Competencies for Home Health Nursing: A Literature Review

Prepared for the Community Health Nurses of Canada

By Barb Mildon and Jane Underwood

March 31, 2010

Abstract

Definitions of home health nursing in the literature situate patients, their families and caregivers as the focus of the practice that attends to acutely ill, chronically ill, and terminally ill patients receiving care at home or other places in the community. The results of the literature review presented in this report provide evidence of the vast array of diverse competencies required for the unique and complex practice of home health nursing.

This review was conducted to inform the development of practice competencies for registered nurses working in home health care. The selection of literature was restricted to content which focused exclusively on home health practice competencies or alluded to specific home health nursing competencies through detailed descriptions of practice, orientation, education or outcomes.

The CINAHL and Medline on-line publication databases were searched using the key words “home care nursing/home health nursing and competence/competency” for the years 1996 to 2009. Reference lists of articles retrieved through the on-line search were reviewed to identify possible other relevant articles. Additionally content regarding home care nursing practice competencies were accessed in a convenience sample of text books. Lastly, experts from the field submitted suggestions about literature for the review. Articles and texts from these multiple sources were scanned for relevancy and a total of 105 citations were reviewed: 78 references were ultimately included in this literature review.

Introduction

This literature review was conducted to inform the development of practice competencies for registered nurses working in home health care. The findings of the literature review provide the background for the development of a consensus process amongst experts on a final list of competencies for Canadian home care registered nurses. (For further information contact: info@chnc.ca)

Search Strategy

The CINAHL and Medline on-line publication databases were searched using the key words “home care nursing/home health nursing and competence/competency” for the years 1996 to 2009. The 1996 start date was chosen as it is recognized as a year in which numerous landmark articles were published about home care nursing practice competencies.

The reference lists of articles retrieved through the on-line search were scanned to identify possible additional relevant articles which were then retrieved. Content from a convenience sample of text books regarding home care nursing practice competencies was also accessed.

In addition, suggestions about relevant literature were requested from a convenience sample of home care experts recommended by Community Health Nurses of Canada. These experts submitted suggested resources in the form of articles, web sites or other resources.

Lastly, content-specific publications by key nursing associations such as the Canadian Nursing Association, The Community Health Nurses of Canada (formerly known as the Community Health Nurses Association of Canada) and the American Nursing Association were retrieved and reviewed. For example**, Canadian Community Health Nursing Standards of Practice and the Canadian Nursing Association Community Health Nursing Certification Examination Competencies** reflect the essence of community health practice and were designed to guide the development of questions for the examination and the course of study to prepare for the examination.

Inclusion Criteria

The selection of literature was restricted to content which focused exclusively on home health practice competencies or alluded to specific home health nursing competencies through detailed descriptions of practice, orientation, education or outcomes.

Exclusion Criteria

Basic practice competencies for nurses entering the profession such as those set by regulatory colleges are assumed as foundational for all nurses and were not accessed. Advanced practice competencies (e.g. for the Nurse Practitioner or Clinical Nurse Specialist working in home health nursing) and practice competencies for Licensed Practical Nurses (Registered Practical Nurses in Ontario) are outside the scope of this

literature review. However, it is recognized that the competencies described may be partially or fully enacted by LPNs/RPNs depending on their provincial regulatory scope of practice guidelines and employer protocols. Case management is recognized as a specific practice focus and the detailed competencies for that specialty were not included in this literature review. However, some aspects of case management are shared by case managers and home health nurses (HHNs) and competencies related to those aspects as discussed in the literature are identified.

A fundamental competency for all nurses is the ability to identify knowledge gaps and access the knowledge specific to their unique area of practice. Accordingly, detailed practice competencies required in specialty home care nursing practice such as advanced wound care, enterostomal therapy, end-of-life care, or competencies applied to the care of individuals within unique populations such as the homeless, individuals in correctional settings, First Nations individuals or bands, and those identifying as gay, lesbian, bisexual or transgender are not included in this literature review.

Results of the search

As a result of the combined search strategies, 105 citations were reviewed. Seventy-eight (78) of those citations were assessed as relevant for this literature review. An additional 27 citations (Appendix B) were excluded because they did not fully meet the inclusion criteria for this review.

Definition of Competency

The definition of competency may be viewed as the hub of a wheel, with the specific competencies constituting the spokes. Accordingly, the home health nursing literature was searched for definitions of competency. Competency was defined by some authors as the integration of knowledge, abilities, skills and attitudes that enables job performance (Blevins, 2001; Buckley, Adelson and Hess, 2005; Nolan, 1998). The Community Health Nurses Association of Canada (2008) outlined the multiple types of knowledge expected of community health nurses including “Aesthetics, Empirics, Personal knowledge, ethics and socio-political knowledge (p. 7).

Nolan (1998) specified that competency involves delivering care according to “expectations” (p. 27). Benefield (1998) further elaborated that competency involves “providing services that are both effective and efficient” (p. 25). Astarita, Materna and Blevins (1998) observed that “competency is not a static phenomenon… [but is] ongoing and ever-changing.” Consequently they warned that “competency is not a once-and-done event [but] needs to be assessed at pre-determined intervals” (p. 135). Blevins (2001) suggested that competency leads to best practices and optimal job performance. Blevins also reiterated Benner’s (1984) identification of competency as “a dynamic state influenced by experience and education” (p. 114).

Home Health Nursing

Definitions of home health nursing in the literature situated patients, their families and caregivers as the focus of the practice that attends to acutely ill, chronically ill, and

terminally ill patients receiving care in their residence (American Nurses Association [ANA], 2008); Canadian Home Care Association [CHCA], 2008; Murray, 1998).

As a component of home care programs or services, home health nursing encompasses disease prevention, rehabilitation, restoration of health, health protection and health promotion with the goal of managing existing problems and preventing potential problems (ANA, 2008; CHCA, 2008; CHNAC, 2008; Humphrey, 2002) Home care nursing may substitute for long-term care or contribute to preventing or delaying long term care (Health Canada, 1999; Schoot, Proot, Legius, ter Meulen and de Witte, 2006). Home care nursing activities include "teaching, curative interventions, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver" (CHCA, 2008, p. 2). These activities involve initiating, coordinating, managing and evaluating the resources needed to promote the patient's maximum level of health and function (ANA, 2008).

Promoting patients' independence and self-sufficiency was reported as a key focus of home health nursing (Meyer, 1997; Rice, 1998), with the overriding aim of home health nursing being to maintain or improve the quality of life for patients and their families and other caregivers, or to support patients in their transition to end of life (ANA, 2008).

The practice of home care nursing was frequently identified as unique, or as a specialty (ANA, 2008; CHNAC, 2008; Guthaus and White, 2002; Humphrey and Milone-Nuzzo, 2005; Murray, 1998). In part, this uniqueness arises from caring for patients of all ages with a diversity of diagnoses and conditions that span the health-illness continuum (Glajchen and Bookbinder, 2001; Gorski, 2008; Kaiser and Rudolph, 1996; Murray, 1998). Building on the determinants of health as foundational to practice, home health nursing integrates "environmental, psychosocial, economic, cultural and personal health factors affecting an individual's and family's health status" (ANA, p. 3). As community health nurses, HHNs recognize caring as "an essential and universal human need" (CHNAC, 2008, p. 6) and incorporate the principles of social justice and primary health care into their practice. Neal (1997) asserts that home health nursing is based in caring and to that end, home health nursing care is holistic in nature, encompassing physical, emotional and spiritual care (Barnett, 2006; Rice, 1998; Witter, 2005).

Contextual features of home health nursing abounded in the literature. Examples included "diverse client-centered environments" (Kaiser and Rudolph, 1996, p. 160), treatment of a wide range of patients—"from the elderly to children of all ages (Glajchen and Bookbinder, 2001; Neal, 1997), and the provision and/or management of care for patients with a broad array of diagnoses across the lifespan and the health-illness continuum (Gorski, 2008; Kaiser and Rudolph, 1996, p. 158). Working in isolation and the solitary nature of HHN practice was widely cited (Guthaus and White, 2002; Higuchi, Christensen and Terpstra, 2002; Kihlgren, Fagerberg, Skovdahl, and Kihlgren, 2003). Guthaus and White (2002) identified the unpredictable nature of the home care environment. Several authors discussed the contrast between the hospital setting, in which patients occupy space controlled by the institution, and the home care setting, in which the client is in control and the HHN a guest (Bramadat, Chalmers and

Andrusyszyn, 1996; Higuchi, Christensen and Terpstra, 2002; Peter, 2002; Pastor, 2006; Spiers, 2002). Spiers (2002) discussed "negotiating territoriality" as an important interpersonal consideration. The literature provides evidence that HHNs experience stress related to being a guest in the house and the stranger in the family (Coffman, 1997; Higuchi, Christensen and Terpstra, 2002; Spiers, 2002).

Attributes of Home Health Nurses

"Flexibility, creativity, and innovative approaches to situations and problems in the context of individual and environmental differences and widely varying resource availability" was linked to competence by ANA (2008, p. 7). Benefield (2000) and Boucher (2005) supported flexibility as an attribute of HHNs, with Benefield (2000) adding the attributes of expertise in care delivery and independence. Competence in practicing in a highly independent, autonomous manner was described or endorsed as a central attribute of HHNs by several authors (ANA, 2008; Boucher, 2005; Ellenbecker, Boylan and Samia, 2006; Higuchi, Christensen and Terpstra, 2002; Spiers, 2002; Zurmehly, 2007). Other attributes included incorporating communication and motivation skills and principles in the home health setting, applying critical thinking (Guthaus and White, 2002), utilizing clinical decision-making in applying the nursing process, functioning as an effective team member and demonstrating care management skills (ANA, 2008). Innovation as a characteristic of home care nurses was the focus of a report by Koehler, Cha and Smith (2002).

Specific Competencies for Home Health Nurses

Numerous specific competencies were identified in the literature. For the purpose of this literature review, the competencies are described in three categories:

Category	Description (for purpose of literature review)
Foundational	Competencies involving the knowledge, skills and judgment applied in enacting clinical practice with patients/families.
Organizational	Competencies related to meeting employer expectations.
System	Competencies involving home health nursing funding and administration and navigation of the health system and services.

Foundational Competencies

Assessment and Monitoring

Discussion of the requirement for the HHN to possess and apply highly developed assessment skills was prominent in the literature (ANA, 2008; Barnett, 2006; Gorski, 2008; Government of Australia, 1997; Herleman, 2008; Higuchi, Christensen and Terpstra, 2002; Hughes et al., 2002; Koch, 2007; Meadows, 2009; Murashima et al., 2002; Pastor, 2006; Purkis and Bjornsdottir, 2006; Spiers, 2002; Witter, 2005).

Physical assessment was described as including the patient's ability to meet daily needs and to participate in meaningful activities in the home. Psychosocial assessment encompassed the impact of the patient's disease or condition, family dynamics, and

spiritual and cultural considerations. Environmental assessment focused on the home, exploring safety aspects or risks (Lang et al., 2009; Malone, 2008).

In its "Guidelines for the Provision of Community Nursing Care the Government of Australia, Department of Veterans' Affairs (1997) outlines several specific expectations regarding nursing performance of assessment:

- ⇒ That the RN assessor possesses specific knowledge, competencies and experience relating to comprehensive assessment
- ⇒ The assessment minimizes duplication by making use of relevant assessment information held by other agencies assisting the client
- ⇒ The needs of the client being assessed are determined in conjunction with the client
- ⇒ The assessment is conducted in a safe environment
- ⇒ Assessment results are recorded accurately in accordance with specified record keeping requirements
- ⇒ Clear constructive feed-back is given to clients regarding the assessment outcomes
- ⇒ Any assessment decision is made with the agreement of the client
- ⇒ Confidentiality of the assessment outcome is maintained and access to the assessment records is provided only to authorized personnel."

The competency of expert assessment was often associated with monitoring specific aspects of the patient's status, e.g. nutrition (Li, Morrow-Howell and Proctor, 2004; Witter, 2005), cardiovascular or respiratory condition (Barnett, 2006; Witter, 2005); effectiveness of pain management (Glajchen and Bookbinder, 2001; Spiers, 2006; Vallerand, Hasenau and Templin, 2004), depression (Purkis and Bjornsdottir, 2006) and signs and symptoms of clinical deterioration e.g. hypoglycemia or hyperglycemia (Purkis and Bjornsdottir, 2006) or overall symptom management (Quinn, 2001). Monitoring the patient's compliance with their treatment plan as a key factor in successfully managing a chronic disease was identified by Reeder (1999).

Care Planning

Registered Nurses' demonstration of care planning using the nursing process was highlighted by Linekin (2003) who observed that Registered Nurses "formulate patients' plans of care and coordinate implementation of the plan with all health care team members (p. 220). Health Canada (2002) also identified applying the nursing process as a competency for home and community care nurses working in the First Nations Inuit Health Community Care Program. The identification of the most appropriate nursing care strategies or interventions to meet identified outcomes was embedded in care planning (Hughes, et al., 2002), with those strategies possibly including complementary and cultural therapies (ANA, 2008; Neal, 1997).

Clinical Decision-Making

Higuchi, Christensen and Terpstra (2002) explored the challenges encountered by 16 Canadian HHNs in exercising clinical decision-making skills. Recognizing clinical decision-making as central to their practice, the strategies HHNs employed to facilitate

their decision-making included seeking knowledge about services available to the patient, collecting additional information, adjusting the care plan and consulting with peers during team meetings. Kihlgren, Fagerberg, Skovdahl and Kihlgren (2003) identified the need for community nurses to have expert knowledge and decision-making when considering whether or not to send elderly patients to the emergency room. ANA (2008), Gorski (2008) and O'Neill (1996) also discussed or identified the requirement for competence in clinical decision-making.

Communication

Communication was acknowledged as a competency for home health nursing by several authors (ANA, 2008; Benefield, 1996; CHNC, 2008; Humphrey, 2002). Barnett (2006) called for HHNs to have "effective listening and non-verbal communication skills (p. 2 of 8). Wessel and Rutledge (2005) asserted that "Effective communication with patients and families on end-of-life issues is a primary competency for clinicians" (p. 213). Guthaus and White (2002) noted that "communication skills must reflect the ability of the nurse to relate effectively to diverse patient populations and all levels of care providers and their gatekeepers across the continuum" (p. 257). They further added that in contrast to the acute care nurse, who often has direct access to the physician, the home care nurse must often communicate through a third party, thus adding complexity to the communication process. Finally, Guthaus and White specified that "to avoid inappropriate interventions or changes in treatment plan, communication must be articulate and present a complete and accurate picture that is delivered with the appropriate sense of urgency" (p. 257).

The need to meet documentation requirements of funders and employers was emphasized by Ellenbecker and Warren (1998) and identified as a complex (Herb, 2003) or highly demanding component of home health nursing work (Ellenbecker, Boylan and Samia, 2006). The work of other authors pointed to documentation skills as a sub-set of communication and an important competency for HHNs (Benefield, 1996; Health Canada, 1996; Herb, 2003; Humphrey, 2002).

Establishing and Maintaining the Nurse-Patient Relationship

Establishing a therapeutic relationship with the patient, including respecting the family's privacy and gaining an understanding of client/family expectations, is foundational to home health nursing (Higuchi, Christensen and Terpstra, 2002; Peter, 2002). Zurmehly (2007) described the nature of the nurse-patient relationship as a "blending of boundaries between the family and nurse and client" (p. 166). During interviews for Zurmehly's study, nurses "discussed the long-term relationships they developed with their home health clients as opposed to the relationships they have with patients who have short stays in the acute care setting. Many shared how their relationship created a special bond and the nurse became an extension of the family" (Zurmehly, 2007, p. 166). In palliative care, the nurse-patient relationship was depicted as "central to the role of the nurse and the forming [of] an effective partnership" (Barnett, 2006, p. 2 of 8). Inherent in the nurse-patient relationship is the nurse's care to maintain confidentiality, safety, security, dignity and respect for both patient and family (ANA, 2008, p. 18). This

duty on the nurse's part reflects ethical practice—another practice expectation (ANA, 2008; CHNC, 2008; Health Canada, 2002).

Practice Skills/Nursing Care Interventions

The requirement for expertise in a range of nursing care interventions was revealed by the literature review. *Medication management* involving the monitoring or administration of medications and therapies appeared in several publications (ANA, 2008; Guthaus and White, 2002; Health Canada, 2002; Inglis et al., 2004; Kovner, Menezes and Goldberg, 2005; Li, Morrow-Howell and Proctor, 2004; Murashima et al., 2002; Reeder, 1999). HHNs also provide, or support the patient's self care in a myriad of specific interventions including injections, kidney dialysis, parenteral nutrition, chemotherapy, stoma care, wound care, strategies to address mental health needs and care of patients on respirators or oxygen therapy (Herleman, 2008; Murashima et al., 2002; Shy, Liao, Shao and Yang, 1999).

Patient teaching and education also received attention (ANA, 2008; Gorski, 2008; Hughes et al., 2002; Humphrey, 2002; Inglis, 2004; Murashima et al., 2002). Zurmehly (2007) found that nurses did a significant amount of teaching and shared one nurse's reflection that: "I teach not only the client but also the whole family or sometimes the neighbour" (p. 167). Teaching as an intervention was evident in the description of the development of a "nurse-directed, multidisciplinary intervention that included education about Congestive Heart Failure and its treatment" (Li, Morrow-Howell and Proctor, p. 276). Extending the notion of teaching was the expectation by Bramadat, Chalmers and Andrusyszyn (1996) for the nurse to be competent with *patient counseling.* Competency in teaching peers through orientation and preceptorship was also evident in the literature (DeCicco, 2008; Gavin, Haas, Pendleton, Street and Wormald, 1996; Humphrey, 2002; Meadows, 2009).

Cultural Competency

Although a requirement of all nurses in all settings and roles, cultural competency as demonstrated by the nurse's use of "culturally acceptable and relevant approaches (Kaiser et al., 2003, p. 194) received focused attention in the home health literature (ANA, 2008; Edmunds and Kinnaird-Iler, 2008; Frable, Wallace and Ellison, 2004; Romeo, 2007). Thobaben (2004) called upon HHNs to provide culturally competent care, while Kaiser and Rudolph (1996) further elaborated that the nurse [needs to] consider the patient's "age and culture [in devising] approaches to learning needs" (p. 160). Romeo (2007) documented the journey and specific activities undertaken by a U.S. home health agency to meet specific standards regarding the provision of culturally competent care. Chenoweth et al. (2006) asserted:

> "*A culturally competent nurse recognizes and understands the impact that their own cultural and professional beliefs have on workplace practices…and recognizes that cultural differences occur across all levels of diversity, both primary (age, gender, language, physical ability and sexual preference) and secondary (socio-economic background, geographical location, education and religion). This nurse will recognize the essential humanity in all persons whatever*

their cultural background and therefore will need to learn how to interact effectively with people in providing quality care, despite different social backgrounds, cultures, religions and lifestyle preferences" (p. 36).

A study involving relatives of terminally ill Turks and Moroccans in the Netherlands (de Graaff and Francke, 2003) illustrated the benefits of nurses' cultural competency. The authors speculated that relatives' higher level of satisfaction with the communication of home health nurses was related to HHNs' knowledge of, and adherence to "unwritten rules… [embedded in] culturally defined patterns of behaviours" (p. 803).

Evidence-Based Practice

HHNs' competency in evidence-based practice, including keeping their clinical knowledge current, was illustrated by Purkis and Bjornsdottir (2006) who observed that "the nurse is transforming the evidence that she brings to the home" (p. 249) … and keeping "up with new ideas and information, while being confident in her judgment of the validity and utility of all of this for her local situation" (p. 255). Witter (2005) declared that "Programs must incorporate practice guidelines, clinical pathways and other tools… [and that the nurse must] collect and analyze variances from expected interventions and outcomes (p. 39). Other support for including evidence-based practice as a competency was provided by Inglis et al. (2004) who called on nurses to apply guidelines to ensure optimal management of [patients'] chronic conditions where appropriate. The experience of using clinical guidelines and evidence-based protocols for patients with heart failure was shared by Ervin, Scrivener and Simons (2004). Frable, Wallace and Ellison (2004) discussed utilization of guidelines for patients with diabetes.

Organizational Competencies

Time management and organizational skills

Time management and organizational skills were identified as competencies for HHNs by multiple authors (ANA, 2008; Benefield, 2000; Sherry, 1996; Zurmehly, 2007). These skills influence the nurse's productivity. Benefield (1996; 1998) explained that productivity encompasses the effectiveness and efficiency of the service. Efficiency is viewed as the time it takes for the nurse to complete the visit activities, with effectiveness referring to the outcomes associated with the services provided. Humphrey (2002a) declared that the system for measuring productivity as a specified number of visits per day is inadequate and called for productivity expectations to take into consideration the competencies of the clinicians to "provide the care and reach the necessary clinical outcomes" (p. 743).

Care Coordination

Care coordination was identified by Inglis et al. (2004) as "Optimizing patient access to effective multidisciplinary management (involving their primary care physician, specialist physician, community pharmacist, community nurse, and other allied health professionals where appropriate) with clear treatment and outcome goals" (p. 121). Evidence that HHNs require competency in care coordination (also called case or care

management) was provided by Guthaus and White (2002), Humphrey (2002), Murashima et al (2002) and Witter (2005).

Herleman (2008) undertook a detailed review of the HHN's role in managing the care for their patients which she characterized as case management. The review identified five key components of case management: 1) coordination of care; 2) ensuring continuity of care; 3) identifying changes in the patient's condition; 4) evaluating the care being delivered in association with health care team members and 5) being aware of and understanding the financial implications of the care plan. The author advocated for a structured case management process and presented associated forms and tools.

Some literature sources linked competence in care coordination with the competency of s*upervision and delegation*—e.g. of patient care activities to Licensed Practical Nurses (LPNs) and Home Health Aides (Gorski, 2008; Kihlgren, Fagerberg, Skovdahl, and Kihlgren, 2003; Timm, 2003). Timm (2003) elaborated upon the competency of supervision and delegation, specifying that it involves the components of delegating tasks that fit the educational preparation and ability of the LPN or Aides, providing direction and assistance, observing and monitoring the activities of those supervised and evaluating the effectiveness of the care performed.

Making Referrals

Integral to care coordination is the competency of identifying and *making referrals* to community resources (ANA, 2008; Health Canada, 2002; Purkis and Bjornsdottir, 2006). Zurmehly (2007) observed that "The community nurse must coordinate total care for the client, family and community in an autonomous manner with an ultimate goal of health and well-being" (p. 169). However the author stressed that it is the client who defines the meaning of health and well-being.

Proficiency with Complex Technology

The need to maintain competence in working with complex technology was evident in the literature (ANA, 2008; Murray, 1998). Reeder (1999) called on nurses to be able to "access information in [technological] systems in real time" (p. 44) and manage telemonitoring and virtual home visits as well as email, faxing and intranet systems. Demiris, Oliver and Courtney (2006) discussed ethical considerations that HHNs should be aware of regarding the use of telehealth technologies in home and hospice care. Li, Morrow-Howell and Proctor (2004) discussed telephone follow-up as an intervention, and Buckley, Adelson and Hess (2005) described a wound care photography intervention by nurses. Eck-Casteels (2007) reviewed advances in technology that are beginning to find their way into home care and Struk (2002) described the needs of clinicians as the end users of home care computer technology.

Quality Care

Several literature sources identified the nurse's role in quality care (ANA, 2008; Health Canada, 2002; Reeder, 1999). Specific activities include participating in risk management and quality improvement activities and critical incident reviews, evaluating

personal performance and contributing to the evaluation and measurement of outcomes of care. Herleman (2008) included monitoring the quality of care in the duties encompassed by case management.

System Competencies

Patient Advocacy

Acting as a patient advocate was discussed in several sources (ANA, 2008; Benefield, 1997; CHCA, 2005; CHNC, 2009; Gorski, 2008; Rice, 1998). Rice advised that advocacy involved insisting on "sufficient time and resources to facilitate self-care. For example [if there is] a limited number of home visits, although the patient clearly requires more care, nurses may need to voice concerns about abandoning a sick patient, as well as pointing out the economic advantages of making a few more visits to keep the patient out of more costly systems like the hospital "(p. 53). Rice's discussion was echoed by Humphrey (2002) who likewise identified that pressure on the nurse to work within average or expected visit numbers may adversely impact patient outcomes. Flynn (2007) found that approximately 20 percent of HHNs were not confident in their patient's ability to self-manage care after discharge from home care.

Influencing legislative and regulatory processes may be linked to advocacy and was identified as a competency for HHNs by the American Nurses Association (2008). Additionally CHNC (2009) identified policy development as a competency

System Knowledge

Knowledge and compliance with existing regulations and legislation, and advanced knowledge of financial and regulatory aspects of care was specifically identified by the American Nurses Association (2008) and Astarita, Materna and Blevins (1998). However acceptance of this competency as foundational to practice was a thread throughout much of the literature.

Organizing Frameworks for Home Health Nursing Competencies

More than a dozen organizing frameworks or itemized lists for home health nursing competencies were identified during the course of this literature review (Appendix A). The existence of so many frameworks speaks to the challenge of organizing competencies in a framework that is practical yet comprehensive and meaningful.

Conclusion and Recommendations

The results of the literature review presented in this report have provided evidence of the vast array of diverse competencies required for the unique and complex practice of home health nursing. Canadian HHNs are broadly familiar with the Canadian Community Health Nursing Standards of Practice, and those standards convey the depth and breadth of HHN practice. Accordingly, it is recommended that the Canadian Community Health Nursing Standards of Practice be adapted as needed and utilized as the organizing framework for the finalized HHN practice-specific competencies.

References

American Nurses Association [ANA] (2008). *Home health nursing: Scope and standards of practice.* Maryland: Author

Astarita, T., Materna, G., & Blevins, C. (1998). *Competency in home care.* Maryland: Aspen.

Barnett, M. (2006). Providing palliative care in end-stage COPD within primary care. *Journal of Community Nursing*, 20, 30-34.

Benefield, L.E. (1996). Component analysis of productivity in home care RNs. *Public Health Nursing, 13*(4), 233-243.

Benefield, L.E. (1997). Are you really ready for home health nursing? AJN.

Benefield, L.E. (1998). Competencies of effective and efficient home care nurses. *Home Care Manager, 2*(3), 25-28.

Benefield, L.E. (2000) Critical competencies for nurses in the new millennium. *Home Healthcare Nurse, 18*(1), 17-21.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park: Addison-Wesley.

Blevins, C. (2001). There really is a difference: Home care competencies. *Journal of Continuing Education in Nursing, 32*(3), 114-7.

Boucher, M.A. (2005). "Making it"—Qualities needed for rural home care nursing. *Home Healthcare Nurse, 23*(2), 103-108.

Bramadat, I.J., Chalmers, K., & Andrusyszyn, M.A. (1996). Knowledge, skills and experiences for community health nursing practice: The perceptions of community nurses, administrators and educators. *Journal of Advanced Nursing, 24*, 1224-1233.

Buckley, K.M., Adelson, L.K. & Hess, C. T. (2005). Get the picture! Developing a wound photography competency for home care nurses. *Journal of Wound Care Nursing, 32*(3), 171-177.

Canadian Home Care Association (2005). *Summary of proceedings from the home care case management invitational roundtable.* Ottawa: Author. Retrieved Jan. 5, 2010 from http://www.hc-sc.gc.ca/hcs-sss/pubs/home-domicile/2005-cas-mgmt-gest/index-eng.php

Canadian Home Care Association (2008). *Home care. The next essential service: Meeting the needs of our aging population.* Ottawa: Author. Retrieved January 6, 2010 from http://www.cdnhomecare.ca/media.php?mid=1914

Chenoweth, L., Jeon, Y.-H., Goff, M. & Burke, C. (2006). Cultural competency and nursing care: An Australian perspective. *International Nursing Review, 53*, 34-40.

Coffman, S. (1997). Home-care nurses as strangers in the family. *Western Journal of Nursing Research, 19*(1), 82-96.

Community Health Nurses Association of Canada [CHNAC](2008). *Canadian community health nursing standards of practice*. Toronto: Author.

Community Health Nurses of Canada [CHNC](2009). *Public health nursing discipline specific competencies version 1.0.* Ottawa: Author.

DeCicco, J. (2008). Developing a preceptorship/mentorship model for home health nurses. *Journal of Community Health Nursing, 25*, 1, 15-25.

De Graaff, F.M. & Francke, A.L. (2003). Home care for terminally ill Turks and Moroccans and their families in the Netherlands: Carers' experiences and factors influencing ease of access and use of services. *International Journal of Nursing Studies, 40,* 797-805.

Demiris, G., Oliver, D.P., & Courtney, K.L. (2006). Ethical considerations for the utilization of telehealth technologies in home and hospice care by the nursing profession. *Nursing Administration, 30*(1), 56-66.

Eck-Casteels, H. (2007). Go home and get well soon. *Healthcare Quarterly, 10,* 1-3.

Edmunds, K. & Kinnaird-Iler, ElK. (2008). *Multicultural clients.* In Stamler, L. & Yiu, L. (Eds.) (2008). Community health nursing: A Canadian perspective. (2nd Ed.), Chapter 20, pp. 311-319.

Ellenbecker, C.H. & Warren, K. (1998). Nursing practice and patient care in a changing home healthcare environment. *Home Healthcare Nurse, 16*(8), 531-539.

Ellenbecker, C.H., Boylan, L.N. & Samia, L. (2006). What home healthcare nurses are saying about their jobs. *Home Healthcare Nurse, 24*(5), 315-324.

Ervin, N.E., Scrivener, K., & Simons, T. (2004). Using the linkage model for integrating evidence into home care nursing practice. *Home Healthcare Nurse, 22*(9), 606-611.

Flynn, L. (2007). Managing the care of patients discharged from home health: A quiet threat to patient safety? *Home Healthcare Nurse, 25*(3), 184-190.

Frable, P.J., Wallace, D.C. & Ellison, K.J. (2004). Using clinical guidelines in home care for patients with diabetes. *Home Healthcare Nurse, 22*(7), 462-468.

Gavin, M.J., Haas, L.J., Pendleton, P.B., Street, J.W., & Wormald, A. (1996). Orienting a new graduate nurse to home healthcare. *Home Healthcare Nurse, 14*(5), 381-387.

Glajchen, M. and Bookbinder, M. (2001). Knowledge and perceived competence of home care nurses in pain management: A national survey. *Journal of Pain and Symptom Management, 21*(4), 307-316.

Gorski, L. (2008). Implementing home health standards in clinical practice: An overview of the updated standards. *Home Healthcare Nurse, 26*(5), 308-16.

Government of Australia, Department of Veterans Affairs (1997). *Guidelines for the*

provision of community nursing care, Section Two: Client classification system. Australia: Author.

Guthaus, M.A. & White, D. (2002). Blending the roles of home care nursing and cardiovascular specialties: A model for nursing practice in the community. *Home Health Care Management and Practice, 14*(4), 255-261.

Health Canada (1999). *Provincial and territorial home care programs: A synthesis for Canada. Ottawa:* Author. Retrieved January 7, 2010 from http://www.hc-sc.gc.ca/hcs-sss/pubs/home-domicile/1999-pt-synthes/definition-eng.php

Health Canada (2002). *Standards and competencies for FNIHCC home care nursing services for British Columbia.* Ottawa: Author.

Herb, S. (2003). The evolution of documentation in home health. *Home Health Care Management & Practice, 16*(1), 41-45.

Herleman, L. (2008). Home care primary nurse case management model. *Home Health Care Management and Practice, 20*(3), 235-244.

Higuchi, K.A, Christensen, A. & Terpstra, J. (2002). Challenges in home care practice: A decision-making perspective. *Journal of Community Health Nursing, 19*(4), 225-236.

Hughes, L.C., Robinson, L.A., Cooley, M.E., Nuamah, I., Grobe, S.J. & McCorkle, R. (2002). Describing an episode of home nursing care for elderly postsurgical cancer patients. *Nursing Research, 51*(2), 110-118.

Humphrey, C.J. (2002). The current status of home care nursing practice: Part 1: Clinical practice under PPS. *Home Healthcare Nurse, 20*(10), 677-684.

Humphrey, C.J. (2002a). The current status of home care nursing practice: Part 2: Operational trends and future challenges. *Home Healthcare Nurse, 20*(11), 741-747.

Humphrey, C.J. & Milone-Nuzzo, P. (2005). Transitioning nurses to home care. In Harris, M.D. (Ed). Handbook of Home Health Care Administration, (4th Ed.), (pp. 484-494).

Inglis, S., McLennan, S., Dawson, A., Birchmore, L., Horowitz, J.D., Wilkinson, D. & Stewart, S. (2004). A new solution for an old problem? Effects of a nurse-led, multidisciplinary, home-based intervention on readmission and mortality in patients with chronic atrial fibrillation. *Journal of Cardiovascular Nursing, 19*(2), 118-127.

Kaiser, K.L. & Rudolph, E.J. (1996). In search of meaning: Identifying competencies relevant to evaluation of the community health nurse generalist. *Journal of Nursing Education, 35*(4), 157-162.

Kaiser, K.L., Barr, K.L., & Hays, B.J. (2003). Setting a new course for advanced practice community/public health nursing. *Journal of Professional Nursing, 19*(4), 189-196.

Kihlgren, A.L., Fagerberg, I., Skovdahl, K., & Kihlgren, M. (2003). Referrals from home care to

emergency hospital care: Basis for decisions. *Journal of Clinical Nursing, 12*, 28-36.
Koch, M. (1997). Going home: Is home health care for you? Learn what it takes to be a home health care nurse. *Nursing97,* October, p.49.
Koehler, J.A., Cha, J., & Smith, C.E. (2002). A model for using novel nursing interventions to meet the challenges of community health needs. *Home Health Care Management & Practice, 14*(2), 129-136.
Kovner, C., Menezes, J., & Goldberg, J.D. (2005). Examining nurses' decision process for medication management in home care. *Journal on Quality and Patient Safety, 31*(7), 379-385.
Lang, A., Macdonald, M., Storch, J., Elliott, K., Stevenson, L., Lacroix, H., Donaldson, S., Corsini-Munt, S., Francis, F., & Curry, C.G. (2009). Home care safety perspectives from clients, family members, caregivers and paid providers. *Healthcare Quarterly, 12*, 97-101.
Li, H., Morrow-Howell, N. & Proctor, E.K. (2004). Post-acute home care and hospital readmission of elderly patients with congestive heart failure. *Health & Social work, 29*(4), 275-285.
Linekin, P.L. (2003). Home health care and diabetes assessment, care and education. *Diabetes Spectrum, 16*(4), 217-8, 220, 222.
Malone, M.M. (2008). Violence in families. In Stamler, L. & Yiu, L. (Eds.) (2008). *Community health nursing: A Canadian perspective.* (2nd Ed.), Chapter 26, pp. 368-376.
Meadows, C. (2009). Integrating new graduate nurses in home health care. *Home Healthcare Nurse, 27*(9), 561-568.
Meyer, K.A. (1997). An educational program to prepare acute care nurses for a transition to home health care nursing. *The Journal of Continuing Education in Nursing, 28*(3), 124-129.
Murashima, S., Nagata, S., Magilvy, J.K., Fukui, S., & Kayama, M. (2002). Home care nursing in Japan: A challenge for providing good care at home. *Public Health Nursing, 19*(2), 94-103.
Murray, T.A. (1998). From outside the walls: A qualitative study of nurses who recently changed from hospital-based practice to home health care nursing. *Journal of Continuing Education in Nursing, 29*(2), 55-60.

Neal, L. (1997). Current clinical practice of home care nursing. Home Healthcare Nurse, 15(12), 881-882.

Nolan, P. (1998). Competencies drive decision making. *Nursing Management, 29*(3), 27- 40.
O'Neill, E.S. (1996). An exploratory study of clinical decision making in home health care nursing. *Home Healthcare Nurse, 14*(5), 362-368.
Pastor, D.K. (2006). Home sweet home: A concept analysis of home visiting. *Home Healthcare Nurse, 24*(6), 389-394.
Peter, E. (2002). The history of nursing in the home: Revealing the significance of place in the expression of moral agency. *Nursing Inquiry, 9*(2), 65-72.
Purkis, M.E. & Bjornsdottir, K. (2006). Intelligent nursing: Accounting for knowledge as action in practice. *Nursing Philosophy, 7*, 247-256.
Quinn, C. (2001). Analysis of the home health symptom management model. *Lippincott's Case Management, 6*(3), 104-111.
Reeder, L. (1999). Anatomy of a disease management program. *Nursing Management, 30*, 41-46.
Rice, R. (1998). Key concepts of self-care in the home: Implications for home care nurses. *Geriatric Nursing, 19*(1), 52-54.
Romeo, C. (2007). Caring for culturally diverse patients: One agency's journey toward cultural competence. *Home Healthcare Nurse, 25*(3), 206-213.
Schoot, T., Proot, I., Legius, M., ter Meulen, R., & de Witte, L. (2006). Client-centered home care: Balancing between competing responsibilities. *Clinical Nursing Research, 15*(4), 231-254.
Sherry, D. (1996). Time management strategies for the new home care nurse. *Home Healthcare Nurse, 14*(9), 718-720.
Shyu, Y.L., Liao, M., Shao, J., & Yang, C. (1999). A survey of home nursing services in Taiwan. *Public Health Nursing, 16*(6), 432-440.
Spiers, J.A. (2002). The interpersonal contexts of negotiating care in home care nurse-patient interactions. *Qualitative Health Research, 12*(8), 1033-1057.
Spiers, J. (2006). Expressing and responding to pain and stoicism in home-care nurse-patient interactions. *Scandinavian Journal of Caring Science, 20*, 293-301.
Struk, C. (2002). The end user of home care computer technology…the clinician. *Home Healthcare Nurse, 20*(7), 466-469.
Thobaben, M. (2004). Strategies home health care providers can use to help decrease minority health disparities. *Home Health Care Management & Practice, 17*(1), 56-57.
Timm, S.E. (2003). Effectively delegating nursing. *Home Healthcare Nurse, 21*(4), 260-265.
Vallerand, A.H., Hasenau, S.M., & Templin, T. (2004). Barriers to pain management by home care nurses. *Home Healthcare Nurse, 22*(12), 831-840.

Wessel, E.M. & Rutledge, D.N. (2005). Home care and hospice nurses' attitudes toward death and caring for the dying: Effects of palliative care education. *Journal of Hospice and Palliative Nursing, 7*(4), 212-218.

Witter, P. (2005). The district nurse's role in managing patients with heart failure. *Nursing Standard, 19*(24), 38-42.

Zurmehly, J. (2007). A qualitative case study review of role transition in community nursing. *Nursing Forum, 42*(4), 162-170.

Appendix A

Organizing Frameworks for Home Health Competencies or Standards

Author(s) or Source	Title and Framework for the Competencies or Standards
American Nurses Association (ANA)(2008).	**Home Health Nursing Scope & Standards of Practice** **I Standards of Practice** 1. Assessment 2. Diagnosis 3. Outcomes identification 4. Planning 5. Implementation -Coordination of care -Health teaching and health promotion -Consultation -Prescriptive authority and treatment 6. Evaluation **II Standards of Professional Performance** 7. Quality of practice 8. Education 9. Professional practice evaluation 10. Collegiality 11. Collaboration 12. Ethics 13. Research 14. Resource utilization 15. Leadership
Association of Nursing Directors and Supervisors of Ontario Official Health Agencies (ANDSOOHA), et al. (1985).	**Standards of Nursing Practice for Community Health Nurses in Ontario** *(Also known as "The Blue Book)* Standards (organized by nursing process framework) 1. Assessing 2. Planning 3. Implementing 4. Evaluating 5. Professional Accountability
Benefield, L. (1996).	**Component Analysis of Productivity in Home Care RNs** 1. Knowledge and Ability Variables 2. Client/family Management 3. Practice Management 4. Knowledge/Skill Maintenance 5. Communication 6. Nursing Process 7. Written Documentation 8. Home Health Care Knowledge

Author(s) or Source	Title and Framework for the Competencies or Standards
Benefield, L.E. (1998).	**Competencies of Effective and Efficient Home Care Nurses** **1. Cognitive** • Knowledge that includes the recall or recognition of facts, and the development of intellectual methods for dealing with a new problem or situation **2. Psychomotor** • Manual dexterity of the nurse • Ability to give an injection • Actual physical process of osculating breath sounds • Mechanics of inserting a nasogastric tube • Physical process of changing a dressing 3. **Affective** (the caring part of nursing) • Therapeutic touch • Demonstrating empathy during conversations with a client • Maintaining client privacy • Communicating to seek the client's perspective while not imposing the nurse's own values on the client and family **4. Effectiveness** • The degree to which the nurse has accomplished intended agency goals related to managing and providing home care to a client **5. Efficiency** • The production of home visits and associated activities related to the home visit without time or material waste • Time saving techniques during the home visits • Conscious management of resources to avoid material or time waste
Bramadat, Chalmers & Andrusyszyn, (1996).	**Knowledge, Skills and Experiences for CHN Practice** New CHNs need: • Inquiring mind • Background in change theory • People skills • Counseling skills • Health assessment including assessment of individuals, families and communities • Knowledge of ethics • Cultural awareness • Interviewing skills • Follow through from hospital to community and community preparation for hospitalization

Author(s) or Source	Title and Framework for the Competencies or Standards
Canadian Nurses Association (CNA) (2009).	**Community Health Nursing Certification Exam Development Guidelines/List of Competencies** 1. Facilitating Access to Services in an Efficient and Effective Manner 2. Restoring and Maintaining Health and Providing End-of-Life Care 3. Promoting Health and Preventing Illness and Injury of Vulnerable Individuals, Populations, Aggregates and Targeted Groups within the Community 4. Promoting Health and Wellness across the Lifespan 5. Providing Infection Prevention and Control and Communicable Disease Services 6. Being Involved in Emergency Preparedness/Disaster Management 7. Promoting a Healthy Environment 8. Building Community Capacity to Improve Health 9. Demonstrating Professional Responsibility and Accountability
Canadian Public Health Association (CPHA) (1990).	**Community Health--Public Health Nursing in Canada: Preparation & Practice** *(Also known as "The Green Book")* **1. Roles** ⇒ Role in Health Promotion ⇒ Role in Illness and Injury Prevention **2. Activities** **I** Care/Service Provider **II** Educator **III** Consultant **IV** Community Developer **V** Facilitator -Leader -Enabler -Advocate **VI** Communicator **VII** Resource Manager, Planner, Coordinator **VIII** Team Member/Collaborator **IX** Research/Evaluator **X** Social Marketer **XI** Policy Formulator **3. Competencies** ⇒ Knowledge ⇒ Skills ⇒ Attitudes and Personal Qualities

Author(s) or Source	Title and Framework for the Competencies or Standards
Community Health Nurses Association of Canada (CHNAC) (2003; 2008).	**Canadian Community Health Nursing Standards of Practice** 1. Promoting Health ⇒ Health Promotion ⇒ Prevention and Health Protection ⇒ Health Maintenance, Restoration and Palliation 2. Building Individual/Community Capacity 3. Building Relationships 4. Facilitating Access and Equity 5. Demonstrates Professional Responsibility and Accountability
Community Health Nurses of Canada (CHNC) (2009).	**Public Health Nursing Discipline Specific Competencies** 1. Public health and nursing sciences 2. Assessment and analysis 3. Policy Development, Program planning, implementation and evaluation 4. Partnerships, collaboration and advocacy 5. Diversity and inclusiveness 6. Communication 7. Leadership 8. Professional responsibility and accountability
Health Canada (2002).	**Standards and Competencies for FNIHCC (First Nations and Inuit Home and Community Care) Home Care Nursing Services for British Columbia.** **1. (Standard) Responsibility and Accountability:** Maintains standards of nursing practice and professional behaviour determined by the Nurses (Registered) Act, RNABC and practice setting. **Competencies** ⇒ Demonstrates responsibility and accountability for practice at all times ⇒ Participates in activities to improve the quality of HCN delivery ⇒ Follows local Band's or collectivity's policies ⇒ In collaboration with others, develops and monitors program and care standards. **2. Specialized body of knowledge: Bases practice on nursing science and on related content from other sciences and humanities.** **Competencies** ⇒ Demonstrates an understanding of the administrative structure of the health department within the local band's or collectivity's health units ⇒ Demonstrates an understanding of the band's home and community care program philosophy, mission goals ⇒ Demonstrates an understanding of the role, responsibilities and competencies of the home care nurse

Author(s) or Source	Title and Framework for the Competencies or Standards
Health Canada, 2002 (Continued).	⇒ Bases practice on knowledge of self care concepts ⇒ Bases practice on knowledge of the family as a central and integral partner in home care nursing delivery ⇒ Recognizes the important influence of the client's environment, culture and value system—home and community—in delivering home care nursing services ⇒ Recognizes health promotion as a fundamental components of practice ⇒ Demonstrates awareness of political processes within communities and the healthcare system ⇒ Facilitates effective change processes with clients, families and other care providers ⇒ Demonstrates understanding of the dynamics of chronic illness and implications for delivery of home care nursing ⇒ Describes the adaptation challenges and needs of clients with mental and/or physical disabilities, including developmentally disabled clients ⇒ Demonstrates understanding of the aging process, common health problems of the aged and general principles of gerontological nursing in t he community ⇒ Describes central principles and concepts in palliative care in the home and community setting ⇒ Demonstrates knowledge of and sensitivity to cultural norms and practices of First Nations clients ⇒ Demonstrates knowledge of ⇒ Common medical and surgical problems, conditions and disorders affecting adults/children for home care management in the community, with consultation with the physician as appropriate ⇒ Gerontological and palliative car expertise for home care management in the community, with consultation with a physician as appropriate ⇒ Common problems, conditions and disorders affecting pediatric clients based on an understanding of normal growth and development/child care for home care management in the community, with consultation with the physician as appropriate ⇒ Common problems, conditions and disorders affecting the high risk post partum client will be managed by home care in the community, in consultation with the physician as appropriate ⇒ Mental health problems, conditions and disorders requiring consultation, crisis intervention and home care management in the community, with consultation with the physician as appropriate

Author(s) or Source	Title and Framework for the Competencies or Standards
Health Canada, 2002 (Continued).	**3. Competent Applications of Knowledge: Diagnoses actual or potential problems and strengths, plans interventions, performs planned interventions and evaluates outcomes** **Competencies** ⇒ Applies the five steps of the nursing process to meet the home care nursing needs of clients and families, including assessment, diagnoses, planning, implementation and evaluation ⇒ Recognizes health behaviour as influenced by culture and value systems ⇒ Adapts the nursing process to the home environment and identifies community resources and services ⇒ Analyzes and validates data collected to identify the actual and potential nursing diagnoses/self care deficits and capability of the client ⇒ Develops a plan of care in consultation with client and family ⇒ Implements the plan of care by providing health education, health promotion and prevention services, monitoring and supporting acutely and chronically ill clients in consultation with other care givers ⇒ Applies knowledge and skill to care for clients with HIV/AIDS, chronically ill elderly clients, palliative clients, and others ⇒ Evaluates results of nursing and client actions by comparing with goals and determining degree of achievement ⇒ Complies with basic principles of effective documentation/charting as per RNABC guidelines. Documents all care completely, accurate and in a timely manner using standardized records and forms as per HCN policies and guidelines (see also Zurmehly, 2007) ⇒ Adapts clinical strategies to the home environment for provision of care, with client's permission and involvement ⇒ Applies universal and specialized nursing skills in an individualized safe and consistent manner as per RNABC guidelines and FNIHCC policies and procedures ⇒ Applies specialized knowledge and skills to specific high risk and frail client groups ⇒ Supports clients to manage care that it is dependent on specialized technology and equipment ⇒ Describes specific client programs and associated resources in which HCN is involved (e.g. home IV therapy, in-home respite, foot care, wound care, palliative care, oxygen therapy, administering/monitoring of medications, etc.) ⇒ Communicates effectively with clients by applying helping and interpersonal relating skills to all phases of the nurse-client relationship

Author(s) or Source	Title and Framework for the Competencies or Standards
Health Canada, 2002 (Continued).	⇒ Coordinates case management with client, family and other service providers ⇒ Applies specialized knowledge and skills to more effectively manage challenging client situations such as poverty, low literacy, abusive environments, substance abuse/addiction **4. Code of Ethics: Adheres to the Ethical Standards of the Nursing Profession** **Competencies** ⇒ Practices ethically in accordance with the CNA code of ethics ⇒ Identifies ethical principles and steps to follow when faced with ethical dilemmas ⇒ Applies the decision making process of ethical analysis to ethical dilemmas ⇒ Seeks support and guidance with ethical issues **5. Provision of Service to the Public: Provides nursing services, coordinates activities and collaborates with others in providing health care services** **Competencies** ⇒ Operates within a primary care nursing model of care delivery, assuming total responsibility for planning, care provision and coordination of client's home care nursing needs, from admission to discharge ⇒ Complies with risk management policies and procedures regarding staff and client safety, WMIS, infection control and universal precautions ⇒ Complies with principles of effective communicable disease control and all infection control measures including universal precautions as per HCN policies and procedures ⇒ Evaluates and acts to promote personal safety and the safety of the client and home/community environment ⇒ Participates actively in quality improvement activities to promote efficiency, productivity and optimum client outcomes ⇒ Applies caseload management skills effectively ⇒ Demonstrates understanding of the importance of resource management, planning and funding ⇒ Demonstrates efficient and cost effective use of supplies and equipment ⇒ Provides continuity of care by facilitating a systematic approach to discharge planning ⇒ Performs liaison role to identify client needs and resources available to meet needs in the community

Author(s) or Source	Title and Framework for the Competencies or Standards
Health Canada, 2002 (Continued).	⇒ Assists in the development of other home and community care team members ⇒ Complies with referral process as per HCN policies and procedures ⇒ Coordinates provision of care including delegation and supervision of home support workers (using HWS guidelines) ⇒ Participates and/or leads client conferences on a regular basis ⇒ Demonstrates knowledge of health information systems in the community and how to access them ⇒ Collaborates and consults with the client and with all members of the multidisciplinary health team ⇒ Acknowledges the major purposes and role responsibilities of supervision by the health director (or equivalent) and home care nurse supervisor 6. **Self Regulation: Assumes primary responsibility for maintaining competence, fitness to practice and acquiring new knowledge and skills** **Competencies** ⇒ Manages personal and professional health and well being effectively ⇒ Maintains competence and acquires new knowledge and skills
Herleman, L. (2008, p. 235).	**Home Care Primary Nurse Case Management Model** **Competencies needed by Home Care Nurses** • Assessment skills • Teaching process • Nursing care and treatment skills • Home care reimbursement complexities • Referral process • Admission process • Interviewing skills • Development of a plan of care to include all of the needs of the patient • Medication monitoring and teaching • IV and central line knowledge and skills • Various wound care treatments and products • A broad spectrum of treatments (e.g. application of una boots, biliary catheter flushes, urinary catheterizations, colostomy care, suprapubic catheter care, etc.)

Author(s) or Source	Title and Framework for the Competencies or Standards
Higuchi, Christensen, & Terpstra, (2002).	**Challenges in Home Care Practice: A Decision-Making Perspective** Four Domains of Home Care Practice 1. Assessment and use of physiological data 2. Initiation and monitoring of therapeutic interventions 3. Assessment and use of family and environmental data 4. Integration of physiological data and interventions
Kaiser, Barr and Hays (2003, p. 194).	**Competencies for Community/Public Health Nurse Health Systems Nurse Specialists (selected)** ⇒ Applies ethical thinking to practice situations ⇒ Uses professional standards, guidelines and best practices ⇒ Engages in systems thinking ⇒ Articulates for self and others practice values and beliefs ⇒ Understands quality management ⇒ Evaluates health programs ⇒ Identifies best clinical practices ⇒ Fosters evidence-based practice ⇒ Partners with individuals, organizations… ⇒ Participates in resolving conflict ⇒ Communicates effectively in oral discussions and presentations ⇒ Communicates effectively in written forms
Kaiser and Rudolph (1996).	**In Search of Meaning: Identifying Competencies Relevant to Evaluation of the CHN Generalist** **Socialization Domain** ⇒ Recognizing world view differences between client and nurse ⇒ Understanding the CHN role responsibility and practice parameters ⇒ Sensitivity to worth and living conditions of vulnerable clients (works at getting family or individual perceptions; displays acceptance of poor environmental conditions—see also Zurmehly, 2007) ⇒ Using peers as resources through sharing and camaraderie (promotes learning of cooperation and understanding of interdependence) ⇒ Professional behaviours: resourceful, progressive self-reliance ⇒ Recognizing values of CHN: "going the extra mile"; greatest good for greatest number ⇒ Recognition of community systems and functions **Overlap of Domains** ⇒ Long-term relationship development ⇒ Promoting empowerment and self-efficacy ⇒ Home visiting skills ⇒ Autonomy in organization and/or scheduling of contacts ⇒ Accountability in unstructured clinical settings

Author(s) or Source	Title and Framework for the Competencies or Standards
	⇒ Providing direction for care/intervention ⇒ Case finding—e.g. with extended family (e.g. grandchildren in the home) ⇒ [knowledge of] interactive effect of individual, family and community ⇒ Individualized care for individuals, families [and populations] ⇒ Using comprehensive approach (e.g. contact with school nurse) ⇒ Managing community resources/workers ⇒ Picking up on client cues ⇒ Analysis of practice/care approaches ⇒ Assessments: cultural, psychological, environmental ⇒ Fostering consumer participation ⇒ Problem-solving and motivating with clients ⇒ Preventive focus ⇒ Examining health behaviour change potential ⇒ Documentation norms/record management **Clinical Practice Domains** ⇒ Theoretical concepts synthesized in practice ⇒ Asepsis and universal precautions ⇒ Systematic interviewing (ability to flow with the client…"being able to obtain accurate information involves not only what to ask but also how and when to ask questions when nurse-client priorities differ", p. 160). ⇒ Data collection, analysis and problem identification for family [and populations] ⇒ Assessments: physical, developmental ⇒ Analysis of data from multiple sources ⇒ Judges appropriateness of options, priorities, resources ⇒ Seeks alternate plans of care or implementation strategies for family [and populations] ⇒ Client-relevant teaching (considers age and culture for approaches to learning needs) ⇒ "Sees family as unit of care….identifies problem of caregiver strain….recognizes family dynamics"….."creates individualized approaches in caring for families" (p. 160)

Appendix B
Additional References for Home Health Nursing

Algera, M., Francke, A.L., Kerkstra, A., & van der Zee, J. (2004). Home care needs of patients with long-term conditions: Literature review. Journal of Advanced Nursing, 46(4), 417-429.

Anonymous (2002). Are nursing and agency responsibilities of the 1920s still relevant today? *Home Healthcare Nurse, 20*(10), 638-640.

Aponte, J. (2009). Meeting the linguistic needs of urban communities. *Home Healthcare Nurse, 27*(5), 324-329.

Baich, L., Wilson, D., & Cummings, G.G. (2010). Enterostomal therapy nursing in the Canadian home care sector: What is its value? *Journal of Wound, Ostomy and Continence Nursing, 37*(1), 53-64.

Benefield, L.E. (1996). Productivity in home healthcare: Part One: Assessing nurse effectiveness and efficiency. *Home Healthcare Nurse (14),* 9. 699-706.

Benefield, L.E. (1996), Productivity in home healthcare: Part Two: Maintaining and improving nurse performance. *Home Healthcare Nurse, 24*(10), 803-812.

Blomqvist, K. & Edberg, A. (2002). Living with persistent pain: Experiences of older people receiving home care. *Journal of Advanced Nursing, 40*(3), 297-306.

Brown, T. (2009). Literacy and healthcare: The challenge of communication in home healthcare and hospice. *Home Healthcare Nurse, 27*(1), 55-59.

Canadian Nurses Association (2009). The Community health nursing certification exam list of competencies. Ottawa: Author. Retrieved January 21, 2010 from http://www.cna-aiic.ca/CNA/documents/pdf/publications/CERT_Comm_Health_2009_e.pdf

Canadian Public Health Association (1990). *Community health-Public health nursing in Canada: Preparation & Practice.* Ottawa: Author.

Canzanello, V.J., Jensen, P., Schwartz, L.L., Worra, J.B. & Klein, L.K. (2005). Improved blood pressure control with a physician-nurse team and home blood pressure measurement. *Mayo Clinic Proceedings, 80*(1), 31-36.

Doran, D. M., Hirdes, J., Blais, R., Baker, G.R., Pickard, J., & Jantzi, M. (2009). The nature of safety problems among Canadian homecare clients: Evidence from the RAI-HC reporting system. *Journal of Nursing Management, 17*, 165-174.

Doran, D.M., Hirdes, J., Poss, J., Jantzi, M., Blais, R., Baker, G.R. & Pickard, J. (2009a). Identification of safety outcomes for Canadian home care clients: Evidence from the RAI-Home Care reporting system concerning emergency room visits. *Healthcare Quarterly, 12*, 40-48.

Frazier, S.C. (2003). Magnet home care agencies: A professional way to impact quality and retention. *Home Healthcare Nurse, 21*(9), 603-610.

Hasson, H., & Arnetz, J.E. (2007). Nursing staff competence, work strain, stress and satisfaction in elderly care: A comparison of home-based care and nursing homes. *Journal of Clinical Nursing, 17*, 468-481.

Maida, V. (2002). Factors that promote success in home palliative care: A study of a large suburban palliative care practice. *Journal of Palliative Care, 18*(4), 282-286.

Mensik, J.S. (2007). The essentials of magnetism for home health. *The Journal of Nursing Administration, 37*(5), 230-234.

Naylor, M., & McCauley, K. (1999). The effects of a discharge planning and home follow-up intervention on elders hospitalized with common medical and surgical cardiac conditions. *Journal of Cardiovascular Nursing, 14*(1), 44-54.

Peckover, S., & Chidlaw, R.G. (2007). The (un)-certainties of district nurses in the context of cultural diversity. *Journal of Advanced Nursing, 58*(4), 377-385.

Porter, E.J., Ganong, L.H., Drew, N., & Lanes, T.I. (2004). A new typology of home-care helpers. *The Gerontologist, 44*(6), 750-759.

Public Health Agency of Canada (2008). Core competencies for public health in Canada: Release 1.0 Health Canada: Ottawa. Retrieved January 5, 2010 from http://www.phac-aspc.gc.ca/ccph-cesp/pdfs/cc-manual-eng090407.pdf

Registered Nurses' Association of Ontario (1985). *Standards of nursing practice for community health nurses in Ontario.* Toronto: Author.

Rice, R. (1998). Implementing undergraduate student learning in home care. *Geriatric Nursing, 19*(2), 106-108.

Skott, C. & Lundgren, S. (2009). Complexity and contradiction: Home care in a multicultural area. *Nursing Inquiry, 16*(3), 223-231.

Townes, J., & Cook, P.R. (2001). Standards of practice: A measure of competence. *Home Healthcare Nurse, 19*(6), 383-386.

Yamashita, M., Forchuk, C., & Mound, B. (2005). Nurse case management: Negotiating care together within a developing relationship. *Perspectives in Psychiatric Care, 41*(2), 62-70.

Zander, K. (2002). Nursing case management in the 21st century: Intervening where margin meets mission. *Nursing Administration Quarterly, 26*(5), 58-67.

Zarbock, S.F. (1998). Wound care into the new millennium. *Home Care Provider, 3*(4), 192-193.