

Visible, Accessible and Integrated Care
Capability Framework for Community Health Nursing





CONTENTS

1 Introduction	2
2 Developing the capability framework	6
3 Structure of the framework	8
Glossary of Terms	24
References	29
Appendix 1	31

1 INTRODUCTION

Nurses have a strong tradition of providing services in the community. They have many diverse roles and work with a range of social groups in the community, homes and schools, including children, young people, families and older people. Nurses working in the community face many current and future challenges. The structure of health services and definitions of professional roles and boundaries are changing rapidly, with more emphasis on delivering services closer to home. Changes in current ways of working are bringing together healthcare professionals from different disciplines, agencies and geographical boundaries to develop integrated services that respond to people's needs (SEHD, 2005a; SEHD, 2006a; SEHD, 2006b). There is a drive to develop community-based services that are proactive, modern, and safe. To prevent ill health, health services must focus on health improvement and 'wellness', rather than just treating illness (SEHD, 2005a; SEHD, 2006a; SEHD, 2006c).

Three important considerations face health professionals in planning future services in the community: people living longer; persistent health inequalities; and a rising incidence of long-term conditions. These factors are gaining prominence and are changing the nature of demands on health and care services, with more age-related conditions, complex needs, hospital admissions and emergency admissions (SEHD, 2005b; SEHD, 2007a). We must also centre services on children and young people to promote and protect their health, treat disease, and address the needs of those who may be vulnerable or at risk from an early age (SEHD, 2007a; SEHD, 2007b).

Nurses in the community are seen as key players in responding to the complex and changing demands on health and care services. To respond to these demands and work in new and different ways as part of multi-disciplinary and multi-agency teams, nurses must continually adapt and improve (SEHD, 2005c; SEHD, 2006a). They must become ever more capable, which, with other future changes, has major implications for education and training (Price, 2004). Capability is a key component of Scotland's nursing, midwifery and allied health professions' action plan, *Delivering Health, Enabling Health* (SEHD, 2006b). Capability goes beyond competence; it includes the ability to apply knowledge, skills and attitudes across a range of complex and changing settings (SCMH, 2001). A capability approach means making education and training more flexible and adaptable, to meet the future demands of healthcare delivery (Price, 2004). Such an approach therefore seems an appropriate basis for the professional development of existing nurses in the community as they make the transition to a new role as community health nurses, and for developing future educational programmes for community health nursing.

Who is this framework for?

This framework is for the new discipline of community health nursing. The community health nurse is core to the nursing team depicted in the service model proposed in *Visible, Accessible and Integrated Care* (SEHD, 2006a) (figure 1).



Figure 1: New service model for nursing in the community (SEHD, 2006a; p16)

The service model for nursing in the community is intended to create nursing services that can:

- improve and promote health and self care
- support people to live healthier lives in their homes
- reduce health inequalities
- develop career options

The new discipline of community health nursing will include elements common to district nursing, public health nursing (health visiting and school nursing) and family health nursing. The new community health nursing role is based on seven core elements of practice. These elements build on the strengths of the main nursing disciplines in the community (SEHD, 2006a). The seven core elements of nursing in the community are:

- working directly with individuals and their carers
- adopting public health approaches to protecting the public
- coordinating services
- supporting self-care
- multi-disciplinary and multi-agency team working
- meeting the health needs of the community
- supporting anticipatory care

The role of the community health nurse follows a 'generalist' approach to practice, which includes a broad range of duties. As a generalist role, community health nursing centres on providing services that meet the needs of the local community, seeing the community as the 'client', rather than focusing on caseloads of individual clients and specific social groups (Parfitt et al, 2006; SEHD, 2006d). Community health nurses will act as a visible point of access for people in the community to the nursing service. They will coordinate nursing care and intervention through an appropriately qualified and defined team; deal with more complex needs; and refer people to, and seek support for them, from those with greater expertise as required (Parfitt et al, 2006; SEHD, 2006a; SEHD, 2006d). The generalist role of the nurse is therefore similar to that of the general medical practitioner (GP) and by definition demands a broad knowledge base (Parfitt et al, 2006; McKenna et al, 2003).

This framework is an initial starting point in clarifying the intended practice and required knowledge, skills and approaches of the nursing roles in the new service model (figure 1). Roles of nurses working at different levels in the core nursing team and with increasing expertise in the community will need to be defined. Work will also need to be done on the role of healthcare support workers. Future aspects of work must aim for clarity and consistency across the sector in line with current developments across the UK, such as Modernising Nursing Careers (SEHD, 2006e), advanced practice and the regulation of healthcare support workers (SEHD, 2006f), to give meaning to career progression and to ensure fitness for purpose.

Figure 2 shows how the roles in the core nursing team of the new service model may fit with the Careers Framework for NHSScotland (SEHD, 2006g).

Figure 2: Possible professional development framework for nurses working in the community



2 DEVELOPING THE CAPABILITY FRAMEWORK

This framework is underpinned by the idea of capability, which goes beyond the idea of competence. Capability is based on the theory of how adults learn and develop, and includes the notion of complexity (Price, 2004; Fraser and Greenhalgh, 2001). Capability is essential to practitioners' continuing development. It has been defined as:

'an integration of knowledge, skills, personal qualities and understanding used appropriately and effectively – not just in familiar and highly focused specialist contexts but in response to new and changing circumstances.' (Price, 2004; p2)

Competence describes what individuals know or are able to do in terms of knowledge, skills and attitudes at a particular point (Fraser and Greenhalgh, 2001; Stephenson, 1998). It has been argued that competencies do not take into account complexity (Wilson and Holt, 2001) and that practitioners need more than a prescribed set of competencies to carry out their roles effectively (SCMH, 2001). Capability includes gaining competence in carrying out the current job and the ability to develop further competence to meet future demands (Stephenson, 1998). Capability therefore describes how far an individual can apply, adapt and combine new knowledge from experience and continue to improve their performance (Fraser and Greenhalgh, 2001). It also involves having confidence in one's ability and a commitment to learn from experience (Stephenson, 1998). The ability to adapt involves professional judgement, decision-making skills and knowledge gained from experience in many similar situations. The more expert the practitioner, the more likely they are to adapt in unpredictable and unfamiliar circumstances (Benner, 1984).

Capability frameworks focus on:

- realising people's full potential
- developing the ability to adapt and apply knowledge and skills
- learning from experience
- envisaging the future and helping to make it happen

These elements are part of continuing professional development, lifelong learning and personal development goals, each of which is vital to current and future healthcare practitioners. A capability approach to learning incorporates flexibility to respond to the specific, self-identified learning needs of practitioners (Gardener et al, 2006). A capability approach fits well with the NHS Knowledge and Skills Framework (NHS KSF) (DH, 2004a). The NHS KSF is the overarching framework for reviewing the development of most staff groups in the NHS, as part of the Agenda for Change agreement. The NHS KSF defines and describes the knowledge and skills that staff need to apply in practice to deliver quality services (DH, 2004a) and the review process is the means for providing evidence of continuing capability.

The *Capable Practitioner* framework (SCMH, 2001) aimed to identify the skills, knowledge and attitudes a multi-professional workforce would need in providing safe and effective care. It also sought to define what type of education and training practitioners would need. This framework for community health nursing has been developed from the core-level professional development framework for nurses and allied health professionals working with people with cancer (NES, 2006), which included these ideas. It has also been informed and adapted from previous work by the Combined Universities Interprofessional Learning Unit (2004) and the Department of Health (2004b).

Capabilities include several parts (SCMH, 2001; p2):

- a performance component – identifies what skills people need to possess and what they need to achieve in the workplace
- an ethical component – concerned with integrating knowledge of culture, values and social awareness into professional practice
- a component that emphasises reflective practice in action
- the capability to effectively implement evidence-based interventions in the changing context of health services
- a commitment to working with new models of professional practice and accepting responsibility for lifelong learning

A capability framework is a broad outline of what practitioners should be able to do in practice. Capability frameworks are usually supported in practice by competency frameworks, which detail the level of expertise required. As community health nursing is a new discipline emerging in Scotland, for which there was no established description, this capability framework sets out to broadly define the intended practice and the knowledge and skills that community health nurses should be able to demonstrate in practice.

3 STRUCTURE OF THE FRAMEWORK

This framework was initially developed by NHS Education for Scotland from the seven core elements of nursing in the community (SEHD, 2006a) and existing competency and proficiency frameworks for district nursing (CDNA, 2006), family health nursing (NES, 2004) and specialist community public health nursing (NMC, 2004). To identify philosophies, principles and a focus of practice for community health nursing, a focused discussion was held with seven community nurses in April 2007 and a small review of international literature on community health nursing and public health nursing was conducted. The framework was further developed following discussions of the initial draft with several mixed groups of practitioners from various community nursing disciplines across health board areas in May and June 2007. The findings from these meetings were compared with the findings from events arranged by the Scottish Executive to explore the potential role of the community health nurse. Key individuals and groups with specific expertise also provided specific comments. A national consultation on the second draft of the framework was held between July and September 2007, feedback from which has helped shape the final version of the framework. For further information on how this capability framework has developed, see the NHS Education for Scotland website on Visible, Accessible, and Integrated Care at www.nes.scot.nhs.uk/nursing/review.

The framework is presented under four areas:

- practising ethically
- knowledge for practice
- leadership for practice
- coordinating and delivering care and intervention

Each area contains:

- capabilities – broad statements of intent
- practice learning achievements – detailing the knowledge, skills, attitudes and behaviours that community health nurses should be able to demonstrate in practice
- key content – providing an outline knowledge base required to achieve practice learning achievements

The capability framework reflects the core values and principles described as essential capabilities for all nurses working in the community, as presented in the second draft. The framework gives an indication of links between the practice learning achievements and areas of the NHS KSF (DH, 2004a). The links were identified in partnership with the lead person for implementation of the NHS KSF from the workforce modernisation division of NHSScotland. The seven core elements of nursing in the community (SEHD, 2006a) have been mapped with the practice learning achievements, as shown in appendix 1. The mapping is based on the descriptions of each of the core elements presented in *Visible, Accessible, and Integrated Care* (SEHD, 2006a, p17).

Throughout the framework 'people' has been used to mean individuals of all ages in families; groups and communities to whom nurses provide services in the community setting. Nursing includes the promotion of physical, mental, emotional and social health and well-being; prevention of illness and vulnerability; and the care of ill, disabled and dying people (NES 2004). In this context it is recognised that 'people' is a broad and generic term. Knowledge, skills and approaches listed in the framework will be applied differently and in varying levels of complexity to take account of the needs of individuals in various social groups and in the varying contexts in which community health nurses will practise. The range of health needs of individuals and social groups will also vary according to the demographics of the local community, which will differ between and across urban, rural and remote geographical areas. The people and groups that community health nurses may provide services to could, for example, include: adults; older people; carers; families; children and young people; parents; looked-after children; trafficked children and adults; children, young people, adults and older people with learning disabilities, physical disabilities, mental health problems, long-term conditions or more complex needs; people who misuse substances; homeless people and families; travelling families; immigrants; asylum seekers; and EU nationals.

How can the framework be used?

The framework has been developed as one part of the educational work that NHS Education for Scotland is leading on for the national project to test the new service model (figure 1) in four of Scotland's health board areas. NHS Education for Scotland is also looking at transition education requirements for existing nurses working in the community and education to prepare community health nurses, as well as addressing regulatory issues with the Nursing and Midwifery Council (NMC). The educational work is one of the three overarching aspects of work to support the national project, the other two being workforce and workload planning, and evaluation. This capability framework will be used in the health board areas where the service model is being tested. These health boards reflect urban, rural and remote geographical areas. The framework will also be included in the evaluation project. During consultation, suggestions on how the framework could be used in practice were received.

It can be used as a supplement to the NHS KSF as part of its development review process:

- to identify gaps in knowledge and skills of practitioners
- to identify required skills and roles in a team to meet the needs of a local community
- to help identify and meet the learning needs of community nurses
- for completing an NHS KSF post outline for the community health nurse role

The capability framework can also be used:

- to identify individual professional development needs to meet the capability required of a community health nurse
- to plan and develop education curricula and provision
- as a guide to ensure practitioners are working towards the same goals and promote lifelong learning
- as a basis for job descriptions for the new community health nurse role

Domain 1. Practising ethically

Capability 1.1 The community health nurse continually develops and uses knowledge of culture, diversity and professional, legal and ethical frameworks to ensure health and care needs of people in the community are identified and addressed in an inclusive, safe and non-discriminatory way.

Practice learning achievements	Indicative KSF link	Key content
1.1.1 Uses knowledge to ensure ethical, legal, safe and effective practice by self and within the nursing team.	C5	<ul style="list-style-type: none"> Ethical and legal considerations, including accountability and responsibility Theoretical knowledge and sources of evidence that inform decisions and practice NMC code of professional conduct Understanding the generalist approach to practice and recognising limitations in knowledge base Scope of professional practice Reflection on practice Lifelong learning Appropriate approaches and methods to remove barriers to communication Legal capacity to consent Culture, equality and diversity issues Children's and human rights Carers' rights Equity of service provision
1.1.2 Continually assesses the limitations of own knowledge and experience, and how these may put people at risk, and takes steps to address shortcomings.	C5, HWB2, HWB5	
1.1.3 Uses a reflective approach to review, evaluate and develop nursing practice; and encourages other team members to take the same approach.	C2	
1.1.4 Is always aware of their own belief and value systems and how this may affect their practice and interactions with people.	C6	
1.1.5 Continually seeks ways to communicate with people, communities and colleagues in an inclusive way that enables people to express their views and needs and to work in partnership.	C1	
1.1.6 Maintains a respectful, non-judgmental and empathetic approach to people.	C1, C6	
1.1.7 Respects people's right to information, choice and self-determination, where possible.	C1, HWB1, HWB2, HWB5	
1.1.8 Enables people to understand the information they get to support their choices, decisions and informed consent.	C1, HWB1, HWB2, HWB5	
1.1.9 Recognises the rights, aspirations and responsibilities of individuals, carers, parents and families, identifying different levels of authority between them.	C6	
1.1.10 Acts as an advocate for people's needs, particularly for those who are vulnerable, disempowered or disengaged in society.	C6, HWB1, HWB2	

Domain 2. Knowledge for practice

Capability 2.1 The community health nurse continually maintains and develops an integrated knowledge of the legislation and policy that form the current framework in which the health and care needs of people in the community are addressed.

Practice learning achievements	Indicative KSF link	Key content
2.1.1 Is particularly aware of the impact of different agencies' and sectors' policy, guidelines and priorities on people across key social groups.	C4	<ul style="list-style-type: none"> • Key local and national policies, guidelines and priorities relating to: community care; education; employment; health and social care; housing; inequalities; protection of children and young people, adults and older people; public health; rehabilitation; social inclusion; vulnerable families and other social groups; welfare provision • Care in the community • Children's and human rights • Carers' rights • Corporate policies on equality and diversity • Legislation relating to the protection of children and young people, adults and older people; people with mental health problems • Legislation relating children's, young people's and adults' capacity to provide consent and make decisions • Statutory duties • Duty of care of different agencies • Understanding of the policy process
2.1.2 Keeps aware of and understands the implications of changing national policies and guidelines and diverse service needs.	C2, C4	
2.1.3 Is critically aware of current and related legislation on equality and diversity; children's and human rights; consent and care provision within the community.	C5	
2.1.4 Maintains a detailed knowledge of the current legislation, principles and procedures involved in the protection of children and young people, adults, older people and families.	C5, HWB3	
2.1.5 Is critically aware of statutory arrangements and how they affect practice within and between teams.	C5	
2.1.6 Shows political awareness with regard to influencing policy development and implementation.	C2, C4	

Domain 2. Knowledge for practice

Capability 2.2 The community health nurse, in collaboration with others, continually maintains and develops a detailed understanding of available resources, services, and networks across agencies and sectors to meet the health and care needs of people in the community.

Practice learning achievements	Indicative KSF link	Key content
2.2.1 Maintains a working knowledge of how the structures and functions of relevant agencies, organisations and teams interrelate and differ in meeting the health and care needs of people within the community.	C4, HWB2, HWB5	<ul style="list-style-type: none"> • Application of knowledge to effective partnership and team working • Interface between primary, secondary, tertiary and specialist services • Specialist service provision • Services for children, young people, parents and families across health, local authority, private and voluntary sectors • Care provision in the community across health, local authority, private and voluntary sectors • Social work services • Primary care • Community health partnerships • Community planning structures and partners • Learning disability services • Mental health services • Public health departments • Community development projects and self-help groups
2.2.2 Maintains an extensive working knowledge of local resources, services, networks and referral pathways available within and for the community.	C2	
2.2.3 Recognises the roles and functions of team members and services provided by professionals and agencies across the statutory, independent and voluntary sectors.	C5	

Domain 2. Knowledge for practice

Capability 2.3 The community health nurse continually develops and analyses different and sometimes conflicting theories and perspectives in making professional judgements and decisions when anticipating, assessing and meeting the health and care needs of people in the community.

Practice learning achievements	Indicative KSF link	Key content
2.3.1 Critically understands theory, models, principles and concepts relevant to community nursing and public health nursing, and collaborates with other team members to include them in practice.	C5, IK2	<ul style="list-style-type: none"> • Family nursing theory • Nursing theory, models and concepts • Public health and health promotion principles, concepts, approaches and methods • Community health development • Professional principles for practice • Sociology of health and illness • Health psychology, including attitudes, values and beliefs; models of change in health behaviour • Empowerment • Theory of prescribing • Determinants of health and illness • Equality, diversity and culture • Human development – physiological, psychological and sociological • Principles, methods, evidence sources and tools for assessment of health and care needs at individual, family and community level • Assessment and prediction of risk • Health impact assessment • Community profiling • Principles of screening • Access to and appraisal of relevant research, demographical, epidemiological, sociological, and environmental sources of evidence
2.3.2 Is critically aware of all aspects of social, cultural and environmental diversity and its impact upon health, illness and disease.	C6, HWB1, IK2	
2.3.3 Critically understands holistic theoretical perspectives on human development across the lifespan and at key life stages, recognising signs of deviation from normal development.	HWB2	
2.3.4 Maintains a critical understanding of the principles and types of health needs assessment, risk assessment, screening and surveillance, and relevant sources of data.	HWB2	
2.3.5 Critically understands how to access, structure, analyse and interpret appropriate data and information on the health needs of defined populations across the lifespan and within the geographical community.	IK2	

Domain 2. Knowledge for practice

Capability 2.3 The community health nurse continually develops and analyses different and sometimes conflicting theories and perspectives in making professional judgements and decisions when anticipating, assessing and meeting the health and care needs of people in the community.

Practice learning achievements	Indicative KSF link	Key content
2.3.6 Maintains a critical understanding of theories and interventions relating to resilience, vulnerability and abuse, applicable to children and young people, adults, older people and families.	HWB2, HWB3	<ul style="list-style-type: none"> • Family theory • Resilience • Vulnerability • Theories on violence and abuse relating to children and young people, adults, older people and families • Causes and effects of inequality, poverty, social exclusion and vulnerability • Transitions and key life stages, such as adolescence, pregnancy, parenting, ageing, caring role, bereavement • Factors affecting family health, such as substance misuse; domestic violence; long-term conditions • Self-care, anticipatory care, intermediate care, rehabilitation, palliative care • Long-term conditions • Congenital conditions • Mental health problems • Learning disability and physical disability • Care management principles • Pathways of care • Decision-making models • Ethical principles • Communication theories and approaches applied at a higher level with people across the lifespan, different social groups and settings in the community • Knowledge of access to and use of interpreters and literacy support
2.3.7 Has a working knowledge of the main principles of disease processes, management and care associated with acute, chronic and complex needs of people across the lifespan, as commonly encountered within the scope of professional practice.	HWB5	
2.3.8 Is aware of the ethical frameworks informing decision-making.	C5	
2.3.9 Is critically aware of communication theories and approaches relevant to people of differing culture, language and literacy ability, life-stage, needs and setting.	C1	
2.3.10 Is aware of teaching and learning theories and methods and how they apply to people across the lifespan and in different settings.	HWB1	

Domain 3. Leadership for practice

Capability 3.1 The community health nurse collaborates with nursing, multi-disciplinary and multi-agency team members, service users and the public to ensure provision of high-quality, evidence-based, sustainable nursing care services and public health programmes that meet the health and care needs of people in the community.

Practice learning achievements	Indicative KSF link	Key content
3.1.1 Uses knowledge of current local and national policies and guidelines and collaborates with other team members to apply them in practice.	C5	<ul style="list-style-type: none"> • SIGN guidelines • Quality Improvement Scotland standards • Health Board policies • Knowledge of pathways of care, referral procedures and discharge planning procedures • Evidence base for referring on • Scope of professional practice • NMC guidelines on record keeping • Organisational policies and guidelines on record keeping; documentation; data protection and use of information technology • Knowledge of codes of practices for sharing information when a person is at risk of harm • Applying knowledge of effective partnership working • Influencing skills • Negotiation skills
3.1.2 Ensures that clear pathways of care in the nursing team are available and used, and helps to evaluate them.	C5	
3.1.3 Uses knowledge of referral pathways and procedures to ensure people's needs are met when these are beyond the knowledge and skills within the nursing team.	HWB2, HWB5	
3.1.4 Communicates clearly in speech and writing to ensure that systems of referral, liaison and discharge planning are used effectively, appropriately and responsively.	C1	
3.1.5 Is aware of, and able to help break down, barriers to inter-agency and partnership working.	C4	
3.1.6 Works collaboratively to help develop and implement services and interventions and make them accessible.	C4	
3.1.7 Identifies and highlights gaps in resources and service provision when needs cannot be met.	C4	

Domain 3. Leadership for practice

Capability 3.1 The community health nurse collaborates with nursing, multi-disciplinary and multi-agency team members, service users and the public to ensure provision of high-quality, evidence-based, sustainable nursing care services and public health programmes that meet the health and care needs of people in the community.

Practice learning achievements	Indicative KSF link	Key content
3.1.8 With other team members, raises awareness of and influences policy relating to peoples' health and care needs.	C4	<ul style="list-style-type: none"> • Awareness of policy process and strategic planning • Community planning structures • Local policies and procedures on patient and public involvement • Community development approaches • Knowledge of sources of funding and resources • Appropriate evidence base to support arguments • Application of knowledge on and skills in leadership theories and principles • Appropriate evidence base to inform changes • Application of knowledge on and skills in change management; project management; management of people; practice development
3.1.9 Works within recognised systems to give people in the community and professionals an opportunity to contribute to joint decision-making.	C4	
3.1.10 Puts forward reasonable arguments to influence sustainable funding streams and resource allocation.	C5	
3.1.11 Tries ways of working that challenge service provision and traditional boundaries.	C4	
3.1.12 Objectively initiates and manages change in practice to meet local health and care needs.	C4	

Domain 3. Leadership for practice

Capability 3.2 The community health nurse uses leadership, professional judgement and knowledge to coordinate, maintain and develop the community nursing team in the wider multi-disciplinary, multi-agency context to meet the health and care needs of people in the community.

Practice learning achievements	Indicative KSF link	Key content
3.2.1 Acts as a visible and accessible point of contact for people to the community nursing service, ensuring appropriate and timely responses.	C1,C5	<ul style="list-style-type: none"> • Decision-making and prioritisation skills • Accountability and responsibility • Integrated team working • People and resource management • Capacity building • Culture, equality and diversity issues • Equity of service provision • Appraisal and objective setting • Preceptorship, mentorship, and clinical supervision • Facilitation of learning • Team working and development • Professional development • Emotional intelligence • Reflection on practice • Knowledge of how clinical and case supervision is arranged within the organisation • Application of knowledge on national and local clinical governance and quality improvement frameworks • Standards, guidelines, protocols, audit • Appraisal of appropriate evidence • Knowledge of best evidence and best practice • Critical incident analysis • Organisational policies on lone working; safety at work; moving and handling; and the application of health and safety principles and policies within different settings
3.2.2 Appraises, manages and prioritises workload, resources and time ethically and effectively in the nursing team.	G6	
3.2.3 Appropriately delegates and supervises others within the scope of each individual's role, competence and capabilities.	G6	
3.2.4 Develops staff, building strengths and areas of expertise within the team, in collaboration with others, to respond to health and care needs in the local community.	C2, G6	
3.2.5 Shows respect for colleagues and understanding of emotions in self and others to enhance team working and maintain healthy working relationships.	C2, C5	
3.2.6 Uses available sources of professional and specialist support, and participates in clinical supervision.	C2, C3, C5	
3.2.7 Ensures high-quality, safe and effective practice in the nursing team.	C5	
3.2.8 Analyses, applies and disseminates relevant research and evidence-based findings, working with other team members to incorporate them into practice.	C5	
3.2.9 Works with others to assess and manage critical events, reporting on them and passing on the lessons learnt.	C3, C5	
3.2.10 Applies health and safety principles to identify and manage risk to team members.	C3	

Domain 4. Coordinating and delivering care and intervention

Capability 4.1 The community health nurse continually uses knowledge and appropriate evidence to identify early any circumstances recognised or previously unrecognised that may harm people’s health; and to assess risk and health and care needs in complex situations.

Practice learning achievements	Indicative KSF link	Key content
4.1.1 Identifies and highlights unmet needs, health inequalities, those at risk, and groups most in need of health care, and acts to address service inadequacies.	C5	<ul style="list-style-type: none"> • Culture, equality and diversity issues • Equity of service provision • Health needs assessment • Awareness of under-resourced services and how to report them • Anticipatory care • Range of tools for health needs assessment • Interagency assessment tools and approaches • Community profiling • Caseload profiling • Case finding, in collaboration with others
4.1.2 Builds and maintains relationships based on mutual trust, respect and rapport in order to anticipate, assess and address health needs, and encourages others to take the same approach.	C1	
4.1.3 Assesses the individual in society and the impact of biological, psychological, social and societal processes on health, development and disease.	HWB2	
4.1.4 In assessing individual, family and community health needs, interprets relevant demographic and epidemiological data; and uses social, environmental, biological and public health knowledge.	IK2	
4.1.5 Uses knowledge of the community and population group to identify and work with those most at risk.	HWB1, IK2	

Domain 4. Coordinating and delivering care and intervention

Capability 4.2 The community health nurse continually analyses and uses knowledge and appropriate evidence to make decisions and prioritise in the coordination and evaluation of evidence-based nursing care and public health interventions.

Practice learning achievements	Indicative KSF link	Key content
4.2.1 Works with people in forming, implementing and evaluating plans of care, taking account of strengths and resources in people.	HWB1, HWB2, HWB4, HWB5	<ul style="list-style-type: none"> • Resilience • Empowerment • Social support networks • Self-care management • Intermediate care, rehabilitation and palliative care • Care management principles • Family health plans • Plans for children and young people • Inter-agency plans of care • Knowledge of available resources, services, networks and public health programmes • Knowledge of the diverse range of services across sectors and the interface between them • Skill mix of team • Pathways of care • Telehealth • Scope of professional practice • Accountability and responsibility • Carers' rights and legislation
4.2.2 Uses detailed local knowledge to coordinate and provide tailored services to meet identified health and care needs for people within the community.	C5	
4.2.3 Refers in good time and ensures people receive appropriate and timely care and intervention, working with staff from relevant disciplines, agencies and specialist services.	HWB2, HWB3, HWB5	
4.2.4 Incorporates carers' health needs into care and service plans.	HWB2	

Domain 4. Coordinating and delivering care and intervention

Capability 4.2 The community health nurse continually analyses and uses knowledge and appropriate evidence to make decisions and prioritise in the coordination and evaluation of evidence-based nursing care and public health interventions.

Practice learning achievements	Indicative KSF link	Key content
4.2.5 Ensures a coordinated response to the screening and surveillance of populations and individuals within established and evidence-based programmes; and responds appropriately to findings.	HWB1	<ul style="list-style-type: none"> • Child health surveillance programmes • Screening in primary care • Anticipatory care • Contact tracing • Scope of professional practice • Accountability and responsibility • Knowledge of referral pathways • NMC guidelines on record keeping • Organisational policies and guidelines on record keeping; documentation; data protection and use of information technology • Knowledge of codes of practices for sharing information when a person is at risk of harm
4.2.6 Ensures that appropriate diagnostic interventions, investigations and referrals are carried out.	HWB2	
4.2.7 Consults with and involves other professionals, organisations and agencies when people's needs fall outside the scope of practice and are complex.	HWB2, HWB5	
4.2.8 Confidently uses and gets others to use effective means of communicating and documenting information, concerns and professional judgements.	C1	
4.2.9 Ensures confidentiality and security of written, verbal and electronic information that may be used in a professional capacity.	C1	

Domain 4. Coordinating and delivering care and intervention

Capability

4.3 The community health nurse, working with others, applies knowledge and appropriate research findings and uses skills to lead on and contribute to the prevention, promotion, maintenance and protection of the health and well-being of people in the community and to address health inequalities.

Practice learning achievements	Indicative KSF link	Key content
4.3.1 Communicates appropriate levels of knowledge to educate a diverse range of people and groups across the lifespan; inform them of their rights; and enable them to take part in meeting their needs.	C1, HWB1	<ul style="list-style-type: none"> • Health education and preventative guidance • Advanced communication skills • Awareness of barriers created by professional attitudes to key groups within society • Access to universal and targeted services • Availability of and gaps in services to address identified health needs • Non-judgmental attitudes • Primary, secondary and tertiary prevention and health-promotion strategies in relation to current public-health priorities, targets and identified health needs • Empowerment • Self-care • Carers' rights and legislation • Primary prevention and early detection of vulnerability and risk • Knowledge of contextual issues affecting families, such as poverty; mental health problems; substance misuse; domestic violence • Knowledge of effective preventative interventions • Knowledge of local procedures and policies to protect children and young people; adults; older people and families • Key worker role
4.3.2 Takes into account the multiple barriers that people from socially excluded, low-income, vulnerable and ethnic minority groups face in accessing and attending health care services, interventions and other services.	C6	
4.3.3 Encompasses different ways of thinking and working to get public health accepted as a core concern in practice.	HWB1	
4.3.4 Practises with a health-oriented, health-maintenance outlook and promotes this approach in others.	HWB1	
4.3.5 Applies knowledge to prevent vulnerability, abuse and neglect, and to protect children, young people, adults, older people and families.	HWB2, HWB3	

Domain 4. Coordinating and delivering care and intervention

Capability

4.3 The community health nurse, working with others, applies knowledge and appropriate research findings and uses skills to lead on and contribute to the prevention, promotion, maintenance and protection of the health and well-being of people in the community and to address health inequalities.

Practice learning achievements	Indicative KSF link	Key content
4.3.6 Supports and enables people to identify and address factors that affect their health so that they are able to manage their own health-related conditions as far as possible.	HWB1	<ul style="list-style-type: none"> • Anticipatory care • Supported self-care.
4.3.7 Provides evidence-based care and intervention where people need higher-level nursing skills.	HWB2, HWB5	<ul style="list-style-type: none"> • Medicine management • Brief interventions
4.3.8 Applies knowledge of care management principles with individuals and families who have more complex needs, including vulnerable families.	HWB2, HWB3	<ul style="list-style-type: none"> • Clinical skills relevant to the scope and level of practice • Acute and chronic wound management
4.3.9 Keeps up to date with changes in practice, taking part in lifelong learning.	C2	<ul style="list-style-type: none"> • Palliative, end-of-life and cancer care • Long-term conditions • Protection of children, young people, adults and older people • Support and intervention for vulnerable children and young people, families, adults and older people • Key worker role • Care management principles

GLOSSARY OF TERMS

Anticipatory care

The overall aim of anticipatory care is to work with people to help them identify early any circumstances which have a negative impact on their long-term condition and support them to develop strategies to avoid them or reduce their effects. To support anticipatory care nursing needs to develop its health improvement focus, moving away from an illness focus to one that looks to promote health. To do this, nurses' work needs to have a strong emphasis on assessing risk, promoting health, preventing illness and understanding and addressing health inequalities (SEHD, 2006a)

Brief interventions

Brief interventions involve opportunistic advice, discussion, negotiation or encouragement. Interventions vary from basic advice to more extended, individually focused attempts to identify and change factors that influence activity levels, for example, motivational interviewing (NHS Health Scotland, 2006)

Care

Care means the act of providing nursing care to individuals. This includes doing things for people who are ill or disabled but it does not just mean this. It also includes promoting self-care and enabling people with long-term conditions to live as independently as possible, manage their conditions to the best of their ability and directing services in providing the support they need (SEHD, 2006b)

Care management

Care management (disease specific) involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways (DH, 2005)

Care pathway

A pre-determined plan of care for people with a specific condition (DH, 2007)

Clinical governance

The system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care (DH, 2007)

Community

A community is a group of people living or working in a geographically defined area (geographical community) or who have a characteristic, cause, need or experience in common (community of interest). A community is one form of group (NMC, 2004)

Community care

Care provided by social services departments and the NHS to assist people in their day-to-day living (DH, 2007)

Determinants of health

The range of personal, social, economic and environmental factors which determine the health status of individuals or populations. They include an individual's age, sex, family history or ethnic background; biological factors such as disability, genetics, infections; behavioral factors such as diet and nutrition; environmental factors such as housing, noise, pollution; positive factors such as the degree of social inclusion, networks and relationships, the quality and nature of social support, availability and accessibility of services; risk factors such as poverty; crime; exposure to abuse, bullying, racism, social exclusion or poor physical environment (WHO, 1998; NMC, 2004)

Disease prevention

Measures to not only prevent the occurrence of disease, such as risk factor reduction, but also to stop its progress and reduce its consequences once established. Primary prevention seeks to prevent the initial occurrence of a disorder; secondary prevention seeks to stop existing disease and its effects through early detection and appropriate treatment; tertiary prevention seeks to reduce the occurrence of relapses and the establishment of chronic diseases though, for example, effective rehabilitation (WHO, 1998)

Diversity

Recognising and valuing the fact that society comprises people with different characteristics, cultures, beliefs, values, talents, abilities and needs

Empowerment

A process through which people gain greater control over decisions and actions affecting their health. It may be a social, cultural, political or psychological process through which individuals and social groups are able to express their needs, present their concerns, find ways for involvement in decision-making, and achieve political, social and cultural action to meet those needs (WHO, 1998)

Equality and diversity

The promotion of equal opportunities across NHSScotland. The initiative seeks to ensure NHSScotland recognises and responds sensitively to the individual needs, background and circumstances of people's lives

Equity

Equity means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being. It implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health. It is not the same as equality in health status. Inequalities in health status between individuals and populations occur as a result of genetic differences, different social and economic conditions or as a result of personal lifestyle choice. Inequities occur as a result of differences in opportunity which result, for example, in unequal access to health services (WHO, 1998)

Family

People seen as a social unit or collective whole, composed of members connected through blood, kinship, emotional or legal relationships

Group see 'community'

The term group includes families (one form of social group) – partners, relatives and friends, whether living in the same household or not; those brought together by a common interest (e.g. user groups); those brought together by a common aspect (e.g. disability, age, gender, or by living in the same social area) (NMC 2004)

Health

Health is not an all-or-nothing state. There is a continuum from complete 'wellness' to chronic and complex illness. The continuum represents a gradually changing state with no neatly defined or measurable cut-off points. Health should be regarded from physical, mental and emotional perspectives. It should also be seen as a positive resource for everyday life in an overall socio-economic context (DH, 1999; WHO, 1998)

Health promotion

The process of enabling people to increase control over, and to improve their health. It includes actions directed at strengthening skills and capabilities of people as well as action directed towards changing social, environment and economic conditions so as to alleviate their impact on public and individual health (WHO, 1998)

Healthcare support worker

Support workers who provide a direct service to patients and members of the public in the name of the NHS. This will include those in support roles to the healthcare professions (such as care assistants). Anyone who has direct contact with a patient and who is not already statutorily regulated, or due to be, would be included (SEHD, 2006f)

Informal carer

People who provide unpaid care for family members, friends, neighbours or others who are sick, disabled or elderly (DH, 2007)

Integrated teamwork

This requires clearly defined boundaries of responsibility. It includes a referral system where individuals and families are allocated to the most appropriate member of the team, recognising the different skills and abilities of all members (SEHD, 2006d)

Intermediate care

Integrated services for older people that promote faster recovery from illness, prevent unnecessary hospital admissions and maximise independent living (DH, 2007)

Intervention

Intervention means activities initiated by a health professional intended to deal with a problem affecting health or development, taking account of the needs of people. Interventions may be at an individual, group or community level. Activities may be intended to prevent ill health, such as nurse prescribing, disease prevention; to promote health and social wellbeing, such as smoking cessation, parenting programmes; or to increase social inclusion and reduce health inequalities such as targeting services to particular groups and communities (NMC, 2004)

Long-term conditions

Conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. They include diabetes, asthma, and chronic obstructive pulmonary disease

Multi-agency

Professional groups and agencies working with the health sector, such as local authorities, voluntary agencies, independent sector, criminal justice system, emergencies services (SEHD, 2006a)

Multi-disciplinary

All professional groups involved in delivery of health services (SEHD, 2006a)

Network

A grouping of individuals, organisations and agencies organised on an equal basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust (WHO, 1998).

Palliative care

Improving the quality of life of patients who have a life-threatening illness (DH, 2007)

Public health

Public health is about the health of populations or communities. People work at a population or community level to bring about improvements for individuals with needs and problems. A population can be geographical; a client group, such as children, elderly people; people with a particular health problem, such as heart disease. Public health has a number of strands such as health protection; health promotion; maintaining or restoring health (DH, 1999)

Rehabilitation

Rehabilitation is fundamentally about enabling and supporting people to recover or adjust, achieve their full potential and, where possible, to live full and active lives after their quality of life has been affected by challenges to their physical and mental wellbeing (SEHD, 2007c)

Risk

The likelihood, high or low, that somebody or something will be harmed by an unwanted event or incident multiplied by the severity of the potential harm. Risks are measured in terms of their likelihood and consequences

Risk assessment

The systematic process to identifying risk and evaluating the potential likelihood and consequences

Risk management

The systematic identification, evaluation and treatment of risk. A continuous process with the aim of reducing risk to organisations and individuals alike

Self-care

The actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health; prevent illness or accidents; care for minor ailments or long-term conditions and maintain health and wellbeing after an acute illness or discharge from hospital (DH, 2005)

Settings

Settings are the places or social contexts in which people engage in daily activities and in which environmental, organisational and personal factors interact to affect health and wellbeing (WHO, 1998)

Social exclusion

The process that can take place when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown (DH,2007)

Social support

The assistance available to individuals and groups from within communities which can protect against adverse life events and living conditions, and can provide a positive resource for enhancing the quality of life (WHO, 1998)

Telehealth

Use of monitoring devices linked to the telecommunications network to check a person's health status remotely

Universal services

Services provided for the whole community, including education and health, housing, leisure facilities and transport (DH, 2007)

Vulnerability

Vulnerability is a poorly defined concept which means it can be interpreted differently by different people. The concept can be used to describe those people and families with additional health and social needs. Input from health professionals should focus on early intervention to proactively meet need and protect and manage risks. Vulnerability may be due to intrinsic factors, such as mental illness or learning disability; or extrinsic factors relating to a person's or family's circumstances, such as lack of family support or unemployment. A person can also be vulnerable to exploitation and abuse due to being in a dependent or unequal relationship. People and families can shift in and out of being vulnerable

Wellness

The optimal state of health of individuals and groups. It includes the realisation of the fullest potential of an individual physically, psychologically, socially, spiritually and economically; and the fulfilment of one's role expectations in the family, community, workplace or other setting (Smith et al, 2006)

REFERENCES

Benner PA (1984) *From Novice to Expert: Excellence and power in clinical nursing practice*. Menlo Park, California: Addison Wesley.

Combined Universities Interprofessional Learning Unit (2004) *Interprofessional capability framework*. Sheffield: The University of Sheffield and Sheffield Hallam University.

Community and District Nursing Association (2006) District nurse competencies – draft. [Online] Available from: http://www.cdnaonline.org/index.php?option=com_content&task=view&id=68&Itemid=70. Accessed 29 October 2007

Department of Health (1999) *Public health resource pack*. [Online] Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006891. Accessed 6 November 2007.

Department of Health (2004a) *The NHS knowledge and skills framework (NHS KSF) and the development review process*. London: DH.

Department of Health (2004b) *The Ten Essential Shared Capabilities: A framework for the whole of the mental health workforce*. London: DH.

Department of Health (2005) *Self care – a real choice: Self care support*. London: DH.

Department of Health (2007) *The all new DH glossary*. [Online] Available from: http://www.dh.gov.uk/en/News/DH_076439. Accessed 6 November 2007.

Fraser SW, Greenhalgh T (2001) *Coping with complexity: educating for capability*. *British Medical Journal* 323: 799-803.

Gardener G, Dunn S, Carryer J and Gardener A (2006) Competency and capability: imperative for the nurse practitioner education. *Australian Journal of Advanced Nursing* 24, 1: 8-14.

McKenna H, Keeney S and Bradley M (2003) Generic and specialist nursing roles in the community: an investigation of professional and lay views. *Health and Social care in the Community* 11, 6: 537-545.

NHS Education for Scotland (2004) *Partnerships in education: Guidelines for the design and delivery of family health nurse education programmes in Scotland*. Edinburgh: NES.

NHS Education for Scotland (2006) *Working with individuals with cancer, their families, and carers. Professional development framework for nurses and allied health professionals. Core level*. Edinburgh: NES.

NHS Health Scotland (2006) *Prevention 2010. Interventions: overview of guidelines and evidence. A resource for pilots*. Edinburgh: NHS Health Scotland.

Nursing and Midwifery Council (2004) *Standards of proficiency for specialist community public health nurses*. London: NMC.

Parfitt B, Cornish F, Whyte L and Van Hooren M (2006) *Family-centred health care: An evaluation of the family health nurse role, phase 2*. Glasgow: Glasgow Caledonian University.

Price J (2004) Educating the healthcare professional for capability. In: Kernick D (ed.) *Complexity and Healthcare Organization: A View from the Street*. Oxford: Radcliffe (p227-243).

Sainsbury Centre for Mental Health (2001) *The Capable Practitioner*. London: SCMH.

Scottish Executive Health Department (2005a) *Delivering for Health*. Edinburgh: SEHD.

Scottish Executive Health Department (2005b) *Building a Health Service Fit for the Future*. Edinburgh: SEHD.

Scottish Executive Health Department (2005c) *Framework for Development of Nursing Roles*. Edinburgh: SEHD.

Scottish Executive Health Department (2006a) *Visible, Accessible and Integrated Care*. Report of the review of nursing in the community in Scotland. Edinburgh: SEHD.

Scottish Executive Health Department (2006b) *Delivering Care, Enabling Health: Harnessing the nursing, midwifery and allied health professions' contribution to implementing Delivering for Health in Scotland*. Edinburgh: SEHD.

Scottish Executive Health Department (2006c) *Delivering a Healthy Scotland Meeting the Challenge: Health Improvement in Scotland Annual report*. Edinburgh: SEHD.

Scottish Executive Health Department (2006d) *The WHO Europe family health nursing pilot in Scotland: Final report*. Edinburgh: SEHD.

Scottish Executive Health Department (2006e) *Modernising Nursing Careers – Setting the direction*. Edinburgh: SEHD.

Scottish Executive Health Department (2006f) *National standards relating to healthcare support workers in Scotland – consultation document*. Edinburgh: SEHD.

Scottish Executive Health Department (2006g) *Careers Framework for NHSScotland*. Edinburgh: SEHD.

Scottish Executive Health Department (2007a) *Better Health, Better Care: A discussion document*. Edinburgh: SEHD.

Scottish Executive Health Department (2007b) *Delivering a Healthy Future. An action framework for children and young people's health in Scotland*. Edinburgh: SEHD.

Scottish Executive Health Department (2007c) *Co-ordinated, integrated and fit for purpose: A delivery framework for adult rehabilitation in Scotland*. Edinburgh: SEHD.

Smith BJ, Kwok CT and Nutbeam D (2006) WHO health promotion glossary: new terms. *Health Promotion International Advance Access* [Online]. Available from: <http://www.who.int/healthpromotion/about/HPG/en/>. Accessed 5 November 2007.

Stephenson J (1998) The concept of capability and its importance for higher education. In: Stephenson J, Yorke M (Eds.) *Capability and Quality in Higher Education*. London: Kogan Page (p 1-13).

Wilson T, Holt T (2001) Complexity and clinical care. *British Medical Journal* 323: 685-688.

World Health Organisation (1998) *Health promotion glossary*. [Online]. Available from: <http://www.who.int/healthpromotion/about/HPG/en/>. Accessed 5 November 2007.

APPENDIX 1

Seven core elements of nursing in the community (SEHD 2006a)	Practice Learning Achievements
Working directly with individuals and their carers	1.1.1; 1.1.2; 1.1.3; 1.1.10; 2.3.1; 2.3.2; 2.3.3; 2.3.4; 2.3.7; 2.3.9; 2.3.6; 3.1.1; 3.1.3; 3.2.7; 3.2.8; 3.2.9; 3.2.10; 4.1.2; 4.1.3; 4.1.4; 4.1.6; 4.2.1; 4.2.4; 4.2.6; 4.2.7; 4.2.8; 4.3.4; 4.3.7; 4.3.8.
Adopting public health approaches to protecting the public	1.1.1; 1.1.2; 1.1.5; 1.1.9; 1.1.10; 2.1.3; 2.1.4; 2.3.1; 2.3.2; 2.3.3; 2.3.4; 2.3.5; 2.3.6; 2.3.9; 3.1.3; 3.1.6; 3.1.8; 4.1.2; 4.1.3; 4.1.4; 4.1.5; 4.1.6; 4.2.1; 4.2.5; 4.2.6; 4.2.7; 4.2.8; 4.3.3; 4.3.4; 4.3.5; 4.3.7; 4.3.8.
Co-ordinating services	1.1.1; 2.1.1; 2.1.2; 2.2.1; 2.2.2; 2.3.8; 3.1.2; 3.1.3; 3.1.4; 3.1.6; 3.1.12; 3.2.1; 3.2.2; 3.2.3; 3.2.4; 4.1.1; 4.2.2; 4.2.3; 4.2.5; 4.2.7.
Supporting self care	1.1.6; 1.1.7; 1.1.8; 1.1.9; 2.3.1; 2.3.2; 2.3.3; 2.3.4; 2.3.9; 2.3.10; 4.1.2; 4.1.3; 4.1.6; 4.2.1; 4.2.4; 4.3.1; 4.3.4; 4.3.6.
Multi-disciplinary and multi-agency team working	1.1.5; 2.1.1; 2.1.3; 2.1.4; 2.1.5; 2.2.1; 2.2.3; 3.1.4; 3.1.5; 3.1.7; 3.1.11; 3.2.5; 3.2.9; 4.2.3.
Meeting health needs of the community	1.1.5; 1.1.6; 1.1.7; 1.1.8; 1.1.9; 1.1.10; 2.1.1; 2.1.6; 2.2.1; 2.2.2; 2.3.1; 2.3.4; 2.3.5; 2.3.6; 2.3.9; 3.1.6; 3.1.7; 3.1.8; 3.1.9; 3.1.10; 3.1.11; 3.1.12; 4.1.1; 4.1.2; 4.1.5; 4.3.2.
Supporting anticipatory care	1.1.6; 1.1.7; 1.1.8; 1.1.9; 1.1.10; 2.3.1; 2.3.2; 2.3.3; 2.3.4; 2.3.5; 2.3.9; 2.3.10; 3.1.8; 3.1.10; 3.1.11; 4.1.1; 4.1.2; 4.1.3; 4.1.5; 4.2.5; 4.3.1; 4.3.2; 4.3.3; 4.3.4.



NHS Education for Scotland

Floor 5, Thistle House

91 Haymarket Terrace

EDINBURGH

EH12 5HE

Tel: 0131 313 8000

Fax: 0131 313 8001

Email: enquiries@nes.scot.nhs.uk

Website: www.nes.scot.nhs.uk

