Community Health Nurses of Canada

Implementing Home Health Nursing Competencies: Strategies that will get results!

May 2011

Developed for the Community Health Nurses of Canada
Innovative Solutions Health Plus
www.innovativesolutions.ca

Objectives

Integrate / make live the HH Competencies within your own practice, and at your organization

- ↑familiarity with the home health nursing
- Sharing of current practices r/t integration
- Sharing strategies for effective implementation, uptake and measurement
- Sharing tools / strategies for developing leaders and action teams
  - A slide deck for oral presentations
  - Handouts

Agenda

1300-1330	**Welcome and Introductions** – Review of objectives and agenda
1330-1415	**About the HH Competencies** (ppt presentation)
1415-1430	**Question Period**
1430-1445	**Break**
1445-1530	**Small Group Work #1** How are the Competencies already living?
1530-1615	**Small Group Work #2** Implementation / Strengthening
1615-1645	**Reporting Back**
1645-1700	**Wrap up and Next Steps** Commitment to continue

Presentation Objectives

- ↑understanding of the term “competency”
  - The relationship between competency and professional nursing practice
- ↑ awareness / understanding of the benefits of integrating the competencies:
  - At individual and organizational levels
- Review domains of the competencies
- ↑ understanding of the relationship between the competencies and their practice

What has been done?

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Before we start …

- **Lets introduce ourselves**
  - What is your knowledge of the competencies?
  - Have work have you / your organization done to integrate the competencies?
  - What do you hope is different about where you are right now at the end of this session

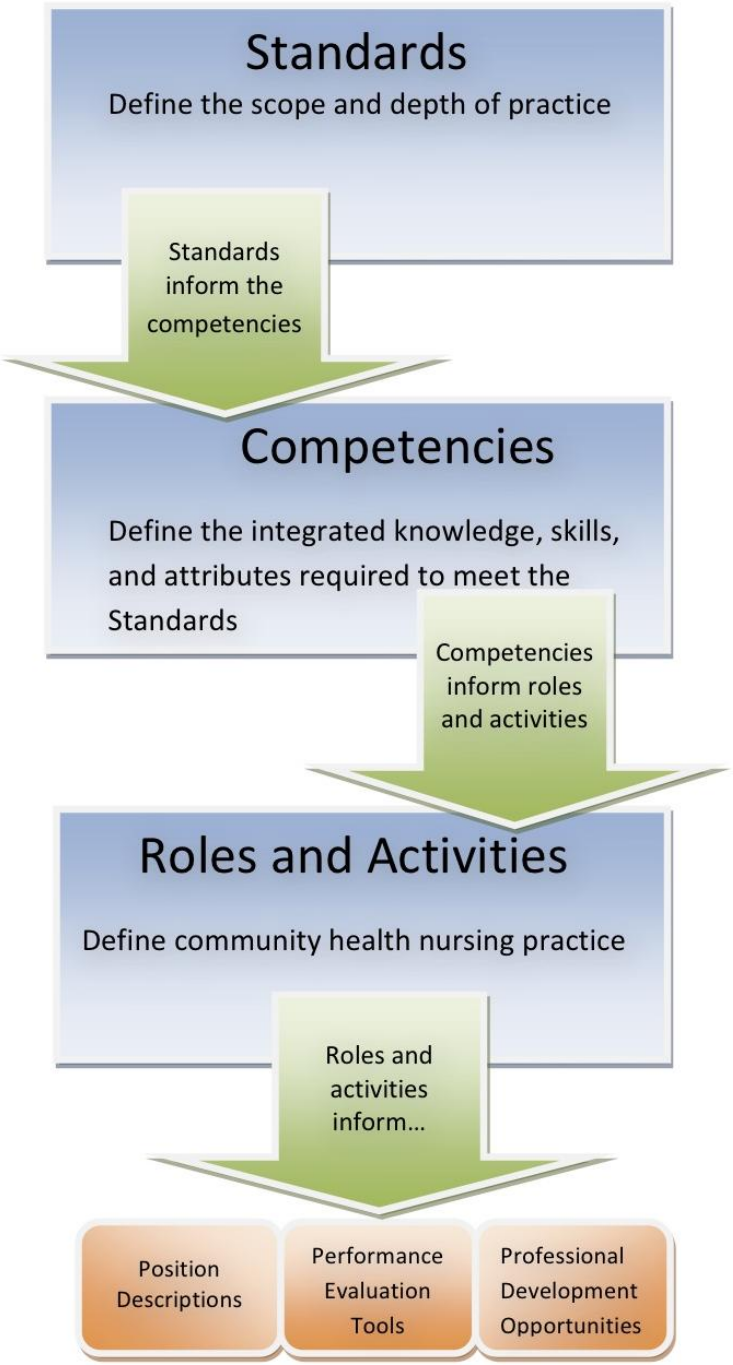
Standards & Competencies

Standards:

Standards define the scope and depth of practice by establishing criteria for acceptable nursing practice. (Adapted from CNA and CHNC Standards of Practice)

Competencies:

Competencies define the integrated knowledge, skills, and attributes of the practitioner required to achieve the standards and inform the roles and activities of individual practitioners and organizations.


Standards
Define the scope and depth of practice
Standards inform the competencies
Competencies
Define the integrated knowledge, skills, and attributes required to meet the Standards
Competencies inform roles and activities
Roles and Activities
Define community health nursing practice
Roles and activities inform…
Position Descriptions
Performance Evaluation Tools
Professional Development Opportunities

What are Competencies?

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Competencies…

- Describe the skills, attributes and knowledge required to perform specific activities required to practice safely and ethically
- Are broad in scope and apply in multiple settings
- Can be used to develop position descriptions and performance appraisal tools

Integrating Competencies at the Individual Level

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Benefits …

- Provide a solid foundation for job descriptions and interview questions
- Support the development and implementation of performance evaluation tools
- Link a practitioner's role to the mission of the organization
- Help practitioners plan and manage their career paths
- Allow both managers and employees to identify gaps
- Identify staff development and training needs

Integrating Competencies at the Organizational Level?

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Benefits ...

- Can be used to identify the appropriate number and mix of practitioners in a given setting
- Support the development and implementation of frameworks for evaluation and quality assurance
- Provide rationale for securing funds to support workforce development
- Improve organizational performance

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“Home health nurses are committed to the provision of accessible, responsive and timely care which allows people to stay in their homes with safety and dignity.”

Home Health Nursing Competencies

- **78 home health nursing discipline specific competencies**
  - **Organized into 12 domains**
  - **A framework organizes these into three broad categories**

They follow ….

1. Elements of Home Health Nursing

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These elements and associated competencies focus on the nursing activities, functions, goals and outcomes that are central to home health nursing

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Assessment, Monitoring and Clinical Decision Making

Assessment, Monitoring and Clinical Decision Making

- conduct comprehensive health assessments
- critical thinking creative problem-solving
- analyze
- collaborate
- incorporate knowledge
- keep knowledge current and use evidence
- assess safety

1a. Assessment, Monitoring and Clinical Decision Making

Competency 1 a) vi

The home health nurse is able to keep knowledge current and use evidence to inform practice to ensure optimal case management

Practice Example:

Evidence from a recent research study resulted in the need to change current practice guidelines related to wound care.

Care Planning and Care Coordination

Care Planning and Care Coordination

- plan and prioritize visits
- use the nursing process to develop care plans
- support clients and families to build on their strengths
- anticipate the need for alternative ways of providing services
- ensure discharge planning is integrated within the care plan
- optimize collaborative approach to care planning
- understand the roles and responsibilities of other regulated and unregulated health workers involved in the client care plan
- facilitate and coordinate access to the multidisciplinary team
- evaluate care plan interventions

1b. Care Planning and Care Coordination

Competency 1 b) vii

Appreciate and understand the roles and responsibilities and the contributions of other regulated and unregulated health workers involved in the client care plan

Practice Example:

The home health nurse initiated the use of a “communication book" in the client’s home to support communication between client, family and support workers.

Health Maintenance, Restoration & Palliation

Health Maintenance, Restoration & Palliation

- use mix of strategies to maintain and/or restore health
- educate clients in the safe use of equipment, technology and treatments
- communicate effectively with clients and families
- use basic and advanced nursing skills
- recognize limits of the scope of nursing
- revise interventions and therapies as needed
- self-identify the need for assistance

1.c. Health Maintenance, Restoration & Palliation

Competency 1 c) i

Assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum

Practice Example:

The home health nurse encouraged family members of individuals with chronic illness to take care of their own health by participating in regular physical activity and social interactions.

Teaching and Education

Teaching and Education

- assess the knowledge, values, and skills of the client/family
- create an education plan to support client/family learning
- teach
- apply theory and evidence to teaching
- evaluate the effectiveness of health education

1.d.Teaching and Education

Competency 1 d). v.

Include family, volunteers and caregivers in teaching and education

Practice Example:

The home health nurse purposely schedules the home visit to coincide at a time when a family member will be present

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Communication

Communication

- use effective listening, verbal and non-verbal communication skills
- use effective interviewing skills and strategies
- use effective communication skills
- use strategies to overcome language and communication barriers
- manage multiple distractions within the home
- employ negotiation and conflict management skills
- use techniques that are client-centered, client-driven, and strength-based
- use documentation as an effective communication tool
- use technology to augment communication

1.e) Communication

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Competency 1 e) iv

Identify and use strategies to overcome language and communication barriers

Practice Example:

The home health nurse arranged for an interpreter to come on the home visit to a newly diagnosed diabetic client who only spoke Korean

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Relationships

Relationships

- establish and maintain a therapeutic nurse-client
- relationship based on mutual trust, respect, caring, and listening
- acknowledge the contribution that the family/caregiver
- work effectively / non-judgmentally in any environment
- Build and sustain partnerships
- involve clients and families as active partners

1. f) Relationships

Competency 1 f) iv

Use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships

Practice Example:

The home health nurse used her negotiation skills to facilitate a discussion between two co-workers who had different approaches to working with the same client.

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Access and Equity

Access and Equity

- advocate for healthy public policies and accessible, inclusive and integrated services
- apply culturally-relevant and appropriate approaches
- recognize opportunities to promote social justice
- optimize allocation of resources
- advocate for the reduction of inequities in health

1.g. Access and Equity

Competency 1 g) iii

Recognize opportunities to promote social justice and advocate in collaboration with, and on behalf of clients and families on related issues to give voice to the vulnerable

Practice Example:

The HHN worked with her supervisor to obtain additional resources for an elderly client who was not managing well.

Building Capacity

Building Capacity

- mobilize clients, families and others to take action
- assist the client / family to recognize their capacity
- support and build on client capacities
- cultural competency
- be flexible and responsive to the changing health needs of the client and family

1.h. Building Capacity

Competency 1 h) i

Mobilize clients, families and others to take action to address health needs, deficits and gaps accessing and using available resources

Practice Example:

The home health nurse worked with the client and their family to identify the community resources available to them.

2. Foundations of Home Health Nursing

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These competencies focus on the core knowledge and primary health care philosophy that is central to home health nursing practice.

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Health Promotion

2.a. Health Promotion

Competency 2 a) iv

Assesses the readiness and capacity of the client and family to make changes to promote health

Practice Example:

The home health nurse worked with the client and their family to develop a plan to create a non smoking environment.

Illness Prevention & Health Protection

2.b. Illness Prevention & Health Protection

Competency 2 b) iii

Support clients and families to identify risks to health and make informed choices about protective and preventive health measures

Practice Example:

The home health nurse reviewed the risks and benefits of seasonal influenza immunization and encouraged the client and family to participate in the discussion.

3. Quality and Professional Responsibility

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These competencies focus on practice activities and / or strategies by which the home health nurse promotes quality of care and demonstrated professional responsibility.

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Quality Care

Quality Care

- initiate, lead and participate in risk management and quality improvement
- initiate and participate in critical incident reviews
- evaluate nursing interventions
- evaluate programs
- contribute to the quality of work environments
- understand the financial aspects of care

3.a. Quality Care

Competency 3 a) i

Contribute to the quality of work environments by identifying needs, issues, solutions and actively participating in team and organizational quality improvement processes

Practice Example:

The home health nurse participated as an active member of the nursing practice council.

Professional Responsibility

Professional Responsibility

- demonstrate professionalism, leadership, judgment and accountability
- practice independently and autonomously
- use reflective practice
- integrate multiple ways of knowing
- contribute to the development and generation of evidence-informed nursing practice
- pursue lifelong learning opportunities
- use nursing ethics, ethical standards and principles and self-awareness to
- describe the mission, values and priorities of the health organization
- mentor students and new practitioners
- be self aware

Professional Responsibility

Competency 3 b) vii

Use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies

Practice Example:

The home health nurse reported a suspected case of elder abuse to the authorities after learning that a client's nephew was intimidating her and forced her to involuntarily sign over her cheques to him

In summary

Discipline specific competencies define the integrated knowledge, skills, and attributes required to practice as a home health nurse in Canada.

Elements of Home Health Nursing

Foundations of Home Health Nursing

Quality and Professional Responsibility

A copy of the discipline specific competencies for Home Health nurses can be found on the CHNC website at: http://www.chnc.ca/nursing-publications.cfm

Exploring the Competencies

- Divide into 3 groups
  - in a few minutes

First Discussion Focus

40 Minutes

- Review and explore the section
- Share examples of how they already live in your practice
  - What are examples from your own practice
  - What are examples from your organization

Second Focused Discussion

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40 Minutes

- How can they be strengthened
  - Individual level
  - Organizational level
- What are the barriers / facilitators to the implementation of the competencies?
- What would key steps be to implementing the standards from your perspective?
- How would you go about measuring the outcomes of the measurement?

Reporting Back

Each group to bring back one key finding:

- What would strengthening implementation of competencies?
- What is one barrier / enabler to implementation?
- What would key steps be to implementing the competencies from your perspective?
- How would you go about measuring the outcomes of the implementation?
- What do you need to get started?

Wrap up

- PPT presentation will be posted to the CHNC web site
  - Paper being passed around to collect email addresses to inform participants when this will happen
- Proceedings from this session will also be posted
- What would help you as you go back to your organizations with an eye on implementing

Sources of information:

- Community Health Nurses of Canada (2010). Home Health Nursing Competencies Version 1.0. Retrieved from http://www.chnc.ca/nursing-publications.cfm
- Canadian Nurses Association. (n.d.). Standards and best practices. retrieved fromhttp://www.cna-aiic.ca/CNA/practice/standards/default_e.aspx
- Community Health Nurses of Canada. (2008). Canadian community health nursing standards of practice. Available from www.chnc.ca
- Ontario Public Health Association. Core Competencies for Public Health in Canada – Orientation Module . Retrieved February 19, 2011 from www.corecompetencies.ca
- Public Health Agency of Canada (2008). Core Competencies for Public Health in Canada: Release 1.0. Retrieved Feb 18, 2011 from http://www.phac-aspc.gc.ca/ccph-cesp/stmts-enon-eng.php

Assessment, Monitoring and Clinical Decision Making

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- conduct comprehensive health assessments to determine the health status,
- functional and psychosocial need and competence of clients and their families within the context of their environment and social supports
- apply critical thinking skills and creative problem-solving analysis
- analyze information to determine appropriate nursing actions, implications, applications, gaps and limitations
- collaborate with health care team members and others who are involved with the client, to determine appropriateness and availability of required services
- incorporate a combination of basic and advanced knowledge of health and nursing across the lifespan and the health-illness continuum
- keep knowledge current and use evidence to inform practice to ensure optimal case management
- assess the safety of the home environment with the goal of optimizing client safety and taking actions to support a safe work environment for all members of the home health care team

Care Planning and Care Coordination

- plan and prioritize visits to meet the health and scheduling needs of clients
- use the nursing process to collaboratively develop, coordinate and implement mutually agreed upon care plans, negotiating priorities in care with clear treatment and outcome goals and supporting client navigation and transition through the continuum of care
- support clients and families to build on their strengths to attain or maintain a desired health status within available resources
- anticipate the need for alternative ways of providing services and use creative problem solving skills to overcome obstacles in delivery of client care i.e. weather, lack of resources etc.
- ensure discharge planning is integrated within the care plan and occurs in collaboration with the client, family, health care team and community
- promote an integrated assessment and develop a unified care and treatment plan that is collaboratively carried out by team members to maximize continuity of care within a client-centered approach
- appreciate and understand the roles and responsibilities and the contributions of other regulated and unregulated health workers involved in the client care plan
- facilitate and coordinate access to other members of the multidisciplinary team such as primary care providers, specialist physician, community pharmacist, nurses, and other allied health professionals to address a specific health issue
- collaboratively evaluate care plan interventions through reassessment and ongoing evaluation of results and adapt them to the changing conditions of the client and the client's family

Health Maintenance, Restoration & Palliation

- assist clients and families to maintain and/or restore health by using a comprehensive mix of strategies to address their health needs across the life span and illness continuum
- understand and/or educate clients, their families/caregivers and colleagues in the safe and appropriate use and maintenance of various types of equipment, technology and treatments to maintain health and assist clients and families to integrate them into their everyday life/routine
- communicate effectively with clients and families while supporting them through the decision making process about end of life issues
- use basic and advanced nursing skills to perform and adapt complex procedures in the home health setting
- recognize when specialized counselling beyond the scope of nursing is required and facilitate an appropriate referral
- respond to the ever-changing and evolving health care needs of the client and family by strategically revising interventions and therapies
- self-identify the need for assistance when not familiar with care requirements and seeks support to assure continued excellence in care

Teaching and Education

- assess the knowledge, attitudes, level of motivation, values, beliefs, behaviours, practices, stage of change, and skills of the client/family
- consider and integrate into educational planning the factors that may impact the client/family's ability to learn.
  - For example: environment, readiness, willingness, literacy level, educational background, socioeconomic situation health status etc.
- interpret and explain complex information for clients and families
- apply appropriate learning principles, teaching methods and educational theories to educational activities
- include family, volunteers and caregivers in teaching and education
- evaluate the effectiveness of health education interventions

Communication

- use effective listening, verbal and non-verbal communication skills to understand the client's perspective and be understood by the client, family and other caregivers involved in the care
- use effective interviewing skills and strategies to engage in constructive dialogue with clients and their families
- use effective communication skills to engage, connect, appreciate, respond, empathize and support the empowerment of others
- identify and use strategies to overcome language and communication barriers
- maintain a focused approach amidst multiple distractions within the home environment
- employ negotiation and conflict management skills
- use techniques that are client-centered, client-driven, and strength-based when counselling clients
- use documentation as an effective communication tool
- use technology to effectively communicate and manage client care in a confidential manner

Relationships

- optimize the health of the client and caregiver(s) by establishing and maintaining a therapeutic nurse-client
- relationship based on mutual trust, respect, caring, and listening within the context of being ‘a guest in the house’
- acknowledge the contribution that the family/caregiver provides to client health in a way that makes them feel
- valued and respected and support them to maintain relationships that support effective care
- work effectively and non-judgmentally in a wide range of environments with varying conditions of cleanliness
- use skills such as team building, negotiation, conflict management and group facilitation to build and sustain partnerships
- involve clients and families as active partners to identify assets, strengths and available resources

Access and Equity

- advocate for healthy public policies and accessible, inclusive and integrated services that promote and protect the health and well-being of all individuals and communities
- apply culturally-relevant and appropriate approaches with people of diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities
- recognize opportunities to promote social justice and advocate in collaboration with, and on behalf of clients and families on related issues to give voice to the vulnerable
- optimize allocation of human, financial, and infrastructure resources in order to provide a safe and accessible health delivery system
- advocate for the reduction of inequities in health by participating in legislative and policy making activities

Building Capacity

- mobilize clients / families to take action to address health needs, deficits and gaps accessing and using available resources
- assist the client and their family to recognize their capacity for managing their own health
- assist colleagues, partners and/or clients to support and build on the capacities that are inherent in the individual, families and the communities to influence policy change
- demonstrate cultural competency
- adapt and be flexible and responsive to the changing health needs of the client and family

Health Promotion

- facilitate planned change with clients and families by applying and incorporating health promotion theory, primary health care principles and change theory into practice
- recognize how the determinants of health infl uence the health and well-being of clients and families
- assess the impact specific issues may have on the client's health such as; political climate; priorities, values and culture; social and systemic structures and settings
- assess the readiness and capacity of the client and family to make changes to promote their health

Illness Prevention & Health Protection

- use a broad base of knowledge and theory to inform
- use critical thinking r/t ethical, political, scientific, socio-cultural and economic contexts
- support clients and families to identify risks to health and make informed choices
- take action to protect clients, families and groups
- participate in collaborative, interdisciplinary and intersectoral partnerships

Quality Care

- initiate, lead and participate in risk management and quality improvement activities to measure effectiveness of services, cost implications and processes
- initiate and participate in critical incident reviews
- evaluate nursing interventions in a systematic and continuous manner by measuring their effect on clients and families
- evaluate programs in relation to determinants of health and health outcomes
- contribute to the quality of work environments by identifying needs, issues, solutions and actively participating in team and organizational quality improvement processes
- understand the financial aspects of care and be accountable for effective, efficient and responsible use of time and
- resources when delivering care to clients and families

Professional Responsibility

- demonstrate professionalism, leadership, judgment and accountability in independent practice in multiple settings with multiple stakeholders
- practice independently and autonomously providing client centered services in a wide variety of settings where nursing care and services are needed
- use reflective practice to continually assess and improve practice
- integrate multiple ways of knowing into practice
- contribute to the development and generation of evidence-informed nursing practice
- pursue lifelong learning opportunities to support professional practice
- use nursing ethics, ethical standards and principles and self-awareness to manage self and practice in accordance with all relevant legislation, regulatory body standards, codes and organizational policies
- describe the mission, values and priorities of the health organization where one works
- participate in the advancement of home health nursing by mentoring students and new practitioners
- recognize and understand that one's attitudes, beliefs, feelings and values about health can have an effect on relationships and interventions