PRACTICE STANDARDS

for

Victorian Community Health Nurses

Community Health Nurses Special Interest Group
Australian Nursing & Midwifery Federation (Victorian Branch)

2013
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PROJECT TEAM
Olive Aumann, Giancarlo Di Stefano, Mary Greene CHN SIG ANMF (VB) Committee
Maureen Ward RN FACN, Project worker
Trish O’Hara, Professional Officer, ANMF (Vic Branch)

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These practice standards draw significantly from the following documents:


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Foreword

These Practice Standards are the culmination of more than a decade of deliberation, investigation and research led by the Victorian ANMF Community Health Nurses Special Interest Group (CHN SIG). The process involved participation from a broad cross section of community health nurses working in a range of settings and local contexts and undertaking a variety of roles and functions throughout Victoria.

Over the past decade, community health nurses (CNH) have felt their roles increasingly misunderstood and subject to practice change led by policy and funding imperatives rather than evidence of population health and wellbeing needs. An issue compounded by the changing face of health care systems in Australia; shrinking health budgets, increasing health inequity across population groups and geographies, a rapidly ageing population and the explosion in chronic disease. Taking account of these trends, the CHN SIG instigated a two-phase research study (2008, 2010), which recommended the development of Practice Standards for Victorian Community Health Nurses that articulates their role and scope of practice and the underpinning theoretical and philosophical basis for community health nursing practice.

The Practice Standards for Victorian Community Health Nurses contained in this document reflect the breadth and depth of contemporary community health nursing practice across four domains: professional practice, critical thinking and analysis, provision and coordination of care and, communication and collaboration. The standards provide comprehensive descriptions of the theoretical frameworks, knowledge, skills and competencies that underpin modern day community health nursing practice in Victoria.

The development of the Standards would not have been possible without the support of the ANMF (Victorian Branch) who provided generous financial support through consecutive Elizabeth Hulme SIG grants; and that of committee members Giancarlo Di Stefano, Mary Greene, ANMF’s Trish O’Hara and the many others who committed much time and effort to considering content, sourcing information and reviewing drafts. Overwhelmingly, however, these Practice Standards for Victorian Community Health Nurses would not have achieved their quality and calibre were it not for the committed and dedicated work of their author, Maureen Ward. Maureen devoted herself over many months to capturing not only the proficiency and expertise of CHN but importantly imbuing its spirit and essence throughout the Standards of Practice.

Olive Aumann

Chair, Victorian (ANMF) Community Health Nurses Special Interest Group
INTRODUCTION

The Community Health Nurses Special Interest Group (CHN SIG) is a special interest group of the Australian Nursing & Midwifery Federation (Victorian Branch) which provides a forum for nurses working in community health to exchange ideas, network and access professional development opportunities. The CHN SIG ANMF (VB) is committed to promoting the professional, educational and economic interest of nurses engaged in community health nursing by

- participating in decision-making forums, in projects and research
- raising awareness, issues and emerging trends in community health and primary health care
- increasing public and health industry awareness of the value of the community health nurse role
- enhancing the unity among, and the profile of community health nurses (CHN SIG ANMF (VB) 2013).

Overview of community health nursing in Victoria

There is a long tradition of community health nursing in Victoria, even before the arrival of the Community Health Program in 1973. The role was often defined by the setting or target population: bush nursing, district nursing, industrial nursing, school nursing, infant welfare, public health etc.

The intent of the Commonwealth Community Health Program was to shift the emphasis from treatment to prevention, to provide an alternative to general practice (fee-for-service at that time) for the delivery of primary health care and to reduce the dependence of the communities on large institutions. The key initiative was the establishment of community health centres as in other countries such as the UK and Canada to provide primary health care to a whole population or in an area of health service shortage. The community health centre concept stresses the importance of the multidisciplinary team of health workers. Palmer and Short (2010 p133) go so far as to suggest that the Community Health Program has produced a group of workers with a “different... superior...conception of the appropriate aims of the health care system” and although a weak group, it provides the basis for the new public health movement.

By the mid-1980s the ideals and initiatives of the Community Health Program began to be dismantled. Reports repeatedly identified inequalities in health status among population groups yet new initiatives and programs set priority targets and goals within illness or health problem categories. Innovations in public health policy were few, mainly focused on Medicare or epidemiologically measurable targets symbolising the medical approach to public health. However, reports and committees did begin to acknowledge the relevance of community participation, advocacy and collaboration among consumers, industry and governments. By the early 1990s movement towards the inclusion of lifestyle and the new public health approaches to health promotion began. There is continuing tension between different approaches to disease prevention and health promotion and towards agreement on priorities. By the close of the twentieth century a worldwide focus was directed towards the social determinants of health, which drive the work in promoting advocacy in health and wellbeing.

In 2008 the Australian federal government began to focus on decreasing the inequalities in health status between population groups, including prevention within public hospitals and with due regard to the environment. This is reflected in the National Health and Hospitals Reform Commission final report (2009) and the National Preventive Health Taskforce work (2008). These reports revisit aspects of the Community Health Program such as the development of multidisciplinary centres and the Commonwealth government taking full responsibility for primary health care (Palmer and Short 2010).

The new public health philosophy is consistent with the Declaration of Human Rights (UN 1948), is embodied in the Declaration of Alma Ata (WHO 1978) and reaffirmed by the Ottawa Charter (WHO, 1986). The principle of equity is central to these foundation documents which attempt to address the unequal distribution of health status and health care services among population groups.
Despite these promising initiatives, public health continues to have a low priority in the allocation of resources and expenditure remains at a low percentage, compared to overall health services (Palmer and Short 2010). Even in recent reform documents, there is little specific reference to CHNs other than to practice nurses.

There has been a proliferation of community based nursing roles, not labelled as Community Health Nursing for example: hospital in the home, chronic disease management, palliative care nursing, refugee health nurse and practice nurse.

Community health nursing is a specialty within the discipline of nursing, a unique role, promoting and protecting health in the community. Community health nursing maintains a population focus on community strengths and needs in addition to providing direct primary health care nursing for individuals and families from high-risk groups and vulnerable communities, the focus is on health promotion and prevention of disease (Condon et al 2008 p15). Health is described as a human right; the right to care and protection, optimum health functioning, informed choice, advocacy and self-determination (CHN SIG 1993 p2).

Background to the development of practice standards
The development of these practice standards came out of recommendations made in Phase 2 of a major research project undertaken by the CHN SIG ANMF (VB). These standards must be read in conjunction with Phase 1 (Condon et al 2008) and Phase 2 (CHN SIG 2010).

The project work undertaken in Phase 1 points out that the place of community health nurses (CHNs) is not obvious in the Australian health care funding system, making CHNs’ practice invisible. This is despite the belief that CHNs play a significant role in the provision of community health care. The authors also point out that their findings show that CHNs believe their role to be misunderstood, suffering erosion, at risk of destabilisation and that it may be lost to society. Nurses must understand and articulate the types of community health nursing services and the value of these services to communities. Phase 1 explores and describes the role and identifies common characteristics of CHNs who work in community health centres in Victoria. All CHNs working in community health centres in Victoria were invited to complete a self-administered questionnaire. Key findings include: demographic data, populations worked with (especially marginalised or vulnerable groups), major areas of practice and competencies and knowledge used. Analyses indicate that CHNs are calling for more community health nursing resources and a ‘stronger role in advancing comprehensive primary health care practice’ (Condon et al 2008 p7). It was found that CHNs consider themselves underutilised by the community health sector. The results portray CHNs as a body of experienced nurses, prepared at postgraduate level for independent community health nursing work within multidisciplinary health services. The study identified comprehensive assessment and advocacy as key elements of community health nursing. Recommendations from Phase 1 include: further research [the need for research is also called for by McMurray and Clendon (2011p90)]; evaluation of existing models of community health nursing; promotion of best practice models amongst CHNs, policy makers and funding bodies; establishment of a formal dialogue with policy makers to develop community health policy in Victoria; that the CHN SIG ANMF (VB) be supported to have an annual conference/workshop for collective action with community health key stakeholders; that CHNs be encouraged and supported to contribute to evidence-based primary health care; that a series of focus groups be held to identify models of best practice currently in use, to agree on indicators to be used in evaluation of interventions and to develop strategies for establishing strategic alliances for accessing policy makers (Condon et al 2008).

Phase 2 of the project set out to explore the manner in which community health nursing interventions, identified in Phase 1, contribute to communities and to identify factors that influence CHN capacity to provide community health services. Four focus groups and two individual interviews involving thirty-two
(32) CHNs were conducted and transcripts thematically analysed. Participants described *advocacy* and its influence on their work. Three advocacy themes emerged: ‘giving voice’ ‘encouraging agency’ and ‘standing beside’. Each of these themes is described in detail in Phase 2. In this study CHNs were not always able to articulate the theoretical or philosophical basis that informed their practice. Those who did emphasised the Social Model of Health, the Social Determinants of Health and the contribution of CHNs to the multidisciplinary team. Tensions in community health nursing are described namely: attitudes towards community health nursing and health promotion of people in the acute sector and that CHNs are ‘too expensive’. Trends influencing the future of community health nursing are discussed. Recommendations from Phase 2 include: develop a set of practice standards that articulates the role, scope of practice and the theoretical and philosophical basis for community health nursing practice; continue to apply the Social Model of Health framework to community health nursing practice, promoting consistent interpretation and application of the model; combine the generalist and specialist nursing role within the role and scope of practice; seek opportunities to advocate for community health nursing positions in health promotion teams through leadership roles within community health structures; seek to undertake research and dissemination of knowledge, including presenting at conferences and publishing in community and primary health care literature; undertake evaluation that gives voice to clients and communities. This project highlights the benefits of community health nursing interventions on the health and wellbeing of groups and communities served. CHNs stated that they “…gain the most satisfaction” from health promotion but it’s “not reflected in statistical data produced” therefore not known or valued by organisations and health policy makers who devise and analyse the statistics collected by CHNs (CHN SIG 2010 p13, 16). More research and evaluation of practice is urgently required to make these benefits known and valued by health policy makers (CHN SIG 2010).

Phase 1, Phase 2 and this set of standards of practice seek to clarify and consolidate the CHN role and scope of practice within primary health care in Victoria. The standards of practice build on the foundation of the previous work in this major community health nursing project. This set of standards is complementary to the competencies all registered nurses are required to meet as per the *National competency standards for the registered nurse* (NMBA 2006). The standards are built on the foundation of nursing theory and practice (See Appendix A) and earlier community health nursing standards (CHN SIG 1993).

**Rationale for practice standards**

There are many reasons and uses for standards of practice. Standards of practice are the shared notion of ‘good practice’. The driving force for the development of these standards is to articulate the role, the scope of practice and the theoretical and philosophical underpinning of community health nurses who work in community health centres and services in Victoria, as recommended in Phase 2 and outlined in the project brief (See Appendix D). Standards of practice represent a valuable tool in guiding the professional nursing practice of Victorian community health nurses. Standards also promote consistent interpretation and application of models of practice, in this case the Social Model of Health.

Development of these standards by the CHN SIG ANMF (VB) has occurred at the same time as the development of an expanded career structure for Victorian CHNs from entry level to executive level positions. These standards describe the scope of practice of both ‘generalist’ and ‘specialist’ community health nurses in Victoria. Standards are instrumental in promoting:

- the profession,
- community health nursing positions in health promotion teams,
- leadership roles within community health structures,
- community health nursing practice-related research,
- dissemination of knowledge about the community health nurse role and
- development of community health nursing curricula.
Standards of practice are based on the values of the profession as articulated in the Code of Ethics (NMBA 2008a) and the Code of Professional Conduct (NMBA 2008). Standards may be used by the Nursing and Midwifery Board of Australia (NMBA) in professional conduct matters. Standards protect the public and enable nurses to promote safe, competent and ethical practice.

The profession has the responsibility of setting standards for its practitioners as a means of improving the quality of care and guiding professional practice. Standards of practice represent agreed-upon levels of quality in practice; they characterise, measure and provide guidance in achieving excellence in practice.

Standards of practice are an objective basis for the development of evaluation tools to

- identify areas of practice strengths and weaknesses
- document the benefits and outcomes of community health nursing practice
- measure impact and effectiveness of community health nurse action
- develop research to validate practice
- give voice to clients and communities
- generate research questions that lead to improvement in community health nursing practice

Standards of practice can be used to guide, support and evaluate individual practice, to assist nurses to plan their continuing professional development, to increase scope of practice and to guide mentoring of future nurses and new practitioners.

Standards can be used as the foundation for:

- community health nurse role definition
- job description development
- performance review processes
- peer review processes
- self-assessment
- selection criteria
- career structure
- skill mix
- initial registration, annual renewal and re-registration (Benner et al 2002; CNA 2011; CNSIGWA 2001).

It’s the ‘combination of specialist clinical and population-based skills and knowledge that underpins the CHN’s ability to make the link between health and its social determinants’ (Condon et al 2008 p39 italics added).

**Intended audience**
The standards of practice will be of use to:

- community health nurses
- community health centres and services and other health care services
- stakeholders in community health and primary health care
- employers of community health nurses
- the public, community members, community groups, users, consumers,
- government departments
- professional organisations
- Nursing and Midwifery Board of Australia (NMBA)
- institutions offering education in nursing, community health nursing, primary health care, health promotion
Influencing the future of community health nursing
In an effort to counter these trends the CHN SIG ANMF (VB) has embarked on this multiphase research, to articulate CHNs’ contribution within the primary health care sector, and to the health and wellbeing of Victorian communities by:

- better voicing and articulating what they do and how effectively they do it... (Condon et al 2008 p39)
- evaluating outcomes of their work and disseminating the findings
- better articulating the basis that inform their practice
- advocating for community health / primary health care content in accreditation for undergraduate programs
- preparing nurses for the primary health care sector, for example developing clinical placements and a graduate year program in PHC
- promoting best practice, by developing best practice indicators, evaluating and reporting on the social reforms and health outcomes of primary health care nursing interventions (Condon et al 2008 p39)
- doing population health work, within the ‘new public health’ model, as CHNs were early drivers of this model
- place more emphasis on re-orienting health services to meet the needs of their communities
- advocating for people and communities to exercise their right to self-determination in decision making about their health

Regular review
Standards of practice reflect the current state of knowledge in the field and are provisional, dynamic and subject to regular review and subsequent changes. It is envisaged that these standards will be reviewed every three years and are therefore due for review in 2016.

TERMINOLOGY

PHASE 2: refers to the second part of the CHN SIG ANMF (VB) research project - Community Health Nurse Special Interest Group (CHN SIG). 2010. The role and scope of practice of community health nurses in Victoria, and their capacity to promote health and wellbeing (Phase 2) Advocating for health. Melbourne: Community Health Nurse Special Interest Group ANF (Vic Branch). Retrieved June 3 2013 from http://www.anfvic.asn.au/multiversions/41890/FileName/CHN_Role_scope_Phase_2.pdf

CARE: service, practice; in partnership, that which is delivered/provided to an individual, family, group or community by a community health nurse

COMMUNITY HEALTH NURSING: community health nursing is a speciality practice area of the discipline of nursing (Condon et al 2008; St John 2007)
COMMUNITY HEALTH NURSE (CHN): requires specific knowledge and skills to work effectively in community settings which are common across all areas of community health nursing practice (St John 2007 p8); has full understanding of the social model of health; delivers nursing care in partnership with the individual/group/community; practice is evidence based; knowledge and skills of community health nursing, social determinants of health, health promotion, care coordination and early intervention;

SPECIALIST CHN: in addition, many CHNs have specialist expertise in a particular area of community health nursing; such as diabetes education, women’s health, adolescent health (St John 2007 p8); these specialty areas may relate to 1) client group 2) the setting or 3) health issue. Many of these specialty areas overlap with non-community based specialties (St John 2007 p8); Condon et al (2008) noted that Victorian CHNs have developed specialty area of practice. Five specialties emerged from Phase 1 research: 1) Chronicity: case management, coordination, rehabilitation, aged care, wound care and education related to chronic conditions; 2) Women and families; 3) Generalist; 4) Adolescent health and 5) Health promotion. Phase 2 found that the focus on advocacy and social determinants of health was common to all CHNs whether working as generalists or specialist roles (CHN SIG 2010 p 15).

GENERALIST CHN: does not practise in a specialty area or may work some of the time in a specialist role, works with various individuals/groups, linking people to required services/agencies etc. Generalist skills to address needs as they arise in the community (St John 2007 p8); acts as a community advocate focusing on health promotion in generalist roles that allows them to work with the community as a whole, rather than with predetermined public health priorities (McMurray and Clendon 2011p89); works in partnership with the community, in an empowering way, having cultural relevance as a cultural broker, liaison, advocate and activist rather than case manager or project manager (McMurray and Clendon 2011p90)

FAMILY: includes people in consensual relationship with the person receiving nursing care and others who play an important role in the life of that person (NMBA 2008); a social unit composed of members connected through blood, kinship, emotional or legal relationships (ICN 2006)

INDIVIDUAL/GROUP/COMMUNITY: used in this document, to indicate the recipient of community health nursing care; client, consumer, user, patient, family, significant other

TEAM: used to indicate the health care, multidisciplinary, inter-disciplinary, interprofessional, trans-disciplinary, intersectoral group of people with whom CHNs collaborate

SUMMARY of PRACTICE STANDARDS

DOMAIN ONE: PROFESSIONAL PRACTICE

Standard 1: Demonstrates a comprehensive knowledge of community health nursing incorporating population health, primary health care and health promotion

Standard 2: Advocates for individuals/groups/communities and their rights for community health nursing service, primary health care, health equity and healthy environments, policies, and legislation

Standard 3: Practises within an ethical and professional nursing framework

Standard 4: Practises in accordance with legislation affecting community health nursing practice and primary health care

Standard 5: Demonstrates leadership in the development, coordination and management of systems and processes to anticipate and facilitate safe quality health and wellbeing services

DOMAIN TWO: CRITICAL THINKING AND ANALYSIS

Standard 6: Participates in continuing professional development (CPD) of self and others

Standard 7: Practises within an evidence-based framework

DOMAIN THREE: PROVISION AND COORDINATION OF CARE

Standard 8: The community health nurse (CHN) conducts comprehensive and systematic assessment, planning, implementation and evaluation in an ongoing way in collaboration with the individual, family, group, team and community

Standard 9: Coordinates, organises and provides integrated health promotion (IHP) considering a whole of community approach

Standard 10: Facilitates a physical, emotional, social and cultural environment that promotes individual/group/community safety, security, respect and health and wellbeing

DOMAIN FOUR: COMMUNICATION AND COLLABORATION

Standard 11: Establishes, maintains and concludes therapeutic relationships with individuals, groups and communities

Standard 12: Collaborates with the multidisciplinary team to provide community health nursing
DOMAIN ONE: PROFESSIONAL PRACTICE

Standard 1: Demonstrates a comprehensive knowledge of community health nursing incorporating population health, primary health care and health promotion

Rationale
Community health nursing is based on nursing theory (Appendix A: Summary of nursing theories), primary health care and integrated health promotion. Community health nursing aims to improve population health outcomes and is underpinned by the social model of health, the social determinants of health, health equity, health literacy, preventive health, early intervention, and self-management. Community health nursing draws on knowledge from epidemiology, life and social sciences, educational principles, economics and physical sciences.

Criteria
1.1 Identifies up-to-date theoretical/conceptual frameworks to inform community health nursing practice
1.2 Demonstrates well-developed knowledge of advocacy; assessment; complex chronic disease management; working in settings with groups and health issues; funding arrangements/trends; public and private health services; Medicare; pharmacotherapy; mental health; disability; care across the life span and end of life care
1.3 Demonstrates well-developed population health knowledge and skills to make the link between health and its social, economic, cultural, environmental, biological-genetic and behavioural determinants
1.4 Knowledge of multisectoral systems that impact on the health of individuals and the community: the health care system, its processes and component services; housing; education; transport; employment;
1.5 Practises community health nursing based on the best available evidence, across the continuum of care in response to identified health needs of individuals, groups and communities: taking upstream, midstream and downstream action as required
1.6 Demonstrates cultural competency and culturally safe practice in working with individuals and groups of differing backgrounds, values, beliefs, language, lifestyles, ethnicity, faith and sexual orientation
- Acknowledges, respects and embraces diversity

Standard 2: Advocates for individuals/groups/communities and their rights for community health nursing service, primary health care, health equity and healthy environments, policies, and legislation

Rationale
Condon et al (2008 p36) in Phase 1 found advocacy to be ‘fundamental to community health nursing’ and ‘integral to the ethical principles of health care essential to all nursing practice’. Community health nursing aims to achieve health equity through action on the social determinants of health. These being largely outside the scope of health services, effective action requires partnerships and advocacy with other sectors in order to effect change. The key elements of community health nursing identified in Phase 1 are integral to nursing advocacy applied to individuals, families, groups and communities (Appendix B: A model of nursing advocacy). Advocacy involves collaborative and participatory relationships with the community: ‘giving voice’, ‘encouraging agency’ and ‘standing beside’ (CHN SIG 2010 p4-7).

Criteria
2.1 Protects the rights of individuals, groups and the community to be enabled to access health care, advice and information for the best possible outcomes
- identifies and adheres to strategies to promote and protect individual, group and community autonomy and self determination
- recognises and accepts the rights of individual, group and community
• fosters participation and ownership in the decisions and processes affecting rights to health care
• enables self-reliance in managing, maintaining and enhancing health status
• ensures that personal values and attitudes are not imposed on others

2.2 Advocates for individuals, groups and the community within the community health service
• maintains an effective process of care when faced with differing values, culture, beliefs and biases
• enables individual/group/community participation and ownership in planning, development, review and evaluation processes
• supports the individual, group and community to identify own needs and strengths and focuses on their experience
• familiarises individuals, groups and community with health, welfare and social support systems and processes

2.3 Advocates for improved population health at the local, regional, state and national levels
• enables the individual/group/community to identify health and wellbeing needs
• supports community members in bringing these to the attention of individuals, institutions, governments and sectors who can positively impact on health and wellbeing needs
• enables individual/group/community to identify, understand and access community and institutional resources available to them
• enables individuals, groups and communities to achieve independence and have ongoing control over their health
• enables vulnerable and marginalised groups to access optimal health and health care services

2.4 Supports individuals/groups/community to make informed decisions about health care
• supports and respects an individual's/ group's/community’s decision through communication with other members of the multidisciplinary health care team
• enables the individual, group and community to make choices about how to work towards optimal independence

2.5 Advocates for change
• works in partnership across sectors to positively influence the social determinants of health and improve health equity
• participates in political advocacy to secure resources for population groups

Standard 3: Practises within an ethical and professional nursing framework
3.1 Complies with the Code of ethics for nurses in Australia (NMBA 2008a) and the Code of professional conduct for nurses in Australia (NMBA 2008)
3.2 Maintains current registration with the Australian Health Practitioners Regulation Agency (AHPRA) - Nursing and Midwifery Board of Australia (NMBA)
• maintains currency of qualifications in areas of expertise which require specific courses e.g. Diabetes Nurse Educator, Women’s Health
• demonstrates sophisticated knowledge and skills in field of speciality
3.3 Demonstrates awareness and understanding of developments in nursing that have an impact on the individual’s capacity to practice community health nursing
3.4 Considers personal health and wellbeing in relation to being fit for practice
3.5 Integrates nursing and health care knowledge, skills and attitudes to provide safe and effective community health nursing practice
3.6 Integrates organisational policies, procedures, role description and guidelines with practice standards
• reviews and provides feedback on organisational policies, procedures, role descriptions and guidelines
3.7 Understands and practises within own competency and qualifications (scope of practice)
• raises concerns about inappropriate delegation with the appropriate organisational or regulatory personnel
• demonstrates accountability and responsibility for own actions within nursing practice

3.8 Recognises the differences in accountability, responsibility and scope of practice between registered nurses, enrolled nurses and unregulated health workers
• understands requirements of statutory and professionally regulated practice
• understands requirements for delegation and supervision of practice
• raises concerns about inappropriate delegation with relevant organisational or regulatory personnel
• understands the role of multidisciplinary team members

3.9 Recognises and responds appropriately to unsafe or unprofessional practice or misconduct or interventions which appear inappropriate
• ensures safe nursing practice at all times
• identifies behaviour that is detrimental to achieving optimal health of the individual/group/community
• follows up incidents of unsafe practice to prevent re-occurrence

3.10 Assumes professional responsibilities demonstrated by membership, active support and participation in professional organisations

**Standard 4: Practises in accordance with the law affecting community health nursing practice and primary health care**

4.1 Practises in accordance with legislation, common law, duty of care, regulation, policies and procedures as they apply in the community health nursing context
4.2 identifies the legal aspects of nursing activities such as drugs, poisons and controlled substances; occupational health and safety; medical records and information; confidentiality and privacy;
4.3 Identifies and explains effects of legislation on the care of individuals, groups and community
4.4 Maintains confidentiality and privacy as per policy and legal requirements

**Standard 5: Demonstrates leadership in the development, coordination and management of systems and processes to anticipate and facilitate safe quality health and wellbeing services**

5.1 Leads and participates in decision making at the organisational level
• decision making is consultative, inclusive and transparent
• develops and demonstrates leadership in professional relationships with stakeholders and colleagues
• facilities strategic thinking
• provides clinical leadership, including establishing parameters of services and clinical standards

5.2 Leads and participates in organisational administration and management including allocation of budget and resources
• accepts responsibility for fiscal management, review and reporting
• participates in service and organisation planning and design
• participates in development, implementation and review of policies, procedures, protocols and guidelines based on contemporary evidence
• participates in committees and working parties within and beyond the work place
• coordinates multidisciplinary team for population group or program area
• participates actively in performance review processes which are systematic, monitored and reviewed
• leads and participates in organisational change processes to strengthen organisational capacity for health promoting practice

5.3 Effectively and efficiently manages resources to promote optimal community health
• prioritises workload considering the individual’s/group’s/community’s preferences
• effectively utilises resources in the context of changing workloads
• modifies practice to accommodate needs in different environments
• responds effectively to unexpected or rapidly changing situations, emergencies
• participates in emergency management practices and drills
• implements crisis interventions and emergency procedures
• maintains current knowledge of disaster preparedness and management,
• recognises when resources are insufficient to meet needs
• takes appropriate action when level of resources risks or compromises quality and safety of service delivery

5.4 Demonstrates leadership in community capacity building
5.5 Demonstrates leadership in the development of community health nursing as a specialty area of nursing
5.6 Supports population health collaboration and integration with partners and planning and policy-making bodies for example: Municipal Public Health and Wellbeing Plans in local government, Population Health Plans in Medicare Locals, Primary Care Partnerships and Integrated Health Promotion planning in the population health sector
5.7 Delegates aspects of care to enrolled nurses and other healthcare workers according to their competence and scope of practice
• delegates to and supervises others consistent with regulations and organisational policy
5.8 Provides effective and timely direction and supervision to ensure that delegated care is provided safely and accurately
• supervises and evaluates nursing care provided by enrolled nurses and others
• uses a range of direct and indirect techniques such as instructing, coaching, mentoring, and collaborating in the supervision and support of others
• documents support provided to those being supervised or to whom care has been delegated

DOMAIN TWO: CRITICAL THINKING AND ANALYSIS

Standard 6: Participates in continuing professional development (CPD) of self and others
6.1 Meets the CPD registration standard of the Nursing and Midwifery Board of Australia (NMBA 2010)
6.2 Identifies and prioritises learning needs, based on an evaluation of practice against the relevant professional practice standards
• develops a learning plan based on identified learning needs
• participates in effective evidence-based learning activities relevant to learning needs
• reflects on the value of the learning activities or the effect that participation has on their practice
• maintains a CPD Portfolio
6.3 Engages in peer review
• seeks and considers feedback from colleagues about and critically reflects on own nursing practice
6.4 Accepts personal responsibility for continual expansion and updating of community health nursing knowledge and skills
• maintains mandatory skills such as: cardiopulmonary resuscitation (CPR) and first aid as appropriate to the setting for example: anaphylaxis management, asthma first aid
6.5 Contributes to the formal and informal professional development of others
• supports health practitioner students and novice CHNs to meet their learning objectives in cooperation with other members of the multidisciplinary team
• facilitates mutual sharing of knowledge and experience with colleagues
• contributes to the orientation of new staff and ongoing education programs
• participates in instructing, preceptorship, coaching and mentoring to assist and develop colleagues

6.6 Ensures participation in regular professional clinical supervision processes
• uses appropriate strategies and seeks support to manage own practice in response to the professional work environment, including issues of professional isolation
• identifies self care activities to assist with working in a complex and demanding environment
• shares experiences related to professional issues mutually with colleagues
• uses reflective practice to identify personal and professional needs and to seek appropriate support
• where no professional nursing clinical supervision is available seeks appropriate alternative

Standard 7: Practises within an evidence-based framework
7.1 Understands the role of the community health nurse in research
• identifies issues in community health nursing which may be investigated through research; qualitative, quantitative or mixed method
• identifies and engages in research activities which add new knowledge to health promotion and community health
• demonstrates awareness of current research and discusses implications of research with colleagues
7.2 Uses evidence based practice
• uses relevant literature and research findings to improve current practice
• uses information technology skills to access current research, evidence and guidelines for practice
• demonstrates analytical skills in accessing and evaluating health information and research evidence
• undertakes critical analysis of research findings in considering their application to practice
• demonstrates research translation to practice skills
7.3 Supports, contributes to and participates in quality improvement activities
• recognises that quality improvement involves ongoing consideration and review of practice in relation to practice outcomes, standards and guidelines and new developments
• participates in case review activities/case conferences
• participates in clinical audits
• participates in service accreditation processes
7.4 Evaluates in a timely manner the impact, process and effectiveness of community health nursing to improve health and wellbeing outcomes
• encourages participation in the evaluation that gives voice to individuals, groups and communities
• informs community of research results
• formulates evaluation plans, collects and analyses data and implements findings of community health nursing evaluation
• publishes results in professional literature as appropriate
• disseminates information about community health nursing best practice

DOMAIN THREE: PROVISION AND COORDINATION OF CARE

Standard 8: The community health nurse (CHN) conducts comprehensive and systematic assessment, planning, implementation and evaluation in an ongoing way in collaboration with the individual, family, group, team and community
Rationale
Community health nursing practice enables, mediates and advocates improvement and conservation of health status, preservation of function, avoidance of harmful changes, restoration and amelioration of illness and its effects in partnership with the individual/family/group/community. The nursing process framework affords the development of customised care plans for individuals, families, groups and communities. The nursing process facilitates the coordination, organisation and provision of integrated services.

Criteria
Assessment and data collection
Assessment and data collection are essential for the delivery of community health nursing. Comprehensive assessment was identified as a key element of community health nursing in Phase 1, whether working with individuals, families, groups or communities (Condon et al 2008). It must be accurate, systematic and ongoing in order to achieve the individual’s/family’s/group’s/community’s desired health outcomes. “To attempt to simplify assessment would compromise professional practice and could lead to unethical practices” (Condon et al 2008 p37)

8.1 Uses a relevant evidence-based assessment framework to collect data
- approaches and organises assessment in a structured and culturally sensitive manner
- ensures an appropriate triage system is used for referrals
- uses all available evidence sources, including individual/family/group/significant others, health care team, records, reports, and own knowledge and experience
- uses a range of data gathering techniques, including observation, interview, physical examination and mental health assessment
- collects data that relates to physiological, mental health, cultural, spiritual, psychosocial, socio-economic and environmental indicators on an ongoing basis
- confirms data with the individual/family/group and members of the team

8.2 Analyses data by comparing it with norms and standards
- collaboratively identifies strengths and protective factors
- collaboratively identifies actual and potential health problems through accurate interpretation of data
- identifies deviations from normal
- identifies improvements or setbacks in health status

8.3 Assesses individual’s/family’s/group’s receptiveness (readiness) for change

8.4 Identifies, in collaboration with the individual/family/group, what they need or desire to know to be able to decide what actions to take to achieve optimal wellbeing

Planning

8.5 Develops and records nursing care plan in partnership with individual/family/group, and if appropriate with significant other(s), that includes agreed priorities and expected outcomes

8.6 Identifies expected and agreed health goals including time frame
- incorporates the needs and preferences of individual/family/group into the plan
- respects the rights of individual/family/group to determine their own health care requirements (within the limits of safe professional practice)

8.7 Plans for continuity of care to achieve expected goals

Implementation

8.8 Implements planned, comprehensive, safe, and effective evidence-based community health nursing action to achieve identified, agreed health goals
- involves and integrates care with other health care providers, social and welfare services and other sectors, as appropriate
- observes, monitors and records health status of the individual/family/group
- monitors progress towards health goals in a format suitable to individual/family/group
- provides specialised community health practice to meet community needs for management of complex and chronic health and social issues
Evaluation

8.9 Evaluates progress towards planned health outcomes
- evaluates interventions on basis of individual/family/group outcome criteria in collaboration with individual/family/group and team
- ensures that the evaluation is documented so that it contributes to the development of community health nursing knowledge
- documents and revises plan as individual/family/group goals achieved or changed as indicated by evaluation data

Standard 9: Coordinates, organises and provides integrated health promotion (IHP) considering a whole of community approach

Rationale
Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health (WHO 2005). Health promotion practice moves beyond a focus on individual behaviours and lifestyles (downstream) towards a wide range of social, environmental and policy interventions (upstream). IHP practice is underpinned by the Social Determinants of Health framework (Wilkinson and Marmot 2007). Health promotion aims to improve the health and wellbeing of populations, and to reduce health inequities of specific disadvantaged population groups. It takes into account the environmental, economic, political, social, cultural and behavioural factors that contribute to the health and wellbeing of communities and population groups. IHP practice is governed by the five Key Action Areas of the Ottawa Charter: build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services (WHO 1986). Health promotion is essential to the professional practice of CHNs and part of the therapeutic process in health counselling, health coaching and secondary consultation (Condon et al 2008 p37). Every interaction can be a health promoting opportunity. Formal and informal methods can be used whenever working with individuals, families, groups or the community. Partnership and collaboration between and across sectors is critical to effective IHP practice. CHNs collaborate with others to form partnerships and engage all stakeholders in assessing, planning, implementing, and evaluating health promotion action. Health promotion is conducted in settings where people live, work, study and play (WHO 1997). There are numerous models for health promotion planning, such as that developed by the Victorian Healthcare Association (VHA 2012). The Population Health Planning Framework was developed to support collaborative planning approaches such as those required to successfully plan IHP action with partners and communities in the Victorian context.

Criteria

Assessment
9.1 Works with colleagues and other stakeholders to collect, analyse and synthesise population health data to determine the population groups experiencing health inequities and inequalities
9.2 Works with the community, to identify their expressed, felt, normative and comparative strengths and needs
9.3 Engages community in prioritising their health and wellbeing needs, pertinent social determinants, strengths and assets, taking account of those with special needs
9.4 Assesses community assets, capacity, health literacy and readiness to participate in community action
9.5 Collaborates between and across sectors and levels of government, including with health, welfare, community and support agencies and networks to achieve partnerships for effective health promotion planning and action

Planning
9.6 Facilitates and participates in health promotion decision-making at local, regional and state level
9.7 Formulates health promotion plans in collaboration with partners that
- recognise the impact and role of population health, primary health care and integrated health care models
• demonstrate understanding of the implications of national and state health policy and strategies for community health nursing and health promotion

9.8 Determines realistic goals, objectives and evidence-informed strategies in collaboration with the community and stakeholders

9.9 Applies knowledge of the dynamic field of health promotion to plan strategies that enable communities to:
  • participate in decision making and taking action
  • become self-determining
  • build capacity of individuals, groups and communities

9.10 Identifies and advocates for appropriate resources to support effective implementation and evaluation of health promotion action

9.11 Proactively seeks out and accesses funding for health promotion initiatives

Implementation

9.12 Utilises the health promotion skills of advocacy, enabling and mediating to achieve health equity and effective outcomes in the community

9.13 Implements and monitors the broad range of planned health promotion strategies in collaboration with community, partners and stakeholders

9.14 Undertakes activities to improve health equity and promote health within the community including but not limited to: community development, partnership work, advocacy, building healthy public policy, capacity building, organisational development, reorientation of health services, health literacy, creating supportive environments, strengthening community actions, developing personal skills

9.15 Promotes health equity through respecting and promoting diversity and difference, human dignity, self-worth, socio-economic status and health care needs
  • enables, advocates and mediates for intersectoral action on healthy public policy across all levels
  • initiates, facilitates and participates in intersectoral networks and partnerships to promote health across all levels of government
  • is an active member of community and stakeholder networks advocating for health promotion

9.16 Leads and supports the reorientation of health services; building organisational capacity to support the changes required to advance health equity in primary health care, health and wellbeing promotion and population health planning

Evaluation

9.17 Plans and conducts health promotion evaluation in line with best practice

9.18 Works with the community and partners in evaluating health promotion action

9.19 Collates evaluation data for reporting, dissemination and publication

9.20 Ensures that evaluation is documented so that it contributes to the development of community health nursing and health promotion evidence based knowledge

9.21 Reviews and modifies strategies as appropriate in response to health promotion evaluation

Standard 10: Facilitates a physical, emotional, social and cultural environment that promotes individual/group/community safety, security, respect and health and wellbeing

Criteria

10.1 Facilitates intersectoral collaboration that supports the development of healthy environments and neighbourhoods through planning, legislation and policy

10.2 Advocates and mediates to create environments and resources in communities and neighbourhoods that support the making of healthy choices

10.3 Targets settings approach focusing on the provision of safe environments for individuals, groups and communities

10.4 Environmental health and safety is considered through formal and informal activities
  • identifies, eliminates or prevents environmental hazards
• applies relevant principles to ensure community safety and security
• maintains standards for hazard control
• applies ergonomic principles and appropriate aids to prevent injury and to promote comfort for individual/group and self

10.5 Enacts evidence-based risk assessment and risk management
• applies a systems approach to safety and quality through systems analysis
• prioritises safety

10.6 Errors, adverse events and near misses are prevented and managed systematically using
• organisational risk management techniques such as root cause analysis and
• open disclosure policies and procedures

10.7 Emotional climate is addressed to prevent and eliminate bullying and violence

DOMAIN FOUR: COLLABORATIVE AND THERAPEUTIC PRACTICE

Standard 11: Establishes, maintains and concludes therapeutic relationships with individuals, groups and communities

11.1 Provides confidentiality, respect and dignity
• ensures that environmental surroundings are conducive to effective communication
• establishes initial and ongoing effective communication with individuals and groups
• facilitates open communication in consultations
• maintains confidentiality and privacy
• ensures that consultations are conducted within accepted professional nursing limits (professional boundaries)
• advocates for financial resources and support to be available to provide appropriate health care information in an acceptable format and style
• assesses health literacy needs; simplifies, discusses and clarifies health related information
• verifies that the person understands the health information
• actively enables informed decision-making

11.2 Demonstrates well developed skills in written, verbal and electronic communication
• initiates and follows up communication: face to face, telephone, electronic, paper based as appropriate
• utilises appropriate communication tools and strategies to effect communication with clients from cultural and linguistic diverse (CALD) backgrounds, including the engagement of accredited interpreters
• documents, as soon as possible, forms of communication, care plans, interventions and responses
• records information systematically in an accessible and retrievable form
• maintains health records, statistics, data and databases including e-health, Personally Controlled Electronic Health Record (PCEHR), computerised health records, health conferencing, telehealth
• ensures that written communication is comprehensive, logical, legible, clear and concise, spelling is accurate and only acceptable abbreviations are used
• prepares reports

11.3 Demonstrates communication strategies to aid implementation of significant change and transition
• listening: building trust, assessing, learning

11.4 Effective knowledge management technology and systems are in place
• knowledge is shared, accessible and applied

11.5 Record keeping is current, concise, comprehensive, accurate, ongoing, confidential, safe, retrievable, contemporaneous, and systematic
Standard 12: Collaborates with the multidisciplinary team to provide community health nursing

**Rationale**
Effective communication skills foster collaborative relationships. Collaboration has an impact on the safe and effective provision of comprehensive community health nursing

**Criteria**
12.1 Recognised as an effective member of the multidisciplinary team, community networks and partnerships
- establishes positive and productive working relationships with colleagues
- contributes to the multidisciplinary team
- establishes and maintains a network of collaboration with colleagues within the community health service and other health care providers in the area
- collaborates with other health workers on matters pertaining to attainment of optimum health
- offers support and assistance to colleagues and other local and regional health and associated workers
- explains the community health nursing role to the multidisciplinary team, service providers and the community

12.2 Initiates opportunities for collaboration and partnerships to support the community's health at local and regional levels

12.3 Appropriately refers to other health care or service providers
- ensures there is documented exchange of information between referral services—joint referral protocols

12.4 Encourages appropriate and co-ordinated use of local and regional health care resources
RESOURCES and REFERENCES

Introduction
Appendix C: Specialist nursing standards
Australian Nursing and Midwifery Council (ANMC). 2007. Delegation and supervision for nurses and midwives.
Community Nurses Special Interest Group, Western Australia (CHSIGWA) and Department of Health, Western Australia. 2001. Competency standards for the community health nurse. 2nd edition. Perth: Department of Health, Western Australia in association with the Community Nurses Special Interest Group, Western Australia.


Standard 1


Appendix A: Summary of nursing theories (Phase 1 App D Summary of nursing theories)


Standard 2
Appendix B: A model of nursing advocacy

Australian charters of healthcare rights Retrieved March 13 2013 from

June.

Australian Nursing Federation and Royal College of Nursing Australia. 2006. Joint position statement
indigenous Australian people and nursing education. Retrieved May 14 2013 from


Community Health Nurse Special Interest Group. 2010. The role and scope of practice of community
health nurses in Victoria, and their capacity to promote health and wellbeing (Phase 2) Advocating
for health. Melbourne: Community Health Nurse Special Interest Group ANF (Vic Branch).
Retrieved June 3 2013 from
http://www.anfvic.asn.au/multiversions/41890/FileName/CHN_ROLE_scope_Phase_2.pdf

in Victoria phase 1. Melbourne: Community Health Nurses Special Interest Group ANF (Vic Branch)
and ANF (Vic Branch). Retrieved June 3 2013 from

March 13 2013 from
http://docs.health.vic.gov.au/docs/A828F4D7161E1D77CA2578AA007DDA38/$FILE/1105029
_ACHCR_A5_FA_web.pdf

Disability Services Commissioner. Free Call: 1800 677 342 Email: complaints@odsc.vic.gov.au Website:

Community nursing practice theory, skills and issues. Crows Nest, NSW: Allen & Unwin. Chapter
19 p358-372.


Marquis, B.L. and Huston, C.J. 2012. Leadership roles and management functions in nursing theory and
Patient, subordinate and professional advocacy. p116-135.

O’Brien, L. and Bethavas, E. 2013. The Victorian Charter of Human Rights and its impact on the nursing

Office of the Health Services Commissioner. Toll Free: 1800 136 066 Email: hsc@health.vic.gov.au

Victorian Equal Opportunity and Human Rights Commission website:
www.humanrightscommission.vic.gov.au


Standard 3

Australian Health Practitioner Regulation Agency (AHPRA) – Nursing and Midwifery Board Australia


Chapter 19 p408-412.


Nursing and Midwifery Health Program (NMHP) www.nmhp.org.au 03 9415 7551


### Standard 4

**Age Discrimination Act 2004 (Australia)**


**Australian Human Rights Commission Act 1986 (Australia)**


**Children, Youth and Families Act 2005 (CYFA)**

**Climate Change Act 2010**


**Disability Act 2006 (Victoria)**

**Disability Discrimination Act 1992(Australia)**

**Drugs, Poisons and Controlled Substances Act 1981 (Victoria)**

Drugs, Poisons and Controlled Substances Regulations 2006

**Equal Opportunity Act 2010**


*Medicines, Poisons and Therapeutic Goods Act 2008* (Australia)


Drafting of a new mental health bill is underway; see http://www.health.vic.gov.au/mentalhealth/mhactreform/


*Privacy Act* (Australia)


*Racial and Religious Tolerance Act 2001*

*Racial Discrimination Act 1975* (Australia)

*Sex Discrimination Act 1984* (Australia)

*Whistleblowers Protection Act 2001*


**Standard 5**


*Rural Women’s Network.* Where it all started: an interview with the Hon Joan Kirner AM. November 2012 p6-7 ruralwomen@dhs.vic.gov.au


**Standard 6**

Community and Primary Health Care - Community of Interest (COI)

Australian Nursing & Midwifery Federation (Victorian Branch) [http://www.anfvic.asn.au/](http://www.anfvic.asn.au/)  
Community Health Nurses Special Interest Group

Australian Primary Health Care Nurses Association (APNA) [www.apna.asn.au](http://www.apna.asn.au)


**Standard 7**


The Cochrane Library: Cochrane Collaboration Public Health Review Group

Joanna Briggs Institute [www.joannabriggs.edu.au](http://www.joannabriggs.edu.au)


**Standard 8**


**Standard 9**


Local Government Areas


Standard 10


Climate and Health Alliance Retrieved March 6 2013 from http://caha.org.au/

CRANAplus magazine. Health groups call for urgent action to address health risks from coal and coal seam gas. CRANAplus magazine 89:74-75 March 2013.


**Standard 11 Communication skills**


**Standards 12 Collaboration**


APPENDIX A: A SUMMARY OF NURSING THEORIES

<table>
<thead>
<tr>
<th>Theorist</th>
<th>Goal of Nursing</th>
<th>Framework for practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nightingale (1860)</td>
<td>To facilitate ‘the body’s reparative processes’ by manipulating client’s environment (Torres, 1986)</td>
<td>Client’s environment is manipulated to include appropriate noise, nutrition, hygiene, light, comfort, socialization and hope</td>
</tr>
<tr>
<td>Peplau (1952)</td>
<td>To develop interaction between nurse and client (Peplau, 1952)</td>
<td>Nursing is a significant, therapeutic, interpersonal process (Peplau, 1952). Nurses participate in ‘structuring health care systems to facilitate natural ongoing tendency of humans to develop interpersonal relationships’ (Marriner-Tomey and Alligood, 1998)</td>
</tr>
<tr>
<td>Henderson (1955)</td>
<td>To work independently with other health care workers (Marriner-Tomey and Alligood, 1998), assisting client to gain independence as quickly as possible (Henderson, 1966); to help client gain lacking strength (Torres, 1986)</td>
<td>Nurses help client to perform Henderson’s 14 basic needs (Henderson, 1966)</td>
</tr>
<tr>
<td>Abdellah (1960)</td>
<td>To provide service to individuals, families, society; to be kind, caring intelligent, competent and technically well prepared to provide this service (Marriner-Tomey and Alligood, 1998)</td>
<td>This theory involves Abdellah’s 21 nursing problems (Abdellah et al., 1960)</td>
</tr>
<tr>
<td>Orlando (1961)</td>
<td>To respond to client’s behaviour in terms of immediate needs; to interact with client to meet immediate needs by identifying client’s behaviour, reaction of nurse, and nursing action to be taken (Torres, 1986; Chinn and Kramer, 1999)</td>
<td>Three elements - client behaviour, nurse reaction and nurse action comprise nursing situation (Orlando, 1961)</td>
</tr>
<tr>
<td>Hall (1962)</td>
<td>To provide care and comfort to client during disease process (Torres, 1986)</td>
<td>The client is composed of the following overlapping parts: person (core), pathological state and treatment (cure) and body (care). Nurse is caregiver (Marriner-Tomey and Alligood, 1998; Chinn and Kramer, 1999)</td>
</tr>
<tr>
<td>Wiedenbach (1964)</td>
<td>To assist individuals in overcoming obstacles that interfere with the ability to meet demands or needs brought about by condition, environment, situation or time (Torres, 1986)</td>
<td>To assist individuals in overcoming obstacles that interfere with the ability to meet demands or needs brought about by condition, environment, situation or time (Torres, 1986)</td>
</tr>
<tr>
<td>Levine (1966)</td>
<td>To use conversation activities aimed at optimal use of client’s resources</td>
<td>An adaptation model of human as integral whole based on ‘four conversation principles of nursing’ (Levine, 1973)</td>
</tr>
<tr>
<td>Johnson (1968)</td>
<td>To reduce stress so that client can move more easily through recovery process</td>
<td>This theory of basic needs focuses on seven categories of behaviour. Individual’s goal is to achieve behavioural balance and steady state by adjustment and adaptation to certain forces (Johnson, 1980; Torres, 1986)</td>
</tr>
<tr>
<td>Author (Year)</td>
<td>Description</td>
<td>Other Information</td>
</tr>
<tr>
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</tr>
<tr>
<td>Rogers (1970)</td>
<td>To maintain and promote health, prevent illness, and care for and rehabilitate ill and disabled client through ‘humanistic science of nursing’ (Rogers, 1970)</td>
<td>‘Unitary man’ evolves along life process. Client continuously changes and coexists with environment</td>
</tr>
<tr>
<td>Orem (1971)</td>
<td>To care for and help client attain total self-care</td>
<td>A self-care deficit theory, nursing care becomes necessary when client is unable to fulfil biological, psychological, developmental or social needs (Orem, 1991)</td>
</tr>
<tr>
<td>King (1971)</td>
<td>To use communication to help client re-establish positive adaptation to environment</td>
<td>Nursing process is defined as dynamic interpersonal process between nurse, client and health care system. Interpersonal process is viewed as human-to-human</td>
</tr>
<tr>
<td>Travelbee (1971)</td>
<td>To assist individual or family in preventing or coping with illness, regaining health, finding meaning in illness or maintaining maximal degree of health (Marriner-Tomey and Alligood, 1998)</td>
<td>Interpersonal process is viewed as human-to-human relationship formed during illness and ‘experience of suffering’</td>
</tr>
<tr>
<td>Neuman (1972)</td>
<td>To assist individuals, families and groups in attaining and maintaining maximal level of total wellness by purposeful interventions</td>
<td>Stress reduction is goal of systems model of nursing practice (Torres, 1986). Nursing actions are in primary, secondary or tertiary level of prevention</td>
</tr>
<tr>
<td>Patterson &amp; Zderad (1976)</td>
<td>To respond to human needs and build humanistic nursing science (Patterson and Zderad, 1976; Chinn and Kramer, 1999)</td>
<td>Humanistic nursing requires participants to be aware of their ‘uniqueness’ and ‘commonality’ with others (Chinn and Kramer, 1999)</td>
</tr>
<tr>
<td>Leininger (1978)</td>
<td>To provide care consistent with nursing’s emerging science and knowledge, with caring as central focus (Chinn and Kramer, 1999)</td>
<td>With this transcultural care theory, caring is the central and unifying domain for nursing knowledge and practice</td>
</tr>
<tr>
<td>Roy (1979)</td>
<td>To identify types of demands placed on client, assess adaptation to demands and help client adapt</td>
<td>This adaptation model is based on the physiological, psychological, sociological and dependence-independence adaptive modes (Roy, 1980)</td>
</tr>
<tr>
<td>Watson (1979)</td>
<td>To promote health, restore client to health, and prevent illness (Marriner-Tomey and Alligood, 1998)</td>
<td>This theory involves philosophy and science of caring; caring is interpersonal process comprising interventions that result in meeting human needs (Torres, 1986)</td>
</tr>
</tbody>
</table>
Benner & Wrubel (1989) | To focus on client’s need for caring as a means of coping with stressors of illness (Chinn and Kramer, 1999) | Caring is central to the essence of nursing. Caring creates the possibilities for coping and enables possibilities for connecting with and concern for others (Benner and Wrubel, 1989)

Boykin & Schoenhofer (2001) | Built upon the knowledge of other nursing scholars who have developed theories of caring, this work invites all nurses to develop nursing knowledge and to theorize from within the nursing situation in sharing both the content and context of nursing experiences as they are lived in meaning patterns | Draws on Mayeroff’s caring components: knowing, trust, humility, hope and courage

APPENDIX B: A MODEL OF NURSING ADVOCACY

Key elements of nursing advocacy*

Key elements of health promotion

- Community assessment
- Community consultation
- Community development
- Health screening
- Directing services to locally defined health priorities
- Informing community groups of research results
- Developing leadership skills in the community
- National/state health promotion strategies

Key elements of health protection

- Health assessment
- Secondary consultation
- Health education
- Monitoring health status
- Care coordination

Nursing knowledge

- Anatomy and physiology
- Comprehensive assessment
- Ethical principles relating to health
- Management of the disease process
- Biophysical determinants of health
- Pharmacology
- Mental health
- Pathophysiology
- Social model of health
- Primary health care
- Social determinants of health
- Health promotion theory
- Health education theory
- Health legislation and common law
- Health systems and processes
- Public health policy

Clients’ rights as priority

Nursing competencies

- Comprehensive nursing assessment within a multi-disciplinary process
- Evaluating progress towards health goals
- Providing health education
- Recommending other services
- Referral through a formal process
- Care coordination

APPENDIX C SPECIALIST NURSING STANDARDS

Includes detailed list of performance criteria for performance assessment for the RN and the advanced RN


Community Nurses Special Interest Group, Western Australia and Department of Health, Western Australia. 2001. Competency standards for the community health nurse. 2nd edition. Perth: Department of Health, Western Australia in association with the Community Nurses Special Interest Group, Western Australia.


Alice Springs Office 1/1B Stokes Street, Alice Springs PMB 203, Alice Springs, NT 0872
Email: crana@crana.org.au Phone: 08 8959 1111 Fax: 08 8959 1199

Australasian Rehabilitation Nurses Association. Rehabilitation nursing competency standards


In partnership with:
Australasian Society for HIV Medicine (ASHM)
Australasian Sexual Health and HIV Nurses Association (ASHHA)
Australian Practice Nurse Association (APNA)
Family Planning NSW (FPNSW)
Sydney Local Health District
NSW Sexual Health Infoline (SHIL)
APPENDIX D: PROJECT CONSULTANCY BRIEF

Community Health Nurses Special Interest Group

Practice Standards for Victorian Community Health Nurses

Project Consultancy Brief

1. PROJECT BACKGROUND
In 2008, the ANF (Vic Branch) Community Health Nurses Special Interest Group (CHN SIG), representing community health nurses in Victoria embarked on a two phased project to identify the role and scope of practice of community health nurses. The purpose of this project was to identify the direction the CHN SIG could take to represent their membership in strengthening the role of community health nursing in primary health care in Victoria.

Phase 1 of the project explored the role of community health nurses who work within community health centres in Victoria and identified common characteristics of their health care delivery. Analysis of the data collected through a self-administered questionnaire about the role, nursing competencies and knowledge used in community health nursing, indicated that the majority of community health nurses regularly undertook advocacy (83.0%), needs assessment of individuals and family (75.5%), health education/health counselling (75.0%) and monitoring health status of individuals or families (72.5%). The nursing competencies the majority of community health nurses utilised regularly included referral to other services (88.5%), collecting data on clients' functional status (83.0%), contributing to multi-disciplinary services (81.4%) and health education (79.6%). In undertaking their role, the majority of community health nurses drew on their knowledge of anatomy and physiology (87.6%), a social model of health (82.3%), primary health care and the social determinants of health (81.3%) and comprehensive assessment (79.5%).

In Phase 2, CHNs described their role in more detail, expanding on the nursing knowledge and competencies previously reported, and the Phase 2 Report provides clear recommendations to progress this next stage in the development of shared practice standards that articulate the scope and efficacy of the role of Victorian CHNs.

In addition, there has been consultation with CHNSIG members during the 2011 EBA negotiation and further in mid-2012 to develop a new CHN Career Structure which incorporates new entry level Enrolled Nurse, Grade 1 & Grade 2 positions to take into the EBA negotiation process with VHIA and Department of Health in late 2012/2013.

2. RECOMMENDATIONS FROM COMBINED CHN PROJECTS & SIG CONSULTATIONS RE CHN CAREER STRUCTURE:

- Develop a set of Practice Standards that will guide the nursing care delivery of Victorian Community Health Nurses;
- Within the standards, identify the theoretical or philosophical underpinnings of CHN practice and clearly articulate the role and scope of practice of CHN positions in relation to a defined and expanded Career Structure that includes entry level and executive level positions;
- Combine the generalist and specialist nursing role within the CHN role and scope of practice;
- Continue to apply the social model of health framework to CHN practice, promoting consistent interpretation and application of the model amongst CHNs;
- Seek opportunities to advocate community health nursing positions in health promotion and community development teams through leadership roles within community health structures;
• Seek opportunities to undertake CHN practice related research and to promote the role outside the nursing domain, including CHNs presenting at conferences and publishing in primary and community health literature;
• Undertake process and impact evaluation that gives voice to clients and communities through qualitative and quantitative methods, to measure the impact and effectiveness of CHN action.

3. PROJECT DESCRIPTION
The CHNSIG is seeking to engage a suitably skilled consultant to develop a set of agreed Practice Standards for Victorian Community Health Nurses. The Practice Standards will take account of the CHN Phase 2 recommendations and SIG consultations as described above and will provide the foundation for future CHN roles and Career Structure.

4. PROJECT FEE & DELIVERABLES
The total consultancy fee to achieve the project deliverables below will be $3,000
• Documented Practice Standards for Victorian Community Health Nurses.
• Report outlining the process undertaken.

5. MANAGEMENT, REPORTING & TIMELINES
The Consultant will report to & liaise directly with the CHNSIG Executive Committee: Olive Aumann (Chair) & Giancarlo Di Stefano (Secretary). This may include meetings, email and phone contact.

<table>
<thead>
<tr>
<th>Project commencement</th>
<th>September 2012</th>
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<tbody>
<tr>
<td>Draft Practice Standards presented</td>
<td>October/November 2012</td>
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<tr>
<td>Project completion</td>
<td>December 2012</td>
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**USER FEEDBACK**

The CHN SIG ANMF (VB) welcomes feedback on the applicability of these practice standards for community health nurses and communities. This feedback will be taken into consideration in the planned 2015 review of the practice standards document.

To make your comments please contact the CHN SIG ANMF (VB) via:
Carole de Greenlaw | Industrial Professional Secretary
Australian Nursing & Midwifery Federation (Victorian Branch)
540 Elizabeth Street Melbourne Vic 3000
Switchboard: (03) 9275 9333 | Fax: (03) 9275 9344
cdegreenlaw@anfvic.asn.au | www.anfvic.asn.au

To guide your feedback, information is requested on the following:
- General Comments (for example: readability, applicability, user friendliness)
- Use of the document (for example, in the development and use of: job descriptions, performance appraisals, course curricula, self-assessment tools)
- Comments on specific areas of the document:
  - Terminology
  - Domains (please specify which domain you are commenting on)
  - Standards (please specify by number)
  - Criteria – under each Standard (please specify by number)
  - Readings and resources (please specify by Standard number)

GLOSSARY

ACCOUNTABLE: being responsible for care activities and being answerable to the client and others for decisions made and activities performed; accountability cannot be delegated (CHNSIG 1993; ACCN 1982)

ADVERSE EVENT: is an unintended injury or complication resulting in temporary or permanent disability, death or prolonged hospital stay and is caused by health care (mis-) management rather than the person’s health condition (NMBA 2008); ill health caused as a result of treatment (Willis et al 2012); SENTINEL EVENT: serious adverse event (Sorensen & Ledema 2008); error; near miss;

ADVOCACY: Condon et al (2008 p36) in Phase 1 found advocacy to be ‘fundamental to community health nursing’ and ‘integral to the ethical principles of health care essential to all nursing practice’. Community health nursing aims to achieve health equity through action on the social determinants of health. These being largely outside the scope of health services, effective action requires partnerships and advocacy with other sectors in order to effect change. The key elements of community health nursing identified in Phase 1 are integral to nursing advocacy applied to individuals, families, groups and communities (See Appendix B: A model of nursing advocacy). Advocacy involves collaborative and participatory relationships with the community: ‘giving voice’, ‘encouraging agency’ and ‘standing beside’ (CHNSIG 2010 p4-7). Nursing defines advocacy as ‘understanding the worldview, life circumstances and priorities of those requesting or receiving care and exploring possible options with them in light of their preferences’ Gadow, quoted in Anderson and McFarlane 2011 p75; goals of nursing advocacy are client autonomy and self-determination leading to optimal independence and agency (Condon et al 2008 p36); nurse as advocate acts as enabler and communicator, explaining, interpreting, motivating and offering options, enable the client to make choices about how to work towards optimal independence (Condon et al 2008 p37); advocacy as part of community development as it involves collaborative participatory relationship with the community (CHNSIG 2010 p4); a process which openly aims to change laws, regulation, policy and organisational practices that impact on the ability of individual and communities to make healthy choices (Keleher and Murphy 2007p318); to give support and be actively speaking on behalf of those who may be disadvantaged to promote and protect their welfare (Willis et al 2012); speaking on behalf of another, in circumstances where they are unable to represent themselves, their needs, wishes, values and choices (WPSEAR 2006)

AGENCY: ability to act to influence change; recognises people as responsible individuals who can choose to act in one way or another (Condon et al 2008)

ANDROGENY: possession of both male and female personality characteristics (Slee et al 2012)

ASSESSMENT: systematic collection, analysis, synthesis and dissemination of data that assists in identifying the needs, preferences, abilities and strengths of an individual/group/community (CHNSIG 1993); information on the health of the community or population, including statistics on health status, community health needs and epidemiological and other studies of health issues (ANA 2007); the process of obtaining and analysing information from a variety of sources to determine the needs of a particular population or community (ICN 2010);

COMMUNITY ASSESSMENT: process of critically thinking about the community and getting to know and understand the community as client; identify community needs, clarify problems and identify strengths and resources (Daly et al 2006)
AUTHORITY:

AUTONOMY: having a sense of one’s own identity and an ability to act independently and to exert control over one’s environment, including a sense of task mastery, internal locus of control, and self-efficacy (NMBA 2006a); quality of having the ability or tendency to function independently (Willis et al 2012); AUTONOMY of PRACTICE: capacity to work without interference from any other group in terms of what is done and resources used (Willis et al 2012); right to self-determination (Daly et al 2006)

BULLYING:

CAMPBELL COLLABORATION: an international research network that produces systematic reviews of the effects of social interventions; (sibling organisation to the Cochrane Collaboration) Retrieved March 14 2013 from http://www.campbellcollaboration.org/

CAPACITY BUILDING: knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion (Willis et al 2012);

CARE/ service/ practice: in partnership, that which is delivered/provided to an individual, family, group or community by a community health nurse

CHANGE: CHN as change agent, developing an action plan based on assessment and SWOT analysis of the community’s strengths, weaknesses, opportunities and threats; Lewin’s Model 1951; Roger’s Theory of the Diffusion of Innovations 2003; communication, information, consultation, and respect are the key to success; always with us; both a continuous and organic process; ongoing; cyclical; Continuous Change Cycle–Cole 2001; Change management: a way through which change occurs; a skill set required of everyone; strategies; (McMurray & Clendon 2011 p76-7; Ryan et al 2007 p326-9)

CHRONIC DISEASE SELF-MANAGEMENT: what a person does to manage their own chronic illness, includes lifestyle choices, skills and strategies (Willis et al 2012)

CLIENT/PATIENT: A person or persons who engage(s) or is/are served by the professional advice or services of another. May refer to an individual, family or community. Use acknowledges that a significant part of nursing’s services are delivered to people who are well and proactively engaging in health care; ‘client’ and ‘patient’ may be used synonymously to acknowledge that the same services may, at times, be delivered for both clients and patients / Patient: Use acknowledges that nursing provides some of its services to people who are sick and, in the true Latin meaning, are ‘suffering’ (NMBA 2006a)

Person or people requiring or receiving care – includes the full range of alternative terms such as patient, client, resident and consumer; employed for the sake of respect and simplicity (NMBA 2008)

The person requiring or receiving health care, treatment, advice, information or other related services. This term may include the friends, relatives and other members of a person’s nominated social network, and people who are associated with the person who is the recipient of care; human being: health consumer; the term ‘patient’ entails a special ethical and legal relationship to the nurse or midwife, and to others in the context of professional health care, which does not apply to other ‘persons’, and is established in ethical discourse in phrases such as ‘patient autonomy’, ‘patient care’, ‘patient advocacy’ and so on. The Project Team has therefore opted for its use in the Codes of Ethics, and proposed that the term ‘patient’ be defined as ‘the recipient of health care services – whether the recipient is an individual, a
family, a group or the community’; it is appropriate to use this terminology in the Codes because it ‘makes clear that nurses care for groups as well as individuals’ and because the term ‘patient’ can be defined as to include the full range of alternative terms that might be used in different contexts;
alternative viewpoint expressed by people who are recipients of health care and health services is that the nomenclature of ‘patient’ is most inappropriate in 2007. If we ask the ‘what are we here for’ question about nursing, it is about providing high quality, safe care to people. The very word ‘patient’ is heavily weighted with notions of paternalism. The language that paints the context of people who are the recipients of health care abounds with terms laden with passivity, compliance, endurance, power imbalance and control. We need to be aware of just how much the language affects our views of the world. The importance of language and who controls it has been widely recognised and articulated by the feminist movement. Dale Spender talks of ‘man made language’ as defining and controlling the world that women live in; Nurses and midwives object strongly to the ‘medicalisation’ of health language. However, we could nearly identify a health service provider language as controlling a health consumer’s environment. A leading national organisation for recipients of health care is the Consumer Health Forum of Australia. The language of people who have organised in any way to represent the recipients of health services and care have generally called themselves ‘health consumers’ and identify as ‘people’ or as an individual ‘person’. The continuing use of ‘patient’ is rejected by these groups and their very strong grounds for this rejection should be respected by nurses  (NMBA 2008a p14)

CLINICAL GOVERNANCE: (derived from corporate governance) a whole system cultural change which provides means of developing organisational capability to deliver sustainable, accountable, patient-focused, quality-assured healthcare (Johnstone and Kanitsaki 2008 p163); quality framework through which organisations are accountable for continually improving the quality of services (Driscoll and O’Sullivan 2007);

CLINICAL INDICATOR: a measure of the clinical management and outcome of care; a method of monitoring consumer/patient care and services which attempts to ‘flag’ problem areas, evaluate trends and so direct attention to issues requiring further review (ACHS)

CLINICAL PRACTICE GUIDELINES: systematically developed statements that assist practitioners and clients in making decisions about appropriate care; direct performance; assist nurses in clinical decision-making hence improving quality of care (CNA 2011); synthesise evidence-based best practices into sets of summary recommendations, need to keep guidelines updated as new knowledge accumulates (Watcher 2008; Robertson 2007)

CLINICAL PATHWAYS: attempt to articulate a series of steps, more useful for processes (Watcher 2008)

CLINICAL RISK MANAGEMENT (CRM): managing patient safety; the prevention, monitoring, early identification, early management of clinical incidents/risks/hazards, an approach to improving quality in health care (Johnstone and Kanitsaki 2008 p164); assess the likelihood of risk occurring and the severity of the consequences if the risk does occur (ANMC 2007); the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse events (ACHS)

CLINICAL SUPERVISION: plethora of definitions in the literature; diversity of approaches; best practice; central activity in a qualified health professional’s continuing professional development (CPD); satisfies CPD and regulatory needs; regular professional conversation in practice for practice; provide space, time and professional support for colleagues to reflect on encounters with patients and fellow workers; regular reflection on practice with others; improving the quality of healthcare delivery;
first introduced into nursing (in the UK) almost 2 decades ago; an integral part of clinical practice and mandatory accreditation requirement for certain healthcare professionals e.g. social work, counselling and psychotherapy, mental health; many names being used interchangeably (internationally and within nations): critical companionship, clinical facilitation, clinical education, developmental coaching, guided reflection, professional supervision;
different types of supervision happen in 2 dimensions: formal and planned or informal and ad-hoc, e.g. informal peer review – the tea break; reduce professional isolation; the demand for accountability has highlighted the role of clinical supervision; elements or functions of clinical supervision: learning, support, accountability; organisations have to demonstrate staff support structures (such as clinical supervision) as they have become auditable mechanisms; (Driscoll and O’Sullivan 2007)

COLLABORATION: work with another person or group to achieve some end (ANA 2007); all members of the healthcare team working in partnership with consumers and each other to provide the highest standard of, and access to, health care; collaborative relationships depend on mutual respect; on communication, consultation and joint decision making within a risk management framework (ANMC 2007)

COLLEAGUES: includes health care workers, co-workers, staff and others lawfully involved in the care of people (NMBA 2008)

COMMUNICATION SKILLS: oral, written, statistical, electronic, digital, computerised; media representation; including information in personnel files;

COMMUNITY: geographical and interactional components; people in interaction, bound together by some common characteristics, culture, interests, bonds, values, norms, resources and purpose (CHNSIG 1993; ANA 2007; ICN 2010); a community can interact with other entities as a unit (ANA 2007)

COMMUNITY DEVELOPMENT: structured intervention that gives communities greater control over the conditions that affect their lives, works at level of local groups and organisations rather than individuals or families (Willis et al 2012)

COMMUNITY HEALTH: a range of community-based prevention, early intervention, assessment, treatment, health maintenance and continuing care services delivered by a variety of providers; operates from both clinical and social models of health; locally based centres offer potential to develop partnerships with and illicit support from local schools, community agencies, families and volunteers through collaborative social action; many community health services are being retracted into hospital sites and/or management (Rosen, Gurr and Fanning 2010); field that spans public health and primary health care, concerned with the study and improvement of the health of communities (Willis et al 2012); non-residential services offered to people in a community setting, by governments or voluntary organisations; various health services: HACC, family planning; HIV/AIDS services, substance misuse services; delivered to specific groups: Indigenous people, those with mental health problems, refugees, asylum seekers, migrants, women, children, young people (Palmer and Short 2010);

COMMUNITY HEALTH NURSING: nursing that maintains a population focus on community needs in addition to providing direct primary health care nursing for individuals and families from high-risk groups and vulnerable communities, the focus is on health promotion and prevention of disease (Condon et al 2008 p15); a synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations/the entire community (ANA, 2007); identifies with the clients’ individual environment including lifestyle, workplace, culture and family, acknowledges the social, political and economic influences on the environment in a global context, focus on populations (Brookes et al 2004) Generalist CHN: a registered nurse with post-registration education who has demonstrated expertise in Community Health Nursing practice (ANA, 2007); may work some of the time in a
specialist role, works with various clients/groups, linking people to required services/agencies etc. Generalist skills to address needs as they arise in the community (StJohn 2007 p8); acts as community advocate focusing on health promotion in generalist roles that allows them to work with the community as a whole rather than with predetermined public health priorities; works in partnership with the community, in an empowering way, having cultural relevance; cultural broker, liaison, advocate and activist rather than case manager or project manager (McMurray and Clendon 2011p89, 90) Specialist CHN: areas of clinical specialty expertise such as diabetes education, women’s health, adolescent health, palliative care, mental health, child health; these speciality areas may relate to 1.client group (children, elderly) 2.setting (school or domiciliary nursing) 3.medical condition (diabetes, respiratory illness) (StJohn 2007 p8)

Condon et al (2008) in Phase 1, analysed responses with regard to scope of practice and competencies and knowledge utilised. They found ‘very little difference’ between the practice and knowledge use of generalists and other CHNs. Advocacy, assessment, monitoring and health education were the four most commonly reported practices by both generalists and other CHNs (Condon et al 2008 p32). Phase 1 of the study was not able to clearly identify what is meant by the term ‘generalist’. However, the results do indicate that generalist CHNs require a comprehensive suite of knowledge and skills in order to work across a broad range of programs and services, to identify emerging health problems not being address on a population basis.

CONFIDENTIALITY: confidentiality is a separate legal concept from ‘privacy’; where information is given to a person under an obligation to keep the information confidential (for example, a trade secret, or information confided to someone). Confidential information is usually not available or readily accessible to the public, and may be information which is not recorded in some form. The Information Privacy Act protects recorded personal information whenever it is held by the Victorian government or its contracted service providers (Privacy Victoria 2012).

CONSUMER ENGAGEMENT: seeks to increase the uptake of health services by a diverse range of consumers, particularly vulnerable population groups and those experiencing disadvantage and/or social exclusion (Keleher and Murphy 2007p319)

CONTINUUM of CARE: integrated health care system that monitors patients over time through a range of health services and health care (Willis et al 2012)

CRITERION: descriptive statement which is measurable and which reflects the intent of a standard in terms of performance, behaviour, circumstances or clinical states (ACCN 1982 p20); sometimes the term ‘indicator’ is used synonymously (Evans et al 1994)

CULTURAL COMPETENCE: A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A cultural competent system of care acknowledges and incorporates - at all levels - the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansions of cultural knowledge, and the adaptation of services to meet culturally unique needs (Cross, Bazron, Dennis and Isaacs (1989) quoted in Johnstone & Kanitsaki 2007 p98; ANA 2007)
CULTURAL SAFETY: An environment which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening (Williams, 1999 Quoted in Johnstone & Kanitski 2007 p97). Subject of mandated practice standards in nursing in New Zealand.

DELEGATION: level of authority granted to a person who holds an office or position (Willis et al 2012); the registered nurse who delegates an activity is accountable for their delegation decision, for monitoring the standard of performance of the activity and for the evaluation of outcomes of the delegation (ANMC 2007); conferring of authority to perform activities of care (WPSEAR 2006)

DETERMINANT OF HEALTH: a factor or characteristic that brings about a change in health, either for the better or for the worse (Keleher and Murphy 2007p319)

*Distal determinant:* distant either in time or place from the change in health status – upstream factors (Keleher and Murphy 2007p319)

*Proximal determinant:* proximate or near in either time or distance to the change in health status, usually readily and directly associated with the change in health status – downstream factors (Keleher and Murphy 2007p323)

*Social determinants of health:* conditions in which people are born, grow, live, work and age (Willis et al 2012)

Social, economic, and healthcare factors that affect health and well-being independently or in conjunction with each other at the population or community level, environmental, behavioural, political and health indicators, the processes through which change occurs (ANA 2007)

Determinants of health from THE SOLID FACTS:
1. stress and social organisation; 2. early life; 3. social gradient; 4. unemployment; 5. psychosocial environment at work; 6. transport; 7. social support and social connectedness; 8. food security; 9. social exclusion; 10. diversity and discrimination; 11. education; 12. gender; 13. addiction and substance misuse; 14. environments; 15. personal skills (Palmer and Short 2010; StJohn and Keleher2007)

DIVERSITY: coexistence of different ethnic, gender, racial, and socioeconomic groups (ANA 2007)

DOMAIN: an organised cluster of competencies in nursing practice (NMBA 2006; WPSEAR 2006)

**PROFESSIONAL PRACTICE:** relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights (NMBA 2006)

**CRITICAL THINKING and ANALYSIS:** relates to self – appraisal, professional development, and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark (NMBA 2006)

**PROVISION AND COORDINATION OF CARE:** relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals /groups, planning, implementation and evaluation of care (NMBA 2006)

**COLLABORATION and THERAPEUTIC PRACTICE:** establishing, sustaining and concluding professional relationships with individuals/groups; relates also to the nurse understanding their contribution to the interdisciplinary health care team (NMBA 2006)
DUTY OF CARE: principle which underlies the concept of negligence; owed to clients and colleagues; reflects the degree of care and skill to be expected from the average, reasonable, ordinarily careful and competent practitioner (WPSEAR 2006)

EFFECTIVENESS: extent to which a service achieves its intended objectives (Evans et al 1994)

EFFICACY: the power to produce a desired effect or intended result or outcome (ICN 2010); a measure of demonstrable beneficial effect (Evans et al 1994)

EFFICIENCY: relationship between the cost of various inputs and the output produced (Willis et al 2012); producing maximum benefit with minimum cost (Evans et al 1994)

EMPOWERMENT: process through which people gain greater control over decisions and actions affecting their health (Willis et al 2012)
EMPOWERING: to give someone greater control or power over decisions and actions affecting their health (Willis et al 2012)

EMOTIONAL CLIMATE:

EMOTIONAL INTELLIGENCE (EI): ability to perceive, control and evaluated emotions (Slee et al 2012)

ENABLES:

ENVIRONMENTAL HEALTH: those aspects of human health, including quality of life, that are determined by physical, chemical, biological, social, and psychological processes in the environment; theory and practice of assessing, correcting, controlling, or preventing those factors in the environment that can adversely affect the health of present and future generations (ANA, 2007)

EPIDEMIOLOGY: a prime diagnostic tool to identify problems and needs, but community medicine has a therapeutic responsibility to go beyond diagnosis to achieve action for improvement (Brotherston quoted in Gray 2001 p316)
Study of causes, transmission, incidence and prevalence of health and disease in human populations (Willis et al 2012)

EQUITY: fair distribution of resources in relation to needs (Keleher and Murphy 2007p320)
Health equity: rights of people to have equitable access to services on the basis of need, and the resources, capacities and power they need to act upon the circumstances of their lives that determine their health (Keleher and Murphy 2007p321; Willis et al 2012)
Health inequity: differences which are unnecessary, avoidable, unfair and unjust (Willis et al 2012)

ETHICS: the fulfilment of moral obligations and intentions in practice;

EVALUATION: on-going process to determine the value of something; appraisal of planned actions toward defined objectives (CHNSIG 1993); identification of the outcome of care and service (ACHS); ascertainment of extent to which a particular social action is achieving its goals (Wadsworth 2011); a systematic process that records and analyses what was done in a program or intervention, to whom, and how, and what short- and long term behavioural effects or outcomes were experienced. Types of evaluation include exposure, formative, process, implementation, and outcome evaluation (ICN 2010); actual performance or quality is compared with standards (ACCN 1982);
OUTCOME EVALUATION: analysis of the extent to which a program achieved it intended objectives (Evans et al 1994)

EVIDENCE-BASED PRACTICE: involves the judicious use of current best evidence from health care research in the treatment and management of individual patients (Keleher and Murphy 2007p320); an approach where all practice should be based on evidence from Random Controlled Trials, to ensure treatment effectiveness and efficacy (Willis et al 2012); approach to public healthcare practice in which the public health nurse is aware of the evidence in support of one’s clinical practice and the strength of that evidence (ANA, 2007); conscientious, explicit and judicious use of current best evidence in making decisions about healthcare; integrating individual healthcare expertise with the best available external evidence from systematic research (Hudson 1997)

EVIDENCE-BASED NURSING: gives access to the best research related to nursing, provides regular updates of new evidence within nursing, facilitates implementation of the evidence as expert commentators put articles in clinical context and draw out the key research findings http://ebn.bmj.com/ and Joanna Briggs Institute http://www.joannabriggs.edu.au/Home

FAMILY: two or more persons who are joined together by bonds of sharing and emotional closeness and who identify themselves as being part of the family (ACCYPN 2006). Another style of nomenclature may include: Nominated partners, family and friends – includes people in consensual relationship with the person receiving nursing care and others who play an important role in the life of that person (NMBA 2008); blended; extended; nuclear; sole-parent; a social unit composed of members connected through blood, kinship, emotional or legal relationships (ICN 2006)

GUIDELINES: recommended principles; systematically developed statements aimed at assisting the practitioner in making decisions about health care in specific circumstances (Keogh and Courtney 2001) See above ‘clinical practice guideline’; multidisciplinary;

HEALTH IMPACT ASSESSMENT (HIA): ensures that the impact on health is considered in the policy making processes of non-health government portfolios; modelled on the environmental impact statement; evolved rapidly over last decade; an important process considering the promotion of sustainable development by considering the environment, human health, policies and developments; (Palmer and Short 2010)

HEALTH LITERACY: the knowledge of health-related issues including factors that create health and how to seek health information, the ability to recognise specific disorders, of self-treatment and how to find professional help (Keleher and Murphy 2007p321); the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions, the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions (ICN 2010);
MENTAL HEALTH LITERACY: ability to recognise specific disorders; know how to seek mental health information; knowledge of risk factors and causes; knowledge of self-treatment, of professional help available; appropriate help-seeking skills and behaviours (Keleher and Murphy 2007p322);

HEALTH PROMOTION: process of enabling people to take control over factors that determine and improve their health (Keleher and Murphy 2007p321; Willis et al 2012) not just the responsibility of the health sector but goes beyond health life-styles to wellbeing (CHNSIG
INTERVENTION: upstream, midstream and downstream; a movement which gathered momentum in the 1980s, a radical movement which challenges the medicalisation of health, stresses its social and economic aspects and portrays health as central in a flourishing life (Palmer and Short 2010 p227) engages individuals and groups in understanding and nurturing their own health; ‘works with people not on them’ (Brown and Szoke in Palmer and Short 2010 p228)

INTEGRATED HEALTH PROMOTION: collaboration of organisations, agencies and sectors to develop strategies concerning priority health and wellbeing issues in communities (Willis et al 2012)

MENTAL HEALTH PROMOTION: through families and schools; school-community partnerships positively influence outcomes for students, achieve best life outcomes (Slee et al 2012)

HEALTHY PUBLIC POLICY: public policy that adopts an explicit concern for health and equity and recognises accountability for health impact (Willis et al 2012)

IMPLEMENTATION: delivery of planned nursing intervention (ACCN 1982)

INTERVENTION: an action taken by a nurse alone or in partnership with the community to promote health or to treat a health problem, independently in the autonomous domain of nursing practice or in collaboration with other health practitioners (ANA, 2007)

DOWNSTREAM PUBLIC HEALTH INTERVENTIONS: micro level including treatment systems, disease management, and investment in clinical research (Keleher and Murphy 2007p319); referred to as medical approach, locates causes in biology and places responsibility for prevention on the medical profession;

MIDSTREAM PUBLIC HEALTH INTERVENTIONS: intermediate level focused on lifestyle, behavioural and individual prevention programs (Keleher and Murphy 2007p323); referred to as lifestyle strategy, attributable to the way individuals choose to live, about their own individual behaviour, responsibility on individuals with action by health educators and health practitioners;

UPSTREAM PUBLIC HEALTH INTERVENTIONS: macro level including government policies, global trade agreements and investment in population health research (Keleher and Murphy 2007p325); referred to as new public health perspective, locates the aetiology of disease within the occupational and environmental context, places responsibility on owners and managers of industry and calls for action from governments and private and community organisations to create a healthier environment;

INFORMED DECISIONS:

INTERSECTORAL COLLABORATION: relationship between different sectors of society to achieve health outcomes in a way which is more efficient, effective or sustainable than is possible by the health sector alone (Willis et al 2012) multisectoral:

JOB DESCRIPTION: details accountability, responsibility, formal lines of communication, duties, entitlements, and performance appraisal; qualifications;

LEADERSHIP: vision, trust in staff and the courage to take the risk of leading change, development and evolution of community health nursing; transformative and visionary leadership skills in the development of community health organisations and community health nursing; positioning community health nursing within primary health care; foresight, planning and communication, interpersonal, educative and collaborative skills (Ryan et al 2007 p314)
MEDICARE LOCALS: organisations established to support health professionals to improve delivery of primary health care services at the local level and to improve access to afterhours primary care (Willis et al 2012)

MENTORING: considered an example of supervised practice; functions and roles differ across healthcare disciplines and cultures; associated with career progression and personal development (Driscoll and O’Sullivan 2007)

MILLENIUM DEVELOPMENT GOALS (MDG):
- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education
- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce child mortality
- Goal 5: Improve maternal health
- Goal 6: Combat HIV/AIDS, malaria and other diseases
- Goal 7: Ensure environmental sustainability
- Goal 8: Develop a global partnership for development (UN 2012); ‘efficient, effective nursing and midwifery services are critical to achieving the Millennium Development Goals ... primary health care ... and the general health of all nations’ (WHO 2007)

MONITORING: process of collecting and analysing information about program implementation over time to ensure planned activities are carried out and problems identified (Evans et al 1994)

NEGLIGENCE:

NETWORK: a grouping of individuals, organizations and agencies organized on a non-hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust (ICN 2010);

NURSING: clinical, managerial, educational, research, planning, policy development, project management, regulatory activities, ‘crucial contribution of the nursing profession to health systems and the health of the people they serve’ (WHO 2007)

NURSING PROCESS: problem-solving approach to nursing care; structures how nursing care is determined, delivered, communicated and documented (Daly et al 2000); interrelated activities include assessment, planning, implementation and evaluation (ACCN 1982)

OPEN DISCLOSURE: talking openly to the person or relatives when a patient experiences an adverse event as a result of medical treatment (Willis et al 2012)

OUTCOME: long-term objectives that define optimal, measurable future levels of health status, maximum acceptable levels of disease, injury or dysfunction, or prevalence of risk factors (ANA, 2007); a change in an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status (ICN 2010);

PARTNERSHIP: voluntary arrangement developed between parties who agree to work cooperatively towards shared or compatible objectives (Willis et al 2012) may include members of interdisciplinary professional groups, community members, policymakers, and community institutions and organisations (ANA, 2007)
PEER REVIEW: process by which nurses actively engaged in the practice of nursing, appraise the quality of nursing care in a given situation in accordance with established standards of practice (CHNSIG 1993; ANA 2007); Self-regulation within the profession (Willis et al 2012); evaluation of quality of performance of individuals or groups by peers/colleagues using established criteria (ACCN 1982)

PERSONAL SKILLS: how a person manages and expresses themselves (Willis et al 2012)

PLANNING: the development of a scheme of how to achieve a desired outcome; setting goals and priorities, and designing methods to resolve problems (CHNSIG 1993); a conscious process of identifying goals and target populations (Wadsworth 2011)

POLICY: a documented statement that formalises the approach to tasks and concepts which is consistent with organisational objectives (ACHS)

POPULATION: in statistics, a group of individuals sharing at least one common characteristic (Slee et al 2012)

POPULATION HEALTH: improving the health of whole populations or specific populations, particularly to reduce inequities, through policies, programs, research and interventions designed to protect and enhance health (Keleher & Murphy 2007 p5)

PRECEPTORSHIP: formalised source of support for new professional registrants; formally introduced to UK nursing in the 1990s; informal buddying system with a more experienced clinical colleague; a way of accessing formal support and in-service education for newly qualified staff; (Driscoll and O'Sullivan 2007)

PRIMARY HEALTH CARE: universally accessible, generalist services that address the health needs of individuals, families and communities across the life cycle, with their full participation and at a cost the community can afford; fee-for-service practitioners provide the majority of primary health care services in Australia; provides a comprehensive system response to health promotion, disease prevention and addressing disorders by ameliorating social disadvantage and inequities (Rosen, Gurr and Fanning. 2010; CHNSIG 1993)

Both a level of service provision (first contact) available to people where they live and work and a healthcare policy approach which involves: collaborative networking, consumer and community participation, balancing priorities between immediate and long-term needs and partnerships; reorienting health system towards health promotion rather than the treatment of disease (Brookes et al 2004; Palmer and Short 2010 p228); philosophy, strategy, and level of care (ACCYPN 2006)

COMPREHENSIVE PRIMARY HEALTH CARE: includes early intervention and health promotion, treatment, rehabilitation and ongoing care; often the first point of contact; universally available and accessible essential health services provided by practitioners committed to tackling inequities through advocacy, self-determination, participation and empowerment, work in partnership with multilevel community-based strategies that address social and economic determinants of health (Willis et al 2012)

All people should have access to nurses who provide care, supervision and support in all settings; strengthen and mobilise nursing services; scale up nursing capacity, skill mix of existing and new cadres of workers, positive workplace environments; multisectoral approach (WHO 2007)

PRIVACY: central to all ideas of 'privacy' is keeping your own actions, conversations, information and movements free from public knowledge and attention; under law only certain types of information and activities are protected by privacy legislation; most privacy laws are more
correctly described as data protection laws, as they are limited to regulating the handling of personal information by organisations (Privacy Victoria 2012)

PROCEDURE: a set of documented instructions conveying the approved and recommended steps for a particular act or sequence of acts (ACHS)

PROCESS: a series of actions, changes/functions that bring about an end or a result (ACHS)

PROFESSION: a discipline which requires an extensive educational practice period; has a unique body of knowledge; is autonomous in its decision making and practice; provides a service; has its own code of ethics; and whose membership carries a degree of status (CHNSIG 1993)

PROFESSIONAL BOUNDARIES: are the limits of a relationship between a nurse and an individual or the individual's significant other. These limits facilitate safe and therapeutic practice and result in safe and effective care. Limits of a relationship may include under- or over-involvement in the provision of care (NMBA 2008)

PROFESSIONAL INDEMNITY:

PROTOCOLS: more formal (than guidelines); statements specifying in detail how a process or intervention is to be conducted; standardised approach; do not allow for deviation; (Keogh and Courtney 2001); established sets of procedures; synthesize information into a concise structure; promote translation of knowledge into actions; sequence of actions; evidence-based (Best practices 2007)

PUBLIC HEALTH: improve the health of populations through the organised efforts of society; practitioners have to be evidence based in the promotion of health (Gray 2001); referred to as Social Health in early days of the 19th century; promotion, prevention, maintenance services and programs concerned with the health and wellbeing of the community (Willis et al 2012); organised response by society to protect and promote health and to prevent illness, injury and disability; for the public, by the public and in the public interest (Palmer and Short 2010 p227); focused on communities and groups of people rather than on individuals; usually provided by governments; may include environmental health measures, health education, health promotion, disease-prevention activities, immunisation (Palmer and Short 2010 p9)

QUALITY: a degree of excellence (ACCN 1982); doing the right things right to the right people at the right time; getting it right first time; (Gray 2001); the degree to which a service conforms to pre-set standards of care (Donabedian quoted in Gray 2001); the degree to which objectives of care are achieved; setting quality standards, delivering quality standards, monitoring quality standards, action for quality (Gray 2001); differing perspective of those delivering health care, those receiving health care, governments and health insurance companies (funders), managers; a multidimensional concept; components: 1.Effectiveness 2. Efficiency 3.Equity 4.Access 5.Acceptability 6.Appropriateness (Willis et al 2012); approaches: craft based peer review process; inspection or audit usually called Quality Assurance (QA); continuous improvement; adverse events/errors research lead to the current approach which focuses on safety of the patient in managing risk, indentifying the sources of error and reducing them (Willis et al 2012); The extent to which the properties of a service or product produces a desired outcome (ACHS);

QUALITY IMPROVEMENT: process by which members of an organisation systematically examine what they are doing, the purpose for which it is done, the environment in which it occurs and the
consequences or outcomes of their actions with the goal of continually improving the services they provide (MCHNSIG 1999)

RELATIONSHIPS: therapeutic

REORIENTING HEALTH SERVICES: organisation and funding of the health system that reflects an explicit concern for the achievement of population health outcomes (Willis et al 2012)

RESEARCH: spectrum of logical and systematic methods for answering original questions (Evans et al 1994)

RESPONSIBILITY: obligation that an individual assumes when undertaking to carry out a delegated function; the individual who authorises the delegated function retains accountability (WPSEAR 2006)

RISK MANAGEMENT: see clinical risk management

SAFETY: a state in which risk has been reduced to an acceptable level (ACHS)

SCOPE OF PRACTICE: scope of nursing practice is that which nurses are educated, competent and authorised to perform (CoNNO 2004); full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within the profession are educated, competent and authorised to perform; set by legislation, professional standards, codes of ethics, conduct and practice, public need, demand and expectation; SCOPE OF AN INDIVIDUAL’S PRACTICE: influenced by context; client’s health needs; level of competence, education, qualifications and experience; service provider’s policy, quality and risk management framework and organisational culture (ANMC 2007)

SELF-DETERMINATION:

SETTINGS: spatial or physical locations or institutions such as schools or workplaces in which health promotion may be undertaken and which addresses institutionally determined norms and factors that impact on health such as bullying, discrimination; may also be contextual e.g. cities, islands, villages (Keleher and Murphy 2007p324)

SOCIAL CAPITAL: networks which provide a basis for trust, cooperation and perceptions of safety (Slee et al 2012); degree of social cohesion which exists in communities, processes between people which establish networks, norms and social trust and facilitate co-ordination and cooperation for mutual benefit (Daly et al 2006; ICN 2010);

SOCIAL MODEL OF HEALTH: an approach to health promotion and community development that addresses the broader determinants of health and acts to reduce social inequalities and injustices with an emphasis on community engagement and participation and empowerment of individuals and communities (Keleher and Murphy 2007p325)

SPECIALISATION: implies a level of knowledge and skill in a particular aspect of nursing which is greater than that acquired during basic nursing education (CoNNO 2004)

STANDARD: A standard is generally accepted to refer to "an accepted measure of quality", it may refer to a minimal acceptable level of performance or a performance can be judged higher than the minimal level according to certain criteria; the level of performance of a specific nursing action; standards are principles for putting nursing ability into action; (ACCYPN 2006); desired and achievable level or range of performance (CHNSIG 1993; ACCN); agreed level of excellence (Evans et al 1994); a subjective judgement of a level of performance that could be delivered; minimal, excellent or optimal, achievable; a comparison of actual performance with the standard enables a target for quality improvement (Gray 2001p221); a statement of a level of performance to be achieved (ACHS); includes national policies, position statements, best practice standards, guidelines (WPSEAR 2006) STANDARDS OF CARE: accepted principles that help to operationalise patient care processes (Keogh and Courtney 2001);

SUPERVISION: 3 types in a practice context: 1) managerial: involving performance appraisal, rostering, staffing mix, orientation, induction, team leadership etc. 2) professional: preceptors a student, supports and supervises the practice of an enrolled nurse 3) clinical: providing education, guidance and support for individuals who are performing delegated activity, directing the individual’s performance, monitoring and evaluating outcomes especially the consumer's response to the activity (ANMC 2007); See also above ‘Clinical supervision'; incorporates direction, guidance, oversight and co-ordination of activities (WPSEAR 2006)

TEAM: multi-disciplinary, trans-disciplinary, intersectoral, inter-professional,
Interdisciplinary: group of individuals who rely on each other’s overlapping skills and discipline-based knowledge to achieve synergistic effect where outcomes are enhanced and more comprehensive that the simple aggregation of individual efforts (ANA, 2007)

TELEMEDICINE: the use of modern telecommunications and information technologies for the provision of clinical care to individuals at a distance and the transmission of information to provide that care. Telemedicine is not one specific technology but a means for providing health services at a distance using telecommunications and medical computer science (ICN 2010)

TRANSPARENCY: disseminating the results of quality measures or research results to key stakeholders (Watcher 2008)

UNLICENSED / UNREGULATED (however titled) HEALTHCARE WORKER: person who performs care duties but is not granted a licence under nursing registration (Willis et al 2012); those workers not regulated by statute for example: assistants-in-nursing, personal care attendants/assistants, support worker, doula, receptionists, home help, home care workers, health aides, (ANF & RCNA 2008; ANMC 2007)

UNSATISFACTORY PROFESSIONAL CONDUCT: is professional conduct below the standard reasonably expected of a nurse with an equivalent level of training or experience. This includes conduct that demonstrates incompetence, compromises care and/or discredits the nursing profession (NMBA 2008)

VIOLENCE:

WELLBEING:

WELLNESS: Wellness has been described as a measure of optimal health, an expression of the process of life, and the subjective experience of integrated or congruent functioning. Wellness is a way of
life, a lifestyle designed to achieve the highest potential for well-being... it involves the whole being, physical, emotional, mental and spiritual ... an ever expanding experience of purposeful living. Health-disease and wellness-illness are both relational and contextual. "Two important elements of healthiness are balance and potential. When people are healthy their lives are in balance they recognise the potential for higher levels of wellness." (McMurray 1999, p.8 quoted in ACCYPN 2006)

WHISTLEBLOWING: the disclosure of information to protect public interest; usually by former or current employees of an organisation; about misconduct, illegal, unethical or illegitimate practices that are within the control of their employers; to persons or an organisation that have the authority or power to take action. The person or organisation to which the disclosure is made may be outside the normal internal reporting systems of the organisation where the person is or was employed (NMBA 2008a p14)
REFERENCES
Australian Nursing and Midwifery Council (ANMC). 2007. Delegation and supervision for nurses and midwives.


Western Pacific & South East Asia Region (WPSEAR). 2006. WPSEAR common competencies for registered nurses.

LITERATURE REVIEW


PHN standards of practice as above (ANA 2007); cost containment, competition, mergers; bioterrorism, emerging infectious diseases, antibiotic resistance; demographics, globalisation, poverty and growing disparities;

Anderson, E.T. and McFarlane, J. 2011. Community as partner. 6th edition. Philadelphia: Wolters Kluver/Lippincott Williams & Wilkins. Principle client-aggregate community; epidemiology, demography and community health; environment; pollution; hazards; health care without harm www.noharm.org; ethics; cultural competence; healthy public policy; informatics, vocabulary; disasters, emergencies and infectious diseases; community assessment; community analysis; planning; implementing; evaluating; schools; faith communities; marginalised groups; workplace; elders; rural;
4th edition: refugees and immigrants; homeless populations; chronically ill;

Literature review; Role ambiguity, conflict, entanglement, lack of authority, pressure to prove one’s worth; “increasing use of skill-mix, combined with work intensification has resulted in more medicalised and clinically focused services in community nursing and further perpetuated unrealised occupational ideals” p5; “introduction of advanced roles is argued to reinforce de-professionalization and undermine inter-professional working by reviving rivalries and territorialism” p5; “healthcare intermediary [my italics] where the main focus of nursing work involves managing multiple agendas, bringing individuals into organisations or managing others, information or prioritising care and rationing resources”p6; “making rather than taking new roles” p8
Asylum Seeker Resource Centre (ASRC). www.asrc.org.au


Australian Bureau of Statistics (ABS). www.abs.gov.au; Socio-economic Indexes for Areas (SEIFA) data; Index of Relative Socioeconomic Disadvantage (IRSD);


ANF and RCNA were voting members of the Standards Development Committee and participated in the development and endorsement of this standard. It is for public and private hospitals but may be a useful resource for adapting for primary health care/community health


Australian Health Review: (Journal of the Australian Healthcare & Hospitals Association) explores major national and international health issues and questions. Topics covered by the journal include all aspects of health policy and management, healthcare delivery systems, clinical programs, health financing and other matters of interest to those working in health care Retrieved March 7 2013 from http://ahha.asn.au/australian-health-review


Australian Nursing and Midwifery Council (ANMC). 2007. Delegation and supervision for nurses and midwives.


Personal copies filed in SIG Standards cited references, good glossary


Previous 1997; differentiating standards. This means they do not repeat the Australian Nursing and Midwifery Council’s core domains of registered nurse practice, but build on them; the


Good definitions, resources; uses; standards compared;


Role of nurses and unlicensed workers in the provision of personal care including in the community


Delegation, supervision, assessment, RNs, ENs, roles, responsibilities, accountabilities, regulatory authorities


62
Glossary,


Definitions, good resources and references


Various articles and authors;
‘cognitive constriction’
Monash University, specialty unit on refugee health, social model of health;
Cardinia-Casey Community Health Service, Refugee Health Clinic: nurse-led, Doveton clinic;
human rights; SDH; B12 deficiency


Re. Liz Crock, Beth Hatch, Tom Carter, HIV/AIDS advocacy; Human rights and nursing awards at the International Centre of Nursing Ethics (ICNE)


Australian Primary Health Care Nurses Association (APNA) http://www.apna.asn.au

[DU 610.73Bar/Cpa] theory of care planning, models of nursing ++, assessment tools: nutritional screening tools, alcohol misuse screening,


List of consumer organisations; measuring people’s preferences

“Practice standards are the shared notion of ‘good practice’” (Benner, P. et al 2002 p510); Systems experiential learning vs. shame and blame of individual practitioner; Root cause analysis-focuses on conditions that make errors possible, improved system design;


Excellent review and summary of issues and where community health nursing is at present (2004) almost 10 years ago; societal changes affecting CHNs; trends in health care; themes emerging from lit review Table1 p197; management and funding varies within and between states; variation in terminology/titles; historical perspectives; lack of research and publication; educational preparation; generalist and specialist;

Review of competency standards; NPs in primary care; scope of practice projects;


Safety and risk management long a part of nursing practice

Centre for Health Promotion Interact! South Australia Retrieved March 15 2013 from https://www.chpinteract.net/

Centre of Excellence in Intervention and Preventive Science (CEIPS). Pelham House, Ground Floor, 15-31 Pelham St. Carlton South 3053. Ph: 03 9667 1320 Website: http://ceips.org.au/ Email: admin@ceips.org.au


New edition in preparation

Reasons/rationale for standards


Hard copy filed in SIG-Stands Lit review July 2009

Hard copy filed in SIG-Stands Lit review July 2009


Climate and Health Alliance. No date. *Climate change is a health issue Briefing paper no.1.* [http://www.caha.org.au](http://www.caha.org.au)


The Cochrane Library: Cochrane Collaboration Public Health Review Group [http://www.cochrane.org/contact/review-groups](http://www.cochrane.org/contact/review-groups)


One word titles: Accountability, continuing competence, ethics, knowledge, knowledge application, leadership, relationships: therapeutic nurse-client relationships, professional relationships. *Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.* — College of Nurses of Ontario “Professional Standards includes seven broad standard statements, a description of each statement and indicators that illustrate how the standard may be demonstrated.”p3 the seven standards are presented in alphabetical order. All standards have equal importance and are interconnected.p4

HP involves the facilitation of skills in individuals and changes in environments that impact positively on health; Improve daily living conditions; tackle the inequitable distribution of power, money and resources; measure and understand the problem and assess the impact of action; Hard copy in VicHealth short course folder


“Health reform initiatives have not added much hope for progress for national consistency of reform” (Rosen, Gurr and Fanning. 2010)


Includes philosophical statement, glossary, reference; Compiled by Rhae Kiehne, Jennifer Greenhalgh and Deborah Crook


Community Indicators Victoria (CIV) www.communityindicators.net.au

Community Nurses Special Interest Group, Western Australia and Department of Health, Western Australia. 2001. *Competency standards for the community health nurse. 2nd edition*. Perth: Department of Health, Western Australia in association with the Community Nurses Special Interest Group, Western Australia.

Foreword by Anne McMurray, Griffiths University; beginning level and advanced practice in CHNsg; first document: *Competency Standards for community health nurses*, 1998. Community Health Nurses and Health Department of Western Australia. Includes process used to start the journey; “…focuses on the promotion of the community’s health rather than disease and on partnership with the client in health care decision making” p8; specialist area of nursing practice p8; wide variety of practice settings p8; living document owned by Community Health Nurses throughout the State, CNSIG, WA 2001 p8; quick reference format p10-11 may be useful to Lisa and Trish for the EBA career structure


Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) http://catsin.org.au/

**CRANApplus Magazine** available from CRANApplus website: https://crana.org.au/

**CRANApplus magazine.** 2013. Health groups call for urgent action to address health risks from coal and coal seam gas. *CRANApplus magazine* 89:74-75 March.

Energy Roundtable February 2012: statement on adverse health impacts and environmental damages associated with current minerals energy policy, particularly those relating to coal and coal seam gas;


Glossary


Deakin University, Department of Human Services and VicHealth. 2006. *Evidence-based mental health promotion resources*. Melbourne: Deakin University, Department of Human Services and VicHealth.


Whole-of-government ways for education, youth and family support, justice, homelessness and mental health sectors to work collaboratively to support individual young people experiencing problems; early intervention, assessment and referral, entry points; new resources; seven demonstration sites;


Emergencies, disasters, climate change, drinking water supplies, urban development,


Comprehensive and effective health response in the event of a disaster or mass casualty event, including a bioterrorist act, natural disaster, bombing or communicable disease outbreak.


Marginalised group, includes Medicare ineligible asylum seekers, RHNP coordinated approach by recruiting CHNs with expertise in working with CALD and marginalised communities, health clinics, Refugee Minor Program, school nursing in ELSCs, Refugee Brokerage Program, health within a social context, determined by social, environmental and economic factors, RHN role, RHNP facilitator, Foundation House, PCPs, CHSs, refugee health assessment tool.


Primary health services; change management; leadership; evidence-based practice, quality improvement; cross disciplinary practice/teamwork; person-centred care; PCPs; Health Workforce Australia; The Rural Workforce Agency of Victoria (RWAV); Dental Health Services Victoria (DHSV); The Victorian Health Service Management Innovation Council (HSMIC); Skills Victoria;


Permanent protection on Humanitarian Program Visas; malaria; traumatic events; multiple and complex health needs; RHN program developed in 2005 based in CHSs;


Access; response of health services to refugee needs; CHNs; newly arrived refugees; coordinated model of care; coordination manual; early identification and intervention; builds capacity; advocacy; Foundation House; Refugee Health Nurse facilitator; PCPs;

Programs in settings: early childhood, schools, workplaces, and communities; targeting ‘underlying causes’ of chronic diseases: smoking, poor nutrition, alcohol misuse, physical activity; ‘lifestyle-related’ chronic diseases; local partnerships to design and deliver tailored interventions; council Municipal Public Health Plan; Victoria’s Preventive Community Model: 12 local consortia of 14 LGAs and community health agencies across 40 high-needs communities to improve health and ‘reduce disparities’; health promoting policies in schools and workplaces; health promotion networks; community mapping and system mapping; ‘healthy living programs’; CEIPS;


Uses new public health rhetoric e.g. environment, sustained, lasting, coordinated responsive sustainable and compliment our healthcare system, partnership, determinants of health, social marketing, settings, healthy living programs but is focused on preventing chronic diseases by lifestyle, behaviour changes; state public health and wellbeing plan; Australian national preventive health agency;


State-funded primary health sector, Clinical governance in community health project, 3 years, partnership with VHA, accreditation bodies, Victorian Managed Insurance Authority (VMIA), trials and consultations re development of resources, courses and training materials,


Support to local government for MPHWP; Victorian Public Health and Wellbeing Plan (VPHWP) 13Sept2011; Victorian Public Health and Wellbeing Act (2008); PCPs; IHP; Local Government Area Profiles; access to health measures; Prevention Community Model (PCM); Regional Public Health Manager; *Climate Change Act* (2010);


Primary Care=CHSs (funded by Health Dept); general practice, privately funded services, other health and support services; state-funded PHC=dental, allied health, counselling, nursing, health promotion; CHSs – comprehensive PHC, on social model of health, acknowledge social environmental and economic factors that affect health;


Statewide services: Victorian Foundation for Survivors of Torture; International Diabetes Institute, Centre for Adolescent Health, Centre for Culture Ethnicity and Health;
Health promotion and prevention; coordination with GPs, primary providers, acute, aged care, mental health, human services; child health teams 0-12 years with priority 0-6 years; refugee health nursing;

Quality, safety and monitoring; community health program guidelines + community health indicators + community health data;

Development, intervene early, parent’s active participation; care coordination, dietetics, family counselling, physiotherapy, psychology, podiatry, occupational therapy and speech pathology, health promotion; maternal health; early childhood; youth health: IHSHY-18 around Victoria; counselling;

In 2006, 12 teams in CHSs-developmental difficulties and behavioural issues or at risk of falling behind key early developmental milestones; partnerships; priorities; target population; family-centred; quality person-centred; IHP; EBP; resources;

Mental health and wellbeing; supportive counselling, therapy, practical support, advocacy, referral, linkage; 1:1, groups, adults, adolescents, children and families; alcohol and drug, problem gambling, financial counselling, family support, family violence; co-located, integration, coordination; Suicide Helpline; Lifeline; Crisis Support Services;

Funded till July 2014; 8 LGAs; evaluation completed Aug 2011; the Bouverie Centre, LaTrobe University – workforce support

Health care for homeless and at risk young people; health promotion; service delivery; 18 CHSs in Vic provide IHSHY program; maximise prevention and early intervention;

Statewide organisations: FPV; MSHS;
Person-centred; coordination, consistency, continuity of care; all CHSs and PCPs; quality of life; written care plans; engage GPs; carers; ICDM clearing house, case studies, fact sheets, monitoring resources; self-help groups;

Working with GPs; Medicare for community health;

Integrated health promotion framework; evaluation; continuous quality improvement tool; IHP resource kit;

100 CHSs operating from 350 sites; determinants of health; social model of health; clinical governance; PCPs and CHS identify their community’s health and wellbeing needs;


*Action plan to address violence against women and children – everyone has a responsibility to act.* 2012. Preventing violence happening; holding perpetrators accountable; providing support to women and children who experience violence; partnerships; early intervention; response measures; change attitudes and behaviours; schools, media, workplaces, communities; respectful and non-violent relationships; people with disabilities; CALD communities; training and skills for workers in health services; boys and men;


More children surviving and growing up with chronic condition or disability; care requirements into the future; transition to adult services; nursing workforce; multiplicity of roles, titles, practice, settings, educational preparation;

Examination of UK, USA, Canada, NZ and Australia; UK framework for standards for post-registration nursing NMC 2005 saved to CHNSIG prac stands2012;
Standardisation and certification limits scope of practice and profession’s ability to meet changing needs...?
Confusion around APN, lack of clarity nationally and internationally,

New nursing roles and position titles; poorly defined, no national consistency; role proliferation, role blurring, role confusion; impact on patient outcomes; consistency in position titles, responsibilities and areas of special practice; child and family nursing role titles; titles for advanced practice nurses in NSW; first-line nurse manager and advanced practice nurse titles in Australia;


Professional development


Glossary.

Expanded scope of practice, strength-based approach, OC: 5 action strategies; “the strong, informed leadership capacity of public health nurses has been vital in ensuring that innovative programs are implemented, evaluated and receive ongoing funding.” p254; definition of community assessment p258; 3 examples presented;


Faculty of Health. 2012. *Patient safety and risk management study guide and readings.* Geelong: Deakin University Faculty of Health HNN749.


Active (sharp end) and latent (blunt end) failures, multiple causes, unfortunate combination / accumulation,


AUSLAN fast facts,


Laurie presented at the ICN Congress in Melbourne May 2013. Flora Madeline Shaw Chair of Nursing at McGill University, Montréal. Formerly my lecturer at Vanier College CEGEP. Long conversation about the development of her approach, based on the McGill Model of Nursing; Wonderful, inspiring presentation and discussion; will pursue this thoroughly; appears to be very applicable, useful for community health nursing;


Uses of standards;
Evidence-based primary care; e-b decision making; ease of access to information by practitioners; dissemination by researchers; appraisal skills;
Evidence-based public health – decision making based on guidelines and laws; ancient evolution;
fear as an agent of social change: TB, typhus, cholera (*Vibrio cholera*); fear of disease as stimulus for change; knowledge as an agent for social change: weak agent for change; cleanliness vs. poor as unclean; order is an enemy of disease; threat to the health of individuals was also a threat to the health of society; disorder of the poor; built on observation; statistically based public health: Florence Nightingale 1855 etc. Epidemiology: 20th C – pellagra; Social Medicine; Cochrane; rigour;
information revolution and resulting need to cope with uncertainty; involvement and participation of patients in decision-making; explicitness; references to part 8.1; Fig 8.1 The determinants of health p320; Fig 6.9 Levels of quality standards p222;


**Health Care without Harm.** An international organisation, partner of Climate Change and Health Retrieved March 6 2013 from [http://www.noharm.org/](http://www.noharm.org/)

Health Issues Centre, Level 8 255 Bourke St. Melbourne 3000. Phone: 03 9664 9343 Email: info@healthissuescentre.org.au Website: [http://www.healthissuescentre.org.au/](http://www.healthissuescentre.org.au/) Victoria’s health consumer organisation


Multidisciplinary teams; case management; housing; employment; mental health consumer; advocacy; assessment and crisis teams; community care; human rights;

Working as a member of a community health team; intercultural communication; advocating; communicating with the community; preparing a community health proposal;


community nursing teams, mapping current nursing information,

Japanese Nursing Association and Japan Academy of Public Health Nursing. 2013. Move together call from Japanese public health nurses. Poster presentation at ICN Congress: Melbourne. Email contact: japanese-phin@tau.ac.jp

Separate license for PHN; 45,028 PHNs, mostly in Health Care Centres in the community (32,633); certified RN + 1 year education institution or study 4 year university with PHN curriculum + annual national examination to obtain license;


PHC and health promotion principles which frame community nursing practice; evidence-based practice in the community setting; community nursing culture; organisational culture influenced by international factors: World Bank, national and state/territory, professional organisations: Public Health Association of Australia, Australian College of Nursing,


2009-10 reforms give attention to PHC because of cost increases in hospital and acute care; NHHRC Final Report(Aust Gov 2009); National Access Targets; PHC organisations: Medicare Locals: improve after hours services, plan, coordinate and support comprehensive face-to-face after hours GP Services; prevention; equity and fairness; National PHC Strategy: community-based PHC focus of reform, frontline health care; social model of health; urban hospital to community-based settings; CH Workers especially CHNs and community development workers will need to change way of working; health and social development and determinants of health, health-creating environments, community participation decision-making; universal to marginalised/vulnerable groups; multidisciplinary; Primary Care to PHC continuum p58; Primary care anomalous with GPs (self-employed practitioners) and Divisions of GP and AGPNetwork 2010 restructure PHC organisations called Medicare Locals p59; Strategy silent re community and women’s health public sector p60; SDoH; health in partnership with other government sectors; political choices

Public health: definition p67; 150 years; range of disciplines; 2.1% of total recurrent Commonwealth allocation of health budget; PHAA-definition of public health;


Thorough description and analysis of community nursing in UK: history; political discourses; sociological; public health: containment of epidemics and social order, management of poverty; public discourses; nursing: good works and public duty, separate path for nursing separate from medicine, new model nurse; CHNs slow to articulate how patterns of care should change; primary public health; primary health care vs. primary medical care;


Definitions: guidelines, protocols, standards of care, critical pathways,


Excellent succinct summary of CH Nsg in Australia;

Community: 3 dimensions – aggregate of people, geographical or physical location/ political boundaries; social relations-networks create systems; in CHP set up in 1970s nurses held key health promotion roles, by 1990s funding and support shifted from nurses to doctors and then to GPs (GP Divisions); larger social health agenda neglected; making nursing practice INVISIBLE;


Seminal document on health promotion;


McCaughey Centre: VicHealth Centre for the Promotion of Mental Health and Community Wellbeing, Melbourne School of Population and Global Health, University of Melbourne. www.mccaugheycentre.unimelb.edu.au
Research, policy development, teaching, workforce development, knowledge translation,


see revised edition: Victorian Association of M&CHN 2010


National Preventive Health Taskforce and strategy---see Commonwealth of Aust 2010 for government response


North Yarra Community Health. Independent not-for-profit organisation governed by Board of Directors. Health promotion, social model of health, FARREP, groups, community liaison, volunteers, members... Collingwood, Fitzroy, Carlton, InnerSpace. www.nych.org.au


Reprinted 2005 and 2006


Glossary


Glossary, references,

Persons or people requiring or receiving care – includes the full range of alternative terms such as patient, client, resident and consumer and is employed for the sake of respect and simplicity (Glossary of terms p8)


Attention to footnote 10 p14 regarding use of words: patient/client/consumer/person(s)/people

‘patient’ defined as ‘the recipient of health care services – whether the recipient is an individual, a family, or the community’ includes ‘client’, ‘resident’ and ‘consumer’, as well as family, friends, relatives and others associated with the patient where appropriate; other object to

‘patient’ and prefer ‘health consumers’ ‘people’ or ‘person’ (footnote 10 p14)


Glossary, specialist community public health nurses—-one of 3 parts to register!!! With nurses, midwives; standards of proficiency: 1. for entry, 2. of education programs;


Environment


Chapter 8 Public Health p227-270


Rural Women’s Network. Where it all started: an interview with the Hon Joan Kirner AM. November 2012 p6-7 ruralwomen@dhs.vic.gov.au
Re quote: “Social inclusion is at the core of leadership” “partnership” “using all the many talents in the community is what creates change” p7


Recent developments in health promotion in Australia; National Preventive Health Agency (NPHA) established 2011;

Management, ‘the learning organisation’, cost effectiveness, boundaries of professional responsibility, open disclosure, developing standards of care, sentinel events

Cultural literacy; cultural and civic competence; cultural respect;

STI Programs Unit, NSW. 2013. Sexual Health Competency Standards for Primary Health Care Nurses. www.stipu.nsw.gov.au
In partnership with:
Australasian Society for HIV Medicine (ASHM)
Australasian Sexual Health and HIV Nurses Association (ASHHA)
Australian Practice Nurse Association (APNA)
Family Planning NSW (FPNSW)
Sydney Local Health District
NSW Sexual Health Infoline (SHIL)


St Luke’s, Bendigo. www.stlukes.org.au Resources: health, mental health, education, Child First, Gambler’s Help,


Talukdar, J. and Aspland, T. 2013. Review of STI-related 'knowledge' and 'attitude' studies: implications for teacher education in South Australia. Asia-Pacific Journal of Health, Sport and Physical Education 4 (1): Sexually transmitted infection (STI) rates are on the rise in South Australia as evident from a number of statistical reports. Pre-service teacher education forms the first step towards the professional development of teachers. Attributes such as knowledge and attitude are integral not only for teachers entering the profession but also for enhanced student learning outcomes. However, a review of the literature related to STI knowledge and attitudes of pre-service teachers reveal sufficient gaps in the knowledge and a lack of confidence of this cohort in addressing STI-related education. This is imperative towards the call for an effective teacher education in South Australia given the increased incidence of STIs in the state and the inconsistencies related to the inclusion of knowledge about STIs in pre-service teacher education undergraduate degrees.


Primary care/CN’s role less well defined; less specialised nursing staff and the addition of lower paid unlicensed staff; more task oriented; at risk of disappearing; away from community to individuals; crisis intervention; privatisation; refocus on health promotion, chronic disease self-management, culture of proactive or anticipatory care; articulation, definition and professional development of the primary care/community nursing discipline; better define the role; challenges: PD, external policy, changes in economy; voice needs to be stronger (this also comes out of Phase II);


The ANF does not support credentialing of nurses who already hold an appropriate qualification that enables them to work in an area of practice.


Funds health promotion projects, grants, scholarships, see VicHealth Letter and documents listed below, resources, training, etc

Victorian Health Promotion Foundation (VicHealth). 2011. Participation for health short course addressing the social and economic determinants of mental and physical health. Carlton: Victorian Health Promotion Foundation (VicHealth).
The Melbourne Charter for promoting mental health and preventing mental and behavioural disorders
Flow chart to help organizations reflect on their mental and physical health promotion training needs
10 key action areas for health promotion
Population and sub-populations vulnerable to ill health due to socioeconomic disadvantage or geographic isolation
By, with and for people, encourages participation
Iceberg metaphor


Victorian Health Promotion Foundation (VicHealth). 2008c. *Key influences on health inequalities research summary*. Carlton: Victorian Health Promotion Foundation (VicHealth).


Victorian Health Promotion Foundation (VicHealth). 2008e. *Connecting and participating for mental health and wellbeing*. DVD. Carlton: Victorian Health Promotion Foundation (VicHealth).


Victorian Healthy Eating Advisory Service (VHEAS). 2012. Telephone advice line for early childhood services and schools 1300 2252 88 or vheas@nutritionaustralia.org by Nutrition Australia


See previous edition: MCHNSiG 1999


Wadsworth, Y. 2011. *Do it yourself social research*. 3rd edition. Crows Nest, NSW: Allen & Unwin. Examples; glossary; bibliography and further reading; social research; action research;

Informal care; carers; volunteers; HACC; ACAT; consumer involvement/ user rights based movement; participation; public partnership; user-centred; social model;


Ward R. and Scott, M. No date. Stand out against homophobia in schools. Melbourne: Safe Schools Coalition Victoria (SSCV) and Minus 18.

Western Pacific & South East Asia Region (WPSEAR). 2006. WPSEAR common competencies for registered nurses. [hard copy filed in SIG-Stands Lit Review July 2009]


Glossary;


Means to attain health for all is through PHC

Prerequisites for health, 5 areas,


