



**Community Nursing**  
**Scope of Practice, Standards, and Competencies**

**2017**

## **The Jordanian Nursing Council**

The Jordanian Nursing Council (JNC) is a national governmental regulatory institution for nursing and midwifery in Jordan. The JNC is governed by a board headed by Her Royal Highness Princess Muna Al Hussein as president of the council. The board is comprised of 14 key representatives of the health care institutions and through regulating and governing the nursing profession in education, practice and research.

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## **Foreword**

The “*Community Nursing: Scope of Practice, Standards, and Competencies*” is a policy document developed by the Jordanian Nursing Council to regulate and unify the standards for the practice of community nurses. It includes national standards and competencies for the general and advance practice roles .The aims of this document are to standardize practice and safeguard the health and wellbeing of community. The document is a guide for academic and practice institutions; educational institutions need to transfer the content of this very important document and deal with it as a national curricula for the undergraduate and graduate education of community nurses to prepare them for fitness for practice roles, and create a generation that are responsive, ethically committed and supportive for community and public health.

Practice institutions need to take this document as a policy umbrella for the practice of community health and their commitment to implement and create positive environment to allow nurses to function within the agreed upon scope of practice and competencies stated in this document. Institutions need to use these competencies in finalizing job description, roles and responsibilities as a tool for performance evaluation.

This document was developed with distinguished efforts from national academic and services intuitions.

I would like to express my sincere appreciation for all who contributed to the development of this unique document. The implementation of this document at the national level by all institution is a challenge, but we trust your good will and abilities to take it forward and present Jordan as a regional model in the community nursing area.

**Secretary General**

**Professor Muntaha Gharaibeh**

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## **Introduction**

The National Professional and practice Standards for Advance Community Health Nurse Specialist (ACHNS), 2017 was developed by the Committee of Community Health Nursing established by JNC as part of its mission to promote the health status of the community through a sound regulatory system that assures quality services and safe practices. These standards aim to protect the public and the profession by strengthening community nursing care and practices in the country. In general, the JNC aims to enhance community health nursing services in Jordan which would protect community members and promote their health through a sound regulatory system that includes laws, bylaws, standards, and policies.

## **Methodology in Developing the JNC ACHNS Standards**

The JNC national advanced community health professional standards and standards of practice were developed based on national registered nurse framework ,using the best possible evidence of international models and frameworks of community health nursing professional and practice standards, consulting community nurse specialists , reviewing feedback provided by community nurses in a variety of community health practice settings and consulting community nurses faculty members from different academic nursing schools.

## **Purpose of the JNC ACHNS Professional Standards**

The primary objectives of these standards are to promote, guide, and direct community health nursing professional practice. The JNC considers the professional standards as legal guidance to protect the public by regulating community health nurses' practice to determine entry-level and re-entry to practice for advanced community health nurses, providing clarity to managers and other health and educational institutions on the expectations of its members, providing guidance to nurses regarding their professional obligations, and providing a framework to assess professional performance and address incompetence among nurses.

This document is intended to describe the practice of community health nursing regarding the scope of practice, the standards of clinical practice, the standards of professional performance, roles, activities, qualifications, and competencies. This document is intended for use by all professionals involved in community health nursing, including nursing students, teachers, faculty, non-nursing colleagues, other health professionals, and the public.

## **Section 1: The National Framework for Professional Standards of Advanced Practice of Community Nursing**

### **Scope of Practice for ACHNS**

The scope of practice for the ACHNS is defined as promoting and protecting people's health using a body of knowledge from nursing, biostatistics, socio-behavioral, and public health sciences. The certified nurse fulfills the requirements for this profession after completing a two-year academic program post registration of community health nursing science, including clinical and didactic training, and is certified to practice according to legislation and standards that govern the nursing profession. That can be considered as a legislative framework for nurses to practice competently and safely within this specialty.

The scope of practice for an ACHNS requires self-determination; cognitive, integrative and technical abilities within ethical and culturally safe acts; procedures; and protocol and practice guidelines. An ACHNS will deliver evidence-based practice in primary and secondary care settings, in rural and urban communities, and practice within a high level of advocacy for client-centered care needs, provision of health protection, promotion and management of health problems.

The scope of practice of ACHNS entails client and peer education, mentorship, leadership and management of the practice environment, improving community health nursing practice through population-based research utilization, and implementation of meaningful research findings. Additionally, it entails collaborating with the client, other health professionals, and other disciplines to

assess, plan, implement and evaluate client-centered care and healthcare services utilizing and administering appropriate resources needed for continuous care and partnership with stakeholders to influence policies that direct the healthcare environment.

## **Definition and Role of Scope**

There are at least two definitions that need to be addressed when discussing nursing in community settings: community health nursing and community-based nursing.

The term community health nursing is based on the systematic process of designing and delivering health services and nursing care to improve the health of the entire community. Community health nursing is a specialty in nursing.

According to the American Nursing Association (ANA), public health nursing is the practice of promoting and protecting the health of communities using knowledge from nursing, social, and public health sciences (Waldorf, 1999). The primary goal of community health nursing is to help a community to protect and preserve their health and to promote self-care among individuals and families. In healthcare reform, the community health nurse will probably continue to care for individuals and families, particularly high-risk clients and those with communicable diseases. Community health nursing involves the identification of high-risk groups in the community and the development of appropriate and workable policies and interventions to ensure accessible services for all groups of the population.

Community-based nursing is nursing care provided to individuals, families, and groups wherever they live, work, play or go to school. Community-based nursing care is characterized by collaboration, continuity of care, client and family responsibility for self-care, and preventive healthcare (Hunt, 2005). Community-based nursing is individually- and family-centered in orientation. Community-based nursing applies to all nurses who practice in a community setting outside of the hospital. The main activities include case management,

patient education, individual and family advocacy, and an interdisciplinary approach (Zotti, Brown, Stotts, 1996). According to this definition, community-based nursing is not a specialty in nursing, rather a philosophy that guides care, design, and delivery of all nursing specialties.

## **Classification of the Target Population for Community Health Nurse Services**

There are two types of people in the community with whom nurses work. First, the key actors in community healthcare are identified in a mapping of social (human) capital. Second, the target people of community healthcare are categorized using critical analysis of health conditions, health problems, and health risks; for example, people who are at risk for diseases and health problems, people who are ill, people living with certain diseases or illnesses, and people who require welfare and other support. These are used as the basis for designing and implementing community health interventions, services, care, and programs.

## **Dimensions of the Community as the Client**

A community has three dimensions: location, population, and a social system. It may be useful to think of these dimensions as a rough map to follow in assessing needs or planning for service provision in a community.

## **Advanced Community Nurse Specialist:**

- Is registered by the Jordan Nurses and Midwives Council (JNMC) and licensed according to the provisions of the Public Health Law.
- Has a minimum of a second university degree (master's degree) from an accredited university or educational institution in a field of specialty listed and recognized by the JNC (community health nursing or relevant to public health).
- Pass the certifications exam mandated by the Jordanian Nursing Council (JNC).



## **1. Domains of the Standards**

The JNC Professional Standards for community health Nurses are divided into two domains: a) professional standards and b) practice standards.

### **Professional and practice standards:**

A “standard refers to a level of service intervention or outcome” (Underwood, 2007, Canadian Nurses Association, revised 2008). Professional standards and competencies for community health nurses are statements about levels of performance that nurses are required to achieve in their professional practice.

### **Core Competencies:**

Core competencies are the essential knowledge, skills, and attitudes necessary for the practice of community health. They provide the building blocks for effective community health practice. The generic core competencies provide a baseline for what is required to fulfill community health system core functions. These include population health assessment, surveillance, disease and injury prevention, health promotion and health protection.

### **A. Professional Standards**

**This domain focus on professional standards that contain seven main standards relating to:**

#### **1. Performance**

Refers to the professional, legal and ethical responsibilities, accountability, and the advocacy of individual and group rights.

#### **2. Knowledge**

Refers to the evidence-based knowledge, skills, judgment, critical thinking and analysis, and self-appraisal.

### **3. Professional relationships**

Refers to professional communication, collaboration, consultation, and coordination with individuals, groups, peers and colleagues, all levels of nursing staff, and interdisciplinary healthcare team to provide healthcare services in the best interest of the clients.

### **4. Capacity building**

Refers to development activities, and articulating organizational policies and guidelines to enhance the quality of care

### **5. Professional leadership**

Refers to the nursing leadership, management, and administration to carry out the responsibilities of nursing services

### **6. Access and equity**

Refers to the use of appropriate resources to plan and provide nursing services that are safe and efficient

## **B. Practice standards**

This domain focuses on the provision of comprehensive, systematic and prioritized nursing care to achieve identified health outcomes. It consists of one standard “provision of client-centered care” and six sub-standards; assessment; identify issues, problems or trends; outcome identification; planning; implementation; and evaluation

### **Scope of Applications**

The standards are designed to address four relevant areas of community health nursing in which they are practiced

1. **Homes:** The most frequently used settings for community health nursing practice. It is a setting for health promotion where community health nursing is assisting families to prac-

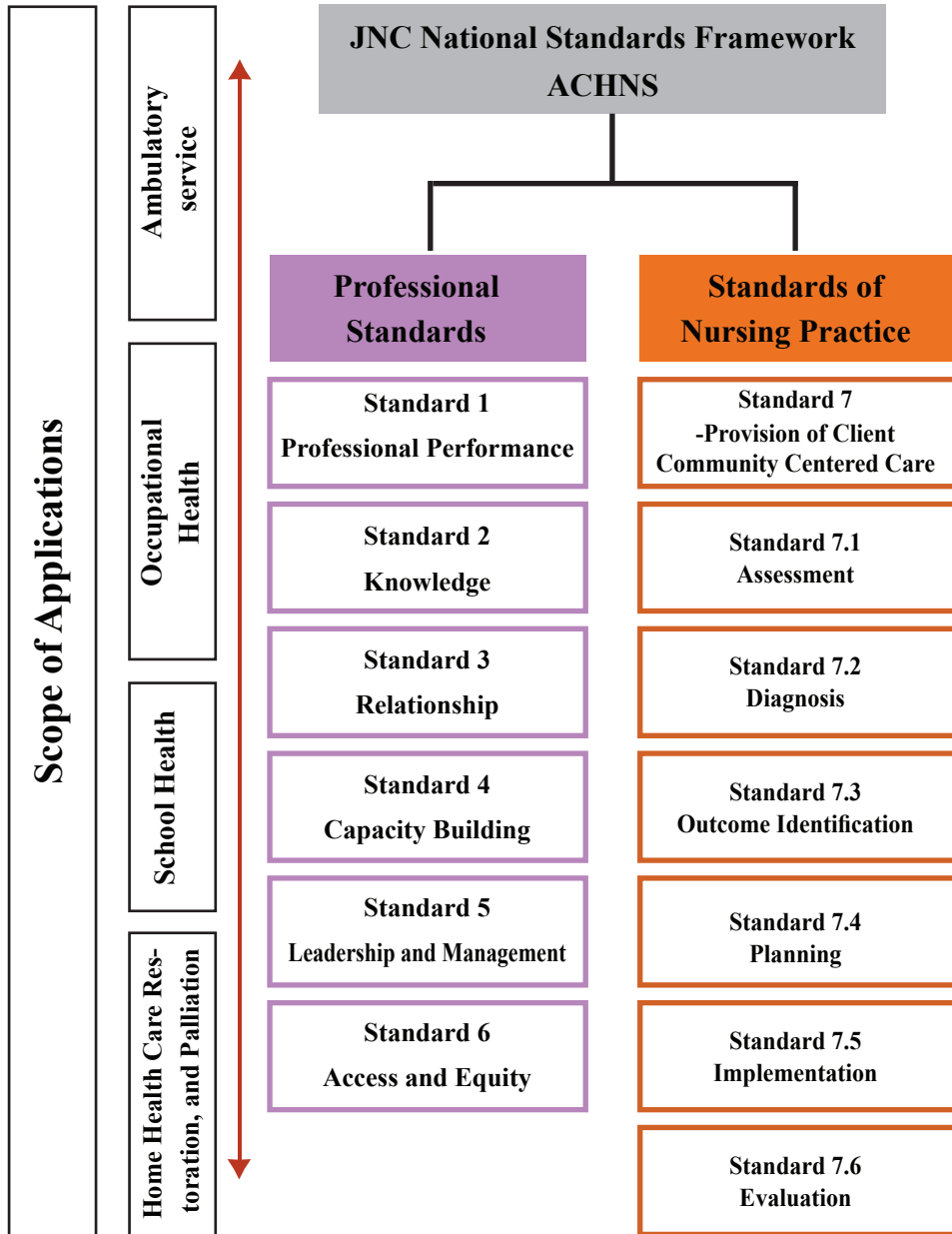
tice healthier living behaviors.

2. **Ambulatory Service Settings:** The community health nursing practice settings in which clients come for day or evening services that do not include overnight stays such as family planning or a well-child clinic.
3. **Schools:** The major settings for community health nursing practice at all levels.
4. **Occupational Health Settings:** Workplace and occupational settings make up another group of settings for community health nursing practice settings.

### **Measurement Criteria**

Measurement criteria are specific and measurable elements for meeting each standard to measure the actual performance of the nurse. Measurement criteria are not written in order of importance, nor are intended to be an exhaustive list of criteria for each professional standard. The measurement criteria will be particularly useful for nurses to assume responsibilities in practice, education, and research.

## Section 2: JNC National Professional Standards and Competencies for ACHNS



## **Standard 1: Performance**

The ACHNS meets the professional performance; legal and ethical responsibilities; accountability; safety; and the advocacy of individual, family and population rights in all scopes of community nursing applications.

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### **Core competency 1.1**

**Fulfills the responsibility and accountability of nursing professional activities within all relevant national legislation.**

#### **Measurement criteria**

- Identifies and adheres to legislation governing the nursing profession.
- Identifies and adheres to JNC nursing standards and competencies.
- Demonstrate awareness that actions have legal implications in nursing practice.
- Recognizes the ACHNS roles and responsibilities.

### **Core competency 1.2**

**Practices in a way that acknowledges the dignity, culture, values, and beliefs within the national nursing code of ethics.**

#### **Measurement criteria**

- Maintains a professional and ethical practice in meeting individuals' needs in a different community context.
- Demonstrates commitment to health equity and advocates for it through policy-making activities.
- Uses the decision-making framework to solve an ethical dilemma or ethical conflict in community settings.

- Assists individuals, families, and communities regardless of race, culture, religion, age, gender, physical or mental state.
- Serves as an advocate for culturally diverse groups.
- Protects client's privacy and confidentiality.
- Demonstrates respect and promotes the client right to health, self-determination, being informed and making informed choices, beneficence, and equity.
- Maintains an effective process of care when challenged by differing values, beliefs, and risks.

### **Core competency 1.3**

#### **Advocates for individuals, families, and communities and their rights to nursing and healthcare within their contexts.**

##### **Measurement criteria**

- Protects the rights of individuals, families, and communities and supports informed choices.
- Assesses vulnerable populations and assures their right in receiving quality and equitable health services.
- Identifies insufficient resources to meet the needs of clients.
- Identifies procedures and practices which infringe the rights of clients.
- Illuminates and recommends policies and guidelines when the rights of clients are compromised.

## **Core competency 1.4**

**Undertakes safe responses and activities to improve the nursing profession.**

### **Measurement criteria**

- Facilitates a physical, psychosocial, cultural, and spiritual environment that promotes individual or group safety and security.
- Adheres to nursing national safety guidelines for patients.
- Articulates appropriate emotional and psychological responses with clients in a professional manner.
- Demonstrates responsibility for the protection and well-being of individuals, groups, and communities within their settings.
- Maintains responsibility in providing safety information to risk groups, such as workers, teachers in school, etc.
- Utilizes health legislation to monitor health and safety in different community settings.

## **Standard 2: Knowledge**

The ACHNS articulates theoretically-based community health knowledge, evidence-based use of analytical skills, clinical judgment, and critical thinking and analysis in all scopes of community nursing applications.

### **Core competency 2.1**

**Has sufficient community health knowledge-related basic concepts, theories, and conceptual models in community health practice.**

#### **Measurement criteria**

- Identifies theories and concepts of human development, and epidemiology and biostatistics (e.g., life span of populations, individual developmental theory, group developmental theory, family developmental theory, and community developmental theory).
- Defines community health core functions—assessment, assurance, and policy development (defined in the Institute of Medicine’s report).
- Identifies social justice (e.g., health disparities, allocation of resources, principles, contrast with market justice, individual versus population, access to care, vulnerable populations, and environmental justice).
- Identifies cultural competence skills (e.g., dimensions of diversity such as race, ethnicity, spiritual beliefs, gender, sexual orientation, etc.; differences and similarities; and customization of programs to community needs).
- Recognizes scope and standards of professional practice (e.g., legal implications, position statements, professional organizations, public health nursing scope and standards, boundaries of practice, education, practice level, and competencies).



- Defines ethical principles and processes (e.g., autonomy, beneficence, truth-telling, informed consent, advance directives, confidentiality, anonymity, utilitarian perspective, and other ethical perspectives).
- Differentiates communication principles (e.g., media interaction, partnership building, social marketing, risk communication such as the U.S. Centers for Disease Control and Prevention guidelines, health literacy, community outreach, cross-cultural/interpersonal communication, and information dissemination).
- Identifies uses of information systems and technology (e.g., health informatics, accessing and interpreting information, electronic health records, telehealth, standardized nursing languages, and nursing minimum dataset).

## **Core competency 2.2**

**Bases education and practice on current evidence reflection from nursing and other sciences.**

**2.2.1 Participates and utilizes research to create or cultivate evidence in the field of nursing science and/or other sciences and humanities.**

### **Measurement criteria**

- Provides evidence-based rationale for all decisions and actions.
- Collaborates with multidisciplinary health groups and professionals to conduct research to promote health and well-being.
- Identifies gaps in scientific evidence related to community health issues.
- Retrieves credible, recent, and relevant scientific evidence health information.

- Relies on official national and international, and credible health statistics and surveys to compare the health status of the population and to make effective decisions.
- Critically appraises evidence for advocacy of individual and community health needs.
- Utilizes official national and international health research priority documents to analyze or to solve research problems important for the community.
- Uses different research approaches to assess population health needs and recommend or implement change.
- Uses empirical methodology to design, implement, and evaluate community-level interventions.
- Disseminates research outcomes to a wide audience through the most visible channels.

### **2.2.2 Demonstrates critical thinking and analytical skills in assessing, interpreting, and evaluating health information and evidence-based knowledge to promote individual, group, and community health and wellbeing.**

#### **Measurement criteria**

- Assesses a population's health status and related determinants of health and illness.
- Diagnoses individual, group, and community health problems or needs.
- Develops data collection plan using epidemiology, demography, and biostatistics to collect data about community health.
- Collects information about groups or population using national and international organizational resources such as geographical information, maps, etc., in planning healthcare services.

- Understands the knowledge required to meet the needs of complex situations and identifies a full range of options based on a depth and breadth of knowledge.
- Analyzes how bio-psychosocial needs and cultural background relate to healthcare needs.
- Uses the related theoretical framework to address adaptive versus maladaptive health-related responses for individual, groups, and population.
- Reflects primary healthcare principles in collaborative partnerships to encourage client independence and self responsibility.
- Participates in and supports initiatives to assist learning and individual behavior change by using learning theories as a reference in the domain of health promotion and prevention.

## **Standard 3: Relationship**

The ACHNS establishes professional communication, collaboration, consultation, and partnerships with individuals, groups, and communities in addition to intra and interprofessional teams to provide healthcare services in all scopes of community nursing applications.

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### **Core competency 3.1**

**Demonstrates collaboration and partnership in community health practice.**

#### **Measurement criteria**

- Sets shared goals for collaboration.
- Identifies the collaborative reference and partners who are capable of effectively meeting goals through shared participation.
- Sets clear guidelines on responsibility with collaborative partners.
- Utilizes contracting for agreements with individuals or community partners.
- Demonstrates negotiation skills to achieve mutual goals and equal benefits for respective parties.
- Demonstrates professional communication with individuals, groups, communities, and healthcare personnel in collaboration, coordination and consultation to provide the best professional services.

## **Core competency 3.2**

**Promotes and maintains respectful communication in all professional interactions.**

### **Measurement criteria**

- Treats colleagues, students, and other healthcare workers in a respectful manner.
- Recognizes and respects the contribution of others on the healthcare team.
- Initiates, maintains, and terminates nurse-client relationships in an appropriate manner.

## **Core competency 3.3**

**Establishes relationships that are goal directed and recognizes professional boundaries.**

### **Measurement criteria**

- Applies human relationship and conflict management skills in interacting with other healthcare professionals and clients.
- Uses effective verbal and non-verbal communication strategies and interpersonal skills.
- Communicates effectively in written and verbal formats to promote the health and wellbeing of individual, groups, and communities.
- Assesses barriers in communication with individuals, groups, and communities.
- Assesses health literacy level of individuals, groups, and communities.
- Facilitates group health-related decision-making.
- Establishes culturally acceptable communication strategies.

- Demonstrates communication strategies that include advocacy, discussion group facilitation, public speaking, and written information.
- Establishes helping relationships with clients, groups, and communities to find options for making choices that will meet their health needs and/or allow them to speak up for themselves.
- Builds trust, rapport with clients, groups and other healthcare professionals
- Includes the clients and groups in the planing and provision of healthcare.
- Enacts different advanced nursing roles appropriate for the situation.
- Maintains current understanding of nursing and its relationships in the healthcare delivery system.

### **Core competency 3.4**

**Collaborates with the interdisciplinary healthcare team to provide comprehensive nursing care.**

#### **Measurement criteria**

- Communicates effectively with individuals and groups to facilitate provision of care.
- Communicates nursing assessments and decisions to the interdisciplinary healthcare team and other relevant service providers.
- Collaborates with the healthcare team to inform policy and guideline development.
- Collaborates with relevant healthcare systems and partners in managing healthcare programs.

### **Core competency 3.5**

**Coordinates client's care, educational activities, strategies, and other associated processes to achieve agreed professional outcomes.**

#### **Measurement criteria**

- Organizes the implementation of community health services with health team members or with interdisciplinary health members.
- Plans and assures sustainability of a proposed community health program.
- Builds a referral directory to refer clients to appropriate agencies through formal and informal channels to ensure continuity of care.
- Promotes and supports linkages with appropriate community resources when the individual or community is ready to receive them (e.g., prevention activities, parenting groups, case meetings, and coalitions).
- Uses educational strategies to meet the needs of the profession and practice environment.
- Coordinates learning activities that reflect current evidence to improve nursing skills competence and professional development.
- Coordinates human, capital, system and community resources, and strategies including policies, services, and environmental modifications for developed professional care.
- Promotes open communication systems with professional organizations.

## **Standard 4: Capacity Building**

An ACHNS enhances the quality and effectiveness of the profession and practice of community health nursing, and articulates organizational policies and guidelines to enhance clinical nursing in all scope of community nursing applications.

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### **Core competency 4.1**

#### **promotes capacity building**

#### **Measurement criteria**

- Conducts individual and community assessments to identify needs, strengths, and available resources (e.g., primary and secondary data, and windshield survey).
- Assesses the readiness of an individual and community for planned change (e.g., perception of needs, ability to mobilize, and previous history).
- Develops health plans in collaboration with individual and key community members.
- Uses capacity building and community development principles to improve health outcomes for individuals and communities (e.g., advocacy, partnership, empowerment).
- Uses population health promotion strategies to address health issues (e.g., coalition building, partnerships, and networks).
- Evaluates actions, policies or programs related to capacity building by measuring their effect on health outcomes.



## **Standard 5: Leadership and Management**

The ACHNS demonstrates leadership and management skills to carry out the responsibility of nursing services in all scope of community nursing applications.

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### **Core competency 5.1**

**Promotes self-awareness of values and beliefs, self-development, and personal resilience.**

#### **Measurement criteria**

- Demonstrates effective planner, organizer, director, and controller nursing roles in managing healthcare services and community health programs.
- Possesses experience in establishing and leading teams.
- Exhibits creativity and flexibility during times of change.
- Demonstrates energy and passion for quality work.
- Accepts mistakes of one's self and others to create a practice culture in which risk taking is promoted and expected.
- Inspires loyalty and equity in valuing clients and colleagues.

### **Core competency 5.2**

**Provides nursing professional leadership and management skills.**

#### **Measurement criteria**

- Leads group or partners in identifying a vision, values, and principles for community health actions.
- Analyzes internal and external factors that may impact the delivery of health services.

- Develops funding proposals for internal or external sources.
- Manages care delivery to individuals, groups, and communities within current or forecasted budget constraints.
- Assume key roles in a work setting by participating on committees, councils, and administrative roles.
- Delegates profession practices and aspects of care to others according to their competence and scope of practice.
- Provides effective supervision to ensure that delegated care and profession practices are provided safely and accurately.
- Participates in professional organizational activities.
- Influences decision-making bodies and policy makers to improve patient care, health services and policies.
- Provides direction to enhance effectiveness of interdisciplinary and multidisciplinary teams.
- Accepts changes based on evidence and addresses emerging situations.

## **Standard 6: Access and Equity**

The ACHNS utilizes appropriate resources to plan and promote accessible and equitable community provide nursing care services that are safe, effective, and financially responsible in all scopes of community nursing applications.

### **Core competency 6.1: promotes accessible and equitable community nursing care services**

#### **Measurement criteria**

- Assesses the impact of community norms, values, beliefs, and resources on the health of individuals and the community (e.g., informed consent and community needs assessment).
- Supports care that is respectful of culture in all settings (e.g., religious or cultural ceremonies).
- Supports individuals and communities in making informed choices about alternative and/or complementary healthcare options (e.g., herbal medications, meditation, and prayer).
- Advocates for appropriate resource allocations (e.g., human and financial) to promote access to services (e.g., transportation and location of off-site programs).
- Applies strategies to promote access to services (e.g., case finding, outreach, referrals, and advocacy).
- Practices response to changing and emerging health needs of an individual and community (e.g., communicable disease outbreaks and threats to the safety of the client or nurse).
- Identifies service inequities or gaps that influence health determinants (e.g., victimization and vulnerable populations).

- Works collaboratively with clients and/or professional colleagues to enhance access and minimize inequities (e.g., case conference, social services, community agencies, using appropriate channels for advocacy).
- Applies strategies designed to promote access to needed services (e.g., child care and transportation).
- Evaluates strategies designed to promote access to needed services (e.g., survey of participants and focus groups).

## **Standard 7: Provision of Client-Centered Care**

The ACHNS provide comprehensive, systematic, and prioritized nursing care to clients, families to achieve identified health outcomes

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### **7.1 Community Assessment**

An ACHNS collects and evaluates information about a community's health status to discover existing or potential needs as a basis for planning future action. Community assessment includes two major activities: collecting pertinent community data and analyzing and interpreting the collected data.

#### **Measurement criteria**

- Develops and uses data collection tools that have been established as reliable and valid.
- Uses multiple data collection sources—primary or secondary from international, national, state, or local sources—to enhance and complete a community assessment
- Collects data using multiple assessment methods: surveys, descriptive epidemiologic studies, community fora or town meetings, and focus groups.
- Collects data about community assets, which focuses on the strengths and capacities of a community rather than its problems.
- Considers all risk factors about the community and assesses their importance: the physical environment where people live, their social environment, poverty, behavior, lifestyle, family genetics, and individual biology.

- Profiles the community by collecting demographic data, vital health statistics, utilizes health services, health status, family dynamics, environmental factors, patterns of coping, and community dynamics that will inform the nurse about the state of the community's health and health needs.

## **Population health assessment and health surveillance:**

### **Measurement criteria**

- Participates in assessing health status indicators such as infant mortality, methods, and data sources such as census data, key informant, and windshield survey; criteria-based assessment; population needs, concerns, values, and beliefs; resources; community capacity; and community diagnoses.
- Participates in environmental health assessments (e.g., air quality, sanitation, lead, exposure history, food, and water).
- Uses health surveillance data to launch new services or revise existing ones.
- Contributes to population health assessments including community viewpoints.
- Plays a key role in producing and using knowledge about the health of communities (or certain populations or groups) and the factors that support good health or pose potential risks (determinants of health), to produce better policies and services.
- Maintains awareness of health surveillance data and trends and applies this knowledge in day-to-day work.
- Integrates eco-social surveillance that focuses on broad, multi-level conditions that contribute to health inequalities.
- Mobilizes formal and/or informal networks to systematically

and routinely collect and report health data for tracking and forecasting health events or health determinants.

- Collects and stores data within confidential data systems and integrates, analyzes, and interprets this data.
- Provides expertise to those who develop and/or contribute to surveillance systems, including risk surveillance.

## **7.2 Community analysis and nursing diagnosis:**

An ACHNS analyzes data assessments to determine community health needs and strengths and to identify essential factors related to a healthful response, and trends in healthcare use. A community diagnosis forms the basis for community-based interventions.

### **Measurement criteria**

- Analyzes findings and sets data categorization (demographic, geographic, socioeconomic, health resource, and services, etc.).
- Summaries data using charts, graphs, and tables.
- Analyzes and compares data with similar data, identifies data gaps, inconsistencies, etc.).
- Examines and synthesizes data to detect patterns and trends.
- Uses data spreadsheets as a structure for data organization.
- Interprets data and analyzes the information to identify major health issues.
- Draws inferences logical conclusions from the evidence that lead to a community diagnosis.
- Presents findings to peers and uses their expertise to assist in formulating community diagnoses.

- Formulates differential diagnoses by systematically recording a client's response—healthy and unhealthy responses including a wellness diagnosis.
- Derives diagnoses from the assessment data, encompassing the whole health-illness continuum including the community's strength, and identifying potential sources of community solutions, weaknesses or problem areas.
- Validates data for accuracy by several means: checking data with the community team, comparing subjective and objective data, and considering the findings and verifying them with community members.
- Prioritizes and documents diagnoses to facilitate developing a plan of care and to achieve expected outcomes.
- Sets specific objectives and alternative design interventions.
- Reports results, including implications, recommendations, and next steps needed, and provides feedback to the population surveyed through a community forum.



## **7.3 Outcome Identification**

### **ACHNS Identifies expected outcomes for group /community plan.**

- Formulates expected outcomes with the community, other professionals, and agencies that are based on current clinical and scientific knowledge.
- Identifies expected outcomes by considering associated risks, benefits, and costs.
- Modifies expected outcomes and plan of care or actions based on changes in condition or needs.
- Documents expected outcomes as measurable goals.

## **7.4 : Planning**

An ACHNS develops and facilitates a logical, decision-making process of design for orderly and detailed programs of action to accomplish specific goals and objectives based on an assessment of the community and the nursing diagnosis.

### **Measurement criteria**

- Lists needs in order of priority.
- Assigns rank/importance to the community's needs.
- Establishes goals and objectives.
- Determines the order to address goals: immediate, intermediate or long-range goals.
- Develops a plan collaboratively promotes a community's contributions towards achieving the expected outcomes.
- Writes an action plan and activities specific to accomplishing the objectives or expected outcomes.
- Records the plan in a format easily accessible to, and understandable by, all community and team members involved.
- Plans community healthcare programs to address priority issues.

## **Standard 7. 5: Implementation**

An ACHNS effectively implements the interventions identified in the plan(s). Community interventions are the therapeutic actions designed to promote and protect community health, treat and remediate community health problems, and support the community as it changes over time.

### **Measurement criteria**

- Links community members with available resources.
- Pulls together information and resources to assist the community in addressing its health concerns and problems.
- Performs evidence-based interventions consistent with the needs of the community.
- Describes how to operationalize the plan.
- Designs a method for monitoring progress.
- Delivers safe interventions in an ethical manner that promotes health and minimizes complications.
- Implements the plan of action collaboratively with community members and the healthcare team.
- Works collaboratively with the community, other professionals, and agencies to determine which health issues cause the greatest concern
- Involves community work in partnership with local people
- Documents data collection efforts using different documentation sheet.
- Documents implementation and any modifications made.

## **Standard 7.6 : Evaluation**

An ACHNS evaluates and judges the effectiveness of goal attainment to determine whether planned actions meet client needs.

### **Measurement criteria**

- Compares systematically the community's response with the outcome as defined by the plan of care.
- Determines progress of the community toward planned outcomes.
- Examines the costs and benefits of proposed solutions.
- Judges the potential outputs, outcomes, and impact of the plan.
- Modifies the diagnoses, expected outcomes, and plan of care to achieve the best plan.
- Provides an estimate of the degree to which a family, group or community is achieving the best level of health possible for them.
- Includes interdisciplinary collaboration and multiple sources of data in the evaluation process
- Documents the evaluation process in an easy and effective manner.

## Appendix A

Advanced Community Nurse Specialist Competencies (Adopted from Canadian Nurses Association, 2011)

### **Core Competency 1: Health Promotion**

#### **The community health nurse:**

1. Identifies the determinants of health.
2. Assesses the health status of individuals and families throughout their lifespans in the context of determinants of health for the following:
  - 1.1 Child-bearing family to the prenatal period (e.g., comprehensive prenatal assessment);
  - 1.2 Child-bearing family to the postpartum period (e.g., comprehensive postnatal assessment);
  - 1.3 Child-bearing family to parenting (e.g., parenting skills, growth, development, and family functioning);
  - 1.4 Infant (e.g., immunization status, infant feeding, safety and security, attachment, and infant behavior);
  - 1.5 Children (e.g., immunization status, nutrition, physical activity, safety and security, behavior, growth and development, socialization, screening, self-esteem, and peer relations);
  - 1.6 Youth (e.g., immunization status, nutrition, physical activity, safety and security, growth and development, body image, self-esteem, peer and adult relationships, sexuality, and work);

- 1.7 Adult (e.g., immunization status, nutrition, physical activity, safety and security, literacy, relationships, housing, food security, work, finances, and sexuality); and
- 1.8 Older adult (e.g., immunization status, nutrition, physical activity, safety and security, relationships, housing, food security, finances, sexuality, and daily living activities).
2. Implements health promotion strategies at the individual and family levels across their lifespans, based on population health promotion models for the following:
  - 2.1 Child-bearing family to prenatal care (e.g., facilitating access to prenatal care, and promoting baby-friendly initiatives);
  - 2.2 Child-bearing family to postpartum care (e.g., breastfeeding support, anticipatory guidance, smoke-free home, sudden infant death syndrome prevention, and building individual and family capacity);
  - 2.3 Child-bearing family to parenting (e.g., parenting education, safety, family nutrition, and facilitating access to community resources);
  - 2.4 Infant (e.g., health teaching, screening and awareness campaigns on developmental milestones, injury prevention, feeding during the first year; and immunization);
  - 2.5 Child (e.g., health teaching, screening and awareness campaigns on developmental milestones, nutritional needs, and injury prevention; immunization, and collaboration with preschool and school communities);

- 2.6 Youth (e.g., health teaching, counseling and awareness campaigns on self-esteem, body image and nutrition; peer support, immunization, lifestyle choices, social marketing, and collaboration with schools and communities);
- 2.7 Adult (e.g., health teaching on work-life balance, smoking cessation, nutrition, sexual health, public awareness campaigns, formal/informal supports, and immunization);  
and
- 2.8 Older adult (e.g., health teaching, public awareness campaigns, advocacy, outreach, socialization, bereavement support, immunization, and lifestyle choices).
3. Assists communities, families, and individuals adopt health beliefs, attitudes, and behaviors that contribute to the overall health of the population.
4. Contributes to the overall health of the population through public policy, community-based action, public participation, and advocacy or action on environmental and socio-economic determinants of health, as well as health inequities.
5. Supports changes in government policy to reduce the risk for disease through modification of physical and social environments.
6. Enables communities, families, and individuals with the knowledge and skills to take responsibility for improving and maintaining their health.
7. Collaborates with others to enhance community, group, or individual plans that will help society to plan for, cope with, and manage change.

8. Encourages skill building by communities, families, and individuals to balance choices with social responsibility and, to create a healthier future for all.
9. Participates in health promotion activities in partnership with others, such as the community and colleagues in other sectors.
10. Conducts community assessments, which include the following:
  - 10.1 Physical environment (e.g., home, school, workplace, day-care, community, and recreation facilities);
  - 10.2 Socioeconomic environment (e.g., social, spiritual and cultural diversity, municipal services, transportation, food security, and employment);
  - 10.3 Political environment (e.g., social programs and services, and policy influence at multiple levels of government);
  - 10.4 Built environment (e.g., traffic, noise, housing, sanitation, lighting, and roads); and
  - 10.5 Natural environment (e.g., water quality, air quality, soil, sun, and allergens).
11. Implements community-level health promotion strategies based on the population health promotion model for the following:
  - 11.1 Physical environment (e.g., hand hygiene stations, social marketing, and advocacy);
  - 11.2 Socioeconomic environment (e.g., meal programs, advocacy for access to transportation, anti-poverty campaigns, and involving diverse groups in resource development);



- 11.3 Political environment (e.g., mobilizing community action and committee participation);
  - 11.4 Built environment (e.g., advocating for lighting on walking trails, road safety, bike lanes, and accessibility); and
  - 11.5 Natural environment (e.g., education on safe food preparation and sun safety; organizing a process for safe medication disposal, and promoting conservation and recycling).
12. Evaluates the impact of health promotion strategies through surveys, focus groups, and surveillance data.

## **Core Competency 2: Prevention and Health Protection**

### **The community health nurse:**

- 1.1 Works through the continuum of prevention (primary, secondary, and tertiary).
- 1.2 Applies appropriate level of preventive intervention and focuses on primary prevention.
- 1.3 Assesses an individual's readiness for undertaking healthy or un-healthy promotion behaviors.
- 1.4 Collaborates with individuals, groups, families, and communities to reduce potential health risks.
- 1.5 Uses multiple sources of data to assess changes in community health status:
  - 1.5.1 Observational data (e.g., trends, unusual events, community-identified concerns, and windshield survey);
  - 1.5.2 Client records (e.g., number of visits, trends, and outcomes);
  - 1.5.3 Organization records and reports (e.g., number of influenza cases and emergency hospital visits);
  - 1.5.4 Key community members and agencies (e.g., key informant interviews, surveys, and focus groups);
  - 1.5.5 Epidemiological data (e.g., incidence rates, prevalence, immunization rates, medical health officer reports, and active and passive surveillance data);

- 1.5.6 Community profile (e.g., demographics);
  - 1.5.7 Evidence-informed research; and
  - 1.5.8 Develops a plan of action to address community health status changes (e.g., healthy food choices in schools, and safe walking trails).
- 1.6 Implements interventions to improve the health of individuals, groups, and communities:
    - 1.6.1 Strengthening community action (e.g., advocacy, coalition building, community organizing, screening, and negotiation or mediation);
    - 1.6.2 Building healthy public policy (e.g., case reporting, advocacy, and coalition building);
    - 1.6.3 Creating supportive environments (e.g., advocacy, social, negotiation or mediation, marketing, screening, surveillance, referral, consultation, collaboration, facilitation, outreach, and harm reduction);
    - 1.6.4 Developing personal skills (e.g., health teaching, advocacy, counseling, and harm reduction); and
    - 1.6.5 Reorienting health services (e.g., case reporting, case finding, advocacy, surveillance, case coordination, disease or health event investigation, and referral).
  - 1.7 Supports individuals and communities to make informed choices about protective and preventive health measures (e.g., immunization, palliative care, infant feeding, and home safety).
  - 1.8 Applies the principles of harm reduction to minimize health risks within the continuum of prevention (e.g., safer sex, needle exchange, safe injection sites, and intimate partner violence).

- 1.9 Evaluates protective and preventive health interventions designed to address identified individual and community health issues.
- 1.10 Applies the principles of immunization:
- 1.11 Informed consent;
- 1.12 Screening;
- 1.13 Contraindications (e.g., allergies, vaccine components, pregnancy); and
- 1.14 Vaccine administration and monitoring (e.g., safety, documentation).
- 1.15 Identifies communicable diseases:
- 1.16 Vaccine preventable (e.g., pertussis, rubella, hepatitis A, and human papillomavirus);
- 1.17 Non-vaccine preventable (e.g., HIV, hepatitis C, febrile respiratory illness, and Chlamydia);
- 1.18 Healthcare-acquired infections (e.g., MRSA and VRE);
- 1.19 Emerging and resurgent (e.g., tuberculosis, and *Clostridium difficile*);
- 1.20 Common food-borne illnesses (e.g., E. Coli infection, hepatitis A, and listeriosis);
- 1.21 Parasitic (e.g., lice, scabies, and bed bugs); and
- 1.22 Water-borne illnesses (e.g., shigellosis, amebiasis, cholera, and giardiasis).

- 1.23 Implements the principles of communicable disease management related to:
  - 1.23.1 Mode of transmission (e.g., agent/organism, reservoir, portal of exit, portal of entry, and susceptible host);
  - 1.23.2 Infection control (e.g., protection of the public);
  - 1.23.3 Active and passive surveillance;
  - 1.23.4 Primary, secondary, and tertiary prevention related to communicable disease exposure (e.g., response to outbreaks, contact tracing, and directly observed therapy);
  - 1.23.5 Understanding the process and rationale of reporting communicable diseases (e.g., surveillance); and
  - 1.23.6 Outbreak management (e.g., endemic, epidemic, and pandemic disease).
- 1.24 Assesses safety and risk as applies to injury prevention (e.g., related to the client, environment, and nurse).
- 1.25 Identifies community health nursing responsibilities throughout the phases of emergency preparedness/disaster management.
- 1.26 Applies nursing interventions to decrease risk in emergency or disaster situations (e.g., triage, call for backup, and self-care).
- 1.27 Reduces the risk of infectious disease outbreaks, including early identification, investigation, contact tracing, preventive measures, and activities promoting safe behaviors.

- 1.28 Applies epidemiological principles and knowledge of the disease process to manage and control communicable diseases using prevention techniques, infection control, behavior change counseling, outbreak management, surveillance, immunization, episodic care, health education, and case management.
- 1.29 Uses appropriate technology for reporting and follow-up.
- 1.30 Uses effective strategies to reduce risk factors that may contribute to chronic disease and disability which may include changes to social and economic environments and inequities that increase the risk of disease.
- 1.31 Helps individuals and families to adopt healthy behaviors that reduce the likelihood of disease, injury, and/or disability.
- 1.32 Encourages behavior changes to improve health outcomes.

## **Core Competency 3: Health Maintenance, Restoration, and Palliation**

### **The community health nurse:**

- 1.1 Assesses health needs of clients to determine whether community health nursing interventions are required (e.g., surveillance, intake assessments, and case findings).
- 1.2 Develops a client-centered plan of care in collaboration with the individual and family, and interprofessional team (e.g., family meetings, case conferences, respite plan, emergency plan, consultation, and referrals).
- 1.3 Manages a prioritized caseload (e.g., time management, acuity of care, resource allocation, and infection control).
- 1.4 Applies the community health nursing process to address health maintenance, health restoration, and palliation needs related to:
  - 1.4.1 Management of chronic diseases (e.g., diabetes, cardiovascular disease, kidney disease, cancer, compromised respiratory system, and obesity);
  - 1.4.2 Activities of daily living (e.g., physical and instrumental);
  - 1.4.3 Newborn and postpartum complications (e.g., depression/psychosis, mastitis, and newborn jaundice);
  - 1.4.4 Palliative and end-of-life care;
  - 1.4.5 Pain management (e.g., acute, chronic, breakthrough, and safety related to medications or controlled substances);

- 1.4.6 Nutrition (e.g., food security, modified diets, hydration and fluid balance, and enteral feeding);
  - 1.4.7 Elimination (e.g., constipation, catheterizations, and Enterostomal therapy);
  - 1.4.8 Wound care (e.g., staging, types, healing, skin integrity, signs of infection, and underlying causes);
  - 1.4.9 Infusion therapy (e.g., fluid balance, medication administration, and peripheral and central venous access devices);
  - 1.4.10 Airway management (e.g., home oxygen, intubation/tracheostomy, home ventilator); and
  - 1.4.11 Infection control (e.g., healthcare acquired, communicable disease, immunocompromised, and safe handling/disposal of products).
- 1.5 Supports the client in making informed choices related to healthcare (e.g., advance directives, and power of attorney).
  - 1.6 Demonstrates the ability to delegate nursing care responsibilities to the client, family or regulated/unregulated healthcare workers.



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Name	Organization	Title
Dr. Nahla Al-Ali	JUST University	Head Committee
Dr. Sukaina Alzyoud	Hashemite University	Committee member
Dr. Andaleeb Abu Kamel	Al-Zytoneh University	Committee member

### Reviewed by:

Prof. Muntaha Gharaibeh : Secretary General , JNC

Dr. safa Al.Ashram , Director of specialization department , JNC

Mr. Bilal Naja, Researcher, Directorate of Research and Development, JNC

Editted by : Christine Kuhn