



**Review of the Canadian Community Health Nursing  
Standards of Practice and Resulting Implications for  
Implementation in British Columbia**

**Prepared for:** Public Health Nurses Leaders Council  
of British Columbia

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January 2005

This report was completed by TGS Consultants Incorporated, and funded by the Public Health Nursing Leaders Council of British Columbia and Ms. Anne Sutherland-Boals, Chief Nursing Officer for the Province of British Columbia.

TGS Consultants Incorporated would like to thank the following individuals for sharing their time and expertise:

Dorothy Cumming, CHNAC - British Columbia Representative  
Joan Reiter, past CHNAC – Communications  
Shirley Sterlinger, CHNAC – past British Columbia Representative  
Leslie Shand, CHNAC - Alberta Representative  
Carol Marz, CHNAC - Saskatchewan Representative  
Claire Betker, CHNAC - Manitoba Representative  
Jan Schmalenberg, Program Specialist, Winnipeg Regional Health Authority  
Yvette Laforet-Fliesser, CHNAC - Ontario Representative  
Donna Smith, CHNAC - Past President [Nova Scotia]  
Rosemarie Goodyear, CHNAC - Co-President [Newfoundland]  
Mary Shaw, Nursing Practice Consultant, RNABC  
Corinne Harrod, Nursing Practice Consultant, CLPNBC  
Kathy Corbett, Registrar, COTBC  
Jan Gauthier, Board Member, COTBC

We would also like to express our appreciation to the PHNLC Advisory Committee for its contribution and direction during this project:

Anne White, Chair – Advisory Committee, Interior Health Authority  
Anne Clarotto, Interior Health Authority  
Denise Fargey, Fraser Health Authority  
Margaret Antolovich, Vancouver Coastal Health Authority  
Jan Adams, Vancouver Island Health Authority  
Cindy Anderson, Vancouver Island Health Authority

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## INTRODUCTION

In May 2003, the Community Health Nurses Association of Canada (CHNAC) released the Canadian Community Health Nursing Standards of Practice. These standards were recognized and accepted by the Canadian Nurses Association (CNA), leading to Community Health Nursing being recognized as a specialized field of nursing.

The Public Health Nursing Leaders' Council of British Columbia (PHNLC) embraced the CNA recognition of the specialized body of knowledge and expertise held by Community Health Nurses. The PHNLC identified the need for clarification of issues and concerns related to the new Standards of Practice. TGS Consultants Incorporated was selected to assist the PHNLC in determining:

- The delineation between home health nursing and public health nursing in relation to the new Standards of Practice
- How implementation of the new Standards of Practice might impact public health nursing practice.

Specifically, the PHNLC requested TGS Consultants Incorporated gather information in response to the following questions:

1. What are the current Standards of Practice that Public Health Nurses follow? How do the current standards differ from the Canadian Community Health Nursing Standards of Practice (May 2003)?
2. Which of the Canadian Community Health Nursing Standards of Practice (May 2003) specifically address the role of the Public Health Nurse (PHN)?
3. What role do employers play in ensuring PHN's meet Standards of Practice?
  - What, if any, implications are there for the employer with regard to training/education needed with the implementation of the Standards?
  - How can employers determine that staff are meeting the Standards of Practice?
  - How does an individual determine that they are meeting the Standards of Practice?
4. How will the implementation of the standards impact PHN practice?
5. What is the impact of the new standards on existing policies related to eligibility for hire?
6. How were/are other standards of nursing practice implemented in BC and other provinces?
  - How have standards of practice been implemented by other healthcare professions?
  - Who needs to be aware of the standards?

- What is the most effective and efficient way of notifying PHN's and stakeholders of the new standards of practice?
7. What competencies do PHN's require as entry to practice? What competencies are required of an experienced PHN?
8. What are the implications of the certification process for the employer?
- What are the implications of certification for the individual?
  - Should certification be a requirement of the position at hiring?
  - Can the certification process be phased in?
  - What are the costs of certification?
  - Who assumes responsibility for the cost?
  - Is there a cost impact on recognition of certification in the collective agreement?

## DEFINITIONS

The following terms were viewed as core concepts requiring definition to ensure consistent understanding of terminology and provide structure for response to the questions posed by the PHNLC. These definitions were reviewed and approved by the PHNLC Advisory Committee:

- a) **Standards** – help clarify nurse's areas of accountability, since standards provide the nurse, the health agency and the client with a basis for evaluating practice; and contribute to the continued improvement of nursing practice. Standards:
- must be developed by members of the nursing profession
  - must express what is desirable nursing practice in Canada
  - must be broad enough to apply to any practice setting
  - must lend themselves to further development and refinement by nurses in a given practice setting
  - are a prerequisite to the evaluation of nursing practice, since they provide a baseline for measurement
  - must respect the freedom of informed choice with regard to the selection of a conceptual model(s) to be used in a given setting
  - must include expectations related to a conceptual model(s) for nursing, the nursing process, the helping relationship and professional responsibilities
  - will influence and be influenced by nursing practice, nursing education, nursing administration and nursing research
  - must be subjected to continuous revision.

(Source: Canadian Nurses Association. (1987). *A Definition of Nursing Practice: Standards for Nursing Practice*. Ottawa: Author.)

- b) **Competency** – ability to integrate and apply, in a manner consistent with the Standards for Nursing Practice in BC, the knowledge, skills, attitudes, and judgment required to perform safely within the scope of nursing practice.  
(Source: Registered Nurses Association of BC. (1998). *Continuing Competency: Self Assessment and Planned Learning Workbook for Registered Nurses*. Vancouver: Author.)
- c) **Certification** – a voluntary program to evaluate a registered nurse's specialized knowledge and skills in a specific nursing specialty area.  
(Source: Canadian Nurses Association. Certification: *Committed to Nursing Excellence*. [www.can-aaiic](http://www.can-aaiic))
- d) **Community Health Nursing** – a practice specialty of nursing that promotes the health of individuals, families, communities, and populations, and an environment that supports health. Practice combines nursing, social and public health science with primary health care; and identifies and promotes care decisions that build on the capacity inherent in the individual/community. A critical part of community health nursing practice is marshalling resources that support health by planning and coordinating care, services and programs with individuals, caregivers, other disciplines, organizations, communities and government(s). Community health nursing is an inclusive term for community-based nursing practice, including public health nursing, home care nursing, community mental health nursing, and occupational health nursing.  
(Sources: Canadian Nurses Association. (2003). *The Value of Nurses in the Community*. Ontario: Jane Underwood. King, M. et al (1995). *Public Health nursing or community health nursing: What's in a name?* In M. Stewart (Ed.), *Community Nursing: Promoting Canadians' Health* (400-412). Toronto: W.B. Saunders Canada.)
- e) **Public Health Nursing** – promotes, protects, and preserves the health of populations. The public health nurse practices population health in a variety of settings, such as community health centres and community agencies (e.g. street health) and with diverse partners to meet the health needs of specific populations. Public health activities include health education, health promotion, prevention of injury and illnesses of populations, assisting with community development, and promoting healthy public policy. Public Health nurses recognize that a community's health is inextricably linked with the health of its constituent members and is often reflected first in individual and family health experiences. The education preparation for entry to practice as a public health nurse is a baccalaureate degree in nursing.  
(Sources: Canadian Nurses Association. (2003). *The Value of Nurses in the Community*. Ontario: Jane Underwood. King, M. et al (1995). *Public health nursing or community health nursing: What's in a name?* In M. Stewart (Ed.), *Community Nursing: Promoting Canadians' Health* (400-412). Toronto: W.B. Saunders Canada.)

- f) **Home Health Nursing** – initiates, manages, and evaluates the resources needed to promote the client's optimal level of well-being and function in the client's home, school or workplace. Clients and their designated caregivers are the focus of home health nursing practice. Nursing activities may be aimed at prevention, maintenance, restoration or palliation.  
(Sources: Canadian Nurses Association. (2003). *The Value of Nurses in the Community*. Ontario: Jane Underwood.)

## DATA COLLECTION

TGS Consultants Incorporated used several methods to gather information in response to the issues and concerns expressed by the PHNLC relating to the implementation of the new Standards of Practice. The consultants:

- Completed a literature review.
- Held a teleconference with the PHNLC Advisory Committee, and met with Public Health Leaders during the Public Health Nursing Leaders Conference in November.
- Developed a grid "Comparison of Canadian CHN Standards of Practice Indicators to Roles and Activities in the "Green" Book (See Appendix A).
- Developed a grid "Comparison of the Canadian Community Health Nursing Standards of Practice to the Standards for Registered Nursing Practice in BC" (See Appendix B).
- Developed a data collection tool and contacted members of the Community Health Nurses Association of Canada (CHNAC) and others identified during these interviews (collectively called "clinical leaders" throughout the Report) regarding the implementation of the Standards in various regions of Canada (See Appendix C).
- Contacted a number of professional health care organizations in British Columbia regarding their process of implementing Standards.

## RESULTS

### ***1. What are the current Standards of Practice that Public Health Nurses' follow? How do the current standards differ from the Canadian Community Health Nursing (CCHN) Standards of Practice (May 2003)?***

Our discussion with Public Health Leaders from around the province universally indicates that the Community Health - Public Health Nursing in Canada (1990) standards, better known as the "Green Book", are the standards and competencies currently followed. In comparing the 1990 and 2003 Standards of Practice (see Appendix A) it is evident that the indicators in the new standards very closely reflect the roles, activities, beliefs and assumptions of the 1990 standards.

Our review indicated that the 2003 Standards and the 1990 Standards differ most in the following areas:

- The 2003 Standards more clearly reflect the clinician's multiple roles (e.g., care provider, educator, consultant, community developer, etc.), through the identification of indicators that illustrate these roles within each Standard.
- The new Standards include indicators specific to professional practice, an area not clearly identified in the 1990 Standards.
- The 2003 Standards reflect more contemporary terminology, in keeping with the advances in nursing in the past decade.

TGS Consultants undertook a comparison of the CCHN Standards of Practice (2003) and the Standards for Registered Nursing Practice in British Columbia (2003). Of importance to note, is the strong relationship between the RNABC Standards of Practice and the CCHN Standards of Practice. This relationship is to be expected, given that Standards, by definition, are broad enough to apply to any practice setting (RNABC Standards) and provide the flexibility to be refined (CCHN Standards).

In general terms, the CCHN Standards 1, 2, 3, and 4 relate to the RNABC Standards 2, 3, and 4; while RNABC Standards 1, 4, and 5 are reflected in the CCHN's Standard 5. A more detailed review demonstrates that CCHN activities actually fall in a number of the RNABC standards, and are interspersed throughout. This has been illustrated with a number of examples in the grid "Comparison of the Canadian Community Health Nursing Standards of Practice to the Standards for Registered Nursing Practice in BC" (see Appendix B).

An Impact Questionnaire (see Appendix C) was developed to facilitate the gathering of data to respond to questions 2 - 8. Clinical leaders in Public Health Nursing from across Canada were interviewed, and responses collated for anonymity.

## ***2. Which of the Canadian Community Health Nursing Standards of Practice (May 2003) specifically address the role of the Public Health Nurse (PHN)?***

Several of the clinical leaders interviewed were involved in the development of the CCHN Standards of Practice. They identified that their intent was to develop Standards that would be applicable to all Community Health Nurses regardless of whether their focus was public health or home health nursing, urban or rural.

The clinical leaders also indicated that there might be some areas within the Standards that could be interpreted as more applicable to one nursing clinical focus than the other. An example of this is Standard 1c, which may be seen as having a stronger focus on home health nursing; whereas Standard 2 – Building Community Capacity may have a stronger focus on Public Health Nursing. There was consensus, however, that all of the standards had applicability to both public health and home health nursing, but that the depth of expected competency, skill, and

expertise would differ. In health unit areas/regions where the Standards had been introduced, staff nurses in the Public Health Nursing and Home Health Nursing roles were able to identify their practice roles in the Standards.

Specific responses included:

- I believe that the standards are general enough to fit both PHN and HHN roles. The issue is really to what degree. For example, both PHN's and HHN's have a role in Health Promotion; however the expression of that role will vary between the roles. The scope of the roles differs, but the basic premise of the standard applies to both roles. Interestingly, when I spoke with HHN's about how they felt the standards "fit", they clearly articulated their ability to see themselves and their roles within the standards.
- I see the standards as fitting both roles. In looking at the competencies however, I did see a group that seemed to fit more appropriately with the HHN group. I did find it a challenge to find competencies that were exclusive to PHN's as opposed to generic to all CHN's. There is definitely a blurring of the role of PHN and HHN in more remote areas, and the overarching generality of the standards ensures that they don't only apply to the more highly resourced or specialized urban roles.
- I have found that HHN's are having trouble finding themselves in the standards related to Population Health, and instead see themselves more predominantly fitting with the individual and family. The scope for the PHN is broader, and includes whole populations, especially the community development aspect.

Yvette Laforet-Fliesser, Ontario Representative, CHNAC shared results of individual responses to a questionnaire and round-table discussions at a workshop held in Ontario regarding the 2003 Standards. The participants of the round-table discussions (n = 17 tables) were asked to identify which standards clearly described their practice. The results indicate that approximately 33% of participants felt that all of the standards described their practice. A further 20% felt that although all of the standards described their practice, some were more applicable depending on the setting, program or position held. Comments from the groups included: (the standards) help define nursing perspective, speak to community as well as individual clients, and provide a way to explain to students/new RNs what a PHN does.

Respondents (n=93) to the questionnaire given to the participants of the above-noted Ontario session showed that 56% felt that the standards could be used as a guideline or framework for practice. A third of the respondents felt that the Standards defined their role and scope of practice.

During the telephone interviews conducted by TGS Consultants Incorporated, one clinical leader cautioned that when asking staff about whether the standards apply to their current practice, it is important to add "in a situation where workload and staffing issues were addressed". She noted that often staff stated the Standards did not describe their practice for three reasons: (1) lack of skill so could not do, (2) workload issue so did not do, or (3) truly did not feel it described responsibilities/activities of their job.

In general, the clinical leaders indicated that the Standards were broad, and applied to both PHN's and HHN's. The degree to which the standard was applied by either PHN's or HHN's was dependent on the focus of the standard. They further noted that the role of PHN's in urban areas is likely expressed differently than that of PHN's in remote regions, and that the application of standards may, therefore, look differently.

### **Recommendations:**

- 1. That the PHNLC support the development, either locally or provincially, of discussion groups that provide PHN's with an opportunity for discussing the 2003 Standards and brainstorming processes for implementation.**
- 2. That the PHNLC develop a "learning package" for the discussion groups that includes a tool identifying the commonalities between the 1990 Standards and the 2003 Standards. That this tool also incorporates the RNABC Standards of Practice and the CNA Code of Ethics.**
- 3. That the PHNLC work with their counterparts in HHN locally and provincially in the development of implementation plans for the 2003 Standards.**
- 4. That all members of the PHNLC will advocate for funding within their own Health Authority to assist in the implementation of these standards.**

***3. What role do employers play in ensuring PHN's meet Standards of Practice?  
What, if any, implications are there for the employer with regard to  
training/education regarding the implementation of the Standards of Practice?  
How does an individual determine that they are meeting the Standards of Practice?***

As noted in the Standards for Registered Nursing Practice in British Columbia, "it is the responsibility of individual registered nurses to act professionally and be accountable for their practice. All Registered Nurses, ... are responsible for understanding the Standards and applying them to their nursing practice, regardless of their setting, role or area of practice" (p. 5, RNABC, 2003). The Standards can be used by PHN's to support their individual practice, either when they are used as the foundation for self-assessment or when illustrating how workload issues are impacting their ability to meet them. Because meeting standards is an individual nurse's responsibility, there is no implication and/or responsibility for the employer to assist an individual to meet the standards. Rather, there is a requirement for an individual to identify their own gaps in knowledge and identify learning goals and plans.

The experience of other provinces indicates that the Standards of Practice (2003) can be used as a tool that supports the employer in seeking funding for global educational initiatives, in evaluating the skills and abilities of their employees, and in working with employees to assist in goal planning to meet learning needs. Further, a group discussion of standards including both the employer and the nurse has fostered clear understanding of the role of each in implementing the standards.

Clinical Leaders agreed that building the Standards into the Performance Appraisal process was a positive experience for both the employer and the employee. One respondent used the Standards as a “jumping off” point for discussion with her employees to determine educational topics for the new fiscal year. The outcome was a planned educational program aimed at supporting all staff to meet the Standards of Practice, and the developed document spoke strongly to the need for the organization to focus funding on education for nurses.

Specific responses included:

- I have built a discussion of the Standards into the monthly meetings I hold with my staff. It has provided insight for me into training and education needs, and also has provided a forum for experienced nurses to share their knowledge with novice PHN's.
- I approached staff to ask how they would like the Standards to be used in the workplace. They indicated that they felt the Standards would be useful for orientation of new staff, and for performance appraisals. They also asked to have them discussed at staff meetings, where they could discuss the standard, determine if they were meeting the standard, and what they might need to better meet the standard.
- As an employer, I am building the Standards into the Performance Appraisal process. They provide a starting place for discussion on learning needs for the individual. It allows for a discussion about “skill level” within the indicators and can assist both the employer and the employee in identifying opportunities for learning.

## **Recommendation:**

### **5. That PHNLC support the development of a provincial Performance Appraisal Tool that incorporates the 2003 Standards.**

#### ***4. How will the implementation of the standards impact PHN practice?***

The clinical leaders interviewed by TGS Consultants Incorporated identified three impacts on PHN practice as a result of the implementation of the standards:

- Improved knowledge and skill based on the ability to identify individual learning needs
- Improved quality of practice for both the novice and the expert clinician
- Provided a recognized means of defining Public Health Nursing practice in the larger health care delivery system.

Participants of an Ontario round-table discussion were asked to identify the value/benefit the standards would have for them. 50% of the respondents indicated that the standards validated the work of PHN's, captured the scope of practice, and the uniqueness of the role. A further 26% (for a total of 76%) indicated that the standards functioned as a framework for practice, providing a benchmark for practice and guiding/directing practice.

## Recommendations:

- 6. That PHNLC support the development, either locally or provincially, of discussion groups that provide PHN's with an opportunity for identifying the benefits/values of the standards in an "applied to practice" format.**
- 7. That PHNLC seek out "value-added" initiatives locally and provincially as a result of the implementation of the 2003 Standards. (For example, opportunities for funding educational initiatives related to standards implementation; the opportunity of developing a provincial PHN job description template.).**

### *5. What is the impact of the new standards on existing policies related to eligibility for hire?*

Currently within the five Health Authorities in British Columbia there is a plethora of PHN job descriptions, both for frontline and leadership roles. It appears some Health Authorities are working internally to standardize job descriptions, but the undertaking is huge as each Health Authority can have a different PHN job description for each community in their region. The basic qualifications are the same; an applicant must have their baccalaureate degree in nursing, community nursing experience, current RNABC practicing registration, and a valid driver's license. The differences in the various job descriptions are in the areas of knowledge and abilities, and the number of items identified in these areas range from a few (2) to many (8 – 10).

In general, the clinical leaders who were interviewed shared the belief that the concepts of health promotion, disease prevention, population health, and community development, found in the 2003 Standards, were important, and could be identified within the job description; and employment interviews could be focused to these questions.

Specific responses were:

- No impact. Perhaps in time there will be a thought to "Certification Required" appearing on the job posting, but that would be significantly down the road. This isn't a direction my health authority is going at this time. Currently, and I don't see this changing, we do not hire without a Diploma in Public Health or a Bachelor of Science in Nursing.
- I don't see any impact on eligibility for hire, but I do see that other policies and approaches may be impacted by the new standards.
- The Standards for Practice are broad based, and may not be reflected in current Baccalaureate education. I don't see as a change in eligibility for hiring, instead more a need to look at whether post-graduate education is required in the future.
- More focus needs to be applied to the educational system to ensure that the community nursing component is maintained in the nursing program. I'm finding that more and more time in the nursing program is being devoted to the knowledge and skills needed in acute care settings, drawing from time previously allocated to community health nursing.

The Saskatchewan Managers of Public Health Nursing Services developed a template that they felt reflected job description parameters in relation to the 2003 CCHN Standards (see Appendix D). The use, content and even adoption of the template was determined at the local level, as the template was not developed as an official organizational position or policy. Health units/regions in Saskatchewan can use the template as is or revise it to meet their specific needs.

### **Recommendations:**

- 8. That PHNLC develop (perhaps working from the Saskatchewan PHNS template) a provincial job description template for PHN's, based on the 2003 Standards.**
- 9. That PHNLC lobby for representation on college and university Curriculum Advisory Committees to ensure the inclusion of community health nursing concepts, skills, knowledge and experience are embedded in nursing programs.**

*6. How were/are other standards of nursing practice implemented in BC and other provinces? How have standards of practice been implemented by other healthcare professions? Who needs to be aware of the standards? What is the most effective and efficient way of notifying PHN's and stakeholders of the new Standards of Practice?*

Provinces are at different stages in implementing the CCHN Standards of Practice (2003). Clinical leaders were very helpful in sharing what they have done, what they anticipate doing, and what they have learned through the process. Some included their experience with the implementation of other Standards, such as post-partum and child protection services standards.

Many of the respondents identified that initially there was the need to take a leadership role/have a champion to ensure that PHN's were aware of the new standards of practice. The multiple options for implementation have been listed below in the recommendation.

### **Recommendation:**

- 10. That PHNLC take a lead role in the implementation of the 2003 Standards by:**
  - a) Working with the Health Authorities to declare a date at which time the Standards will be an expectation of practice. (This step provides confirmation of the need to move forward.) Of note: Collaboration between all Health Authorities in determining a province-wide implementation date could provide benefit in implementation.**
  - b) Providing copies of the Standards to all PHN's.**
  - c) Developing local discussion group(s) to introduce the Standards and set the context: how do the CCHN Standards relate to the current standards, to Provincial standards, to current practice.**

- d) Promoting discussion of the standards at unit meetings (what is meant by the Standard, is it being met, what would it take to meet it).**
- e) Inviting a provincial CHNAC representative(s) to unit meetings to introduce the Standards.**
- f) Using multiple methods to disseminate information on the Standards (face-to-face methods during work hours promoting discussion and relationship-building were found to be the most effective and sustaining).**
- g) Identifying a “leader” or “champion” for the implementation of Standards of Practice in each Health Unit**
- h) Offering workshops that:**
  - **Develop knowledge of specific standards.**
  - **Identify how the Standards can support practice and organizations and contribute to the health of the community.**
  - **Initiate a plan to disseminate and implement the standards in the work place. Which standard(s) would be the easiest to implement?**
  - **Identify the supports needed within the organization and from colleagues within community health nursing to implement the standards.**
- i) Including discussion of Standards of Practice in educational programs.**
- j) Including discussion of Standards of Practice in orientation programs so that it forms an expectation of the position.**
- k) Focusing on the benefits of the Standards (defines practice, assists in recognition as a specialty field in nursing, supports the ongoing development of the PHN, provides a foundation for certification) rather than on the legal aspects of meeting the Standards.**
- l) If resistance to implementing the Standards is met, clarifying what is causing resistance. Is it lack of skill, workload issue, or a lack of knowledge of the intent of the Standard?**
- m) Remaining open to listening and addressing issues once implementation has occurred.**

Other professional organizations that have recently implemented Standards were contacted for information on their approaches to implementation. These organizations include: the Registered Nurses Association of British Columbia (RNABC), the College of Licensed Practical Nurses of British Columbia (CLPNBC), and the College of Occupational Therapists of British Columbia (COTBC).

RNABC recently (2003) implemented a revision to the RNABC Standards document, which required contacting each member and indicating the changes in the Standards document. Central to the success of the implementation was an approach that was based on the development of a strong communication plan that included identifying stakeholders and incorporated a multi-modal approach. Their communication plan included:

- Distributing the document to all members
- Incorporating discussion of the new standards in the “Nursing BC” magazine
- Developing and circulating posters to workplace representatives
- Highlighting significant changes in the Standards for easy visibility
- Publishing the new Standards document on the RNABC website
- Developing and publishing a “frequently asked questions” document
- Identifying key stakeholders: employers, nursing leaders groups, the CNA, and union associations and forwarding packaged information regarding the new Standards
- Placing articles in affiliated magazines – “Health Care Leader Newsletter”
- Developing new Standards displays, including table top displays
- Developing and providing education on the new Standards to workplace representatives, regional practice advisors, and practice consultants
- Developed presentation kits for distribution to individuals interested in speaking about the new Standards

The CLPNBC approached the communication of Standards from a multi-media and in-person perspective. In their communication approach, they determined that the two most cost effective approaches were publishing the documents on the website, and holding teleconferences. The College also employed the following approaches:

- Scheduling open invitation Standards Workshops for LPNs, facility operators/managers and other interested parties throughout the province
- Identifying stakeholders: LPNs, employers, public, other healthcare groups
- Holding teleconferences for Standards discussions
- Holding videoconference discussions about the Standards
- Visiting work sites (on invitation)
- Publishing the new Standards document on the CLPNBC website
- Developing brochures for the public, for distribution during Nurses’ Week

They are currently planning and developing a work place representative program, which they see as another means of disseminating information.

The COTBC is a fairly new professional organization (formed in 1998) so it is still refining its communication plan. In the last few years, the College has notified their members of Essential Competencies, Indicators to the Essential Competencies, and Guidelines for Practice. It has used the following methods to ensure their registrants are aware of these requirements:

- Mailing out documents to each member
- Placing information on the COTBC website
- Highlighting information in a newsletter to indicate what has been developed/adopted and referring members to the website
- Developing a “Watch out for...” section in the newsletter to identify practice guidelines that have been developed, surveys asking for input, and results of surveys
- Summarizing the activities of the year in an annual report and mailing it to all members
- Organizing Registrar visits to all areas of the province to address issues or provide specific information

- Developing a banner that identifies the College's vision, role, and strategic direction for use at the Annual General Meeting (AGM), mall displays, conferences
- Ensuring that the Registrar and Board Members are accessible to members at the AGM
- Developing a pamphlet on safe, ethical care (aimed at the members)
- Surveying membership about how the College can help the membership implement the particular practice guideline or meet a particular competency
- Taking advantage of regular mail-outs by including information such as surveys, flyers, and updates on what the College is doing
- Providing a "Registrant Information Binder" to each OT that registers. The binder provides information about the College, Mandate, Vision, Bylaws, Code of Ethics, Essential Competencies, indicators, and practice guidelines. It is expected that the member will add the new items mailed to them.

The COTBC has not yet developed a communication plan to inform the public about Standards, but is developing a process for notifying employers of the competencies and practice guidelines. The process includes a reciprocal communication plan for employers to provide feedback to the College. The most cost effective method of notifying stakeholders has been the website, however, the most efficient method has been through a direct mail-out.

Although the three professional practice organizations employed somewhat differing approaches, the common thread was the development of a communication plan, including clearly identified stakeholders.

### **Recommendation:**

#### **11. That PHNLC ensure that communication strategies regarding the implementation of the Standards of Practice include the following audiences:**

- a) **Staff: addressed in recommendations listed earlier**
- b) **Public:**
  - **Prominently displaying posters in each Health Unit identifying the Standards that apply to PHN's.**
  - **Developing a "Did You Know?" poster that depicts a PHN demonstrating a Standard.**
  - **Posting the implementation plan for the Standards in each Health Unit.**
  - **Working with media representatives for each Health Authority to develop "good news" stories for the local newspapers regarding the development and implementation of standards.**
- c) **Health Authorities, Provincial Government**
  - **Developing Briefing Notes of the development and implementation of PHN standards and sharing these with Health Authority Senior Management, MLA's, Nursing Directorate and the Minister of Health.**

- **Presenting the status of Standards implementation at Health Authority Forums, in Staff Newsletters, and at conferences and workshops.**

***7. What competencies do PHN's require as entry to practice? What competencies are required of an experienced PHN?***

As Joan Reiter, past-CHNAC Communications noted in her presentation at the Public Health Nurse Leaders Conference in November 2004, competencies related to the CCHN Standards (2003) are currently being developed by a committee with national representation. It is anticipated that draft 2 of the competencies will be ready to circulate for review in January 2005, with input received by March 2005. She also indicated that a consultant has been contracted to compare the competencies identified in the "Green Book" with the newly drafted national competencies. This work will also be completed early in 2005. The competencies will be used to develop certification exam questions.

Given the work that is being done on a national basis, and the expected dates for completion, the response to this question focused on feedback from clinical leaders, many of whom had reviewed the draft competencies, to determine if they saw the competencies changing with the new standards, and whether the competencies were different for the novice and expert nurse.

Responses from clinical leaders included:

- The competencies haven't changed with the advent of the new standards. For the first time, the competencies are clearly articulated.
- The competencies aren't different for novices or experts; it really is only the depth of knowledge around any particular competency. At this time, we are continuing to use the competencies from the "Green Book".
- The competencies required of a PHN or for that matter a HHN will change over time as our knowledge of population health and other indicators of health change.
- The competencies are currently under development.

**Recommendations:**

- 12. That the PHNLC participate in the review of the draft competencies and provide feedback by March 2005.**
- 13. That the PHNLC encourage PHN's to review the draft competencies and provide feedback by March 2005.**

***8. What are the implications of the certification process for the employer? What are the implications of certification for the individual? Should certification be a requirement of the position at hiring? Can the certification process be phased in? What are the costs of certification? Who assumes responsibility for the cost? Is there a cost impact on recognition of certification in collective agreements?***

The certification process does not have direct implications for the employer. The decision to write a certification exam is an individual one, and is based on a self-assessment and a minimum of two years experience working in the specialty area. The implications for an individual in seeking certification, apart from the commitment to studying and paying to write the exam, is the demonstration of clinical expertise. As a successful candidate in a certification exam, the individual has the right to place a series of initials after their signature that signifies their clinical specialty.

None of the respondents felt that certification should be a requirement at hiring. Many discussed the challenge that would place on employers in the near future with the potential number of PHN's reaching retirement age, requiring an infusion of new graduates. There is also the conundrum of a nurse requiring two years experience in a clinical area before they are eligible to write the certification exam. This would deplete the number of eligible applicants, if there was a hiring requirement of CHN certification.

Because the certification process is a voluntary one, an employer does not have to be concerned about "phasing it in". However, many of the respondents indicated that they are supporting their staff to pursue certification. The respondents identified that funding was lacking, but they were finding other methods to support their staff. Some examples of support include: allowing work-time to study for the exam and supporting the development of study groups.

The cost of the certification exam for the CHN certification is not yet known, but will be posted on the CNA website at: [www.cna-aiic.ca](http://www.cna-aiic.ca). In most areas of the country, the individual bears the cost of certification. Recently in British Columbia, grants were made available to Health Authorities from the Nursing Directorate, which could be used to fund certification exam costs for specified certification exams (to date has been for acute care based specialty areas).

At this time, there are no cost impacts in recognition of certification in nursing collective agreements. In fact the Provincial Collective Agreement Between the Health Employers Association of British Columbia and Nurses' Bargaining Association indicates financial recognition (e.g. qualification differential) can only be recognized if a course meets a minimum number of months of study. The self-study for the certification exam does not meet this requirement.

**Recommendations:**

- 14. That the PHNLC develop ways to support staff who wish to write their certification exam.**

- 15. That the PHNLC advocate for education funds or grants to pay or share application costs for staff to write the certification exam.**
- 16. That the PHNLC develop a process to recognize staff that have successfully written and passed the certification exam.**

## **CONCLUSION**

The PHNLC has taken the first step in the implementation of the 2003 CCHN Standards through its request for a review of the standards, impact on practice, and options for implementation. This report specifically provides information to address the concerns raised, and recommends actions that can be taken. The next step will require a decision by the PHNLC on the best way to proceed with implementation.

## **RECOMMENDATIONS**

1. That the PHNLC support the development, either locally or provincially, of discussion groups that provide PHN's with an opportunity for discussing the 2003 Standards and brainstorming processes for implementation.
2. That the PHNLC develop a "learning package" for the discussion groups that includes a tool identifying the commonalities between the 1990 Standards and the 2003 Standards. That this tool also incorporates the RNABC Standards of Practice and the CNA Code of Ethics.
3. That the PHNLC work with their counterparts in HHN locally and provincially in the development of implementation plans for the 2003 Standards.
4. That all members of the PHNLC will advocate for funding within their own Health Authority to assist in the implementation of these standards.
5. That PHNLC support the development of a provincial Performance Appraisal Tool that incorporates the 2003 Standards.
6. That PHNLC support the development, either locally or provincially, of discussion groups that provide PHN's with an opportunity for identifying the benefits/values of the standards in an "applied to practice" format.
7. That PHNLC seek out "value-added" initiatives locally and provincially as a result of the implementation of the 2003 Standards. (For example, opportunities for funding educational initiatives related to standards implementation; the opportunity of developing a provincial PHN job description template.).
8. That PHNLC develop (perhaps working from the Saskatchewan PHNS template) a provincial job description template for PHN's, based on the 2003 Standards.

9. That PHNLC lobby for representation on college and university Curriculum Advisory Committees to ensure the inclusion of community health nursing concepts, skills, knowledge and experience are embedded in nursing programs.
10. That PHNLC take a lead role in the implementation of the 2003 Standards by:
  - a) Working with the Health Authorities to declare a date at which time the Standards will be an expectation of practice. (This step provides confirmation of the need to move forward.) Of note: Collaboration between all Health Authorities in determining a province-wide implementation date could provide benefit in implementation.
  - b) Providing copies of the Standards to all PHN's.
  - c) Developing local discussion group(s) to introduce the Standards and set the context: how do the CCHN Standards relate to the current standards, to Provincial standards, to current practice.
  - d) Promoting discussion of the standards at unit meetings (what is meant by the Standard, is it being met, what would it take to meet it).
  - e) Inviting a provincial CHNAC representative(s) to unit meetings to introduce the Standards.
  - f) Using multiple methods to disseminate information on the Standards (face-to-face methods during work hours promoting discussion and relationship-building were found to be the most effective and sustaining).
  - g) Identifying a "leader" or "champion" for the implementation of Standards of Practice in each Health Unit.
  - h) Offering workshops that:
    - Develop knowledge of specific standards.
    - Identify how the Standards can support practice and organizations and contribute to the health of the community.
    - Initiate a plan to disseminate and implement the standards in the work place. Which standard(s) would be the easiest to implement?
    - Identify the supports needed within the organization and from colleagues within community health nursing to implement the standards.
  - i) Including discussion of Standards of Practice in educational programs.
  - j) Including discussion of Standards of Practice in orientation programs so that it forms an expectation of the position.

- k) Focusing on the benefits of the Standards (defines practice, assists in recognition as a specialty field in nursing, supports the ongoing development of the PHN, provides a foundation for certification) rather than on the legal aspects of meeting the Standards.
  - l) If resistance to implementing the Standards is met, clarifying what is causing resistance. Is it lack of skill, workload issue, or a lack of knowledge of the intent of the Standard?
  - m) Remaining open to listening and addressing issues once implementation has occurred.
11. That PHNLC ensure that communication strategies regarding the implementation of the Standards of Practice include the following audiences:
- a) Staff: addressed in recommendations listed earlier
  - b) Public:
    - Prominently displaying posters in each Health Unit identifying the Standards that apply to PHN's.
    - Developing a "Did You Know?" poster that depicts a PHN demonstrating a Standard.
    - Posting the implementation plan for the Standards in each Health Unit.
    - Working with media representatives for each Health Authority to develop "good news" stories for the local newspapers regarding the development and implementation of standards.
  - c) Health Authorities, Provincial Government
    - Developing Briefing Notes of the development and implementation of PHN standards and sharing these with Health Authority Senior Management, MLA's, Nursing Directorate and the Minister of Health.
    - Presenting the status of Standards implementation at Health Authority Forums, in Staff Newsletters, and at conferences and workshops.
12. That the PHNLC participate in the review of the draft competencies and provide feedback by March 2005.
13. That the PHNLC encourage PHN's to review the draft competencies and provide feedback by March 2005.
14. That the PHNLC develop ways to support staff who wish to write their certification exam.
15. That the PHNLC advocate for education funds or grants to pay or share application costs for staff to write the certification exam.
16. That the PHNLC develop a process to recognize staff that have successfully written and passed the certification exam.

## BIBLIOGRAPHY

Alberta Association of Registered Nurses (2000). AARN Continuing Competence Handbook.

Burbach, C.A., & Brown, B.E. (?). Community Health and Home Health Nursing: Keeping the Concepts Clear. Nursing and Health Care, 9 (2), 97-100.

Canadian Nurses Association & Canadian Association of Schools of Nursing (2004). Joint Position Statement: Promoting Continuing Competence for Registered Nurses. [www.cna-aiic.ca](http://www.cna-aiic.ca)

Canadian Nurses Association (2002). Evidence-Based Decision-Making and Nursing Practice. [www.cna-aiic.ca](http://www.cna-aiic.ca)

Canadian Nurses Association (2002). Code of Ethics for Registered Nurses. [www.cna-aiic.ca](http://www.cna-aiic.ca)

Community Health Nurses Association of Canada (2003). Canadian Community Health Nursing Standards of Practice. [www.communityhealthnursescanada.org](http://www.communityhealthnursescanada.org)

Community Health Nurses' Initiative Group & The Registered Nurses Association of Ontario (2000). Home Health Nursing: A Position Paper.

Kikuchi, J.F. (2004). 2002 CNA Code of Ethics: Some Recommendations. Canadian Journal of Nursing Leadership: Nursing Leadership: Leadership in Nursing Management, Practice, Education and Research, 17 (3), 22-38.

King, M., Harrison M.J., Reutter, L. (1995). Community Nursing: Promoting Canadians' Health (18): Stewart.

Klug, R. M. (1994). Setting Home Care Standards. Pediatric Nursing, 20 (4), 404-406.

Registered Nurses Association of British Columbia (1998). Continuing Competence: Self-Assessment & Planned Learning Workbook for Registered Nurses.

Registered Nurses Association of British Columbia (1999). Professional Development: A Short Guide to Meeting Continuing Competence Requirements.

Registered Nurses Association of British Columbia (2003). Standards for Registered Nursing Practice in British Columbia.

Stamler, L.L. & Yui, L. (2005). Community Health Nursing, a Canadian Perspective. Pearson Prentice Hall: Toronto.

Underwood, J. (2003). The Value of Nurses in the Community. Prepared for the Canadian Nurses Association.

**Comparison of Canadian CHN Standards of Practice Indicators to Roles and Activities in the “Green” Book**  
**(LEGEND: Headings = CCHN Standards, Numbers = specific indicator under CCHN Standard;**  
**Wording = roles and activities listed in the “Green Book”)**

<b>PROMOTING HEALTH</b>						
<b>Health Promotion</b>	<b>Prevention and Health Protection</b>	<b>Health Maintenance, Restoration &amp; Palliation</b>	<b>BUILDING INDIVIDUAL / COMMUNITY CAPACITY</b>	<b>BUILDING RELATIONSHIPS</b>	<b>FACILITATING ACCESS AND EQUITY</b>	<b>DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY</b>
Assists communities, families and individuals to take responsibility for maintaining and/or improving their health by increasing their knowledge of, their control over and their influence on health determinants [1A1, 1A2, 1A4, 1A6, 1A8, 2-9]	Applies epidemiological principles & knowledge of disease process in the management & control of communicable diseases such as prevention, infection control, and outbreak management [1A3, 1B1, 1B2, 1B3, 1B6, 1B7]	Uses appropriate strategies to reduce risk factors regarding chronic disease and disability [1B7, 1B10**, 1C9]	Assists communities, families and individuals to take responsibility for maintaining and/or improving their health by increasing their knowledge of, their control over and their influence on health determinants [2-1, 2-3, 2-5, 2-7, 3-5, 4-9]	Applies knowledge of community assessment and community development models to assist and facilitate public participation in identifying and defining health issues [2-3, 3-5, 4-1]	Uses knowledge of community to link those needing services to the appropriate community resource [1C7, 3-8, 4-5]	Emphasizes health promotion and illness and injury prevention and provides appropriate anticipatory guidance [5-2]
Facilitates and mediates to enhance community, group or individual strategies that assist society to anticipate, cope with and manage maturational changes and the environment [A9, B4, 2-9]	Uses strategies to reduce communicable disease risk factors in the community such as: surveillance, immunization, early case identification, contact tracing, episodic care, health education, and case management [1A5*, 1B6, 1B7]	Uses clinical skills to assess the client's health status to enable joint planning, implementation and evaluation of appropriate nursing interventions [1C1, 1C2, 1C3]	Facilitates and mediates to enhance community, group or individual strategies that assist society to anticipate, cope with and manage maturational changes and the environment [1C6, 1C9, 2-3, 3-5]	Promotes community involvement in decision making and ownership of constructive changes which enhance the community's health [2-3, 3-5, 3-6, 4-1]	Assists in the development of health programs based upon community assessment outcome in order to meet the health needs of the community [1A9, 1C7, 2-7, 3-1, 4-7, 4-11, 5-13]	Incorporates knowledge of behavioural sciences with teaching and learning principles when carrying out educational activities and uses strategies appropriate to the relevant target group [5-5]
Encourages communities', families' and individuals' ability to balance choices with social responsibility to create a healthier future [1A5, 1A6]	Uses appropriate technology for reporting and follow-up [1B8]	Assists client to accept responsibility for health [1C4, 2-2]	Encourages communities', families', and individuals' ability to balance choices with social responsibility to create a healthier future [2-2, 2-7]	Fosters and facilitates inter-agency linkages and working relationships [2-4, 2-9, 3-6]	Applies current knowledge of professional and community/ political issues in developing a proactive approach to health & environmental issues [3-6, 4-1, 4-2, 4-6, 4-7]	Shares research and program evaluation information with colleagues and community members [1C8, 1C10, 5-6, 5-9]

PROMOTING HEALTH			BUILDING INDIVIDUAL / COMMUNITY CAPACITY	BUILDING RELATIONSHIPS	FACILITATING ACCESS AND EQUITY	DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY
Health Promotion	Prevention and Health Protection	Health Maintenance, Restoration & Palliation				
Initiates/participates in health promotion activities in partnership with others including the community, colleagues, and other sectors [1A5, 1A7, 1A8, 1A10, 2-9]	Uses appropriate strategies to encourage the modification of lifestyles that are not conducive to good health and support those which are [1B4, 1B7]		Initiates/participates in health promotion activities in partnership with others including the community, colleagues, and other sectors [2-2, 2-3, 2-4, 2-7, 4-11]	In developing programs, uses awareness of factors which impact on or affect health such as, social, cultural and economic issues as well as environmental hazards. [1C6, 3-2, 3-3, 4-9]	Actively promotes the development of needed resources leading to equal access to health and health-related services [1C7, 4-3, 4-4, 4-5, 4-7, 5-9, 5-13]	Participates in research projects [5-6]
Provides formal presentations and educational programs as well as informal teaching to communities, groups, families and individuals [1A6, 1A7]	Uses appropriate health promotion, illness and injury prevention techniques [1B1, 1B2, 1B4, 1B5, 1B6, 1B7]		Utilizes knowledge and expertise in nursing issues, to provide information to clients, lay helpers, professionals, social and community agencies, professional associations, and government. [2-4, 4-10]	Helps individuals, families and groups who are disadvantaged by reason of social economic status, isolation, culture, lack of knowledge, etc. become aware of issues of significance to their health [2-1, 2-6, 3-3, 4-9]	Uses communication skills to represent, negotiate or contract on behalf of the agency about resource allocation which supports community agencies and endeavours to assist all segments of the community to have access to appropriate health care and/or social services [1C8, 3-6, 4-2, 4-3, 4-4, 4-5]	Uses structure process and outcome-oriented research as a guide to practice [5-6, 5-9, 5-14]
Uses innovative health promotion strategies in service delivery [1A5, 1A10]			Acts as a resource person to communities, groups and individuals [3-7, 4-11]	Uses mediation strategies to facilitate inter-agency and inter governmental cooperation [1B7, 3-6, 4-11]	Allocates human, financial, temporal and physical resources [4-4]	Raises and fosters awareness of the role of the community health nurse [5-5]
Uses marketing techniques and skills to promote community health programs and to promote healthy living [1A7, 1A10]			Acts as an interim leader until the community can take the necessary action [2-2, 2-5, 4-11]	Acts as spokesperson, when appropriate to represent the views of individuals and groups [4-4]	Involves communities, families and individuals in health services planning and priority setting [1C5, 2-9, 3-5, 3-6, 4-7, 4-11]	Assists in establishing clear nursing philosophies, policies, standards of practice and program objectives with measurable outcomes [1B9, 4-6, 5-17]

PROMOTING HEALTH			BUILDING INDIVIDUAL / COMMUNITY CAPACITY	BUILDING RELATIONSHIPS	FACILITATING ACCESS AND EQUITY	DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY
Health Promotion	Prevention and Health Protection	Health Maintenance, Restoration & Palliation				
			Initiates and/or encourages responsible parties, individuals, and community to take action [2-3, 2-5, 2-8, 3-1, 4-11]	Uses communication skills to establish helping relationships which assist the clients to identify options and make choices which will best meet their health needs [2-7, 2-8, 3-5]	Shares information about community resources [3-7]	
			Uses group process, leadership and facilitation skills [2-3, 2-4]	Uses techniques that foster team building, mutual respect and joint decision making in all interactions with the public, peers and colleagues [2-3, 2-9, 3-6]	Identifies and investigates key issues and approaches to community health and wellness [3-2, 4-7, 4-11]	
			Encourages and supports the community to actively participate in identifying and taking ownership of health issues for resolution. Acts as a catalyst to help communities resolve issues and concerns [2-3, 2-5, 2-8]	Fosters interdisciplinary, interagency and intersectoral linkage, cooperation and collaboration [2-1, 2-9, 3-6]	Uses research findings to allocate human and financial resources and to evaluation interventions [4-4, 4-12]	
			Educates comm.. members about the political process as it relates to community health issues, about ways of successfully accessing the system & about ways of participating in decision concerning health issues [2-5]		Identifies program areas which need modification and works with other colleagues to alter programs accordingly [1A10, 1B10, 1C10, 3-1, 3-6, 4-7, 4-11]	

PROMOTING HEALTH			BUILDING INDIVIDUAL / COMMUNITY CAPACITY	BUILDING RELATIONSHIPS	FACILITATING ACCESS AND EQUITY	DEMONSTRATING PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY
Health Promotion	Prevention and Health Protection	Health Maintenance, Restoration & Palliation				
			Increases the awareness of community and its members that their inherent abilities are their own best health resource [2-5, 2-8, 3-5]		Identifies with the community and colleagues, the need for policy and program development; participates in and monitors its implementation and evaluation [1C10]	
<b>1A9:</b> also covered in the assumptions in the "Green" book.	<b>*1A5:</b> includes more than communicable disease	<b>** 1B10:</b> includes evaluating collaborative practice – not reflected in "Green" book <b>1C5:</b> informed choice, diversity and unique needs are concepts that are captured in the Beliefs in the "Green" book. <b>1C8:</b> includes more than communicable disease and includes improvement strategies <b>1C9:</b> deals with health maintenance and healing process, concepts not captured in activities in the "Green" book.		<b>3-4:</b> covered in the beliefs section in the "Green" book <b>3-9:</b> concept of professional boundaries is not addressed in the "Green" book <b>3-10:</b> concept of ending professional relationships is not addressed in the "Green" book	<b>4-8:</b> defining specific types of strategies to ensure access to services is not addressed in the "Green" book	There are a number of indicators in the new standards that are not addressed in the "Green" book: <b>5-1:</b> taking corrective action against unsafe or unethical circumstances <b>5-3:</b> using nursing informatics to support practice <b>5-4:</b> taking action on factors that affect practice and quality of care <b>5-7:</b> making decisions ethically to uphold the greater good of the population as a whole versus the individual <b>5-8:</b> seeking assistance to determine action in response to ethical dilemmas and risks to human rights and freedoms <b>5-10:</b> contributing to the quality of the work environment <b>5-11:</b> providing constructive feedback to peers <b>5-12:</b> documenting all nursing activities

**APPENDIX A**

						<p>including telephone advice</p> <p>The following indicators are covered in the beliefs and assumptions sections of the “Green” book:</p> <p><b>5-14:</b> utilizing reflective practice to improve personal practice</p> <p><b>5-15:</b> seeking professional development experiences</p> <p><b>5-16:</b> acting upon legal obligations</p>
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**OBSERVATIONS:**

1. The new standards and indicators very closely reflect the roles, activities, beliefs, and assumptions in the “Green” book.
2. The new standards utilize more contemporary terminology.
3. The “Green” book identifies how the community health nurse addresses Health Promotion and Illness and Injury Prevention in the different roles of care provider, educator, consultant, etc. The new standards illustrate how each clinician is involved in each of these roles.
4. The new standards’ indicators illustrate the activities of the community health nurse specific to each standard, whereas the “Green” book has this information included in roles, activities, beliefs and assumptions. Much clearer in the new standards.
5. The new standards include indicators specific to professional practice which are not specifically identified in the “Green” book.

**COMPARISON OF THE CANADIAN COMMUNITY HEALTH NURSING STANDARDS OF PRACTICE TO THE  
STANDARDS FOR REGISTERED NURSING PRACTICE IN BC**

**(LEGEND: top row = Standards for Registered Nursing Practice in BC; second row = explanation of standard;  
below double line = examples taken from the CCHN Standards; this is not an all inclusive list)**

<b>RESPONSIBILITY AND ACCOUNTABILITY</b>	<b>SPECIALIZED BODY OF KNOWLEDGE</b>	<b>COMPETENT APPLICATION OF KNOWLEDGE</b>	<b>CODE OF ETHICS</b>	<b>PROVISION OF SERVICE IN THE PUBLIC INTEREST</b>	<b>SELF-REGULATION</b>
Maintains standards of nursing practice and professional conduct determine by RNABC and the practice setting.	Bases practice on the best evidence from nursing science and other sciences and humanities.	Makes decisions about actual or potential problems and strengths, plans and performs interventions, and evaluates outcomes.	Adheres to the ethical standards of the nursing profession.	Provides nursing services and collaborates with other members of the health care team in providing health care services.	Assumes primary responsibility for maintaining competence and fitness to practice.
2-6: Applies principles of social justice and engages in advocacy in support of those who are as yet unable to take action for themselves.	1A4: Facilitates planned change with the individual/community/ population through the application of the Population Health Promotion Model.	1B10: Evaluates collaborative practice (personal, team, and/or intersectoral) in achieving individual/community outcomes such as reductions in communicable disease, injury and chronic disease or reducing the impacts of a disease process.	1B3: Helps individuals/ communities make informed choices about protective and preventative health measures such as immunization, birth control, breastfeeding, and palliative care.	1A1: Collaborates with individual/community and other stakeholders in conducting a holistic assessment of assets and needs of the individual/ community.	5-6: Participates in research and professional activities.
3-1: Recognizes her/his personal attitudes, beliefs, assumptions, feeling and values about health and their potential effect on interventions with individuals/communities.	1B6: Applies epidemiological principles in using strategies such as screening, surveillance, immunization, communicable disease response and outbreak management and education.	1C3: Identifies a range of interventions including health promotion, disease prevention and direct clinical care strategies (including those related to palliation), along with short and long term goals and outcomes.	2-8: Supports community action to influence policy change in support of health.	1B7: Engages collaborative, interdisciplinary and intersectoral partnerships to address risks to the individual, family, community, or population health and to address prevention and protection issues such as communicable disease, injury and chronic disease.	5-14: Utilizes reflective practice as a means of continually assessing and seeking to improve personal community health nursing practice.
3-4: Respects and trusts the family's community's ability to know the issue they are addressing and solve their own problems.	2-9: Actively works to build capacity for health promotion with health professionals and community partners	2-7: Uses a comprehensive mix of interventions and strategies to customize actions to address unique needs and build individual/community capacity.	5-4: Identifies and takes action on factors which impinge on autonomy of practice and quality of care.	2-1: Works collaboratively with the individual/community, other professionals, agencies and sectors to identify needs, strengths and available resources.	5-15: Seeks professional development experiences that are consistent with current community health nursing practice, new and emerging issues, the changing needs of the population, the evolving impact of the determinants of health and emerging research.

**APPENDIX B**

<b>RESPONSIBILITY AND ACCOUNTABILITY</b>	<b>SPECIALIZED BODY OF KNOWLEDGE</b>	<b>COMPETENT APPLICATION OF KNOWLEDGE</b>	<b>CODE OF ETHICS</b>	<b>PROVISION OF SERVICE IN THE PUBLIC INTEREST</b>	<b>SELF-REGULATION</b>
3-9: Maintains professional boundaries within an often long-term relationship in the home or other community setting where professional and social relationships may become blurred.	3-3: Is aware of and utilizes culturally relevant communication in building relationships. May be verbal or non-verbal, written or pictorial. It may involve face-to-face, telephone, group facilitation, print or electronic means.	3-10: Negotiates an end to the relationship when appropriate, e.g. when the client assumes self-care, or when goals for the relationship have been achieved.	5-7: Makes decisions using ethical standards/principles, taking into consideration the tension between individual versus societal good and the responsibility to uphold the greater good of all people or the population as a whole	3-8: Promotes and facilitates linkages with appropriate community resources when the individual/community is ready to receive them (e.g. hospice/ palliative care, parenting groups)/	
4-10: Advocates for healthy public policy by participating in legislative and policymaking activities that influence health determinants and access to services.	4-12: Monitors and evaluates changes/progress in access to the determinants of health and appropriate community services.	4-6: Adapts practice in response to the changing health needs of the individual/community.	5-8: Seeks assistance with problem solving as needed to determine the best course of action in response to ethical dilemmas and risks to human rights and freedoms, new situations, and new knowledge.	4-11: Takes action with and for individuals/communities at the organizational, municipal, provincial/territorial and federal levels to address service gaps and accessibility issues.	
5-16: Acts upon legal obligations to report to appropriate authorities situations of unsafe or unethical care provided by family, friends or other individuals to children or vulnerable adults.	5-3: Utilizes nursing informatics (information and communication technology) to generate, manage and process relevant data to support nursing practice.	5-12: Documents community health nursing activities in a timely and thorough manner, including telephone advice and work with communities and groups.		5-1: Takes preventive and/or corrective action individually or in partnership with others to protect individuals/communities from unsafe or unethical circumstances.	
	5-5: Participates in the advancement of community health nursing by mentoring students and novice practitioners.				

**PUBLIC HEALTH NURSES LEADERS' COUNCIL  
 IMPACT OF THE IMPLEMENTATION OF THE CANADIAN COMMUNITY HEALTH NURSES STANDARDS IN BC  
 Telephone Contact with CHNAC Members**

**PURPOSE:** Contract with the Public Health Nurses Leaders' Council of BC to investigate the impact of the implementation of the CHN Standards in BC. We want to glean information on what other provinces have done, where they are at in the process, and what they would recommend for those just starting the process.

**Name:** \_\_\_\_\_ **From:** \_\_\_\_\_ **Current Position at Work:** \_\_\_\_\_

**PHN:** \_\_\_\_\_ **OR HHN:** \_\_\_\_\_ **How many years?** \_\_\_\_\_ **# of Direct Reports (if applicable):** \_\_\_\_\_

**QUESTIONS:**

1. Are you aware of the new Community Health Nurses Standards (May, 2003)? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Have you been involved in the implementation of these standards in your area? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, ask following questions .....	
3. How were they implemented? OR How are they going to be implemented?	
4. When?	
5. Were there any issues identified around implementation or the standards themselves?	6. If yes, how were the issues handled?
7. What did your communication plan around implementation include? Or How do you see this unfolding?	8. How? 9. And to whom?
10. Anything that you would do differently if you were to do it again?	
11. What worked well that you would recommend be included if just starting the process?	

12. Did the implementation of these new standards have an impact on CHN practice?

YES _____	NO _____
12. If yes, in what way(s)?	13. If no, did you expect an impact? If so, what?

13. Did you find that the standards could be delineated between PHN and HHN? YES \_\_\_\_\_ NO \_\_\_\_\_

14. If yes, which would be assigned to each of the roles?	
PHN	HHN

15. How can an employer determine that a nurse is meeting the standards?

16. Do you feel that as a community health nurse that you can meet the standards? YES \_\_\_\_ NO \_\_\_\_

17. If no, why not?
18. What would you need to meet the standards?

19. What is the impact of the new standards on existing policies related to eligibility for hire?

20. What competencies do PHNs/CHNs need to practice?

Entry level	Experienced
21. Will these competencies change with the new standards? How?	
22. Do you have a listing of the competencies needed as a CHN? YES ____ NO ____ If yes, can we have a copy?	

23. Are you aware of the CNA specialty certification process? YES \_\_\_\_ NO \_\_\_\_

If yes ....
24. Will you be promoting certification for CHNs in your area? YES ____ NO ____
25. How will you support CHNs in receiving their certification?

26. Any thing else we should be considering when we're looking at the impact of the implementation of the standards in BC?

**N.B.: This job description is shared with permission from the Saskatchewan Managers of Public Health Nursing Services. If the template is used, credit must be given to the source.**

### **JOB DESCRIPTION**

#### **Public Health Nurse**

NOTE: THIS IS A PROPOSED CONTENT TO BE ADAPTED AS PER REGIONAL POLICY

<b>POSITION:</b>	Public Health Nurse Somewhere Health Region	<b>AFFILIATION:</b>	S.U.N.
<b>DEPARTMENT:</b>	Public Health Nursing	<b>PAY GRADE:</b>	
<b>DATE:</b>	September/04		

#### **APPROVED by:**

\_\_\_\_\_  
MANAGER

\_\_\_\_\_  
HUMAN RESOURCES

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#### **JOB SUMMARY:**

The Public Health Nurse (PHN), as an integral member of the Public Health Services team, provides nursing services within the framework of the Population Health Promotion Model and Primary Health Care. This employee works relatively independently and is expected to make primary decisions based on sound assessments in accordance with The Public Health Act, the policies of the Public Health Nursing program, the SRNA Standards of Practice, the Canadian Community Health Nursing Standards of Practice, and other relevant legislation. Inherent in this role are knowledge, skills, and abilities specific to health promotion, prevention, and protection. This employee liaises with, and refers to, other health personnel, and other sectors and community groups.

#### **ORGANIZATIONAL STRUCTURE:**

This in-scope position (Saskatchewan Union of Nurses) carries out public health nursing activities under the direction and supervision of the designated supervisor or manager in the Health Region.

#### **NATURE AND SCOPE:**

The Public Health Nurse works within guidelines established by Health Region policy to plan, organize, implement and evaluate nursing programs in an assigned area. The Public Health Nurse translates knowledge from the health and social sciences to support health-enhancing behaviors of individuals, families and population groups through targeted interventions, programs, and advocacy.

#### **EDUCATION:**

- Bachelors' degree in Nursing with course credits in Public Health Nursing
- Current registration with the SRNA.
- Possession of a valid Class 5 drivers license.
- Possession of a valid CPR Basic Life Support Level "C".

**EXPERIENCE:**

- At least one year Public Health Nursing experience is an asset.

**KNOWLEDGE:**

- Demonstrated knowledge and/or ability in health promotion and prevention strategies including:
  - Advocacy for healthy public policy
  - Group education
  - Community development
  - Educational resource development
  - Facilitation
  - Individual counseling
  - Media communication.
- Demonstrates flexibility by adjusting workload to accommodate client needs in a manner that ensures positive customer relations.

**ABILITIES:**

- Ability to be self directed and exercise independent nursing judgment in a community-based environment.
- Ability to work collaboratively with team members and the community at large.
- Ability to communicate effectively orally and in writing with clients of varying ages, socio-economic status, and targeted populations.
- Negotiation and conflict resolutions skills.
- Additional knowledge and skills related to specific duties and responsibilities of the position is preferred.
- Adherence to established Public Health Services policies and procedures.
- High level of accuracy is required in all aspects of assigned responsibility such as health assessment, nursing diagnosis and treatment, immunization, and handling specialized equipment.

**SKILLS:**

- Possesses a sound knowledge of the nursing process and its application to groups, communities, or organizations.
- Ability to make independent nursing judgments based on evidence-based practice and Public Health principles.
- Ability to use critical analysis, reflective practice, assessment and utilize evidence-based practice.
- Ability to analyze health issues in the context of the political and social climate along with individual/community readiness.

**CONTACTS:**

- Engages in extensive interaction with clients, families, other health providers, intersectoral partners (e.g. Department of Community Resources and Employment, Department of Learning), and the community.
- Establishes caring relationships within a complex, changing, undefined, and often ambiguous environment that may present conflicting and unpredictable circumstances.

**PROFESSIONAL ACCOUNTABILITY:**

- Provides guidance and supervision of volunteers and paraprofessionals.
- Contributes to the education of students in health science programs
- Performs Acting Nursing Supervisory responsibilities as assigned.
- Mentors new staff and participates in their orientation.
- Is aware of legal responsibilities related to the position (e.g. Health Information Protection Act, Child Abuse Legislation).

**WORK ENVIRONMENT:**

- Frequent interruptions and occasional multiple deadlines.
- Regular exposure to weather conditions when doing home visits and when providing service to the school.
- Moderate physical effort required in the form of lifting, carrying, bending, driving, walking/standing for more than 30 minutes at a time.
- Manual dexterity is needed to insure precision and accuracy when performing clinical skills such as immunization.
- Intense level of visual and auditory concentration required to observe, monitor and process information simultaneously.

**HAZARDS:**

- Minor risk of exposure to infectious disease.
- Working alone.
- Risk of motor vehicle accidents when traveling and hazardous weather conditions.
- Potential to be in unsafe work environment due to unsafe housing and unpredictable situations.
- Exposure to hazardous material such as sharps, body fluids.

**SPECIFIC ACCOUNTABILITIES:**

- These statements reflect the principle functions of the job, but do not describe all the work assignments inherent in it:

**CLINICAL SKILLS:**

- Applies epidemiological principles and knowledge of disease process in the management and control of communicable diseases such as prevention techniques, infection control and outbreak management.
- Uses strategies to reduce communicable disease including but not limited to surveillance, immunization, early case identification, treatment and required follow-up.
- Understands and applies the principles and practices of immunization.
- Screens infants and preschool children for specific delays and deficiencies related to growth and development and makes appropriate referrals when indicated.
- Provides consultation to physicians, other health professionals and other agencies and groups regarding specific communicable diseases and immunization.

**INDIVIDUAL COUNSELLING:**

- Provides health information, counseling, and referral through telephone and one-on-one contacts in settings such as clinics, school, home, correctional facilities, community, outreach van, etc.
- Provides emotional support through empathetic listening.

**EDUCATION:**

- Provides formal presentations and educational programs for selected population groups in a variety of community and institutional settings on topics relevant to current health and lifestyle issues, and communicable disease and injury prevention.
- Incorporates knowledge of behavioral sciences with teaching and learning principles when carrying out educational activities and uses strategies appropriate to the relevant target group.
- Uses knowledge of group process and facilitation skills to assist individuals to take action to improve their health.

**ADMINISTRATION:**

- Maintains accurate charts and health records upon completion of a service.
- Completes statistical tools for workload analysis and surveillance purposes in a timely manner.
- Assists in the development of health programs and activities based upon community assessment and best practice literature.
- Is accountable for submitting payroll related and any other required forms in a timely manner.

**RESOURCE DEVELOPER:**

- Reviews educational materials for accuracy, relevance, visual appeal, age and cultural appropriateness.
- Develops educational material such as lesson plans, teaching kits/games, pamphlets, information sheets and newsletters.

**COMMUNITY DEVELOPER:**

- Applies knowledge of community assessment and development models to facilitate public participation in identifying and defining health issues.
- In developing programs, uses awareness of factors, which impact on or affect health such as social, cultural, economic issues and environmental factors.
- Fosters inter-agency/care group linkage and working relationships.

**ADVOCATE:**

- Influences community leaders and politicians regarding policy decisions that address the determinants of health and environmental issues.
- Works with and assists individuals, families and groups who are disadvantaged by reasons of social economic status, isolation, culture and lack of knowledge to become aware of issues of significance to their health.
- Uses knowledge of community to link those needing services to the appropriate service provider.

**MEDIA COMMUNICATION:**

- Communicates with the public using a variety of media strategies including newspaper articles, Public Service Announcements, bulletin board displays and television interviews.
- Utilizes social marketing strategies to raise consciousness of health issues, place issues on the public agenda, shift social norms, and change behaviours.

**PERSONAL PROFESSIONAL DEVELOPMENT AND MAINTENANCE OF COMPETENCY:**

- Participates in continuing education/staff development programs including those appropriate to public health nursing.
- Ensures maintenance of required skills and knowledge and competencies related to: immunization, certification in CPR Level “C”, and management of anaphylaxis.
- Participates in on-going work planning and review.
- Participates in research and survey projects.
- Keeps abreast of current research and practice developments in the field of public health nursing and shares knowledge with peers.
- Knows and is compliant with duties and responsibilities under the Occupational Health and Safety Act and Regulations.