to-date information on services and facilities to maintain own knowledge in supporting individual clients and for the use of colleagues.

Key strategies to encouraging changes in patterns of health care utilisation are the provision information and education that is simple, accurate and relevant to client. The gathering, interpretation and strategic dissemination of information on community based resources helps to provide clients with opportunities for health care they may not have considered. Likewise the provision of appropriate education alongside interventions encourages self management by the client or family / significant others thus reducing the reliance on health services. Forbes (1999, p32) describes nicely the role of the nurse case manager in "assisting both the client and the system to negotiate the relationship". Likewise Erci (2005 p37 reports that the "greatest impact of case management was on client knowledge".

11. Provides documented reports of client contact observations and interventions to support the monitoring, evaluation and revision of care.

"Evaluation of care is a central part of case management practice." Carr D.D., (2000) As with the nursing process, review and evaluation are key phases of case management to ensure that all needs are being met to an acceptable standard and health care is being delivered efficiently. As an Enrolled Nurse participating in a team of services and practitioners it is critical that observations from client contact are contributed to the periodic review and evaluation processes to ensure coordinated adjustment of service delivery across the team.

References:

Anderson, D. 2007, 'Community case management: a caring blend of heart, art and science.' *New Definition*, The Centre for Case Management, vol. 22, no. 2, [Online] Available at: http://cfcm.com/pdf/fall-2007.pdf

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Cooper, B.J. & Yarmo Roberts, D.D. 2006, 'National case management standards in Australia – purpose, process and potential impact.' *Australian Health Review* vol. 30, no. 1, pp. 12-16

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Erci, B. 2005, 'Global case management: impact of case management on client outcomes.' *Lippincott's Case Management* vol. 10, no. 1.

Forbes, A.M. 1999, 'The practice of professional nurse case management.' *Nursing Case Management* vol, 4, no. 1, pp. 28-33.

Lee, D.T.F., Mackenzie, A.E., Dudley-Brown, S. & Chin, T.M. 1998, 'Case management: a review of the definitions and practices.' *Journal of Advanced Nursing* vol. 27, pp. 933-939.

Queensland Health: Cairns & Hinterland Health Service District, 2007, *Remote Area Mental Health Service, CASE REVIEW/CONFERENCING, Workplace Protocol,* [Online] Available at: http://qheps.health.qld.gov.au/cairns/docs/mhpra_caservw.pdf

Queensland Nursing Council 2005, *Professional Documentation Standards, Framework Information Sheet No.3* [Online] Available at: http://www.qnc.qld.gov.au/upload/pdfs/information_sheets/Scope_of_practice_framework_2005_Framework_/Framework_information_sheet_03_Professional_documentation_standards.pdf

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Zerull, L.M. 1999, 'Community nurse case management: evolving over time to meet new demands.' *Family & Community Health* vol. 22, no. 3, pp. 12-29.

Created By :	Name: Designation:	**Date**:	
Reviewed By:	Name: Designation:	**Date**:	Include all review dates in descending order

Skills Checklist - Community Nursing

EQuIP Function: Continuum of Care	
Document Custodian: Skill Mix Project	**Next Review Date**: August 2010

Appendix 3.A. Community Health Nursing Health Promotion & Education: Nursing Officer Grade 5

Target Audience: Nursing Officer Grade 5 (Registered Nurse), Community Health Settings.

Associated Policies/ Procedures: (Please list any relevant Policies &/or Procedures related to the content of this Skills Checklist. Please hyperlink where possible)

Name: …… **Payroll Num**:…….

SKILLS CHECKLIST: *Provide and facilitate health teaching and learning and promoting health to clients and communities*	Key C = Competent for Level S = Requires Supervision D = Requires Development		
Performance Criteria			
DEMONSTRATES THE ABILITY TO:	C	S	D
1. recognise and describe the formal and informal educative roles in community health nursing practice.			
2. articulate the purposes of and differences between health teaching and health promotion in community health nursing.			
3. describe the principles in developing, maintaining and concluding therapeutic partnerships with individuals and communities.			
4. use effective communication skills in interactions with individuals and communities.			
5. maintain a client / community centred focus when providing health education or health promotion.			
6. show appropriate respect and acknowledgment of individual's prior experience and learning when preparing, delivering and evaluating health education.			
7. use teaching skills that enhance the transfer of learning into changes in health behaviours.			
8. adapt the health teaching or health promotion strategies to accommodate the particular needs and/or capacities of the individual or group.			
9. monitor and evaluate the outcome of health education or promotion in terms of changes in health behaviours or status.			
10. document health education activities as a part of client care or as evidence of community development activities.			

Towards Excellence:

Following attainment of a mandatory standard of performance against the above criteria nurses are encouraged to strive for excellence in practice. Reflective self assessment supported by peers and mentors can assist this process. The Benner model of skill acquisition is provided here as a guide to facilitate self assessment and reflection on practice on the journey to higher levels of proficiency.

Benner Skill Acquisition Model	
1. Novice	Relies on guiding principles and rules to perform within set parameters.
2. Advanced beginner	Performs routine functions; requires some assistance in complex situations/setting priorities.
3. Competent	Prioritises and completes functions independently; can adapt practice to manage complex situations.
4. Proficient	Demonstrates speed and flexibility in decision making; can predict outcomes independently and plan for contingencies.
5. Expert	Demonstrates mastery in performance; demonstrates creativity and innovation; responds intuitively.

Comments or Plan:

Date	**Assessed by:**	
	Name (print)	**Signature**
Date	**Staff member being assessed:**	
	Name (print)	**Signature**

Clinical Information Guide

1. recognise and describe the formal and informal educative roles of nursing practice.

"Patient education plays a crucial role in health maintenance" and "has long been an important aspect of healthcare in general and particularly in nursing care." (Evans et al, 1993, p171) In a formal sense patient education refers to planned combinations of learning activities to assist people in "recuperate from or cope with an illness, prevent recurrences of health problems or to help 'at risk' populations reduce their chances of becoming ill." (Fleming, 1992, p158) Gregor (2001) asserts however that nurses have an extensive informal educative role that shares the same aim of assisting people to change health related behaviour. Educative functions form the largest component of community health nursing practice. (Schoenfeld & MacDonald 2002)

2. articulate the purposes of and differences between health teaching and health promotion in community health nursing.

"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care". In supporting this, the health practitioner "should take on an enabling approach to care facilitating people to make choices which are right for them, but in so doing providing them with information about health which will help them in their decision making." (Kendall, 1993, p103) While health education is about providing, formally or informally, learning opportunities leading to enhanced ability of the client or community for self care, "Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health." (WHO, 2005, p1), which may include education but in a context of facilitation, advocacy and collaboration.

3. describe the principles in developing, maintaining and concluding therapeutic partnerships with individuals and communities.

The concept of partnership has become a central theme in the delivery of community health nursing. Some of the characteristics of the client nurse partnership are honest and open communication, empathy, sharing and respect for the others expertise, participation and involvement, enabling choice and equity. Such partnerships are the foundation to effective health teaching and health promotion in community nursing practice. (Bidmead & Cowley, 2005) and (St. John & Keleher, 2007)

4. use effective communication skills in interactions with individuals and communities.

Good communication is a core concept in public health nursing and support the roles of client care, client advocacy as well as health teaching. (Tveiten & Severinsson, 2006, p237) and (St. John & Keleher, 2007, p319) some of the skill necessary for effective communication include listening, open ended questioning and reflection. Communication should be purposeful, clear, and concise and demonstrate empathy and respect. Community health nurses may need to develop skills in communicating within their own organisation, with other organisations, clients, community groups and community governance structures. Communication may be through verbal or written means of through the use of body language or gestures.

5. maintain a client / community centred focus when providing health education or health promotion.

"The success of a community based program is dependant upon community member participation and the fostering of a sense of neighbourhood ownership." (Torrisi & Hansen-Turton, 2005, p18) Self-efficacy, the belief that one has the capacity to perform a particular task, is described by Cross et al (2006) has having a measurable association with better health status. Health teaching of both individuals and communities is critical in encouraging and facilitating self care by clients. Maintaining the client or group as the key partner in preparing and delivering health education will enhance the probability of achieving optimal outcomes.

6. show appropriate respect and acknowledgement of individual's prior experience and learning when preparing, delivering and evaluating health education.

One of the key principles of adult learning is relevance to prior life experiences and knowledge. It is critical therefore that in offering educational interventions the recipients past experience, skill and knowledge are explored, valued and used as a foundation for further growth and development. The willingness to engage in such exploration also builds trust and respect in the learning partnership and optimises the transfer of knowledge and skills.

7. use teaching skills that enhance the transfer of learning into changes in health behaviours.

and

8. adapt the health teaching or health promotion strategies to accommodate the particular needs and/or capacities of the individual or group.

In any behaviour change strategy the transfer of knowledge to practice is strongly influenced by the motivation and self efficacy of the individual. Identifying individual goals in health related behaviour change and using strategies to enhance motivation and over come barriers is demonstrated to provide success in many areas of health care. (Kumm et al, 2002)

9. monitor and evaluate the outcome of health education or promotion in terms of changes in health behaviours or status.

The transfer of learning to health behaviour should be monitored to inform adjustments to the health education process or identify challenges that need to be addressed. Whether education was formal or informal the outcomes should be related to the goals identified by the client, group or community in the assessment and planning process.

10. document health education activities as a part of client care or as evidence of community development activities.

Health education is a recognised area of nursing activity and where it involves individual clients should be subject to the same documentation standards as any other nursing interventions. Where health promotion or education has a group or community focus activities should be documents to demonstrate the involvement of nursing in these areas and provide evidence for community development and service development purposes.

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Created By :	Name: Designation:	**Date**:	
Reviewed By:	Name: Designation:	**Date**:	Include all review dates in descending order

Skills Checklist - Community Nursing

EQuIP Function: Continuum of Care	
Document Custodian: Skill Mix Project	**Next Review Date**: August 2010

Appendix 3.B. Community Health Nursing Health Promotion & Education: Nursing Officer Grade 4

Target Audience: Nursing Officer Grade 4 (Enrolled Nurse), Community Health Settings.

Associated Policies/ Procedures: (Please list any relevant Policies &/or Procedures related to the content of this Skills Checklist. Please hyperlink where possible)

Name: …… **Payroll Num**:…….

SKILLS CHECKLIST: *Provide and facilitate health teaching and learning and promoting health to clients and communities*	Key C = Competent for Level S = Requires Supervision D = Requires Development		
Performance Criteria			
DEMONSTRATES THE ABILITY TO:	C	S	D
1. recognise and describe the formal and informal educative roles in community health nursing practice.			
2. articulate the purposes of and differences between health teaching and health promotion in community health nursing.			
3. describe the principles in developing, maintaining and concluding therapeutic relationships with individuals and communities.			
4. use effective communication skills in interactions with individuals and communities.			
5. support a client / community centred focus when participating in the delivery of health education or health promotion.			
6. show appropriate respect and acknowledgment of prior experience and learning when preparing and delivering education to individuals.			
7. use teaching skills that enhance the transfer of learning into changes in health behaviours.			
8. adapt the health teaching or health promotion strategies to accommodate the particular needs and/or capacities of the individual or group.			
9. document health education activities as a part of client care or as evidence of community development activities.			

Towards Excellence:

Following attainment of a mandatory standard of performance against the above criteria nurses are encouraged to strive for excellence in practice. Reflective self assessment supported by peers and mentors can assist this process. The Benner model of skill acquisition is provided here as a guide to facilitate self assessment and reflection on practice on the journey to higher levels of proficiency.

Benner Skill Acquisition Model	
1. Novice	Relies on guiding principles and rules to perform within set parameters.
2. Advanced beginner	Performs routine functions; requires some assistance in complex situations/setting priorities.
3. Competent	Prioritises and completes functions independently; can adapt practice to manage complex situations.
4. Proficient	Demonstrates speed and flexibility in decision making; can predict outcomes independently and plan for contingencies.
5. Expert	Demonstrates mastery in performance; demonstrates creativity and innovation; responds intuitively.

Comments or Plan:

Date	**Assessed by:**	
	Name (print)	**Signature**
Date	**Staff member being assessed:**	
	Name (print)	**Signature**

Clinical Information Guide

1. recognise and describe the formal and informal educative roles of nursing practice.

"Patient education plays a crucial role in health maintenance" and "has long been an important aspect of healthcare in general and particularly in nursing care." (Evans et al, 1993, p171) In a formal sense patient education refers to planned combinations of learning activities to assist people in "recuperate from or cope with an illness, prevent recurrences of health problems or to help 'at risk' populations reduce their chances of becoming ill." (Fleming, 1992, p158) Gregor (2001) asserts however that nurses have an extensive informal educative role that shares the same aim of assisting people to change health related behaviour. Educative functions form the largest component of community health nursing practice. (Schoenfeld & MacDonald 2002)

2. articulate the purposes of and differences between health teaching and health promotion in community health nursing.

"The people have the right and duty to participate individually and collectively in the planning and implementation of their heath care". In supporting this, the health practitioner "should take on an enabling approach to care facilitating people to make choices which are right for them, but in so doing providing them with information about health which will help them in their decision making." (Kendall, 1993, p103) While health education is about providing, formally of informally, learning opportunities leading to enhanced ability of the client or community for self care, "Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health." (WHO, 2005, p1), which may include education but in a context of facilitation, advocacy and collaboration.

3. describe the principles in developing, maintaining and concluding therapeutic partnerships with individuals and communities.

The concept of partnership has become a central theme in the delivery of community health nursing. Some of the characteristics of the client nurse partnership are honest and open communication, empathy, sharing and respect for the others expertise, participation and involvement, enabling choice and equity. Such partnerships are the foundation to effective health teaching and health promotion in community nursing practice. (Bidmead & Cowley, 2005) and (St. John & Keleher, 2007)

4. use effective communication skills in interactions with individuals and communities.

Good communication is a core concept in public health nursing and support the roles of client care, client advocacy as well as health teaching. (Tveiten & Severinsson, 2006, p237) and (St. John & Keleher, 2007, p319) some of the skill necessary for effective communication include listening, open ended questioning and reflection. Communication should be purposeful, clear, and concise and demonstrate empathy and respect. Community health nurses may need to develop skills in communicating within their own organisation, with other organisations, clients, community groups and community governance structures. Communication may be through verbal or written means or through body language or gestures.

5. support a client / community centred focus when participating in the delivery of health education or health promotion.

"The success of a community based program is dependant upon community member participation and the fostering of a sense of neighbourhood ownership." (Torrisi & Hansen-Turton, 2005, p18) Self-efficacy, the belief that one has the capacity to perform a particular task, is described by Cross et al (2006) has having a measurable association with better health status. Health teaching of both individuals and communities is critical in encouraging and facilitating self care by clients. Maintaining the client or group as the key partner in preparing and delivering health education will enhance the probability of achieving optimal outcomes.

6. show appropriate respect and acknowledgement of prior experience and learning when preparing and delivering education to individuals.

One of the key principles of adult learning is relevance to prior life experiences and knowledge. It is critical therefore that in offering educational interventions the recipients past experience, skill and knowledge are explored, valued and used as a foundation for further growth and development. The willingness to engage in such exploration also builds trust and respect in the learning partnership and optimises the transfer of knowledge and skills.

7. ***use teaching skills that enhance the transfer of learning into changes in health behaviours.***

and

8. ***adapt the health teaching or health promotion strategies to accommodate the particular needs and/or capacities of the individual or group.***

In any behaviour change strategy the transfer of knowledge to practice is strongly influenced by the motivation and self efficacy of the individual. Identifying individual goals in health related behaviour change and using strategies to enhance motivation and over come barriers is demonstrated to provide success in many areas of health care. (Kumm et al, 2002)

9. ***document health education activities as a part of client care or as evidence of community development activities.***

Health education is a recognised area of nursing activity and where it involves individual clients should be subject to the same documentation standards as any other nursing interventions. Where health promotion or education has a group or community focus activities should be documents to demonstrate the involvement of nursing in these areas and provide evidence for community development and service development purposes.

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Reviewed By:	Name: Designation:	**Date**:	Include all review dates in descending order

Appendix 4: Skill Checklist Template

Townsville Health Service District

Skills Checklist - Community Nursing

EQuIP Function: Continuum of Care	
Document Custodian:	**Next Review Date**: August 2010

Title: Community Health Nursing Health : Nursing Officer Grade

Target Audience: Nursing Officer Grade ….. Community Health Settings.

Associated Policies/ Procedures: (Please list any relevant Policies &/or Procedures related to the content of this Skills Checklist. Please hyperlink where possible)

Name: …… **Payroll Num**:…….

SKILLS CHECKLIST: ***Provide and facilitate health teaching and learning and promoting health to clients and communities***	Key C = Competent for Level S = Requires Supervision D = Requires Development		
Performance Criteria			
DEMONSTRATES THE ABILITY TO:	C	S	D
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Towards Excellence:

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	Name (print)	**Signature**

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References:

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Reviewed By:	Name: Designation:	**Date**:	Include all review dates in descending order