THE COMMUNITY HEALTH NURSES ASSOCIATION OF CANADA (CHNAC) SUPPORTED BY THE PUBLIC HEALTH AGENCY OF CANADA (PHAC)

PUBLIC HEALTH NURSING PRACTICE IN CANADA: A REVIEW OF THE LITERATURE

Michelle Hogan, RN, BScN, MScN
University of Ontario Institute of Technology
Oshawa, Ontario

May 26, 2008

Contents

Executive Summary

Competency development is recognized as a necessary component of professional development and training for nurses. Competencies ensure a qualified and competent workforce, and thus strengthened health care system. While the existence of competencies for nurses working in acute care settings is familiar to general nursing practice, competencies for public health nursing practice have not yet been developed. In September 2007, the Public Health Agency of Canada released the *Core Competencies for Public Health in Canada*. These competencies define the knowledge and skills necessary for the broad practice of public health, yet are not discipline-specific. The competencies specific to public health nurses go beyond that which is identified in the core competencies for general public health practice and are therefore needed to clearly define what public health nurses do and to guide curriculum planning and professional development opportunities for public health nurses. The initial step in the development of discipline-specific competencies for public health nurses involves an extensive review of the literature. A systematic review of the literature was conducted whereby the key knowledge and skills of public health nurses across Canada were identified. The existing Canadian Community Health Nursing Standards of Practice were used as a guide and overall framework for organizing the key knowledge and skills of public health nurses as standards provide a clear outline of what is expected in terms of service and outcome. Based on the review of the literature, it is apparent that public health nurses are responsible for a vast amount of knowledge and skills across several diverse populations, settings and topic areas. These key knowledge and skills provide a foundation for the development of discipline-specific competencies for public health nurses. Following the literature review, it is recommended that a committee be established to further examine competencies and competency statements within each of the Canadian Community Health Nursing Standards of Practice using the knowledge and skills identified. The development of discipline-specific competencies for public health nurses and their application in practice will assist in contributing to a strengthened, qualified and competent public health workforce and public health system in general.

Introduction

The ever changing needs of our communities, new and emerging public health issues, and current and future health care demands have placed an enormous strain on our public health system. Such changes have created a greater need for public health renewal and capacity building in Canada including the need for a strengthened public health workforce. Fundamental to developing the public health workforce in Canada and therefore the public health system, is to identify the required knowledge, skills, and abilities of public health practitioners, including public health nurses. In September 2007, the Public Health Agency of Canada (2007) released the *Core Competencies for Public Health in Canada*. These competencies define the knowledge and skills necessary for the broad practice of public health. However, due to the uniqueness of public health nursing practice, some of the knowledge and skills specific of public health nurses is not captured in these core competencies. For this reason, discipline-specific competencies which define the unique aspects of public health nursing are necessary. Discipline-specific competencies for public health nurses offer direction and guidance for educational preparation and ongoing professional development and training needs.

Purpose

This project builds on the recommendations outlined in the report by Simpson (2005) on behalf of the Community Health Nurses Association of Canada (CHNAC) and the Public Health Agency of Canada (PHAC) to further examine the competencies (knowledge and skills) reflective of public health nursing practice in Canada and the processes for development. Consistent with these recommendations, this project examines, i) the process of developing discipline-specific competencies for public health nursing through a review of the literature, ii) as well as the practice of public health nurses in Canada through a systematic review of the literature and environmental scan. The results of the systematic review and environmental scan will contribute to the identification of key public health nursing knowledge and skills unique to this specialty nursing role and will inform the development of public health nursing competencies.

Methods

Literature Review

A literature review was accomplished using CINAHL to identify processes for developing discipline-specific competencies. Key terms used in the scan included public health nursing and community health nursing, matched with develop(ed,ing) and competence (y, ies). A total of 96

articles were obtained. However, of those, only six discussed the process used to develop competencies and were therefore included. Additional resources examining the development of competencies outside of public health nursing were also reviewed based on input from subject matter experts.

Environmental Scan

An environmental scan was conducted to identify any documents outlining public health nursing practice within Canada. An e-mail was distributed to members of the Community Health Nurses Association of Canada (CHNAC), Certification, Standards & Competency Standing Committee requesting that they distribute the e-mail to key contacts within their field. The e-mail provided a context for the search and requested that any documents outlining the role of public health nurses in Canada (including knowledge, skills, and/or competencies) be shared for this initiative. A similar e-mail was also sent to members of the Public Health Research Education and Development (PHRED) committee requesting their support. In addition, 14 websites of professional nursing organizations and associations across Canada were searched for similar documents/materials. Over 80 sources of information referring to the role of public health nursing were obtained and reviewed.

Systematic Review

A systematic review of the literature was conducted using CINAHL, MEDLINE, Health Star, the Canadian Research Index, and the CBCA (business, current events, education, reference). Key search terms included Community Health Nursing (inclusive of community health or public health), Canada (inclusive of individual provinces), professional competence, and knowledge (inclusive of skill, role, competence, knowledge, or practice). The search terms were limited to 1998-present and English only. The year 1998 was chosen based on the influence of events on the public health system in the early to mid 1990s and the later influences in 2003 such as the outbreak of Severe Acute Respiratory Syndrome (SARS) in Canada and the introduction of the Canadian Community Health Nursing (CCHN) Standards of Practice (CHNAC, 2003). Over 500 articles were identified from the search. However, of these only 80 appeared to offer relevant subject matter. Abstracts were reviewed for each and selected articles were included in the review (see reference list).

Background

Competence

Competence can be broadly defined as the ability of a registered nurse to integrate and apply the knowledge, skills, judgment, and personal attributes required to practice safely and ethically in a designated role and setting (CNA, 2000). There are several key concepts contained within this definition. These include, i) competence relates to adequacy in a role, ii) competence is influenced by the practice setting and context of the environment, iii) competence is comprised of many attributes and incorporates more than what is visible in a practitioner's actions or performance, iv) and competence is an integration of the various attributes, none of which can stand alone in defining competence (CNA, 2000). Competence is therefore not just a set of mechanical actions but involves continuing developmental processes and a knowledge base for critical thinking and values (King & Erickson, 2006). Competencies define the actual knowledge, skills, and abilities necessary of a health professional, and provide a foundation for assessing competence.

Competencies are a specific set of actions that can be seen in practice, describable in behavioral terms, observable in the performance of system components, and part of a continuous system/organization/individual performance improvement process (OPHA, 2004). There are various levels and types of competencies. Competencies can be stated at the individual, system/organizational, and core services/functions level (OPHA, 2004). Individual competencies can be further broken down into types, including core, functional, or discipline specific/technical (Gebbie, 2002). Core competencies represent a set of cross-cutting skills, knowledge, and attitudes necessary for broad practice (OPHA, 2004). Until recently, clearly defined core competencies, and therefore the ability to assess competency with respect to public health practice, did not exist. New and emerging public health issues however, and threats to water safety, bio-terrorism, and infectious disease outbreaks have reinforced the need for a qualified, competent, public health workforce and system. According to the Naylor Report (2003, p.2), "…an effective public health system is essential to preserve and enhance the health status of Canadians, to reduce health disparities, and to reduce the costs of curative health services." A key component of establishing an effective public health system is the ability of the public health community to clearly articulate what public health is, what public health does, and who does it (OPHA, 2004). After an extensive process, in 2007 a set of core competencies for public health in Canada were released that achieved just that.

In September 2007, the *Core Competencies for Public Health in Canada* (CCPHC) was released (PHAC, 2007). The CCPHC primarily relate to the practice of individuals, including front line

providers, consultants/specialists, and managers/supervisors (PHAC, 2007). These core competencies reflect the general practice of all public heath practitioners and are not specific to any one discipline. In the CCHPC report, 36 core competencies are defined and organized under seven domains (PHAC, 2007). Although much of the skills and knowledge identified in these core competencies relate to the practice of public health nurses, it is felt and has been examined in the literature that public health nurses possess a unique body of knowledge and skills that fall outside some of the core competencies identified.

A public health nurse is a community health nurse who synthesizes knowledge from public health science, nursing science, primary health care, and social science theory and knowledge to promote, protect, and preserve the health of populations (CHNAC, 2003). Public health nurses practice population health promotion in increasingly diverse settings, such as community health centres, schools, street clinics, youth centres, nursing outposts, and with diverse partners, to meet the health needs of specific populations (CHNAC, 2003). The educational preparation for entry to practice as a public health nurse is a baccalaureate degree in nursing. According to Simpson (2005) in her review of the CHNAC/Canadian Nurses Association (CNA) competencies within the context of the *Draft set of Public Health Core Competencies* (replaced with final report in Sept 2007), there are several unique aspects of the public health nursing role that do not fit within the core competencies for public health (PHAC, 2007). These unique aspects of public health nursing practice include: their simultaneity of work, the ability to work with individuals, families or groups while focusing on the larger picture of community or population health; their therapeutic nurse-care partner relationships which involve concepts of caring, trust, autonomy and empowerment; their public health nursing judgment; their focus on health promotion at the population level; and their holistic approach to care (Simpson, 2005). In addition, Moyer (2007) conducted a comparison of CCHN Standards of Practice (CHNAC, 2003) and competencies for Ontario nurses working in the community including the public health core competencies (draft). In this analysis, several gaps were identified in the public health core competencies where public health nursing practice was not reflected. Much of the unique aspects of the public health nurses' practice (knowledge and skills) emerge from nursing education and preparation and compliance with regulating bodies standards of practice. For these reasons, CHNAC and PHAC have begun to examine the development of discipline-specific competencies.

Discipline-specific competencies define necessary specialized roles or practice areas and are required to perform certain jobs (OPHA, 2004). Discipline-specific competencies define the unique aspects of a profession that may not be captured under core competency statements and as a result,

provide ongoing direction and guidance for curriculum planning and development and become a means of quality assurance within the discipline when used to guide the development of orientation programs, continuing in-service education offerings, job descriptions, and performance evaluation tools (King & Erickson, 2006). In Canada, the discipline-specific competency movement is underway as various disciplines in public health have begun to examine aspects of their role that are unique to public health and therefore discipline-specific. Specifically, Public Health Epidemiologists, the Canadian Association of Public Health Dentistry, Medical Officers of Health, Public Health Inspectors, and now Public Health Nurses have begun to examine the development of competencies specific to their own discipline (K. MacDougall, personal communication, Feb 14, 2008). Public Health Nursing representatives have been meeting regularly with representatives from the above disciplines to discuss progress and processes used to develop discipline-specific competencies. Lessons can be learned from other disciplines within Canada who are further along in the process or from our counterparts in the United States and the United Kingdom who have already completed the development of discipline-specific competencies for public health nursing practice.

Developing Discipline-Specific Competencies

An applied approach to developing core competencies has been followed by some organizations to develop discipline-specific competencies. Specifically, much of the literature speaks to the importance of establishing an expert group that will serve to further define the nature of the project, who it is intended to serve, and initial brainstorming (OPHA, 2004). The Association of Schools of Public Health (ASPH; 2006) established a group of 10 content specialists who were nominated by Dean's or public health partners to serve on the core working group for establishing discipline-specific competencies for a Master's in public health curriculum. A chair was then further nominated to facilitate the group and additional nominees not selected to serve on the core working group were invited to serve on the resource group that would provide additional review and input on drafts (ASPH, 2006). In the United States, the Quad Council of Public Health Nursing Organizations was brought together to examine the initial development of public health nursing competencies (King & Erickson, 2006). Two members from each organization and additional members from their respective organizations were invited to participate in the actual development of the competencies in order to limit the number of key individuals involved in the initial development phase (King & Erickson, 2006). According to B. Moloughney (personal communication, Feb 14, 2008), a representative of the Medical Officers of Health in Canada with experience in the development of

discipline-specific competencies, smaller groups are key to the success of this process. This is also evident when looking at the development of immunization competencies for Ontario public health immunization providers of which a working group was assembled that consisted of representatives from the Professional Education Working Group at the Immunization and Respiratory Infections Division (Dias & Matthews, 2008). The initial exploration of public health nursing competencies within Canada has begun under the direction of CHNAC, Certification, Standards & Competency Standing Committee. Representatives from both clinical practice and academic settings with extensive public health nursing/community health nursing experience are represented on this committee. They have begun initial brainstorming on competencies and will provide ongoing feedback and input into their development. Once an expert committee has been established, the next step involves a review of the literature specific to the discipline being examined.

A review of the literature is a necessary first step in defining the role and practice of the specialty discipline. In the initial development phase of the core competencies for public health, a literature review was conducted that sought to define public health functions and services, the purpose and rational for developing competencies and public health discipline specific core competencies (OPHA, 2004). When developing discipline-specific competencies for the Medical Officers of Health, the literature review involved examining public health legislation and how medical officers of health and their roles are defined (B. Moloughney, personal communication, Feb 14, 2008). This information was then compiled into a composite of key roles for medical officers of health common to all jurisdictions. This composite was then mapped against existing competency sets, including CCPHC (PHAC, 2007) and then against the competencies outlined in the Master's of public health program. In the United States, documents pertaining to public health nursing and education were reviewed as well as an assessment of existing competency documents (King & Erickson, 2006). These reviews serve to define the set of skills and knowledge which are unique to that discipline. However, prior to beginning the review, a model or framework needs to be identified that will guide the organization and eventual write up of the literature.

The Quad Council in the United States selected their general public health competency model as their overall framework to guide the organization and development of public health nursing competencies. In Canada to date, the Canadian Association of Public Health Dentistry has examined their own competencies and has begun to cluster these according to the domains identified in the CCPHC (S. Sunell, personal communication, Feb 14, 2008). For public health nurses in Canada, the existence of the CCHN Standards of Practice (CHNAC, 2003) as outlined in the Canadian Community

Health Nursing Practice Model (CCHNPM; Figure 1) provides an overarching framework for all community health nurses in Canada, including public health nurses and can be used to guide the development of discipline-specific competencies.

Community health nursing encompasses several different nursing roles, of which the two main ones are home health nursing, and public health nursing. Nurses are guided by general nursing regulatory standards as well as specialty nursing standards, such as the CCHN Standards of Practice. Standards in general reflect a level of service, intervention or outcome and outline what a public health unit or an individual can be expected to deliver in terms of quantity, quality, timeline, location and unit of work (Simpson, 2007). Standards imply the inclusion of clear goals, expectations and measures. Competencies on the other hand refer to specific behaviors, actions and attitudes that a public health professional would engage in to meet a set standard (Simpson, 2007). Therefore, standards outline what is expected in terms of service and outcome and competencies provide a clear, objective means of achieving such standards. For this reason, a logical approach to competency development for public health nursing practice in Canada involves using the existing and well established CCHN Standards of Practice to guide and inform their development. In addition, developing competencies using the CCHN Standards of Practice as a guiding framework places the specialty role of public health nurses within the broader scope of community health nursing and nursing practice in general. Furthermore, this approach also presents further opportunities for examining similarities and differences across other community health nursing roles, such as home health nursing. This is of particular importance when looking at rural/northern community health nursing whereby the distinctions between public health nursing and home health nursing may be blurred.

Today, public health nurses working in urban communities are sometimes more specialized in their practice, often working in a specific program such as mother and baby care, injury prevention, etc (Oberle & Tenove, 2000). However, working in a rural/northern community can be very different, requiring those nurses to take on more of a generalist role. Specifically, a community health nurse working in rural/northern communities may be the only nurse in that community and therefore responsible for providing care and services that at times cross both that of the public health nursing role and the role of a home health nurse (Dobbelsteyn, 2006; Oberle & Tenove, 2000; Van Hofwegen & Kirkham, 2005). For this reason, examining competencies specific to public health nurses and eventually home health nurses in relation to the larger practice of community health nursing is important in situations such as this, where there is the potential for overlapping responsibilities. Consistent with this recommendation, the literature review of public health nursing practice in Canada,

including roles and responsibilities, has been organized according to the CCHN Standards of Practice (CHNAC, 2003). Specifically, the literature was initially reviewed and organized according to each individual standard (i.e., Health Promotion, Prevention and Health Protection, Facilitating Access and Equity, etc.). Within each standard, the literature was then further analyzed and mapped against each of the individual standard statements (i.e., Health Promotion 1. Collaborates with individual/ community and other stakeholders in conducting a holistic assessment…. etc.). The general Canadian public health nursing literature as well as CCPHC, Community Health Nursing certification competencies, professional standards, and literature specific to rural/northern nursing were mapped against each of these individual standard statements in order to clearly identify key knowledge and skills specific to public health nursing in Canada. The following review presents a detailed overview of these findings.

Canadian Community Health Nursing Standards of Practice

Community health nursing standards are intended to guide and inform the practice of nurses working in, or with the community. Standards of practice define the scope and depth of community health nursing practice, support on-going development of community health nurses, promote community health nursing as a specialty, serve as a foundation to the development of certification of community health nursing as a specialty, and inspire excellence in and commitment to community health nursing practice (CHNAC, 2003). While many of the concepts and competencies of community health nurses are familiar to varied nursing roles across Canada, the CCHN Standards of Practice have the most direct application in areas such as home health nursing and public health nursing (CHNAC, 2003). The standards of practice specific to community health nurses include *Promoting Health, Building Capacity, Building Relationships, Facilitating Access & Equity, and Professional Responsibility & Accountability* (CHNAC, 2003). Each standard is examined further in relation to the specific skills and/or knowledge required. However, in addition to these standards, the CCHNPM (Figure 1) identifies the process used by community health nurses to carry out work in relation to each of the standards, while at the same time upholding the values and beliefs that form the foundation of community health nursing practice. The practice of community health nursing follows the theoretical process of assessment, analysis, planning, implementation, and evaluation. The values and beliefs defined in the CCHNPM (Figure 1) include the Principles of Primary Health Care, Multiple Ways of Knowing, Individual/Community Partnership, Empowerment, and Caring. For public health nurses, it is important to understand each of these and how they inform and influence their practice.

Nursing Process

The nursing process is essential to nurses' work as it provides a systematic process for appraising the type, depth, and scope of health concerns and strengths as perceived by care partners, health providers or both, and guides the selection, carrying out, and evaluation of a series of actions to achieve desired goals (Stanhope & Lancaster, 2008, p. 272). As public health nurses often work independently and in a variety of settings, effective application of the nursing process in addressing health concerns requires that the public health nurse is skilled in clinical decision making, nursing judgment, application of evidence-based practice, knowledgeable in nursing and public health sciences, the determinants of health, the community and community resources, and individual-family-community interrelationships (CHNAC, 2003; PHAC, 2007; Simpson, 2005). A consistent theme in the literature is the simultaneity of public health nursing work. Public health nurses work with individuals/families, communities and populations at all stages of the nursing process and they view health at these levels through a 'lens' that allows them to constantly shift their focus of attention at all levels simultaneously (McMillan, 2007; Simpson, 2005). For example, public health nurses working at the individual/family level are able to examine individual health concerns while considering the larger effects on the community or population. This shifting lens requires that public health nurses are familiar with the various factors impacting health at each of these levels, in particular the determinants of health, as well as how to identify these using the appropriate tools and theoretical frameworks. Familiarity with family assessment tools, systems theory and developmental theory are important when working with individuals and families. However, when working with communities and populations, additional tools are necessary (Stanhope & Lancaster, 2008, p 335).

When working with the community as care partner, the phases of the nursing process that involve the care partner begin with assessment and continue through to the evaluation. Public health nurses need to be familiar with conducting community health assessments including the use of various data collection methods. These can include informant interviews, focus groups, participant observation, windshield surveys, secondary analyses such as statistical data and health surveys, and general surveys (Stanhope & Lancaster, 2008, p 258). Public health nurses then need to organize the data collected so that community strengths and health concerns are identified and can be further analyzed. When analyzing health concerns further, public health nurses need to have a broad understanding of the relationship between the environment and health as well as the social determinants of health (PHAC, 2007; Stanhope & Lancaster, 2008, p 260). With this understanding, the public health nurse can assist the community in identifying strategies to break the health concern

cycle or ways to effect change. An understanding of change theory specific to the target of practice (individual, family, community, and population) needs to be considered when implementing change (Stanhope & Lancaster, 2008, p 263). Public health nurses must be able to develop a plan to implement change taking into account relevant evidence, legislation, regulations, and policies as well as the cultural beliefs, values and practices of the community (PHAC, 2007). Various tools/frameworks can be useful in guiding the public health nurse through the planning and implementation phase including program planning frameworks (PRECEDE-PROCEED), policy development tools (Policy Road Map) etc. However, following implementation public health nurses need to be able to appraise the effects of the activity or program implemented.

When engaging in the evaluation stage, public health nurses need to be familiar with the different types of evaluation (formative and summative; DRHD, 2004). According to Durham Region Health Department (2004), public health nurses must also have knowledge of research practices, be able to critically analyze program implementation, identify changes required, participate in evaluation design and implementation, consider ethical issues and understand the conditions that facilitate evaluation. These conditions can include the use of specific, measurable, attainable, realistic and timely (SMART) goals and objectives; recognition that evaluation is a key component of the early stages of program development; availability of adequate resources; the willingness of staff and care partners to participate; the timing of the evaluation; and the outcome measures. The ability to identify appropriate outcome measures as well as tools to measure these is very important. Outcome measures can answer questions such as to what extent have the goals been met? What changes if any are needed? Which interventions were effective and why? Which were ineffective and why? Has the health concern be resolved or the risk reduced? Often, data collected over time can provide important outcome information about health trends therefore it is important that public health nurses are familiar with epidemiological data and trends (PHAC, 2007). For example, changes in any of the following can illustrate the outcomes of any activities or programs: demographics, socioeconomic factors, environmental factors, individual or community health status, and the use of health services (Stanhope & Lancaster, 2008, p 265).

Although when working from a population-based approach, or population focus, public health nurses follow the similar process of assessment to evaluation, the assessment and measurements they use to determine the health of a population are very different. Consistent in the literature is the emphasis that public health nurses are concerned with the health of populations (British Columbia Ministry of Health, 2000; College of Registered Nurses of British Columbia, 2007; Falk-Rafael, 2005).

Population health is an approach that focuses on the interrelated conditions and factors that impact on the health of human populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and action to improve the health and well-being of those populations (British Columbia Ministry of Health, 2000). Although the strategies appropriate of a population-based approach are discussed in further detail when looking at the standard *Promoting Health*, there are certain aspects of a population health approach that are important when examining the nursing process. Specifically, a population approach implies an understanding of epidemiological principles and these principles are included in the assessment, development and implementation of population health services (British Columbia Ministry of Health, 2000). Epidemiology involves the study of the distribution and determinants of health-states or events in specific populations, and the application of this study to the control of health problems (WHO, 1998). To measure the health of a population, public health nurses need to be familiar with health status indicators. These include but are not limited to, infant mortality rates, teen pregnancy rates, potential years of life lost, life expectancy, and incidence and prevalence (British Columbia Ministry of Health, 2000). Health status issues and therefore their indicators are often related to determinants of health such as poverty, unemployment, income, education, and the environment. An understanding of each of these and their relationship to health is therefore very important to nurses as they engage in the nursing process. If we consider again the simultaneity of the public health nurses work, this understanding is important when working from a population-based approach as well as when working at the individual, family and community level. Such an understanding will further contribute to the planning and implementation of effective strategies to address health concerns at the population level and identifying appropriate methods and measurements to evaluate such strategies.

Values and Beliefs

The values and beliefs defined in the CCHNPM (CHNAC, 2003; Figure 1) include Principles of Primary Health Care, Multiple Ways of Knowing, Individual/Community Partnership, Empowerment, and Caring. For public health nurses, it is important to understand each of these and how they inform and influence practice. The Principles of Primary Health Care provide a philosophy of care that is evident in all of the work that public health nurses do (WHO, 1978). Specifically, consistent with the principles of primary health care, public health nurses are concerned with access to health care services, as evident in the standard *Facilitating Access & Equity*. Public health nurses base their practice on participation from care partners and other disciplines and sectors for health; they are

responsible for upholding an appropriate level of knowledge, as evident in the standard *Professional Responsibility and Accountability*. Their main objective of practice is health promotion, particularly through examining and addressing the determinants of health, as evident in the standard *Promoting Health*. When examining each of the standards in further detail, the values of Principles of Primary Health Care and the multiple ways of knowing become more apparent. However, unlike these two values, the values of individual/community participation and empowerment are often consistent and reflective of a caring approach and are therefore examined further in terms of caring practice.

Caring as a central concept of public health nursing practice

A central theme recognized throughout the literature as being essential to nursing practice is that of caring. A caring approach is foundational to nursing practice when working with individuals and families; however, it is also recognized as an essential approach to public health nursing care when working with groups, communities and populations. In the CCHN Standards of Practice (CHNAC, 2003) caring is recognized as a value and belief upon which community health nurses, including public health nurses, base their practice. These values and beliefs are demonstrated in the various caring actions and attitudes that are consistent throughout each of the CCHN Standards of Practice.

When examining the standard *Building Relationships*, the theme of caring is very apparent and recognized as essential to this process. Specifically, caring actions and attitudes are necessary in a public health nurses ability to establish relationships and partnerships with communities, community agencies and organizations. Caring actions and attitudes are demonstrated through respect, empathy, cultural competence, capacity building, mediating, and developing collaborative partnerships (Falk-Rafael, 2001; McMillan, 2007). A critical caring approach involves being with a care partner, listening, truly listening, and being fully present to their context and needs, and critically and reflectively addressing their needs (Falk-Rafael, 2005; McMillan, 2007). According to the College of Registered Nurses of Nova Scotia (CRNNS; 2005), success in establishing relationships is more likely to occur when nurses follow a philosophy based on caring and respect. However, recently new terms such as population-based practice have necessitated the need for public health nurses to re-examine how caring influences establishing relationships at the community or population level. Caring is demonstrated at these levels through addressing the communities self-identified needs first. This requires the public health nurse to be authentically present with the community and supportive and sustaining of its belief systems and values (Falk-Rafael, 2005). A caring relationship, regardless of the

level of interaction, provides an essential context for the process of empowerment, a key approach and outcome associated with building individual and community capacity (Falk-Rafael, 2001).

The CCHN Standards of Practice (CHNAC, 2003) define building capacity as the process of actively involving individuals, groups, organizations, and communities in all phases of planned change for the purpose of increasing their skills, knowledge and willingness to take action on their own in the future. Caring actions and attitudes that are essential to this standard of practice involve the ability of the public health nurse to assist the community in meeting the basic needs of its members, caring for its most vulnerable members, meeting the social needs of its members, and promoting growth and development of its members (Falk-Rafael, 2005). A caring approach to building capacity aligns with the goal of empowerment stated in the Ottawa Charter (1986) as providing information and education for health and enhancing life skills. In addition, caring is not only recognized as essential to capacity building and establishing relationships but also in the approach public health nurses use to promote the health of communities.

Caring has been identified in the Ottawa Charter (1986) as a necessary component of health promoting practice. To promote the health of communities, public health nurses utilize a variety of strategies, tools, and activities to address issues of social justice, inequalities in health, and environmental factors that influence health. According to Watson (1988), critical caring is informed by an integration of caring and social justice, thus actions to promote social justice are in fact an expression of caring. This can also be said of actions to address issues of inequality and environmental health. Such actions are commonly targeted at the individual and family level using a 'downstream approach' or at the population and community level using an 'upstream' or macroscopic approach. A macroscopic approach to addressing health issues may involve the public health nurse utilizing advocacy skills. Advocacy can be recognized as a caring ethical approach to community health that promotes self-determination (Schroeder & Gadow, 2000). Promoting self-determination is consistent with the strategy, strengthening community action as identified in the Ottawa Charter (1986).

Strengthening community action relies on many of the caring processes and approaches recognized when examining the standard *Building Individual/Community Capacity*, yet despite this emphasis as an approach to promoting health, many public health nurses report feeling distanced from their communities (Falk-Rafael, 1999b). Thus it appears as though public health nurses are being asked to engage in community development approaches to building capacity, which are reflective of caring, while at the same time being distanced from their communities (Falk-Rafael, 1999b). In order to maintain this essential caring approach in their practice, public health nurses need to re-evaluate the

extent to which communities are involved in all aspects of planned change, such as planning, implementation and evaluation.

When looking at the standard *Facilitating Access and Equity*, the concept of caring is also embedded within the approach and processes that are used to collaboratively identify and facilitate universal and equitable access to available services (CHNAC, 2003). Similar to that which is seen with health promoting practice, actions necessary to facilitate access and equity are in fact an expression of caring. For example, providing culturally sensitive care is recognized as a key component when facilitating access and equity. Providing culturally sensitive care requires cultural competence among public health nurses. According to McMillan (2007), cultural competence is recognized as a humanistic caring principle essential to public health nursing caring practice.

Demonstrating Professional Responsibility and Accountability (CHNAC, 2003) recognizes that public health nurses work with a great deal of autonomy in their practice. They are accountable to the individuals, families, groups, and communities that they work with to ensure that their knowledge is evidence-based, current and that they have maintained competence (CHNAC, 2003). Caring actions and attitudes can therefore be reflected in a public health nurses use of evidence-based practice and their level of competency. According to Watson (1988), caring actually presupposes a knowledge base, clinical competence, and expertise. When a public health nurse enters into a relationship, caring actions and attitudes are demonstrated in their level of competence and their commitment to maintaining competence.

Public Health Nursing Practice in Canada

Promoting Health

The CCHN Standards of Practice (CHNAC, 2003) have identified the promotion of health as a key practice of community health (including public health) nurses. Promoting the health of individuals, families, groups and communities is a holistic, simultaneous, multilevel, critically caring, reflective, ecological approach whose outcomes are greater than what would result from the sum of individual activities (Falk-Rafael, 1999; McMillan, 2007). According to the CCHN Standards of Practice (CHNAC, 2003), community health nurses promote health using the following strategies: health promotion; illness and injury prevention and health protection; and health maintenance, restoration, and palliation. Although health promotion, and injury prevention and health protection are the main objectives of public health nursing practice, the strategy health maintenance, restoration and palliation is more consistent with the work of home health nurses. The literature regarding health maintenance,

restoration, and palliation with respect to a public health nurse is sparse and although public health nurses do engage in some work which borders on health maintenance and restoration (for example breastfeeding support and tuberculosis care and follow-up), much of the literature relates these activities to the primary objectives of public health nursing practice which are health promotion and injury prevention and health protection and as such are examined according to these objectives. For example, according to Manitoba Health (1998), health maintenance, restoration and palliation are not central to the public health nursing role. Therefore, when examining the standard *Promoting Health*, only health promotion and injury prevention and health protection will be discussed.

Health Promotion

Health promotion is defined as a mediating strategy between people and their environments, a positive, dynamic, empowering and unifying concept that is based on the socio-environmental approach to health (CHNAC, 2003). The socio-environmental approach to health recognizes that health is the result of the determinants of health, specifically social, economical and environmental, that provide benefits and barriers to individual and community health (Ontario Health Promotion Resource System, 2006). For public health nurses, an understanding of public health sciences including behavioral and social science and environmental public health, is key to their role in health promotion (PHAC, 2007). In addition, public health nurses must have a thorough understanding of inequities in health, including those determinants of health and how they influence the health and well being of specific populations (PHAC, 2007; CNA, 2002; Reutter & Williamson, 2000; Reutter & Duncan, 2000; Cohen & Reutter, 2007; Falk-Rafael, 1999; Thunder Bay District Health Unit, 2008). Key documents such as the *Lalonde Report* (1974), the *Ottawa Charter* (1986), and the *Jakarta Declaration on Health Promotion into the 21st Century* (WHO 2001) provide a solid introduction to social determinants of health for public health nurses. As public health nurses engage in work with individuals, families, groups, communities, and populations, the determinants of health should be at the forefront of their practice. This includes incorporating the social determinants of health into care partner assessments and follow-up plans (CNA, 2005). Although public health nurses may examine the influence of the social determinants of health when working with individuals/families and communities, much of their work from a socio-environmental approach is concerned with the health of populations. As such, in addition to their concern with assessing the health of individuals and families they must also be familiar with their role in health surveillance and population health assessment (PHAC, 2007; Simpson, 2005). For example, public health nurses should be familiar with how socio-

political issues at the population level, influence ill health or problems at the individual/community level. This approach is referred to as a population health approach or population-focused practice and is a key component of a public health nurse's, health promoting practice.

Public health nurses recognize that the populations' health is closely linked with the health of its constituent members (CHNAC, 2003). The population health approach centers on the interrelated conditions and factors that impact on the health of human populations over the life course (British Columbia Ministry of Health, 2000). These factors include the determinants of health and are reflected in the Population Health Promotion Model (PHPM; Hamilton & Bhatti, 1996). The PHPM model clarifies the relationship between health promotion and population health as it allows public health nurses to understand how a population health approach can be implemented through action on the full range of health determinants by means of health promotion strategies (Stanhope & Lancaster, 2008, p.74). Public health nurses should be aware of the PHPM and its various components including, the determinants of health and the health promotion strategies as identified in the Ottawa Charter (WHO, 1986).

When working from a population health approach to address broad factors influencing the health of communities and populations, public health nurses typically engage in five key strategies as outlined in the Ottawa Charter (WHO, 1986). These include Building Healthy Public Policy, Creating Supportive Environments, Reorienting Health Services, Strengthening Community Action, and Developing Personal Skills (WHO, 1986). Public health nurses should be able to demonstrate knowledge of these health promotion strategies and should be familiar with various change theories to assist them in identifying strategies for change that will make it easier for people to make healthier choices (CHNAC, 2003; DRHD, 2004; PHAC, 2007; Schoenfeld & MacDonald, 2002). When utilizing these strategies, public health nurses will often use a similar community development approach that is discussed further when examining the standard *Building Capacity*. This implies that public health nurses will encourage community involvement in planning and priority setting to address the health issues identified (Schoenfeld & MacDonald, 2002). Although public health nurses utilize each of the five key strategies identified, the literature consistently emphasizes the nurses' role in Building Health Public Policy.

Building healthy public policy requires that public health nurses have a solid understanding of the policy formulation process and the various tools available to guide them throughout the process (DRHD, 2004; Reutter & Duncan, 2000). Specifically, public health nurses should understand the policy making environment, legislation process, negotiated nature of policy making, the impact of

policies on the determinants of health, how to propose and advocate for feasible policy options, and examples of policy advocacy engaged by nurses (DRHD, 2004; Reutter & Williamson, 2000). Common tools identified in the literature as useful to policy development for public health nurses include the policy road map (The Health Communication Unit, 2008) and Milio's Framework (as cited in Reutter & Williamson, 2000). With an understanding of the policy formulation process and the tools used to guide this process, public health nurses should be able to assess the entry point into the policy making process; connect policy makers, advocates and residents if it is beyond the mandate of the health department; develop policy relevant information; facilitate community groups through the policy making process; use the policy road map or any related tool when working with groups; and assist in creating or advocating for healthy policy options (DRHD, 2004). Many of the skills required by public health nurses to successfully work through this process include: conflict management, policy analysis, research utilization, networking, negotiation/mediation, collaboration, counseling, social marketing, and most importantly, advocacy (CNA, 2002; DRHD, 2004; OPHA, 2004; Reutter & Williamson, 2000). Advocacy is recognized as one of the essential skills required to effectively change healthy policy options.

Advocacy is a familiar skill to most nurses; however advocacy has typically been limited to advocacy for client rights related to health care needs. For a public health nurse, advocacy needs to focus on public policy that influences population health (Cohen & Reutter, 2007; Reutter & Williamson, 2000; Reutter & Duncan, 2000). According to Cohen & Reutter (2007), few studies have actually examined the extent to which public health nurses actually engage in policy advocacy; however there is some indication in the literature that their involvement in such activities is limited. This limited involvement has been associated with a number of factors including the public health nurses perception that they lack the requisite knowledge and skills to engage in policy advocacy (Cohen & Reutter, 2007). Therefore, the education and training of public health nurses needs to ensure the development of knowledge and skills that will allow them to successfully engage in policy advocacy. Specifically, public health nurses need to have the adequate knowledge and skills to advocate for societal factors and their related policies that influence health. This includes but is not limited to issues of homelessness, unemployment, violence, literacy and of particular importance, poverty (Cohen & Reutter, 2007; Reutter, 2000; Reutter & Williamson, 2000).

According to Cohen & Reutter (2007), public health nurses are in an ideal position to address issues of child and family poverty. In Canada, one out of every six children is living in poverty, although in northern Aboriginal communities these rates are much higher (Cohen & Reutter, 2007).

Poverty can have a lasting impact on the long term health of children and traditional health education sessions with public health nurses alone have not proven to be adequate or effective in significantly enhancing low-income parents' capacities to promote their children's' health (Cohen & Reutter, 2007). Much more is needed to address the issue of child and family poverty in Canada and according to the literature, public health nurses are in an ideal position to address poverty at a political level. There is strong support in the literature for public health nurses' role in addressing poverty through various tools and activities such as advocacy (CHNAC, 2003; CNA, 2005; Cohen & Reutter, 2007; International Council of Nurses, 2004). Public health nurses have a responsibility to address issues of social justice. This can be achieved through working towards projects, programs and/or structural reform of an economic, political or social nature that reduce poverty, increase the standards of living and/or increase the participation of the poor in social life (Cohen & Reutter, 2007). Although healthy public policy is an effective way of achieving this, other health promotion strategies can be utilized alone or in conjunction with building healthy public policies to address poverty or any other determinants of health. Often, multiple strategies can be more effective in creating the desired change.

In addition to building healthy public policies, the Ottawa Charter (WHO, 1986) identifies four other strategies for promoting health. Many of the skills required for building healthy public policy are similar to those used for the remaining strategies. However, there are some differences in the knowledge and skills required when creating supportive environments, reorienting health services, strengthening community action, and developing personal skills. In particular, creating supportive environments requires that public health nurses have a clear understanding of the link between environment and health. This includes understanding the links between people and their social (culture and community), spiritual and physical environments (Manitoba Health, 1998; PHAC, 2007). Public health nurses need to be able to assess and directly act on the factors affecting health in the communities' social, emotional, spiritual, physical, and ecological environment (Manitoba Health, 1998). When using the strategy reorienting health services, public health nurse must be able to conduct a community assessment, provide consultation with decision makers, and promote responsible and effective use of health care system and community resources (Manitoba Health, 1998). In addition to advocating for effective use of the health care system and community resources, public health nurses should be familiar with community resources and services so they may refer individuals, families, groups and communities to the appropriate one(s). Public health nurses should also engage collaboratively with other sectors in addressing the determinants of health and the impact of existing services or the lack of services on these determinants (Manitoba Health, 1998).

The public health nurses' role in strengthening community action is very similar to that observed when using a community development approach to building capacity. The public health nurse is responsible for encouraging community involvement to identify issues, plan and set priorities (Schoenfeld & MacDonald, 2002). Public health nurses should attempt to mobilize individuals, families, groups, and communities to take individual and collective action on the determinants of health, and to develop and support community-based and self-care services to which community members have ownership and an active role (Manitoba Health, 1998). The public health nurse must therefore be skilled in negotiation/mediation, networking, collaboration, facilitation, conflict management, and health teaching.

Developing personal skills involves the public health nurse providing information, education for health, and enhancing life skills (Manitoba Health, 1998). Public health nurses provide information and education in an attempt to mobilize individuals to take individual and collective action on the determinants of health and/or to make healthy choices. Health education is recognized as one of the key tools utilized by public health nurses in developing personal skills. Providing health education empowers clients and promotes clients involvement in healthcare decisions (Stanhope & Lancaster, 2008, p. 90). Empowerment is essential to the development of personal skills and the nurses' expertise is essential to increasing clients' knowledge and skills so that they can make informed choices and take effective actions in pursuing their health goals (Falk-Rafael, 2001). Health education also encourages the adoption of healthier lifestyles through behavioral change (Stanhope & Lancaster, 2008, p. 90). This requires that public health nurses have an understanding of individual behavioral change theory, such as the Health Belief Model as well as adult teaching/learning theory (DRHD, 2004). The role of the nurse in providing health education involves: completing an assessment using an appropriate tool (i.e., at the individual, family or group level); using findings to develop a plan in collaboration with the care partner; utilizing research, evidence and a framework when developing the plan (i.e., program planning); using principles of adult learning; consider evaluation; and evaluate the process and results with the care partner (DRHD, 2004; OPHA, 2004; RNAO, 2008). Key knowledge and skills necessary of the public health nurse therefore include: adult learning, anticipatory guidance, assessment, conflict management, evaluation, facilitation, research utilization, and team building (DRHD, 2004).

While each of the five key strategies are effective in addressing the broader factors (determinants of health) that impact the health of families, groups, communities, and the population, part of a public health nurse's responsibility also involves increasing the public's awareness of the determinants of health and the various factors that impact health. As such, public health nurses must

also be skilled in social marketing, mass communication, media, and risk communication (DRHD, 2004; OPHA, 2004). Public health nurses must understand the target audience in creating these communication mediums and therefore must be familiar with audience analysis and tools to guide the development of health communication campaigns. However, regardless the communication medium utilized, public health nurses must also consider the appropriate means of evaluating the impact of such communications or campaigns on the community. This is also true when developing healthy public policy, strengthening community action, creating supportive environments, reorienting health services, and developing personal skills. Public health nurses must be familiar with and choose the appropriate data collection techniques and tools to evaluate interventions.

Prevention and Health Protection

According to the CCHN Standards of Practice (CHNAC, 2003), community health nurses adopt the principle of prevention and protection and apply a repertoire of activities to minimize the occurrence of diseases or injuries and their consequences to individuals and communities. Prevention and protection efforts require that public heath nurses have a broad understanding of demography, epidemiology and biostatistics, and an ability to apply these in practice (PHAC, 2007). Monitoring the health of a population is important to successful prevention and protection efforts. Therefore, public health nurses must be familiar with measurements of health such as health status indicators (Stanhope & Lancaster, 2008, p. 13). These indicators provide an understanding of trends within a population and provide a basis for further prevention and protection efforts. Public health nurses must also be familiar with the different levels of prevention (primary, secondary, tertiary) and must be able to identify appropriate prevention strategies at each level. When looking at prevention and health protection, public health nurses implement strategies to address issues of family and reproductive health, sexual health, chronic illness, mental health, communicable diseases, and injuries (Manitoba Health, 1998).

In regards to family and reproductive health, the public health nurse needs to be familiar with, and able to monitor, the health needs of the child bearing family during the prenatal, postpartum, and parenting stage. They must also be familiar with risk factors (social, economic, biological, behavioral, or environmental) that are associated with or cause increased susceptibility to a specific disease or health problem (WHO, 1998). With this knowledge, the public health nurse should be prepared to engage in reproductive education, anticipatory guidance, counseling and provision of supplies, preconceptual and prenatal education and support, antenatal monitoring and support for high risk pregnancies, parenting education and support for families, education of infant growth and

development, health counseling and support for parents, education regarding child abuse, support to family resource centers, pregnancy counseling, outreach, advocacy, support and referral for individuals and families at high-risk (British Columbia Ministry of Health, 2000; Manitoba Health, 1998).

Unlike public health nursing in the past whereby the majority of a public health nurses' work with families and reproductive health took place during home visits, today the majority of a public health nurses' role in family and reproductive health takes place in groups or involves developing resources to support families. Specifically, in the past public health nurses visited all families during the early post-partum period. However, current cutbacks and restructuring in several health units have resulted in restricting home visits to primiparae families only or in some cases, to only those who are identified as high-risk (Reutter & Ford, 1998). As a result, public health nurses have fewer opportunities to complete thorough family assessments and instead are often conducting assessments over the phone in an effort to identify those who might benefit from more personalized, individualized care in the form of home visits (Reutter & Ford, 1998). In situations such as this, well developed telephone assessment skills are a necessity. Furthermore, it is recommended that public health nurses include the social determinants of health in their assessments of individuals and families to assist in identifying those who are high-risk (CNA, 2005). Breastfeeding is another focus that has also become a priority for public health nurses as a result of early discharge from hospitals. Consequently, breastfeeding support lines, lactation consultant positions, and breastfeeding classes for new mothers have become many of the services offered by public health nurses through their agencies (Falk-Rafael, 1999). Public health nurses must therefore be familiar with and able to provide support for breastfeeding. In northern communities, reproductive health has been expanded to encompass issues surrounding women's health in general. Violence against women, abuse and addictions are identified as serious concerns for women in the north and need to be included in public health nurses understanding of family health.

Violence against women is a very important issue for the health of Canadian women. Among Aboriginal women, the rate may be as high as 80% due to such reasons as isolation, seasonal employment of men, the belief that leaving one's partner necessitates leaving the town, presence of hunting weapons, fewer social and health supports, along with male dominant values and priorities (Liepert, 1999; Liepert & Reutter, 1998). As public health nurses (community health nurses) working in the north, they may be the only health professional whose mandate is health promotion or prevention and therefore they need to be familiar with such diverse family and reproductive health issues (women's issues) as social support, harm reduction principles for dealing with addictions, sexual

decision making among female adolescents, the special needs of single mothers, breast cancer attitudes and practices, and reproductive and menopause issues (Leipert & Reutter, 1998).

Prevention related to sexual health is another area of focus for public health nurses. Public health nurses must be familiar with monitoring sexual health trends in the community and using such evidence to inform the development of sexual health programs in the community (Manitoba Health, 1998). Public health nurses should be able to educate, counsel, advocate and refer individuals, families and at-risk groups regarding relationships, communication, sexual decision-making and behavior, sexual orientation, personal safety, and sexually transmitted infections (Manitoba Health, 1998). This requires public health nurses to be familiar with available sexual health resources in the community, healthy sex options, at-risk populations, and prevalent sexually transmitted infections.

Prevention in regards to mental health requires the public health nurse to have an understanding of mental health services in the community so that he/she is able to provide support, information, counseling, and resources related to life-transitions, self-esteem, assertiveness, decision-making, communication, stress management, counsel for depression and suicide risk, counsel and/or refer for weight preoccupation, obesity, body image and eating disorders (Manitoba Health, 1998). Public health nurses should also have an understanding of, and be able to recognize, a psycho-social emergency and its broader impact within the community (Health Canada, 2001).

In regards to preventing chronic illnesses, public health nurses should be able to identify risk factors for chronic illness and should be familiar with monitoring and observing for patterns and distributions of health in the community (Health Canada, 2001). This knowledge and understanding should inform prevention efforts including screening and program planning on behalf of public health nurses. Common risk factors for chronic illness(es) that a public health nurse should be familiar with include weight preoccupation, obesity, body image and eating disorders among others (Manitoba Health, 1998). Public health nurses' must then be able to educate, counsel refer and support individuals, families and groups in making healthy lifestyle changes and choices. Understanding individual behavioral change theory is also important to a public health nurses success in this role.

Of the health topics identified, the most recognized focus of public health nursing prevention and protection efforts is that of communicable disease management, control, and reduction (Schoenfeld & MacDonald, 2002). As a foundation, public health nurses must be familiar with the terms pandemic, epidemic, and endemic (CNA, 2002). In the case of a pandemic, they need to be aware of their organizations policies and their College's related standards and guidelines (CNO, 2007). Specifically, public health nurses must be familiar with and able to apply the practice standard, *Infection Prevention*

and Control (CNO, 2005) as well as the practice guidelines, *Preparing for an Influenza Pandemic*, and *Influenza Vaccinations* (CNO, 2007). Public health nurses must apply principles of epidemiology in using strategies such as surveillance to identify both reportable and non-reportable communicable diseases (Health Canada, 2001; Manitoba Health, 1998; PHAC, 2007). Surveillance is consistently recognized in the literature as a necessary skill of public health nurses and involves not only monitoring but also forecasting health trends (CHNAC, 2003; PHAC, 2007). Public health nurses must be familiar with the use of incidence and prevalence in monitoring communicable disease trends and be able to implement communicable disease programs based on information gathered.

Communicable disease prevention activities used by public health nurses include health education and awareness and immunization programs (Manitoba Health, 1998). Health education should be targeted at the community in order to maximize community awareness and participation in controlling an outbreak and preventing future outbreaks (Health Canada, 2001). When planning and implementing immunization programs, public health nurses need to be knowledgeable of the principles of immunization, types of immunity, modes of transmission, infection control practices, and able to educate care partners on the benefits of immunity and give immunizations (CNA, 2002; CNO, 2002; CNO, 2007; Health Canada, 2001). According to Toth, Facklemann, Pigott & Tolomeo (2004), public health nurses' must be very knowledgeable of tuberculosis (TB), including signs and symptoms, risk factors for TB, risk settings, and common treatments. Public health nurses' need to advocate for the prompt diagnosis and isolation of suspected and confirmed TB cases by consulting with physicians, local public health officials for guidance and ensuring that all suspected TB cases are placed in isolation (Toth, Facklemann, Pigott, & Tolomeo 2004).

Public health nurses must also be concerned with preventing injuries and substance abuse within a community. Injury prevention requires the separation of those at risk from injury hazards through strategies such as mobilization of community action groups, healthy public policy related to reducing hazards in the community, safety education, and analysis of injury statistics (British Columbia Ministry of Health, 2000). Public health nurses often advocate for the development of programs and policies that support safer and healthier environments in order to reduce or eliminate injuries or hazards in the environment (Manitoba Health, 1998). Public health nurses facilitate coalition building to address issues of injury prevention and substance abuse as coalition building serves to build the communities capacity to promote falls prevention, car seat safety, road safety, water safety, prevention of alcohol and substance abuse, smoking prevention and cessation and home safety

(RNAO, 2008). Substance abuse often involves principles of harm reduction which place priority on reducing the negative consequences of drug use (British Columbia Ministry of Health, 2000).

Of more recent interest to the practice of public health nurses in regards to prevention and protection is their involvement in emergency preparedness. Today, public health nurses are expected to be skilled in the development and implementation of emergency response plans (Manitoba Health, 1998; OPHA, 2004). All public health nurses should therefore be familiar with the organizations' emergency preparedness plan and they must be able to recognize the potential impact of community disasters, including identifying factors leading up to or contributing to an emergency or disaster (Health Canada, 2001). During an emergency, public health nurses must be prepared and able to provide crisis intervention and trauma postvention services, and provide immediate and post-disaster emotional support for individuals, families, groups and communities. Specifically, the United States has identified competencies for Public Health Nurses during an emergency, including bioterrorism. Twenty five competencies have been identified and categorized into Preparedness, Response, or Recovery areas (Polivka, Stanley, Gordon, Taulbee, Kieffer, & McCorkle, 2008). The Preparedness competencies focus on personal preparedness such as understanding key terms/concepts, and roles in disaster preparedness; familiarity with the health departments disaster plan, with communication equipment and processes; and with the role of a public health nurse in an emergency situation (Polivka, et, al., 2008). During the Response phase, the responsibilities of a public health nurse include conducting a rapid needs assessment; outbreak investigation and surveillance; public health triage; risk communication; and technical skills such as mass dispensing (Polivka, et,al., 2008). Recovery competencies have been identified as participating in the debriefing process, contributing to disaster plan modifications, and coordinating community efforts to address the public health impact of the event (Polivka, et, al., 2008). The capacity for public health nurses to step into an emergency situation and render such services requires advanced preparation and training, beginning in undergraduate nursing curriculums.

The United States has developed a Public Health Nursing Curriculum for emergency preparedness which provides learners with the opportunity to, i) describe aspects of public health nursing disaster and preparedness, ii) distinguish the role of a public health nurse in an emergency from other roles, iii) discuss appropriate public health nursing interventions during the response phase, and iv) identify the role of the public health nurse in the Recovery phase (Stanley, Polivka, Gordon, Taulbee, Kieffer, & McCorkle, 2008). The inclusion of such competencies needs to be examined

within undergraduate nursing curriculums across Canada to ensure qualified, competent practitioners and the ability to perform assigned tasks during an emergency.

Public health nurses are not only responsible for contributing to the planning and monitoring of health issues and regional programs, but also for evaluating such programs. Specifically, they are responsible for participating in the evaluation of regional programs developed to address each of the areas identified. In addition to evaluation, public health nurses' are also responsible for participating in and conducting research around the control of communicable diseases, injury prevention and many others. According to Leipert & Reutter (1998), public health nurses (or community health nurses) need to partner with women to advocate for increased research regarding women's health needs and concerns. This is of particular importance when considering the health of women in rural, northern communities.

Building Individual/Community Capacity

Building individual/community capacity is recognized as one of the key components of public health nursing practice (DRHD, 2004). According to the CCHN Standards of Practice (CHNAC, 2003), *Building Individual/Community Capacity* involves the process of actively involving individuals, groups, organizations and communities in all phases of planned change for the purpose of increasing their skills, knowledge, and willingness to take action on their own in the future. This trend towards greater care partner participation and control is not only essential to building capacity, but is also consistent with the philosophy of Primary Health Care (Reutter & Ford, 1998). In their review of the CCHN Standards of Practice, TGS Consultants (2005) found that building capacity had a stronger focus in public health nursing practice then in home health nursing. In public health nursing practice, empowerment is recognized as a central element of building capacity and it plays an essential role in the way public health nurses work with groups, families, and communities. Furthermore, it is also a desired outcome of capacity building (DRHD, 2004; Falk-Rafael, 2001; Lindsey, Stajduhar & McGuinness, 2001). As a process, empowerment strategies used to build capacity include mutual goal setting, visioning, and facilitation (DRHD, 2004). According to Simpson (2005), the public health nurse's role as a facilitator is often aimed at empowering a community and therefore, they must possess the basic knowledge and skills necessary to engage in these strategies.

Advocacy (personal and political) at the individual, family, group, and community level is also recognized as an empowering strategy (Falk-Rafael, 2001; Simpson, 2005). As a public health nurse, examples of advocacy strategies targeted at building capacity include mediating with other health care

professionals, using positional power and connections as members of a profession and employees in a health agency to cut through red tape, and linking clients with resources available to them in the community (Falk-Rafael, 2001). Much of the role of advocating in public health nursing is targeted at those who are as yet unable to advocate for themselves (CHNAC, 2003; DRHD, 2004). Specifically, vulnerable groups are recognized in the literature as a main target of public health nursing practice (RNAO, 2008; Simpson, 2005). Public health nursing practice targeted at vulnerable groups is based on strategies to increase people's choices and capacity for self-determination (Simpson, 2005). This often involves the public health nurse supporting the client in developing skills for self-advocacy so that they can take charge of their own lives and make their own choices (DRHD, 2004). Specifically, public health nurses' may need to educate the community about how to use the political process to improve their health, acting as a catalyst to help them resolve their issues and concerns (Schoenfeld & MacDonald, 2002)

Building Individual/Community Capacity uses principles of community development in which the theoretical model of assessment, planning, implementation, and evaluation are utilized (Lindsey, Stajduhar, & McGuinness, 2001). One of the key aspects essential throughout this process is the maximum involvement and participation of the community. This often implies that public health nurses must be willing to 'start where the people are' (British Columbia Ministry of Health, 2000; Lindsey et al., 2001) This not only involves meeting the clients in their own physical space, but also having an appreciation for and understanding of where they are in terms of their beliefs, values, and health related practices. Public health nursing incorporates an element of 'outreach' whereby nurses must seek out those who would likely benefit from their care and then go to that group or community to assist them within their own environment (Reutter & Ford, 1996). Working within the care partners environment means that public health nurses often work in diverse settings, including schools, health facilities, work places, the street and community settings. In this respect, 'starting where the people are' often refers to practicing in a 'setting without walls' (RNAO, 2008; Simpson, 2005).

In addition to meeting the care partners in their own physical environment, successful capacity building attempts rely on the public health nurse's ability to understand their patients' beliefs, values and health-related practices. Much of this too relies on the ability of the nurse to establish those trusting relationships whereby such an understanding is fostered. Specifically, public health nurses must have an understanding of cultural norms and practices common to their group or community. Cultural norms and practices influence peoples' perceptions of health and health care. In the CCPHC (PHAC, 2007), *Diversity and Inclusiveness* is recognized as a distinct competency in public health

practice, and identifies the socio-cultural competencies necessary to interact effectively with diverse individuals, groups, and communities. Although clearly stated in the core competencies for public health practice, it is integrated throughout many of the standards of practice in the CCHN Standards of Practice (CHNAC, 2003). Specifically, the standards Building Relationships and Facilitating Access & Equity, speak to the need for culturally competent care. However, despite the emphasis in the literature as a necessary component of *Building Capacity*, it is more implied throughout the actions and processes identified as opposed to being clearly stated. This does not however, diminish the importance of cultural competence as a necessary skill of public health nurses given Canada's multicultural population and the work of public health nurses/community health nurses in rural, northern communities.

Although cultural competence is recognized as a necessary skill of public health nurses working in urban settings, it is particularly important when working in rural, northern communities. Capacity building principles that reflect an awareness of diversity issues are critical in achieving participation from the more disenfranchised populations that public health nurses work with (Johnson, Bhagat, Shuster, & Ross, 2001). Specifically, when working with aboriginal communities, the need for more culturally appropriate care relevant to the needs and strengths of aboriginal women and families has been identified (Smith & Davies, 2006). Successful capacity building depends on public health nurses knowledge of cultural norms, practices and their ability to demonstrate cultural competence. Although public health nurses' should be aware of general cultural beliefs and values prior to engaging contact with the community, much of this understanding can be developed through their assessment skills.

While the nursing process of assessment to evaluation is similar to that in general public health nursing practice, the key difference when using a community development process to building capacity is the involvement and participation of care partners (individuals, families, groups, and communities) in all aspects of planned change (CHNAC, 2003; DRHD, 2004). Public health nurses must be skilled in conducting community assessments alongside community members and must be able to identify the key stakeholders within a community, engage those stakeholders and work collaboratively with those individuals/groups to identify and address the needs of the community as well as barriers faced in attaining health goals (DRHD, 2004; Falk-Rafael, 2001). When involving care partners in all aspects of planned change, public health nurses must also have knowledge of change theory (CNA, 2006; DRHD, 2004). An understanding of the communities' readiness and willingness to initiate change is essential to community development and capacity buildings success. Specifically, the DRHD (2004)

recommends that in order to build capacity, public health nurses must have a solid understanding of change theory and change theory utilization at the individual level (i.e., stages of change model, health belief model), at the interpersonal level (i.e., social learning theory), and at the community level (i.e., community organization theories, organizational change theory, diffusions of innovations theory). Understanding a care partners' readiness to engage in change is consistent with the building capacity notion of 'starting where the people are'. Once public health nurses understand where their care partners are in terms of their willingness to engage in change, they are then better able to involve them in the planning aspects.

When working with care partners to initiate and implement change, public health nurses must also be highly knowledgeable and skilled in knowledge transfer (CHNAC, 2003; Smith & Davies, 2006). They must be willing and able to share knowledge, tools, expertise and experience (Johnson et al., 2001; PHAC, 2007). Being able to share knowledge and expertise is essential to increasing the communities' skills, knowledge and abilities to take action on their own, both now and in the future. Smith & Davies (2006) emphasize that when working in rural, northern communities, a participatory model of knowledge transfer is essential. In addition to these skills and knowledge, the emphasis on community participation and involvement in all aspects of planned changes requires that public health nurses are skilled in adult learning, anticipatory guidance, conflict management, consensus decision making, facilitation, leadership, negotiation, mediation, and networking (DRHD, 2004). Leadership in particular is extremely important in all aspects of public health nursing. Specifically, the PHAC (2007) recognizes leadership as a core competency of public health practice that is essential to building capacity, improving performance, and enhancing the quality of the working environment. Although the CCHN Standards of Practice (CHNAC, 2003) do not recognize leadership as a standard on its own, a public health nurse's ability to build capacity including engaging stakeholders, collaborating with individuals and facilitating planned change depends on their leadership skills. They must therefore be knowledgeable in leadership theory and possess an awareness of their leadership style and how that might influence their success.

Although the community development approach to building capacity is consistently emphasized in the literature as an essential component of public health nursing practice, public health nurses claim they feel 'distanced' from their communities. Reutter & Ford (1998), question whether or not public health nurses are being supported in their efforts to engage community members and build capacity. In a review of the CCHN Standards of Practice (2003), TGS Consultants (2005) discovered public health nurses were not applying the standards of practice due to a lack of skills to do so,

workload issues, or it was not recognized as a necessary responsibility of their job. Support from health agencies in recognizing capacity building as a necessary component of successful public health nursing practice and adequate skills training to assist nurses in engaging in this work is essential to its success and use among public health nurses. According to OPHA (2004), staff of health units across Ontario are required to have skills in community development and capacity building. In Ontario, the Registered Nurses Association of Ontario (RNAO; 2008), recognizes that collaborating with communities to empower them to address health issues and providing support that allows them to maintain control over their lives is a public health activity that should be accessible across Ontario and more importantly, throughout all of Canada.

Building Relationships

The theme of 'caring' is no more apparent in nursing practice then when looking at the process and approach to building relationships. Building relationships has always been recognized as a necessary component of general nursing practice and its success depends on a nurses ability to demonstrate those actions and attitudes that are characteristic of caring. As a public health nurse, establishing caring relationships takes place at the individual, family, group and community level. Although the skills necessary for building these relationships at the individual and family level may be very similar to that across all nursing roles, relationship building at the group or community level often requires a different skill set and knowledge base. This movement from individual/family care to group or community care has presented challenges for public health nurses over the years as they try to redefine their practice and role in light of these new skills and their application. Many public health nurses view this shift as a loss of 'hands on' care to a much more 'arms length' approach (Reutter & Ford, 1998).

For many, the 'arms length' approach to care is felt to hinder one's ability to build solid relationships because of this apparent distance between the nurse and the care partner (Falk-Rafael, 1999). However, this view reflects an attempt to fit old notions of building therapeutic relationships within a new model of care that emphasizes population-based practice. New models of population-based public health nursing practice require that nurses re-examine the meaning of relationship building, recognizing that in fact there is still a 'hands on' approach and that the 'distance' is not as great as it first appears. At the group and community level, 'hands on' simply requires a different knowledge and skill set and the application of these on care partners outside the traditional individual and family unit. Defining the skills and knowledge necessary to build relationships at the group,

community and population level is a necessary step in reaffirming what public health nurses do and in evaluating ones ability to successfully build these relationships.

The College or Registered Nurses of Nova Scotia, (CRNNS; 2005) recognizes that in order to establish relationships, public health nurses must first possess a basic understanding of human behavior, including those factors that can influence health related behavior. Such factors can include individual/community cultural beliefs, values, feelings, and attitudes about health. With this awareness and understanding, public health nurses are in a better position to demonstrate caring attitudes. These caring attitudes are recognized as essential to all nursing practice and are not specific to public health nursing practice in general. Specifically, according to the literature, a nurse establishes caring relationships through demonstrating respect, trust, empathy, non-judgmental attitudes, cultural competence, authenticity, and honesty (CNO, 2002; CRNNS, 2005; Falk-Rafael, 2001; McMillan, 2007; Simpson, 2005). In demonstrating these attitudes, public health nurses are able to create a safe environment for care partners' which is critical to the development of a trusting, caring relationship (Falk-Rafael, 2001).

To further establish caring relationships, public health nurses must recognize and demonstrate actions and attitudes that are also characterized by mutuality. The literature consistently emphasizes the importance of maintaining the clients' needs at the center of care. According to the College of Nurses of Ontario, Professional Standards (CNO, 2002), patient needs are the foci of the nurse-patient relationships. In order to maintain this foci, public health nurses must trust in the family/communities ability to identify their own needs and establish health goals (CHNAC, 2003; CNO, 2002; McMillan, 2007). This trust and emphasis on maximum care partner participation and involvement implies that public health nurses working with whole communities must be highly skilled communicators. Although effective communication is essential to establishing therapeutic relationships when working with an individual care partner, communication becomes as essential when attempting to maintain the interests of multiple individuals for the greater good of the overall community. Specifically, establishing mutual goals within a community can present challenges when conflicting perspectives and interests are present. Therefore, communication skills required by public health nurses working with groups, communities or populations can be different than those required for establishing relationships at the individual or family level.

Communication is recognized throughout the CCHN Standards of Practice (CHNAC, 2003) and the CCPHC (PHAC, 2007) as essential to public health practice. Although the CCPHC have identified communication as a competency on its own, the CCHN Standards of Practice have

integrated and recognized communication as an essential component throughout all of their standards of practice and in health. However, it is no more apparent than when looking at the standard, *Building Relationships*. According the CCHN Standards of Practice (CHNAC, 2003), communication as an essential component of building relationships is reflected in a public health nurse's ability to utilize culturally relevant communication. This includes the familiar verbal, non-verbal, written or pictorial; however, it can also include group facilitation, print or electronic means. Simpson (2005) speaks of traditional nurses' skills in establishing therapeutic relationships as being pushed aside for those more closely aligned with population-based practice. Specifically, establishing relationships from a population-based approach involves knowing how to communicate at the level of the population. Therefore, public health nurses must be skilled in developing media campaigns, social marketing and web-based learning modules. In addition, in order to promote the health of communities, they are also required to build strong working partnerships. Partnerships with other practitioners and disciplines, community agencies and organizations, faith communities, volunteers, and other health sectors are necessary in meeting the needs of the community (CHNAC, 2003; Reutter & Ford, 1998). Forming relationships or partnerships with other disciplines and community agencies/organizations requires an extensive knowledge of community resources (CHNAC, 2003; Manitoba Health, 1998). This knowledge allows the public health nurse to identify key players and to initiate contact. Partnerships are necessary in assisting care partners to access available information and support relevant to their needs and in creating opportunities for agencies and groups in the community to work together to address larger health issues (CHNAC, 2003; Manitoba Health, 1998). That being said, the ability to work in partnership requires experience in multi-disciplinary collaboration and team work.

Multi-disciplinary collaboration requires that groups or individual representatives work together towards a common goal. Therefore, developing working partnerships requires that there is a "give and take" and a valuing and respect of others' points of view (Reutter & Ford, 1998). In this partnership role, public health nurses often see themselves as a facilitator whereby facilitation skills are extremely important (British Columbia Ministry of Health, 2000; CRNNS, 2005; Manitoba Health, 1998; PHAC, 2007; Reutter & Ford, 1998). In order to further establish and maintain these partnerships, public health nurses must also be skilled in team building and when conflicting interests and perspectives present themselves, they must be able to mediate, negotiate, delegate and implement conflict resolution strategies (British Columbia Ministry of Health, 2000; CRNNS, 2005; PHAC, 2007). The ability of public health nurses to carry out these skills can seriously impact the success of

these partnerships and therefore their ability to work together effectively and efficiently to promote the health of communities.

Although not strongly addressed in the literature but perhaps of equal importance in establishing relationships and partnerships, is the professional responsibility of public health nurses to recognize professional boundaries and when professional relationships or partnerships are no longer effective or necessary. When working with a group or community as care partner, public health nurses must have a clear understanding of care partner goals and as mentioned, must maintain the care partners' needs at the foci of their care. When care partners' needs have been met or the care partner is no longer willing to work with the public health nurse to address their health issues, the nurse must negotiate with the care partner (including groups or communities) to end the relationship or partnership (CHNAC, 2003; Thunder Bay District Health Unit, 2008). In addition, although public health nurses find themselves to a lesser degree in the homes of their care partners, there is still the potential within long-term relationships in the home or community setting to blur the boundaries between professional and social relationships. They have a responsibility within their professional relationships to maintain those boundaries (CHNAC, 2003; CNO, 2002; Thunder Bay District Health Unit, 2008). Maintaining boundaries requires knowledge of actions and attitudes that demonstrate professional relationships as well as an understanding of ethical dilemmas unique to public health nursing practice and appropriate actions when faced with such.

Facilitating Access and Equity

Facilitating Access and Equity is consistent with the philosophy of primary health care in which community health nurses (including public health nurses) work collaboratively to identify and facilitate universal and equitable access to available service (CHNAC, 2003). When facilitating access and equity, public health nurses utilize the theoretical model of assessment, planning, implementation and evaluation. During the assessment phase, public health nurses must be able to assess and understand a community's capacity, including their strengths and weaknesses, power structure, community resources, and values and beliefs (CHNAC, 2003). Essential to this is an understanding of cultural norms and practices and in particular how such norms may influence access. In addition, public health nurses must also be aware of the impact of various determinants of health on access to resources and services for individuals, families, groups, communities, and populations.

Public health nursing practice is concerned with individuals, families, groups and communities access to essential resources that determine health (determinants of health; CHNAC, 2003). Several

studies of public health nursing practice in Canada have emphasized the responsibility of public health nurses in addressing the determinants of health, such as poverty and social exclusion (Cohen & Reutter, 2007; Falk-Rafael, 1999; MacDonald & Schoenfeld, 2003). In terms of facilitating access and equity, public health nurses have a responsibility to ensure that their care partners (individual, families, groups and communities) have equal access to the various resources available which could reduce the effects of poverty. In order to achieve these, public health nurses must be skilled in outreach, referrals, meeting people where they live work and play, and advocacy (CHNAC, 2003; CNA, 2006). Although these skills are all very important, advocacy is recognized in the literature as an essential skill in successfully facilitating access and equity. When facilitating access and equity, advocacy is perhaps one of the most recognized and necessary skills of public health nurses. Although advocacy in this respect is also concerned with the health promoting strategy, building healthy public policy, facilitating access and equity often involves advocating for changes to policies that may impede equitable access to resources necessary for health.

Demonstrating Professional Responsibility and Accountability

Due to the high degree of autonomy associated with public health nursing practice, professional responsibility and accountability are vital. According to the CCHN Standards of Practice (CHNAC, 2003), in *Demonstrating Professional Responsibility and Accountability*, nurses' are accountable to ensure that their knowledge is based on evidence, current and maintains competence, and for the quality of their practice. Community health nurses and especially public health nurses have a special responsibility to initiate strategies that will help address the determinants of health (CHNAC, 2003). When examining the determinants of health, public health nurses often find themselves working with vulnerable populations, therefore the importance of maintaining their professional responsibilities and evaluating the effectiveness of these initiatives and their practice is imperative. In order to uphold the level of professional responsibility and accountability expected of public health nurses, they must first possess a foundational knowledge of the standards, practices and guidelines that direct their care.

In addition to regulations, standards, and legislation that guide all nursing practice, public health nurses must also be aware of the CCHN Standards of Practice (CHNAC, 2003), the CCPHC (PHAC, 2007) and any Acts specific to their province of work. Although the CCHN Standards of Practice (CHNAC, 2003) provide a framework to inform and guide the practice of registered nurses, maintaining competence requires a clear set of identified knowledge, skills, and judgments specific to public health nursing practice. The development of the CCPHC (PHAC, 2007) provides an overall

description of the key knowledge and skills necessary of all public health practitioners. However, the skills and knowledge identified here do not necessarily address the unique practice of public health nurses within a public health setting. For that reason, discipline specific competencies for public health nursing practice are an essential component of maintaining competence, and therefore demonstrating professional responsibility and accountability. Public health nurses need to ensure that their practice is consistent with these standards and regulations, and that they are using them to promote health and prevent adverse health outcomes (CNA, 2002; CNO, 2002). Appropriate use and application of these standards and regulations is an ethical responsibility of nurses.

Due to the high degree of autonomy in public health nursing practice, public health nurses are sometimes placed in situations with unique ethical dilemmas (CHNAC, 2003). Public health nurses must possess an understanding of actual and potential ethical dilemmas and how to address these dilemmas using ethical frameworks. As a foundation to ethical practice, public health nurses must understand the *CNA Code of Ethics for Registered Nurses* (2002). The CNA Code of Ethics states that its values are grounded in the professional nursing relationship with individuals, families, communities, and society and by upholding these values in practice, nurses earn and maintain the trust of those in their care (2002, p. 7). However, in applying the ethical principles outlined in this code of ethics, it is less clear when the object of care is the community. For example, a public health nurses' involvement is mutually determined by the care partner and the nurse, however, potential dilemmas can arise when the individual care partner sees his or her interests in a way that potentially places the broader community at risk (Falk-Rafael, 1998). In situations such as this, how does a PHN proceed when the well being of the community may be compromised by decisions made by an individual care partner about his/her own health? Public health nursing training and education must allow for opportunities to examine case scenarios whereby ethical dilemmas are presented and challenged. In addition to the *CNA Code of Ethics*, the PHAC (2007) recognizes the importance of public health ethics in guiding the practice of public health practitioners.

Public Health Ethics examine ethics at the population level of public health (CNA, 2006). According to the PHAC (2007), public health ethics should be used by public health practitioners to manage self, others, information, and resources. Recently, ethicists have begun to revisit and revise ethical principles and frameworks to guide decision making in practice (CNA, 2006). Upshur (2002) suggests four ethical principles for public health practice. These include i) the harm principle, ii) the least restrictive or coercive means, iii) reciprocity, and iv) transparency (Upshur, 2002). Although these ethical principles speak to all public health practitioners, public health nurses in particular may

face ethical challenges not experienced by other public health workers due to the close relationships they often establish with people in the community (CNA, 2006). Although a great deal of literature has examined ethics in relation to nursing practice, very little has examined ethics specific to public health nursing practice (CNA, 2006). The CCHN Standards of Practice (CHNAC, 2003) offer some direction in terms of ethical guidance for community health nurses. However, due to differences in home health nursing and public health nursing practice, further discussion and education are needed to support the unique role of public health nurses. Of particular interest to educators and training sessions for public health nurses should be a review of ethics in advocacy.

As public health nurses, much of their practice involves advocating for, and on behalf of others. Advocacy is recognized in the *CNA Code of Ethics* (2002) and in the CCHN Standards of Practice (CHNAC, 2003) as a nursing responsibility and a new body of literature emphasizes the importance of advocacy ethics in informing public health nursing practice (Cohen & Reutter, 2007; Stanhope & Lancaster, 2008). Public health nurses' need to be aware of their ethical responsibilities related to advocacy. Advocacy ethics is perhaps an area of public health nursing practice that needs to be considered and emphasized when examining public health nursing training and education including familiarity with frameworks for advocacy such as the practical approach to advocacy suggested by Bateman (2000) or the conceptual framework for advocacy identified by Christoffel (2000). Having a better understanding of potential ethical dilemmas in public health nursing practice and how to apply ethical frameworks places public health nurses in a better position to protect individuals/communities from unsafe or unethical circumstances.

Part of a public health nurses' professional responsibility is to identify actual/potential situations that may put others at risk or themselves, and once identified, they must then act appropriately to address the situation (CHNAC, 2003; CNA, 2002). This can involve reporting to the appropriate authority any health team member or colleague whose actions towards care partners are unsafe or reporting to the appropriate authority signs of abuse among care partners (i.e., child abuse, elder abuse etc). Public health nurses must then evaluate actions taken to resolve unsafe or unethical situations, recognizing when further assistance and knowledge may be necessary.

Public health nurses must acknowledge when assistance from other members of the health care sector or community organizations are necessary to provide professional practice that respect the rights of care partners (CNO, 2002; CRNNS, 2005). Recognizing the need for assistance necessitates an awareness of one's own knowledge gaps and level of competence. As with all nurses, public health nurses must continually assess their level of competence and engage in professional development

activities that develop competence. Maintaining competence requires that they possess knowledge relevant to their field and maintain skills necessary to carry out effective practice. Reflective practice, self-assessments, learning plans, and peer feedback are activities expected of nurses in order to maintain nursing competence (CNO, 2002; McMillan, 2007). Public health nurses are also expected to advocate for quality improvements in the workplace, creating quality practice settings that promote continued competence (CNO, 2002). A competent nurse thus has a further responsibility to contribute to the advancement of public health practice in general and public health nursing practice more specifically.

As a member of the public health organization, public health nurses need to demonstrate knowledge of and respect for the various public health roles (CNO, 2002). This includes an understanding of the role of an epidemiologist, health promotion officer, medical officer of health, public health nutritionist, public health dentistry, and public health inspector. Public health nurses must be aware of the mission and priorities of the public health organization in which they work and able to apply these (PHAC, 2007). This awareness will allow public health nurses to positively contribute to team and organizational learning to advance public health goals, to maintain organizational performance standards, and to contribute to developing key values and a shared vision in planning and implementing public health programs and policies in the community (CNO, 2002; PHAC, 2007).

Within their own discipline, public health nurses must also engage in activities that seek to advance the practice of public health nursing. This involves participating in nursing organizations or interest groups, mentoring students or novice public health nurses, role-modeling positive collegial relationships and possessing a clear understanding of their role and promoting their role to others, (CNO, 2002). Promoting the public health nurses' role is a necessary component of successful public health nursing practice. According to Cohen & Reutter (2007), public health nursing activities can be stalled when the public and/or other health professionals have limited understanding/recognition about the potential role of the public health nurse in various activities. Therefore, public health nurses must not only be aware of their role and the various activities that they are responsible for, but they must be effective in communicating this to the public. The use of current technology to communicate effectively and to support nursing practice is recognized in the CCPHC (PHAC, 2007) as well as the CCHN Standards of Practice (CHNAC, 2003) as a professional responsibility of public health nurses.

Recommendations and Next Steps

A review of public health nursing practice in Canada provides a thorough understanding of the roles and responsibilities, and therefore knowledge and skills essential to public health nursing practice. Such an understanding offers a foundation for the development of discipline-specific competencies for public health nursing practice. A literature review is the first step in developing discipline-specific competencies, thus forming the basis for development of a draft set of competencies and competency statements in collaboration with identified committee members (King & Erickson, 2006; OPHA, 2004). Once this list of competencies has been developed, it is then recommended that the list be validated and possibly expanded using a panel of experts external to the initial committee (OPHA, 2004). Feedback on the draft set of competencies for Medical Officers of Health is currently being sought among a panel of experts (B. Moloughney personal communication, Feb 14, 2008). The Quad Council in the United States released a draft set of competencies on the Quad Council members' website in order to obtain feedback. A more structured approach has also been proposed whereby a Delphi method is used (ASPH, 2006; OPHA, 2004).

The Delphi method offers a systematic approach to reaching a consensus on the draft set of competencies, including which competencies are actually included in the list, their wording, and the competency statements. Specifically, the Association of Schools of Public Health (ASPH; 2006) used the modified Delphi method in developing discipline-specific competencies for a Master's degree in public health. The Ohio State University College of Nursing also used a Delphi method to develop consensus regarding public health nursing competencies in the event of a public health surge event related to disaster (Polivka, Stanley, Gordon, Taulbee, Kiefer, & McCorkle, 2008). In each case, the modified Delphi method involved administering three surveys whereby participants (working group members) were asked to examine a draft of each individual competency statement and decide whether or not they accept it, accept it with changes (and list changes suggested), reject it, or consider an alternative (and list alternative; ASPH, 2006; Polivka, et al., 2008). Following this process, the working group would then meet to discuss results, refine the list of competencies, and then repeat the process. During the second Delphi round, a resource group consisting of additional nominees for the working group was invited to participate together with the original working group (ASPH, 2006). This process was repeated for a third time to ensure a consensus was reached for each competency statement. Following this step, the ASPH (2006) sent the completed draft of discipline-specific competencies back to the larger committee for review and feedback. This is equivalent to having members of the CHNAC, Certification Standards & Competency Standing Committee review the first

draft of discipline-specific competencies for public health nursing. Revisions were made based on the input of committee members and revised version 1.0 was then disseminated through a website to members and other stakeholders (ASPH, 2006). This is similar to the approach used by the Quad Council whereby the draft version was posted on the Quad Council member organization website for public comment (King & Erickson, 2006). Subsequent versions (1.1, 1.2…) were developed following necessary revisions before being released and presented to the general public.

Upon completion of the literature review regarding public health nursing practice in Canada and the development of discipline-specific competencies for public health nurses, the following recommendations are proposed:

- Members of the CHNAC, Certification, Standards & Competency Standing Committee establish, or nominate a working group (10 members) including a chair, to move forward with the development of the discipline-specific competencies for public health nursing practice.
- Additional nominated members not willing/able to participate, form part of a resource group responsible for reviewing and providing feedback on a draft set of competencies.
- Committee members define and refine an initial set of competencies and competency statements reflective of the key knowledge and skills outlined in the literature review (competencies will be organized according to the CCHN Standards of Practice [CHNAC, 2003]).
- Key domains (based on the standards of practice) are assigned to pairs of individuals within the working group to further examine the specific competencies and competency statements within that domain.
- Once completed, the list of competencies and their statements are validated through a Delphi process using a panel of experts external to the initial committee (3 rounds)
- During the second and third round of the Delphi method, the resource group participates with the original group to provide additional input.
- Once consensus is reached, the draft version is sent to CHNAC for further review and input (revise as necessary).
- Version 1.0 disseminated via the CHNAC website to members and stakeholders for additional input (revise as necessary)
- The completed report is disseminated to wider public.

Discipline-specific competencies for public health nursing practice are an essential component of effective, quality care and on-going professional development and training. Discipline-specific competencies for public health nurses will provide direction and guidance for curriculum planning and development in undergraduate nursing programs. This contributes to a level of consistency across Canada with respect to new graduates' preparation for public health nursing practice. In addition, within boards of health, public health nursing competencies become a means of quality assurance within the discipline when used to guide the development of orientation programs, continuing in-service education offerings, job descriptions and performance evaluation tools. Discipline-specific competencies and their application in practice therefore assist in contributing to a strengthened, qualified and competent public health nursing workforce and public health system in general.

References

Associations of Schools of Public Health (ASPH). (2006). *Master's Degree in Public Health Core Competency Development Project* (Version 2.3). Washington, DC: Author.

Bateman, N. (2000). *Advocacy skills for health and social care professionals*. Philadelphia, PA: Jessica Kingsley

British Columbia Ministry of Health. (2000). *Orientation Program for Public Health Nurses in British Columbia.* Retrieved Jan 2008 from, http://www.health.gov.bc.ca/library/publications/year/2000/Public_Health_Nursing_Manual.pdf

Canadian Nurses Association (CNA). (2002). *Code of ethics for registered nurses*. Ottawa, ON: Author

Canadian Nurses Association (CNA). (2005). *Community Health Nursing Certification Examination List of competencies.* Ottawa, ON: Author.

Canadian Nurses Association (CNA). (2006). *Summary Chart: Community Health Nursing Certification Exam Development Guidelines*. Ottawa, ON: Author

College of Nurses of Ontario (CNO). (2007). Practice *Guideline: Preparing for an Influenza Pandemic.* Toronto, ON: Author

College of Nurses of Ontario (CNO). (2005). *Practice Standard: Infection Prevention and Control*. Toronto, ON: Author

College of Nurses of Ontario (CNO). (2002). *Professional Standards, Revised 2002*. Retrieved January 2008, from http://www.cno.org/docs/prac/41006_ProfStds.pdf

College of Registered Nurses of British Columbia (CRNBC). (2006). *Scope of Practice for*

Registered Nurses: Standards, limits, conditions. Retrieved Jan 2008 from, http://www.crnbc.ca

College of Registered Nurses of Nova Scotia (CRNNS). (2005). *A Discussion Paper on Scope of Nursing Practice for Registered Nurses in Nova Scotia.* Halifax, NB: Author

Community Health Nurses Association of Canada (CHNAC). (2003). *Canadian Community Health Nursing Standards of Practice*. Ottawa, ON: Author.

Cohen, B.E., & Reutter, L. (2007). Development of the role of public health nurses in addressing child and family poverty: a framework for action. *Journal of Advanced Nursing*, 60(1), 96-107.

Christoffel, K. K. (2000). Public health advocacy: Process and product. *American Journal of Public Health*, 90 (5), 722-723.

Dias, K., & Matthews, M. (unknown). *Immunization Competencies: A learning resource for Ontario Public Health Immunization Providers*. Unpublished document

Dobbelsteyn, J. L. (2006). Nursing in First Nations and Inuit Communities in Atlantic Canada. *The Canadian Nurse*, 102(4), 32-35.

Durham Region Health Department (DRHD). (2004). *Public Health Nursing Competencies.* Unpublished document.

Falk-Rafael, A. (1999). From rhetoric to reality: The changing face of public health nursing in Southern Ontario. *Public Health Nursing*, 16(1), 50-59.

Falk-Rafael, A. (1999b). The politics of health promotion: Influences on public health promoting nursing practice in Ontario, from Nightingale to the Nineties. *Advances in Nursing Science*, 22 (1), 23-29.

Falk-Rafael, A. (2000). Watson's philosophy, science, and theory of human caring as a conceptual

framework for guiding community health nursing practice. *Advances in Nursing Science,* 32 (2), 34-49.

Falk-Rafael, A. (2001). Empowerment as a process of evolving consciousness: a model of empowered caring (Nursing models of care). *Advances in Nursing Science,* 24 (1), 1-16.

Falk-Rafael, A. (2005). Advancing Nursing Theory Through Theory-guided Practice: The emergence of a Critical Caring Perspective. *Advances in Nursing Science,* 28(1), 38-49.

Gebbie, K. (2002). *Competency-to-Curriculum Tool Kit: developing curricula for public health workers*. Discussion draft developed by Competencies and Curriculum Workgroup. Georgia, USA. Retrieved at www.mailman.hs.columbia.edu/CPHP/cdc/Competencies_tool_kit.htm

Hamilton, N., & Bhatti, T. (1996). *Population health promotion: An integrated model of population health and health promotion*. Ottawa, ON: Health Promotion Development Division, Health Canada.

Health Canada. (2001*). Self-Assessment Tool for Community Health Nurses working with First Nations and Inuit Health Branch.* Ottawa, ON: Author.

Johnson, J. L., & Bhagat, R., & Shuster, S., & Ross, S. (2001). Using community development approaches: community health nursing and community development sound like they should be a natural fit, but bringing them together in practice isn't always easy. *The Canadian Nurse,* 97(6), 18-23.

King, M.G., & Erickson, G. P. (2006). Development of Public Health Nursing Competencies: An Oral History. *Public Health Nursing,* 23 (2), 196-201.

Lalonde, M. (1974). *A new perspective on the health of Canadians*. Ottawa, ON: Government of Canada.

Leipert, B., & Reutter, L. I. (1998). Women's Health and Community Health Nursing Practice in

Geographically Isolated Settings: A Canadian Perspective. *Health Care for Women International*, 19(6), 575-588.

Leipert, B. (1999). Women's Health and the Practice of Public Health Nurses in Northern British Columbia. *Public Health Nursing*, 16(4), 280-289.

Lindsey, E., & Stajduhar, K., & McGuinness, L. (2001). Examining the process of community development. Health and Nursing Policy Issues. *Journal of Advanced Nursing*, 33(6), 828-835.

MacDonald, M.B., & Schoenfeld, B.M. (2003). Expanding roles for public health nursing: numerous guidelines have been published in recent years as frameworks for public health, but are the concepts being translated into practice? Are front-line nurses supported as their roles expand? *The Canadian Nurse*, 99(7), 18-25.

Manitoba Health (1998). *The role of the public health nurse within the Regional Health Authority.* Retrieved Jan 2008 from, http://www.gov.mb.ca/health/rha/rolerha.pdf

McMillan, T. (2007). *Public Health Nursing Discipline Specific Competencies: Strategic Planning and Development*. Unpublished document.

Moyer, A. (2007). *Working Documents for Participants of the Ontario Workshop on the CCHN Standards Workshop*. Unpublished document.

Naylor, D. (2003). *Learning's from SARS- Renewal of Public Health in Canada.* National Advisory Committee on SARS and Public Heath, Health Canada.

Oberle, K., & Tenove, S. (2000). Ethical Issues in Public Health Nursing. *Nursing Ethics*, 7(5), 425 438.

Ontario Health Promotion Resource System. (2006). *Online Health Promotion Course*. Retrieved Jan 2008 from, http://www.ohprs.ca/hp101/main.htm

Ontario Public Health Association (OPHA). (2004). *Core Competencies in Public Health: Literature Review.* Ottawa, ON: Author.

Polivka, B., Stanley, S., Gordon, D., Taulbee, K., Kiefer, G., & McCorkle, S. (2008). Public Health Nursing competencies for public health surge events. *Public Health Nursing,* 25(2), 159-165.

Public Health Agency of Canada (PHAC). (2007). *Core Competencies for Public Health in Canada*. Ottawa, ON: Author.

Quad Council of Public Health Nursing Organizations. (2004). *Public Health Nursing Competencies*. Public Health Nursing, 21(5), 443-452.

Registered Nurses Association of Ontario (RNAO). (2005). *Revitalizing Ontario's Public Health Capacity: A Nursing Response; Submission to the Capacity Review Committee. Community Health Nurses' Interest Group/Registered Nurses Association of Ontario*. Retrieved Jan 14, 2008 from, http://chnig.org/downloads/CHNIG_RNAO_CRC_response_final.doc

Registered Nurses Association of Ontario (RNAO). (2008). *Policy Statement: Vision for Nursing in Public Health.* Retrieved Jan 14, 2008 from http://www.rnao.org/Storage/12/710_Policy_Statement_Nursing_Public_health.pdf

Reutter, L. I., & Ford, J. S. (1996). *Perceptions of public health nursing*: Views from the field. In J. Simpson (2005). Action on Recommendations for Core Competencies for Public Health Nurses. The Community Health Association of Canada (CHNAC) in Collaboration with the Canadian Nurses Association. Unpublished document

Reutter, L. I., & Ford, J. S. (1998). Perceptions of changes in public health nursing practice: a Canadian perspective. *International Journal of Nursing Studies*, 35 (1998), 85-94.

Reutter, L. I. (2000). *Socioeconomic determinants of health. In M. J. Stewart (ed.), Community nursing: Promoting Canadians' Health* (2nd Ed), 174-193). Toronto, ON: Harcourt Canada.

Reutter, L. I., & Williamson, D.L. (2000). Advocating Healthy Public Policy: Implications for Baccalaureate Nursing Education. *Journal of Nursing Education*, 39(1). 21-26.

Reutter, L. I., & Duncan, S. (2002). Preparing Nurses to Promote Health-enhancing Public Policies. *Policy, Politics & Nursing Practice,* 3, 294-305.

Schoenfeld, B. M., & MacDonald, M. B. (2002). Saskatchewan Public Health Nursing Survey. *Canadian Journal of Public Health,* 93(6), 452-456.

Schroeder, C., & Gadow, S. (2000). *An Advocacy approach to ethics and community health.* In A. Falk-Rafael. (2005). Advancing Nursing Theory Through Theory-guided Practice: The emergence of a Critical Caring Perspective, 20(26), 38-49.

Simpson, J. (2007). *For Discussion, Competencies and Standards: In a Public Health context, what is the difference?* The Community Health Nurses Association of Canada (CHNAC). Unpublished document

Simpson, J. (2005). *Action on Recommendations for Core Competencies for Public Health Nurses.* The Community Health Nurses Association of Canada (CHNAC) in Collaboration with the Canadian Nurses Association. Unpublished document.

Smith, D., & Davies, B. (2006). Creating a New Dynamic in Aboriginal Health. *The Canadian Nurse,* 102(4), 36-39.

Stanhope, M., & Lancaster, J. (2008). *Community Health Nursing in Canada* (1st Ed). Toronto, ON: Mosby.

Stanley, S.A., Polivka, B.J., Gordon, D., Taulbee, K., Kieffer, G., & McCorkle, S.M. (2008). The Explore Surge Trail Guide and Hiking Workshop: Discipline-specific Education for Public Health Nurses. *Public Health Nursing,* 25 (2), 166-175.

The Health Communication Unit (THCU). *Developing Health Promotion Policies*. Retrieved Jan 14,

2008 from, http://www.thcu.ca/infoandresources/publications/policyworkbook.march04.v1.0.pdf

Thunder Bay District Health Unit. (2008*). Draft Position Description: Public Health Nurse.* Unpublished document.

TGS Consultants (2005). *Review of the Canadian Community Health Nursing Standards of Practice and Resulting Implications for Implementation in British Columbia*. Vancouver, BC: Public Health Nursing Leaders Council of British Columbia.

Toth, A., Fackelmann, J., Pigott, W., & Tolomeo, O. (2004). Tuberculosis prevention and treatment: Occupational Health, infection control, public health, general duty staff, visiting parish nursing or working in a physician's office---all nursing roles are key in improving tuberculosis control. *The Canadian Nurse*, 100(9), 27-42.

Upshur, R.E. G. (2002). Principles for the justification of public health intervention. Canadian *Journal of Public Health*, 93(2), 101-103.

VanHofwegen, L., & Kirkham, S. (2005). The Strength of Rural Nursing: Implications for Undergraduate Nursing Education. *International Journal of Education Scholarship*, 2(1), 1-27.

Watson, J. (1988). Nursing: Human Science and Human Care. A Theory of Nursing. In A. Falk Rafael. (2005). Advancing Nursing Theory Through Theory-guided Practice: The emergence of a Critical Caring Perspective. *Advances in Nursing Science*, 20(26), 38-49.

World Health Organization (WHO). (1978). *Alma-Ata 1978: Report of the International conference on primary health care.* Geneva, Switzerland: Author.

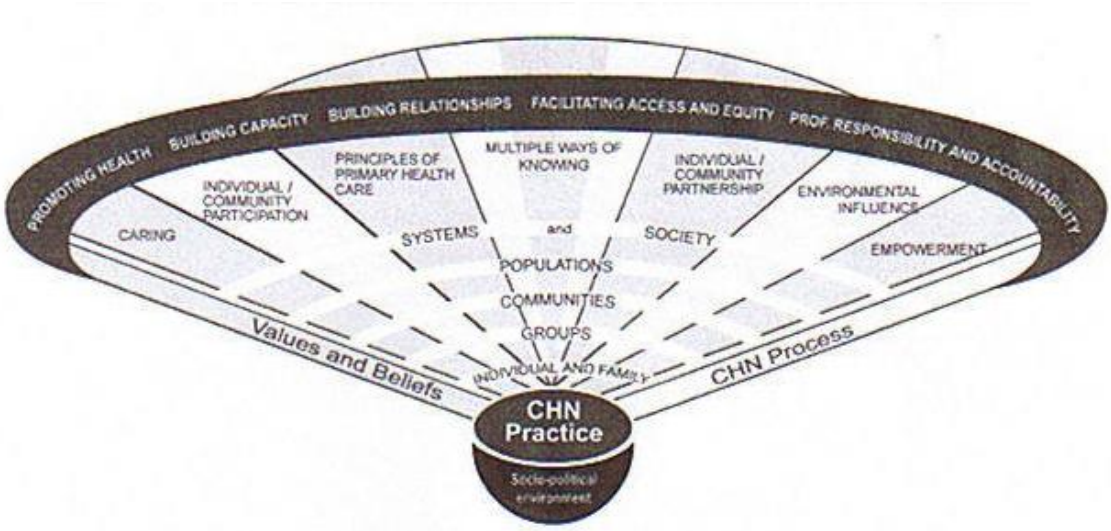
World Health Organization (WHO). (1986). *The Ottawa Charter for Health Promotion*. Geneva, Switzerland: Author

World Health Organization (WHO). (1998). *Health promotion glossary*. Geneva, Switzerland:

Author.

Canadian Community Health Nursing Practice Model

Figure 1: Image of the Canadian Community Health Nursing Practice Model.



Appendix A

Public Health Nursing in Canada: Key Knowledge and Skills

Overview

The following table presents a detailed summary of key knowledge and skills specific to public health nursing practice in Canada as of March 2008 as outlined in the report, *Public Health Nursing Practice in Canada: A Review of the Literature*. The knowledge and skills have been organized according to the Canadian Community Health Nursing Standards of Practice (CHNAC, 2003) and will serve to guide and inform the development of discipline-specific competencies for Public Health Nursing Practice in Canada.

Nursing Process

Key Knowledge and Skills
Familiar with the nursing process when applied to individuals, families, groups, communities and populations
Familiar with population-based approach
Effectively applies the nursing process in practice
Demonstrates appropriate clinical decision making
Demonstrates appropriate nursing judgment
Utilizes current evidence to guide and inform practice
Familiar with nursing and public health sciences
Familiar with principles of epidemiology
Familiar with factors impacting health (social determinants of health)
Familiar with relationship between environment and health
Familiar with the community and community resources
Familiar with individual-family-community interrelationships
Able to work at the individual/family level while considering the larger effects on the community/population
Applies appropriate tools and theory when assessing, planning, implementing and evaluating
Familiar with individual/family assessment tools and developmental theory
Familiar with community health assessments
Familiar with population health assessments
Familiar with health status indicators (i.e., incidence prevalence, life expectancy, morbidity, mortality, etc)
Familiar with the use of various data collection methods (informant interviews, focus groups, participant observation, windshield surveys, secondary analyses [statistical data, health surveys, etc], surveys)
Efficiently organizes data collected
Identifies and analyses communities strengths and concerns based on collected data
Assists community in identifying strategies to break the health concern cycle or ways to effect change
Familiar with and applies change theory appropriate to the individual, family, or community level
Assists the community in developing a plan to implement change taking into account evidence, legislation, regulations, policies, as well as cultural beliefs, values and practices of the

community
Utilizes various tools/frameworks to assist in the planning and implementation phase (PRECEDE-PROCEED framework, Policy Road Map, etc)
Able to appraise the effects of the activity or program implemented
Familiar with the different types of evaluation (formative and summative)
Able to critically analyze program implementation
Able to identify changes required
Able to identify appropriate outcome measures
Utilizes appropriate tools to measure outcomes
Participates in evaluation design and implementation
Considers ethical issues in evaluating
Understands the conditions that facilitate evaluation (SMART goals and objectives, evaluation is a key component of the early stages of program development, adequate resources, willingness of staff and care partners to participate, timing, and outcome measures)

Key Skills (clinical decision-making, nursing judgment, evidence-based practice, change theory utilization, developmental theory utilization, assessments [individual/family, community, or population], data collection, data organization, data analysis, planning, implementation, evaluation)

*the knowledge and skills required to effectively engage in the nursing process are applicable throughout each of the community health nursing standards of practice

Promoting Health: Health Promotion

Key Knowledge and Skills
Familiar with the determinants of health** (i.e., child and family poverty; key articles include the Lalonde Report, Ottawa Charter, Jakarta Declaration on Health Promotion into the 21st Century)
Familiar with public health sciences (behavioral, social, environmental)
Familiar with the relationship between environment and health
Familiar with the population health approach**
Familiar with and applies the Population Health Promotion Model
Familiar with and applies the 5 key Strategies for promoting health (Building Healthy Public Policy, Strengthening Community Action, Creating Supportive Environments, Developing Personal Skills, Reorienting Health Services)
Building Healthy Public Policy
Familiar with policy formulation process
Familiar with policy making environment
Familiar with legislation process
Familiar with negotiated nature of policy making
Assesses impact of policies on determinants of health
Aware of how to propose and advocate for feasible policy options
Familiar with examples of policy advocacy engaged by nurses
Familiar with policy development tools (Policy Road Map, Milio's Framework)
Able to assess entry point into policy making process

Connects policy makers
Develops policy relevant information
Facilitate community groups through policy making process
Use tools to guide process
Assist in creating or advocating for healthy public policy
Increases publics awareness of the determinants of health

Creating Supportive Environments
Familiar with link between environment and health (social [culture, community], spiritual, physical environments)
Assess factors affecting health in the communities social, spiritual, physical environment
Directly acts on factors affecting health in the communities social, spiritual, physical environment
Increases publics awareness of the environmental factors impacting health

Reorienting Health Services
Provides consultation with decision-makers
Promotes responsible and effective use of the health care system and community resources
Aware of community resources and services
Refers individuals, families, and communities to the appropriate community resources/services
Engages other sectors in addressing determinants of health and the impact of existing services, or lack of services on these
Collaborates with other sectors in addressing determinants of health and the impact of existing services, or lack of services on these

Strengthening Community Action
Encourages community involvement to identify issues, plan and set priorities
Mobilizes individuals, families, groups, communities to take individual and collective action on the determinants of health
Develops and supports community-based and self-care services to which community members have ownership and an active role

Developing Personal Skills
Provides information, education for health and enhancing life skills
Promotes client involvement in healthcare decisions
Applies behavioral change theory (Health Belief Model)
Applies principles of adult teaching/learning theory
Completes an assessment using appropriate tool
Develops a plan in collaboration with care partner
Utilizes research, evidence and a framework when developing plan
Uses principles of adult learning

Key Skills (conflict management, policy analysis, research utilization, networking, negotiation/mediation, collaboration, counseling, social marketing, advocacy- policy advocacy, facilitation, health teaching, adult learning, anticipatory guidance, team building, audience analyses, social marketing, developing mass communication, health and media campaigns, developing risk communication campaigns)

Promoting Health: Prevention and Health Protection

Key Knowledge and Skills

Applies principles of epidemiology
Familiar with demography
Familiar with levels of prevention (primary, secondary, tertiary)

Family and Reproductive Health
Familiar with health needs of child bearing family (prenatal period, postpartum period, parenting stage)
Familiar with risk factors (social, economic, biological, behavioral, environmental) that are associated with or cause increased susceptibility to a disease or health problem
Able to engage in:

- reproductive education
- anticipatory guidance
- counseling
- provision of supplies
- preconceptual and prenatal education and support
- antenatal monitoring and support for high risk pregnancies
- parenting education and support for families
- education of infant growth and development
- health counseling and support for families
- education regarding child abuse
- support to family resource centers
- pregnancy counseling
- outreach
- advocacy
- support and referral for individuals and families at high-risk

Develops resources to support families
Well developed telephone assessment skills (due to reduction in home-visits)
Includes social determinants of health in individual and family assessments**
Able to provide support for breastfeeding
(In northern communities: familiar with factors contributing to violence against women, familiar with harm reductions principles for dealing with addictions, familiar with sexual decision making among female adolescents, the special needs of single mothers, breast cancer attitudes, and reproductive and menopause issues)
Participates in the evaluation of regional programs to address family and reproductive health

Sexual health issues
Monitors sexual health trends
Uses evidence to inform the development of sexual health programs in the community
Able to educate, counsel, advocate, and refer individuals, families and at-risk groups regarding relationships, communication, sexual decision-making and behavior, sexual orientation, personal safety, and sexually transmitted infections
Familiar with available sexual health resources in the community

Familiar with contraceptive devices/options
Able to identify at-risk populations
Aware of prevalent sexually transmitted infections
Participates in the evaluation of regional programs to address sexual health

Mental Health Services
Aware of mental health services in the community so that he/she is able to provide support
Able to provide information to care partners regarding mental health concerns
Provides counsel and resources related to life-transitions, self-esteem, assertiveness, decision-making, communication, stress management, counsel for depression and suicide risk, counsel and/or refer for weight preoccupation, obesity, body image and eating disorders
Understands and is able to recognize a psycho-social emergency and its broader impact within the community
Participates in the evaluation of regional programs to address mental health concerns

Chronic illnesses
Able to identify risk factors for chronic illness
Familiar and able to monitor and observe for patterns and distributions of health in the community
Uses knowledge and understanding to inform prevention efforts including screening and program planning
Able to educate, counsel, refer and support individuals, families and groups in making healthy lifestyle choices
Understands and applies behavioral change theory
Participate in the development of programs to address chronic illness in the community
Participates in the evaluation of regional programs to address chronic illnesses

Communicable diseases
Familiar with the terms pandemic, epidemic and endemic
Familiar with the organizations policies and the College's related standards and guidelines (i.e., *Infection Prevention and Control, Preparing for an Influenza Pandemic, and Influenza Vaccinations)*
Able to apply the standards and guidelines in practice
Applies principles of epidemiology in using strategies such as surveillance to identify reportable and non-reportable communicable diseases
Familiar with and utilizes surveillance skills to monitor and forecast health trends
Familiar with the use of incidence and prevalence in monitoring communicable disease trends
Able to implement communicable disease programs such as education, awareness and immunization programs
Able to give immunizations
Educates the community in order to maximize community awareness and participation in controlling an outbreak and preventing future outbreaks
Familiar with the principles of immunization, types of immunity, modes of transmission, infection control practices
Able to educate care partners on the benefits of immunity
Knowledgeable of TB including signs and symptoms, risk factors for TB, risk settings, and common treatments

Advocates for the prompt diagnosis and isolation of suspected and confirmed cases of TB by consulting with physicians, local public health officials for guidance and ensuring that all suspected TB cases are placed in isolation
Participates in the evaluation of regional programs to address communicable diseases
Participates in and conducts research around the control of communicable diseases

Injuries and Substance Abuse
Able to identify risk factors for injury in the community
Able to mobilize community action groups to reduce hazards in the community
Able to advocate for healthy public policy to reduce hazards in the community
Provides safety education to the community
Able to analyze injury statistics
Advocates for the development of programs and policies that support safer healthier environments in order to reduce or eliminate injuries or hazards in the environment
Familiar with principles of harm reduction
Facilitates coalition building to address injury prevention concerns and substance abuse
Familiar with injury prevention programs/services in the community related to falls prevention, car seat safety, road safety, water safety, prevention of alcohol and substance abuse, smoking prevention and cessation and home safety
Participates in the development of prevention efforts alongside community partners
Participates in the evaluation of regional programs to address injuries and substance abuse in the community
Participates in and conducts research around the control of injuries and hazards in the community

Emergency Preparedness
Able to develop and implement emergency response plans
Familiar with the organizations emergency preparedness plan
Familiar with the various roles in disaster preparedness
Familiar with communication equipment available that is suitable for emergency situations (i.e., if power lines are down)
Able to conduct a rapid needs assessment
Able to conduct an outbreak investigation and surveillance
Able to conduct public health triage
Able to develop risk communication campaigns
Able to participate in the debriefing process
Able to contribute to emergency plan modifications
Able to recognize the potential impact of community disasters, including identifying factors leading up to or contributing to an emergency or disaster
Able to coordinate and provide crisis intervention and trauma post-intervention services, and provide immediate post-disaster emotional support for individuals, families, groups and communities
Able to participate in research and evaluation regarding emergency health and emergency preparedness plans

Key Skills (health teaching, anticipatory guidance, counseling, outreach, advocacy, surveillance, screening, research utilization, facilitation, conducting research, mobilizing community, analysis of data, coalition building, team building, crisis intervention, collaboration)

Building Individual/Community Capacity

Key Knowledge and Skills
Actively involves individuals, groups, organizations, communities in all phases of planned change Involves care partners in assessment, through to evaluation Able to conduct community assessments alongside community members Able to identify key stakeholders within a community Able to engage key stakeholders and work collaboratively with them Familiar with Principles of Primary Health Care Familiar with empowerment strategies (mutual goal setting, visioning, facilitation) Familiar with personal and political advocacy as a capacity building tool Familiar with advocacy strategies for building capacity (mediating with other health care professionals, using political power and connections as members of a profession and employees in a health agency to cut through red tape, linking clients with resources available to them in the community) Advocates on behalf of those who are as yet unable to advocate for themselves Able to identify vulnerable groups in the community Supports care partners in developing skills for self-advocacy Educates community about how to use the political process to improve their health Acts as a catalyst with community care partners to help them resolve their issues and concerns Familiar with principles of community development Recognizes importance of meeting care partners in their own physical space (outreach) Understands care partners beliefs, values and health related practices Understands cultural norms and practices Awareness of diversity issues Able to provide culturally relevant care Familiar with change theory and change theory utilization (at the individual, interpersonal, and community level) Familiar with knowledge transfer Able to share knowledge, tools, expertise and experience Utilizes a participatory model of knowledge transfer Familiar with leadership theory Aware of own leadership style and how this might influence practice ***Key Skills*** (adult learning, anticipatory guidance, conflict management, consensus decision making, facilitation, leadership, negotiation/mediation, networking, collaboration, mutual goal setting, visioning, political advocacy, personal advocacy, education, community development, outreach, cultural sensitivity, knowledge transfer)

Building Relationships

Key Knowledge and Skills
Demonstrates actions and attitudes consistent of caring (respect, trust, empathy, non-judgmental attitudes, cultural competence, authenticity, honesty)

Awareness of human behavior and factors that can influence health related behavior (individual/community cultural beliefs, values, feelings, attitudes about health)
Demonstrates actions and attitudes that are characterized by mutuality (maintains care partners needs at center of care)
Trusts in the ability of the individual/family/communities ability to identify own needs and establish health goals
Effectively communicates with care partner(s)
Utilizes culturally relevant communication (verbal, non-verbal, written, pictorial, group facilitation, electronic means)
Recognizes strategies to build relationships with communities
Familiar with process used to develop health communication campaigns, social marketing, web-based learning modules
Familiar with community resources
Able to identify key stakeholders/partners within the community
Able to build partnerships with other practitioners and disciplines, community agencies and organizations, faith communities, volunteers, other health sectors
Familiar with multidisciplinary collaboration and team work
Familiar with professional boundaries
Maintains professional boundaries

Key Skills (cultural sensitivity, mutual goal setting, interpersonal communication, health communication, collaboration, multidisciplinary collaboration, networking, facilitation, team building, negotiation/mediation, delegation, conflict resolution)

Facilitating Access and Equity

Key Knowledge and Skills
Familiar with Principles of Primary Health Care Works collaboratively to identify and facilitate universal and equitable access to available services Able to identify inequities in health and health resources Able to assess and understand a communities capacity including strengths, weaknesses, power structure, community resources and values and beliefs Familiar with cultural norms and how they may influence health seeking behaviors and use of community resources/services Familiar with the impact of the determinants of health on access to resources and services Implements strategies to facilitate equitable access to health related resources/services Familiar with resources available that could reduce/alleviate the impact of determinants of health on health (emphasis on poverty) Assists individuals in accessing available resources (referrals, advocacy) Assists individuals in developing skills for self-advocacy Advocates on behalf of care partners for much needed resources/services Advocates for changes to policies that may impede equitable access to resources necessary for health ***Key Skills*** (outreach, collaboration, community assessments, cultural sensitivity, referrals, advocacy)

Demonstrating Professional Responsibility and Accountability

Key Knowledge and Skills
Familiar with regulations, standards and legislation specific to public health nursing practice Familiar with the Canadian Community Health Nursing Standards of Practice (CHNAC, 2003) Familiar with the Core Competencies for Public Health in Canada (PHAC, 2007) Practices in accordance with regulations and standards Uses standards to promote health and prevent adverse health outcomes Ensures that knowledge and practice are based on current evidence Familiar with actual and potential ethical dilemmas Familiar with the CNA Code of Ethics for Registered Nurses (CNA, 2002) Familiar with public health ethics Familiar with advocacy ethics Applies ethical principles in practice Able to identify unethical situations Able to identify situations that may place self or others at risk Acts appropriately to address unethical or unsafe situations to self or care partners (reports to the appropriate authorities) Able to evaluate actions taken to resolve unsafe or unethical situations Recognizes when further assistance and knowledge is necessary Able to identify knowledge gaps Continually assesses level of competence Engages in professional development activities to maintain competence Engages in reflective practice, self-assessments, learning plans, peer feedback activities Advocates for quality improvements in the workplace Demonstrates knowledge of and respect for other disciplines within public health (understands the role of an epidemiologist, health promotion officer, medical officer of health, health inspector, etc) Familiar with the mission and priorities of the public health organization in which he/she works Contributes to team and organizational learning to advance public health goals, maintain organizational performance standards, and to contribute to developing key values and a shared vision in planning and implementing public health programs and policies Engages in activities to advance the practice of public health nurses (participates in nursing organizations or interest groups, mentoring students or novice public health nurses, role modeling positive collegial relationships, possessing a clear understanding of their role and promoting their role to others*) Effectively communicates the role of a public health nurse to the public Uses current technology to communicate effectively ***Key Skills*** (key skills are not identified when examining professional responsibility and accountability as this standard reflects a level of performance and actions, and attitudes expected of public health nurses to maintain professional, competent care and therefore cannot be defined by a set of skills alone)