

Supplemental  
Document 1

*Public Health Nursing:  
Prenatal, Postpartum and Early  
Childhood Practice Examples*

## Provincial Public Health Nursing Standards: *Prenatal, Postpartum, and Early Childhood*

2015

A Collaborative Project:  
*Manitoba's Regional Health Authorities and  
Manitoba Health, Healthy Living and Seniors*

**Manitoba** 



## Supplemental Document 1: Public Health Nursing: Prenatal, Postpartum and Early Childhood Practice Examples

This supplemental document is a companion document to the *Provincial Public Health Nursing Standards: Prenatal, Postpartum and Early Childhood (2015)*. It is intended to illustrate with concrete examples the standard statements and practice expectations at the individual/family level, and the community/population level in the prenatal, postpartum and early childhood periods.

This document has also incorporated the CHNC (2009) Public Health Nursing Discipline Specific Competencies into each practice expectation. While a single competency is designated for each statement, often several are applicable. The chosen competency is thought to best reflect the most significant required proficiency in completion of the Practice Expectation. However in practice, several competencies may enhance the nurse's capacity for implementation.

The quotations contained within this document are from public health nurses and managers. They were selected from the feedback received during the Delphi Survey.

*“The mind that opens to a new idea never  
returns to its original size.”  
Albert Einstein*



## Standard 1: Relationship Building

### Standard 1.1: Therapeutic Relationships

#### Practice Expectations

1.1.1 Build therapeutic relationships with clients over time, from first contact and ongoing.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/ Population</b>           | Coordinate PHN service in a community or neighbourhood to be as consistent as possible.                   | Collaborate with community organizations to increase opportunities to interact with clients.                 | Attend community meetings to increase familiarity of PHN within the community. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy                                       |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/ Family</b>              | Establish relationship at first prenatal contact and continue to build trust through subsequent contacts. | Continue to build on relationship established in the prenatal period through postpartum and early childhood. | Use active listening and validation to build trust over time.                  |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Communication  |

### Standard 1.1: Therapeutic Relationships

#### Practice Expectations

1.1.2 Recognize and plan for continuity of care.

| Practice Examples and PHN Competencies |  |   |  |
|--|--|---|--|
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Community/ Population</b>           | Ensure that PHNs involved in a prenatal group have a shared understanding of the objectives and group needs. | A consistent PHN provide Public Health Nursing services in a community or neighborhood. | Strive to provide services in the same neighborhood with the same groups, to facilitate relationship building. |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation   | Policy and Program Planning, Implementation and Evaluation                              | Policy and Program Planning, Implementation and Evaluation   |
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Individual/ Family</b>              | Facilitate consistent PHN follow-up of the client throughout the prenatal period.                            | Prioritize consistent PHN service for clients receiving PHN case management.            | Prioritize to have the same PHN follow a family from prenatal to early childhood.                              |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  | Public Health and Nursing Sciences   |

*“Do you know your  
 Public Health Nurse?”*

## Standard 1.1: Therapeutic Relationships

### Practice Expectations

1.1.3 Create connections, trust and shared meaning.

| Practice Examples and PHN Competencies |  |   |   |
|--|--|---|---|
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Community/<br/>Population</b>       | Facilitate education sessions on immunization at Healthy Baby programming.                       | Participate at functions offered by Family Resource Centres, schools, or faith based organizations. | Work with a child care centre, community nutritionist and parents to implement peanut free environment. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy  |
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Connect with a prenatal family to discuss public health nursing services in the prenatal period. | Integrate cultural traditions that influence postpartum practices.                                  | Explore concerns with an early childhood family to identify issues.                                     |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy  |

*“The quality of the relationship between the public health nurse and family often determines whether they will engage and stay engaged in services.”*

## Standard 1.1: Therapeutic Relationships

### Practice Expectations

1.1.4 Use creative engagement to initiate and maintain PHN contact, and continue assessment and intervention with disadvantaged clients.

| Practice Examples and PHN Competencies |  |  |   |
|--|--|--|---|
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Facilitate neighborhood transportation assistance to prenatal programming. | Partner with Income Security to help promote PHN services to families and groups in disadvantaged neighborhoods. | In disadvantaged neighborhoods, partner with community groups involved with young families, to initiate PHN services. |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation                 | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  |
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Engage eligible families to enroll with the Families First program.        | Provide deliberate PHN follow up with disadvantaged families.  | Continue assessment and intervention for those who decline the Families First program.                                |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation                 | Policy and Program Planning, Implementation and Evaluation   | Public Health and Nursing Sciences  |

## Standard 1.1: Therapeutic Relationships

### Practice Expectations

1.1.5 Consider and ameliorate challenges for client engagement (ex: geography, lack of telephone service, client capacity).

| Practice Examples and PHN Competencies |  |  |   |
|--|--|--|---|
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Set up a prenatal education group session at a venue accessible to a disadvantaged population.       | Provide breastfeeding assistance via Telehealth in communities with challenges accessing direct service.   | Offer individual invitations, and work to reduce barriers to attending parenting programs for disadvantaged families.   |
| <b>Competency</b>                      | Diversity and Inclusiveness  | Diversity and Inclusiveness  | Diversity and Inclusiveness   |
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Offer ongoing contact to build a trusting relationship with clients unable to engage in programming. | Use alternate methods of communication (ex: mail, email or text) to connect with a client, where it has been difficult to connect by telephone or in person. | Explore options with client to increase comfort level in attending programming (ex: having a support person accompany). |
| <b>Competency</b>                      | Diversity and Inclusiveness  | Diversity and Inclusiveness  | Diversity and Inclusiveness   |

## Standard 1.1: Therapeutic Relationships

### Practice Expectations

1.1.6 Use effective communication skills.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/<br/>Population</b>       | Use a low literacy poster at a health fair to depict costs of formula versus breast milk. | Use group facilitation skills when working with community partners to initiate breastfeeding friendly areas. | Use principles of adult education when facilitating a parenting session.     |
| <b>Competency</b>                      | Communication   | Communication  | Communication  |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Incorporate cultural competence when engaging prenatal clients (ex: eye contact)          | Use open ended questions to explore family adjustment in the postpartum period.                              | Use age appropriate language in an early childhood developmental assessment. |
| <b>Competency</b>                      | Communication   | Communication  | Communication  |

## Standard 1.1: Therapeutic Relationships

### Practice Expectations

1.1.7 Evaluate the nurse/client relationship as part of regular practice assessment.

| Practice Examples and PHN Competencies |   |   |  |
|--|---|---|--|
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Collect and analyze evaluations from prenatal class clients.                        | Meet with a group of new parents to discuss what they found helpful from postpartum PHN services. | Use a client survey to evaluate satisfaction levels from child health clinics.                   |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation                          | Policy and Program Planning, Implementation and Evaluation  | Policy and Program Planning, Implementation and Evaluation                                       |
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Discuss with a client if the PHN prenatal services received met their expectations. | Reflect on the dynamics of a nurse client relationship over time.                                 | Include a local early childhood mother in an evaluation meeting for the preschool screening day. |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation                          | Policy and Program Planning, Implementation and Evaluation  | Partnerships, Collaboration and Advocacy   |



## Standard 1.2: Professional Relationships

### Practice Expectations

1.2.1 Build relationships with health practitioners, inter-governmental agencies, community and business sectors, and other key stakeholders.

| Practice Examples and PHN Competencies |  |   |  |
|--|--|---|--|
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Community/ Population</b>           | Partner with school division to facilitate education options for pregnant students, (ex: school credit for participation in the Families First program) to encourage high school completion. | Meet with service groups regarding support for postpartum needs in low income areas.  | Collaborate with mental health and health promotion staff to clarify roles in meeting community needs for child mental health promotion. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   |
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Individual/ Family</b>              | Connect with midwifery to initiate a referral for a prenatal client.   | Initiate discussion with a Community Mental Health worker to explore services for a client, in a way that respects confidentiality. | Consult with a Speech Language Pathologist regarding concerns related to a child's developmental assessment findings.                    |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   |

## Standard 1.2: Professional Relationships

### Practice Expectations

1.2.2 Work in partnerships to plan needed resources or programs.

| Practice Examples and PHN Competencies |  |  |   |
|--|--|--|---|
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Partner with stakeholders to facilitate continuum of care for clients relocating to larger centre for delivery (ex: Prenatal Connections). | Meet with First Nations community to coordinate health fair for new parents.           | Collaborate with groups such as town council, ministry and grocery stores to discuss development of a community food bank to improve child nutrition. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  |
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Collaborate with food bank to arrange emergency food supply for a prenatal client.   | Consult with a pediatrician regarding a premature infant's needs when discharged home. | Consult with parenting centre to identify resources best suited for a family's parenting challenge.   |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  |

## Standard 1.2: Professional Relationships

### Practice Expectations

1.2.3 Work with partners to increase access and referrals to public health nursing resources and supports.

| Practice Examples and PHN Competencies |  |   |  |
|--|--|---|--|
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Attend community groups and programs to promote PHN prenatal services.   | Connect with hospital and midwifery staff to increase their awareness of PHN services.  | Partner with agencies connected to early childhood (ex: school, day care etc) to plan for preschool assessment opportunities.                            |
| <b>Competency</b>                      | Leadership   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   |
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | While working with individuals and families (ex: communicable disease investigations), be attentive to opportunities for prenatal referrals. | Work with early childhood partners to create handouts for postpartum families which include information about public health nursing services. | Explain early childhood assessment services from public health nursing, to a physician concerned about the developmental abilities of a preschool child. |
| <b>Competency</b>                      | Assessment and Analysis  | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   |

## Standard 1.2: Professional Relationships

### Practice Expectations

1.2.4 Work collaboratively to develop systems and networks that actively seek out and provide support to those who are not accessing health and social resources, but could benefit from contact.

| Practice Examples and PHN Competencies |  |  |  |
|--|--|--|--|
|  | Prenatal   | Postpartum   | Early Childhood  |
| <b>Community/<br/>Population</b>       | Partner with high school administration to develop a process for referrals for prenatal students not accessing care. | Collaborate with midwifery to develop a referral process for clients who declined initial PHN follow-up.                                 | Partner with area physicians, preschools, immigration centres, social workers, speech language professionals, etc, to elicit early childhood referrals to PHN. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   |
|  | Prenatal   | Postpartum   | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Work with a prenatal client's family to identify alternate locations where PHN may connect with a client.            | Support a postpartum family whose newborn was apprehended, to assess, advocate and explore options to increase connectedness with child. | Follow up with a child care centre's concern related to a family's food security needs.  |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   | Diversity and Inclusiveness  |

## Standard 1.2: Professional Relationships

### Practice Expectations

1.2.5 Engage in inter-professional collaboration with practitioners, community groups, and partners to support clients.

| Practice Examples and PHN Competencies |  |   |   |
|--|--|---|---|
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Community/ Population</b>           | Work with school administrators and child care agencies to assess the need for “in school” child care for pregnant students. | Collaborate with Healthy Child Manitoba to evaluate the milk coupon program.  | Partner with school divisions to coordinate shared resources to support a three year old screening clinic.        |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy  |
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Individual/ Family</b>              | Partner with Income Security to identify financial programs suitable for a prenatal client who expresses financial need.     | Co-visit a postpartum family with social services to explore options for nutritional, financial and safe housing support. | Coordinate a case conference with service providers to address needs for a preschooler with developmental delays. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy  |

## Standard 1.2: Professional Relationships

### Practice Expectations

1.2.6 Share information and collaborate with colleagues and partners regarding available resources to increase cost effectiveness and avoid duplication.

| Practice Examples and PHN Competencies |  |   |   |
|--|--|---|---|
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Community/ Population</b>           | Increase partner awareness regarding a provincial on-line prenatal education resource. | Share and understand the roles and responsibilities of health care providers that serve the community.                          | Share developed resources with other PHNs and partners.                                     |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy  |
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Individual/ Family</b>              | Work collaboratively with midwifery, for care of an adolescent prenatal client.        | Consult and share resources with a colleague to provide possible solutions for a client with a challenging breastfeeding issue. | Collaborate with other professionals to plan for the preschool assessment needs of a child. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Public Health and Nursing Sciences  | Partnerships, Collaboration and Advocacy  |

## Standard 1.2: Professional Relationships

### Practice Expectations

1.2.7 Evaluate the nurse/partner relationship as part of regular practice assessment.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/<br/>Population</b>       | Meet with community partners to review current prenatal services and client resources.  | Set ground rules when leading a planning committee for a breastfeeding support group, and evaluate at the end of each session. | Review the referral process with a local food bank and reflect on need for improvements. |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation.                             | Policy and Program Planning, Implementation and Evaluation.  | Policy and Program Planning, Implementation and Evaluation.                              |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Discuss possible concerns related to the client referral process with the nutritionist. | Connect with a client's midwife regarding the effectiveness of written communications between nurse and midwife.               | Examine the success of networking with a preschooler's speech language therapist.        |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation.                             | Policy and Program Planning, Implementation and Evaluation.  | Policy and Program Planning, Implementation and Evaluation.                              |

## Standard 2: Equity and Access

### Standard 2.1: Equity and Access

#### Practice Expectations:

2.1.1 Increase awareness of services that address the determinants of health and promote health equity.

| Practice Examples and PHN Competencies |   |   |  |
|--|---|---|--|
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Promote distribution of prenatal community resources to a variety of locations that serve disadvantaged families. | Partner with local health practitioners to increase awareness and promotion of breastfeeding clinics available for Northern and/or rural clients. | Meet with a newcomers group to highlight community resources.                            |
| <b>Competency</b>                      | Diversity and Inclusiveness   | Partnerships, Collaboration and Advocacy  | Diversity and Inclusiveness  |
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Discuss the prenatal benefit with a low income prenatal client.   | Invite a family to attend child health clinics at a postpartum visit.   | Attend a crisis shelter and inform families of public health nursing services available. |
| <b>Competency</b>                      | Diversity and Inclusiveness   | Diversity and Inclusiveness   | Diversity and Inclusiveness  |

### Standard 2.1: Equity and Access

#### Practice Expectations:

2.1.2 Provide universal and targeted public health nursing services based on client need, with a focus on disadvantaged populations.

| Practice Examples and PHN Competencies |   |   |  |
|--|---|---|--|
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Offer universal prenatal education resources to all prenatal clients (ex: on-line and print) and target group sessions to disadvantaged families. | Contact all postpartum clients for follow-up and provide case management for disadvantaged clients.   | Partner with a local child care center for developmental screening and refer children with developmental concerns. |
| <b>Competency</b>                      | Policy and Program Planning, Implementation & Evaluation  | Assessment and Analysis   | Partnerships, Collaboration and Advocacy   |
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Provide service navigation for a prenatal client seeking mental health resources.   | Provide breastfeeding assistance to a new mother, which could include video resources, referral to a lactation consultant or an in-home assessment. | Offer a home visit to an early childhood client with a developmental concern in a remote location.                 |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Public Health and Nursing Sciences  | Diversity and Inclusiveness  |

*“Parents want to do their best for their children.”*

## Standard 2.1: Equity and Access

### Practice Expectations:

2.1.3 Consider culture relevant to client.

| Practice Examples and PHN Competencies |   |  |   |
|--|---|--|---|
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Partner with LGBTQ community to plan for prenatal resources that are appropriate.                       | Work in partnership with stakeholders to ensure language programs are available and accessible to newcomers. | Be aware of a population’s cultural practices that may influence parenting, family values or childhood opportunities. |
| <b>Competency</b>                      | Diversity and Inclusiveness   | Diversity and Inclusiveness  | Diversity and Inclusiveness   |
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Examine the family supports present in a home where multi-generations live together as a cultural norm. | When discussing infant care with a family, be aware that snug swaddling may be culturally important.         | Work together with a family to understand their culturally relevant nutritional practices.                            |
| <b>Competency</b>                      | Diversity and Inclusiveness   | Diversity and Inclusiveness  | Diversity and Inclusiveness   |

## Standard 2.1: Equity and Access

### Practice Expectations:

2.1.4 Use language and methods of communication suited to client.

| Practice Examples and PHN Competencies |   |   |   |
|--|---|---|---|
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Community/ Population</b>           | Use print resources for prenatal education, which are a suitable reading level. | Use principles of adult learning, such as respect for what is already known, when meeting with postpartum groups. | Create a display board to highlight immunization at preschool wellness screening day.               |
| <b>Competency</b>                      | Diversity and Inclusiveness   | Communication   | Communication   |
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Individual/ Family</b>              | Include videos in an individual prenatal education session for a pregnant teen. | Use “hands on” teaching to illustrate newborn care for a family with lower reading level.                         | Make use of translation services while screening a preschooler and family who speak little English. |
| <b>Competency</b>                      | Communication   | Communication   | Diversity and Inclusiveness   |

## Standard 2.1: Equity and Access

### Practice Expectations:

2.1.5 Use nursing assessment and professional judgment to tailor services to meet client needs.

| Practice Examples and PHN Competencies |  |  |  |
|--|--|--|--|
|  | Prenatal   | Postpartum   | Early Childhood  |
| <b>Community/ Population</b>           | Screen all prenatal families for Family First and offer home visiting program for all who qualify. | Assess postpartum clients and base follow up on client capacity.   | Where possible, extend regular hours for preschool screening days, to increase numbers screened.       |
| <b>Competency</b>                      | Diversity and Inclusiveness  | Diversity and Inclusiveness  | Diversity and Inclusiveness  |
|  | Prenatal   | Postpartum   | Early Childhood  |
| <b>Individual/ Family</b>              | Offer Saturday prenatal class for a disadvantaged family who is not available during the week.     | Flex hours in working day to provide an evening postpartum visit to a mother who speaks little English, to allow her partner to translate, after the work day. | When possible for the family to attend, schedule preschool immunization during regular business hours. |
| <b>Competency</b>                      | Diversity and Inclusiveness  | Diversity and Inclusiveness  | Diversity and Inclusiveness  |

## Standard 2.1: Equity and Access

### Practice Expectations:

2.1.6 Use approved technology and multi-media to facilitate accessibility and delivery of public health programs and services.

| Practice Examples and PHN Competencies |  |  |   |
|--|--|--|---|
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Refer to reliable internet links and smart phone apps that prenatal clients may find informative.  | Provide web based resources for the postpartum period.   | Use touch screen displays to promote child safety at community events.  |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences   | Communication   |
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Use texting to reach a prenatal client where there has been difficulty reaching via other methods. | Assist a postpartum family in accessing the provincial Child Care Online website to register their baby for daycare. | Provide a reliable link to a family seeking additional information regarding immunizations (ex: Immunize.ca). |
| <b>Competency</b>                      | Public Health and Nursing Science  | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  |

## Standard 2.1: Equity and Access

### Practice Expectations:

2.1.7 Monitor and evaluate changes and progress in access to community services that support the social determinants of health.

| Practice Examples and PHN Competencies |   |  |   |
|--|---|--|---|
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Community/<br/>Population</b>       | Monitor the numbers of Prenatal Benefit recipients for an increase after community promotion of same. | Evaluate availability of fresh produce after community initiative in neighborhoods with previous food access issues. | Monitor immunization completion rates in communities where additional CHC's have been offered.  |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation  | Policy and Program Planning, Implementation and Evaluation   | Policy and Program Planning, Implementation and Evaluation  |
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Examine the success of an assisted referral to a financial support program with a prenatal family.    | Discuss barriers and facilitators found by a family in attending a local breastfeeding support group.                | Assess for transportation needs being met in a disadvantaged family accessing a preschool screening day, who has been provided with free bus tickets. |
| <b>Competency</b>                      | Assessment and Analysis   | Policy and Program Planning, Implementation and Evaluation   | Policy and Program Planning, Implementation and Evaluation  |

## Standard 2.2: Advocacy

### Practice Expectations:

2.2.1 Support and advocate for individuals, families, communities and populations based on identified needs.

| Practice Examples and PHN Competencies |   |   |  |
|--|---|---|--|
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Advocate for midwifery service in communities with poor access to prenatal primary care.  | Participate in conversations with stakeholders, regarding postpartum resource gaps in a community or region.  | Meet with local government to advocate for recreation facilities for families. |
| <b>Competency</b>                      | Professional Responsibility and Accountability  | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy                                       |
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Advocate on behalf of the prenatal client to the local housing authority staff for housing safety improvements, such as mold removal. | Provide complete referral documentation to a lactation consultant in advance of the client meeting with them. | Assist a family to find a primary care provider for their child.               |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Professional Responsibility and Accountability  | Partnerships, Collaboration and Advocacy                                       |



## Standard 2.2: Advocacy

### Practice Expectations

2.2.2 Consider policy implications and work within the organization and with other stakeholders to develop or revise policies and programs.

| Practice Examples and PHN Competencies |   |  |   |
|--|---|--|---|
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Community/<br/>Population</b>       | Work with First Nations & Inuit Health Branch to create policy related to continuity of care for prenatal clients transferring between communities. | Collaborate in the development of workplace policies that support breastfeeding.     | Work with community partners to promote development of playground and green space in the community.       |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation  | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  |
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Consult with Income Security, to identify programs and/or supplements that may benefit a single prenatal client with few social supports.           | Advocate for breast milk collection breaks with postpartum client returning to work. | Begin a conversation with a young family to advocate for additional child care spaces in their community. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Policy and Program Planning, Implementation and Evaluation  |

## Standard 3: Health Assessment, Screening and Case Management

### Standard 3.1: Assessment and Screening

#### Practice Expectations:

3.1.1 Collect and integrate multiple sources of information to understand the trends, gaps, strengths, and concerns of clients.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/ Population</b>           | Examine rates of sexually transmitted infections and note increased cases of prenatal syphilis in a particular community. | Analyze rates of fetal alcohol affected infants to identify neighborhoods more at risk.  | Use Statistics Canada to identify communities with increasing numbers of newcomers and refugees who may have immunization needs. |
| <b>Competency</b>                      | Assessment & Analysis   | Assessment & Analysis  | Assessment & Analysis  |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/ Family</b>              | Be knowledgeable regarding food banks in the community, to offer as a resource to a prenatal client.                      | Note trends (ex: use of amber infant necklaces) and understand potential hazards that can be explained to a postpartum parent. | Work with parents to complete a home safety survey to identify potential concerns for their toddler.                             |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Public Health and Nursing Sciences   | Public Health and Nursing Sciences   |

*“Health continuum is always changing, a family that is perceived to be flourishing may become vulnerable very quickly.”*

## Standard 3.1: Assessment and Screening

### Practice Expectations:

3.1.2 Consider the context of individual, family, community and population, with all contacts.

| Practice Examples and PHN Competencies |  |   |  |
|--|--|---|--|
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | When assessing a northern community, consider how their health may be affected by transport and supply challenges. | Work with First Nations community stakeholders to develop a culturally appropriate safe sleeping education campaign for families. | Consider EDI scores and strategies to engage families in preschool screening in disadvantaged neighborhoods. |
| <b>Competency</b>                      | Assessment and Analysis  | Diversity and Inclusiveness   | Assessment and Analysis  |
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Consider the context of past traumas and how it may affect the birthing process for a refugee client.              | Consider strengths and risks in a neighborhood and how these may impact a family with young children.                             | Discuss job training opportunities with a client considering entering the workforce.                         |
| <b>Competency</b>                      | Public Health and Nursing Science  | Public Health and Nursing Science   | Assessment and Analysis  |

## Standard 3.1: Assessment and Screening

### Practice Expectations:

3.1.3 Assess for opportunities to promote health and learning with every client contact.

| Practice Examples and PHN Competencies |   |   |  |
|--|---|---|--|
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Work with partners to increase awareness of risks associated with prenatal safety issues (ex: hot tub use). | Consider injury prevention statistics to identify collaborative opportunities for programming (ex: Manitoba Public Insurance infant car seat use) | Assess the knowledge base of a Healthy Baby group regarding immunizations. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Assessment and Analysis   | Assessment and Analysis  |
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Explore with a prenatal client their experience and expectations related to breastfeeding.                  | Observe for and reinforce positive caregiver/infant attachment behaviors at a postpartum visit.   | Discuss home safety for parents in advance of their child becoming mobile. |
| <b>Competency</b>                      | Assessment and Analysis   | Public Health and Nursing Sciences  | Public Health and Nursing Sciences   |

## Standard 3.1: Assessment and Screening

### Practice Expectations:

3.1.4 Use every contact as an opportunity to assess, screen and identify needs beyond the original intent.

| Practice Examples and PHN Competencies |   |  |   |
|--|---|--|---|
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Community/<br/>Population</b>       | During school immunization clinics promote PHN reproductive health services.              | When meeting with RCMP to explain PHN services, ask about current neighborhood safety concerns.        | During collaborative food safety presentation with the Public Health Inspector, note the group's interest in bedbugs and plan for future leaning needs. |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Assessment and Analysis  | Assessment and Analysis   |
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Develop a plan to address speech concerns in an older child during a prenatal assessment. | Explore with a family reasons why a school-aged sibling is not attending school at a postpartum visit. | Assess for safety during a child health clinic when multiple bruises are noted on a mother.   |
| <b>Competency</b>                      | Assessment and Analysis   | Assessment and Analysis  | Assessment and Analysis   |

## Standard 3.1: Assessment and Screening

### Practice Expectations:

3.1.5 Use public health nursing knowledge and skills to ensure a broad focus versus a task-based focus.

| Practice Examples and PHN Competencies |   |   |   |
|--|---|---|---|
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Community/<br/>Population</b>       | Use facilitation skills to guide discussion and identify areas of concern at a prenatal group (ex: food security).          | Establish a forum to discuss needs with newcomer population.                                  | Communicate with northern communities to improve continuity of care in areas where residents have been evacuated to larger urban centres. |
| <b>Competency</b>                      | Communication   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy  |
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Increase awareness of environmental hazards to prenatal health, such as exposure to lead paint dust during home renovation. | Assess the family context at a postpartum visit, in addition to mother and infant assessment. | When completing an immunization, note behaviors that may reflect possible abuse.  |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Assessment and Analysis   | Assessment and Analysis   |

## Standard 3.1: Assessment and Screening

### Practice Expectations:

3.1.6 Complete public health nursing assessment to identify client strengths and vulnerabilities.

|                             |  |
|-----------------------------|--|
| <b>Community Assessment</b> | <ul style="list-style-type: none"> <li>- Assess the community on an ongoing basis and at least every 2 years, using a variety of sources.</li> <li>- Maintain an ongoing community/neighborhood health record.</li> </ul>  |
| <b>Prenatal Assessment</b>  | <ul style="list-style-type: none"> <li>- Complete a public health nursing prenatal assessment (in person or by telephone), within two weeks of receipt of prenatal referral or before estimated date of confinement (EDC) if late in pregnancy.</li> <li>- Determine the need, timing, and most appropriate type of public health nursing follow-up based on assessment, with priority “in person” follow-up for disadvantaged clients.</li> <li>- Provide public health nursing case management for disadvantaged families.</li> <li>- Refer acute clinical issues to appropriate professionals and resources (ex: primary care, acute care, mental health).</li> <li>- Collaborate with health and social service providers (ex: midwifery, physicians, child and family services, economic assistance) to support ongoing case management of disadvantaged families.</li> <li>- Facilitate access and referrals to community based programs (ex: prenatal education, Healthy Baby).</li> <li>- Collaborate with community, health, and social partners to seek out disadvantaged prenatal families for whom referrals may not be received.</li> </ul> |

*“A community has many variables and can change rapidly.”*

|                                   |  |
|-----------------------------------|--|
| <b>Postpartum Assessment</b>      | <ul style="list-style-type: none"> <li>- Complete an initial assessment within 48 hours of discharge to identify strengths and risks to determine the need and timing of public health nursing follow-up.</li> <li>- Complete an in-person public health nursing assessment within one week of initial assessment, with priority follow up for disadvantaged clients.</li> <li>- Provide public health nursing case management for disadvantaged families.</li> <li>- Refer acute clinical issues to appropriate health care professionals (ex: primary care, acute care, mental health).</li> <li>- Facilitate access and referrals to community based groups/programs (ex: breastfeeding, postpartum depression, Healthy Baby).</li> <li>- Collaborate with health and social service providers (ex: midwifery, physician, child and family services, income security), to support ongoing case management of disadvantaged families.</li> </ul> |
| <b>Early Childhood Assessment</b> | <ul style="list-style-type: none"> <li>- Complete early childhood public health nursing assessment(s) for disadvantaged infants, children and families.</li> <li>- Provide continuity of public health nurses and service through the prenatal, postpartum and early childhood periods.</li> <li>- Upon receipt of an early childhood referral, the assessment will be completed within 2 weeks.</li> <li>- Complete early childhood assessments (two months to five years) using a variety of methods, tools, sites and opportunities, such as Child Health Clinics, preschool screening and immunization appointments.</li> <li>- Provide public health nursing case management for disadvantaged families.</li> <li>- Work with partners to identify, promote and develop programs and services for early childhood.</li> </ul>   |
| <b>Competency</b>                 | <ul style="list-style-type: none"> <li>- Assessment and Analysis</li> </ul>  |

*“I believe early years assessment for all children is important.”*

## Standard 3.1: Assessment and Screening

### Practice Expectations:

3.1.7 Evaluate the impact of public health nursing interventions on health outcomes for clients.

| Practice Examples and PHN Competencies |   |  |   |
|--|---|--|---|
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Community/<br/>Population</b>       | Compare increases in applications for Prenatal Benefit before and after a promotional intervention.                           | Examine Healthy Child Manitoba statistics, to evaluate if more creative engagement is needed, to increase enrollment of eligible families on Families First program. | Evaluate a preschool screening day by reviewing relevant indicators (ex: number of children screened requiring further assessment). |
| <b>Competency</b>                      | Policy and Program Planning and Evaluation  | Policy and Program Planning and Evaluation   | Policy and Program Planning and Evaluation  |
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Assess for changes in prenatal care use after connecting client with Partners in Inner-city Integrated Prenatal Care (PIIPC). | Evaluate breastfeeding success after latching techniques explored with new mother.   | Re-screen preschool child to determine if additional developmental activities have prompted improvements.                           |
| <b>Competency</b>                      | Assessment and Analysis   | Assessment and Analysis  | Assessment and Analysis   |

### Standard 3.2: Case Management

*Practice Expectations:*

3.2.1 Collaborate with partners and stakeholders to plan interventions for disadvantaged clients.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/ Population</b>           | Work with women’s shelter to develop strategies for prenatal clients utilizing their services.                      | Collaborate with local thrift shops to identify items needed by postpartum families.   | Explore strategies with primary care providers to address anti-immunization myths among newcomers.         |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Diversity and Inclusiveness  |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/ Family</b>              | Plan for continuity of public health nursing care, to support a disadvantaged prenatal client moving to a new area. | Collaborate with the Families First Home Visitor to plan creative engagement activities for a family unsure about enrolling. | Collaborate with a community nutritionist to coordinate services for a family with food security concerns. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   |

*“Case management could benefit from increased collaboration among health care providers.”*

## Standard 3.2: Case Management

### Practice Expectations:

3.2.2 Provide a public health nursing continuum of care, including opportunities for ongoing contact with disadvantaged families and populations.

| Practice Examples and PHN Competencies |   |   |   |
|--|---|---|---|
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Community/ Population</b>           | Participate in program planning to facilitate a seamless transition from the prenatal to postpartum periods.          | Create a welcoming environment to allow communities to view the PHN as a resource for service navigation. | Ensure public health programming is available to disadvantaged clients from prenatal through the early childhood periods. |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation  | Leadership  | Policy and Program Planning, Implementation and Evaluation  |
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Individual/ Family</b>              | Endeavor to develop a relationship with a prenatal client that extends to the postpartum and early childhood periods. | When visiting a disadvantaged postpartum family, schedule the next PHN appointment.                       | Continue to provide public health nursing services with a family who declines the Families First Home visiting program.   |
| <b>Competency</b>                      | Public Health and Nursing Science   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy  |

## Standard 3.2: Case Management

### Practice Expectations:

3.2.3 Assist clients with referrals to other practitioners, agencies or programs, including services that address the social determinants of health and health equity.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/ Population</b>           | Ensure new service providers are aware of referral processes to public health.                                      | Facilitate connection to community health promotion team when a new parent support group expresses a need for community food bank. | Maintain awareness of community resources such as Addictions, Child Development Clinic, Speech therapist, Child & Family Services etc. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/ Family</b>              | Explore potential for referral to mental health when a client requests information regarding postpartum depression. | Assist a new postpartum mother in accessing safe and affordable housing.   | Refer a family to Speech Language Therapist for complete assessment when speech concerns are noted in a preschool child.               |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   |



## Standard 3.2: Case Management

### Practice Expectations:

3.2.4 Promote the right provider and right service for each client.

| Practice Examples and PHN Competencies |  |  |   |
|--|--|--|---|
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Community/<br/>Population</b>       | Provide online prenatal resource information for clients with few identified risks, and offer additional services if needed. | Promote the utilization of french speaking facilitators for a postpartum group in a francophone community. | Offer additional child health clinics in areas where access to other health practitioners is a challenge and/or immunization rates are low. |
| <b>Competency</b>                      | Policy and Program Planning, Implementation and Evaluation.  | Policy and Program Planning, Implementation and Evaluation.  | Policy and Program Planning, Implementation and Evaluation.   |
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Assist a prenatal client to obtain a primary care provider.  | Refer client to breastfeeding clinics where available.   | Provide optometric care options to a family when concerns are noted.  |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  |

## Standard 4: Health Promotion

### Standard 4.1: Health Promotion

#### Practice Expectations:

4.1.1 Use an upstream, population health approach.

| Practice Examples and PHN Competencies |  |  |   |
|--|--|--|---|
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Community/<br/>Population</b>       | Advocate for access to affordable food and housing in northern communities.    | Promote breastfeeding friendly environments by moving forward Baby Friendly Initiatives (BFI). | Work with partners to develop policies regarding living wage to support families. |
| <b>Competency</b>                      | Professional Responsibility and Accountability                                 | Leadership   | Professional Responsibility and Accountability                                    |
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Enroll a client as early as possible prenatally in the Families First program. | Model positive parenting to promote intergenerational change.                                  | Promote early literacy to enhance school readiness.                               |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy                                       | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  |

### Standard 4.1: Health Promotion

#### Practice Expectations:

4.1.2 Address inequities in the social determinants of health.

| Practice Examples and PHN Competencies |   |   |  |
|--|---|---|--|
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Collaborate with community stakeholders to reduce barriers and improve birth outcomes for disadvantaged clients (ex: PIIPC) | Collaborate with school divisions in program planning for parents returning to high school. | Collaborate with community partners to advocate for the provision of debt counseling services. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Policy and Program Planning, Implementation and Evaluation.                                 | Partnerships, Collaboration and Advocacy   |
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Assist families to access free income tax completion programs.  | Assist a postpartum mother to seek child care options, in order to continue schooling.      | Refer a family to a community gardening program, to supplement their food budget.              |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy  | Policy and Program Planning, Implementation and Evaluation                                     |

## Standard 4.1: Health Promotion

### Practice Expectations:

4.1.3 Offer anticipatory guidance, based on assessed client needs.

| Practice Examples and PHN Competencies |  |   |  |
|--|--|---|--|
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Advocate for culturally acceptable prenatal services for all women.  | Work with community groups to identify relevant and credible web sites to access information. | Partner with Healthy Smile, Happy Child to promote community awareness of early childhood dental caries. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Communication   | Partnerships, Collaboration and Advocacy   |
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Refer a newcomer prenatal client with gestational diabetes to a community nutritionist to explore culturally appropriate food choices. | Inform a postpartum client about parent support groups and resources in the community.        | Suggest library programs for a young family interested in literacy.                                      |
| <b>Competency</b>                      | Diversity and Inclusiveness  | Public Health and Nursing Sciences  | Public Health and Nursing Sciences   |

## Standard 4.1: Health Promotion

### Practice Expectations:

4.1.4 Incorporate mental health promotion.

| Practice Examples and PHN Competencies |  |   |   |
|--|--|---|---|
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Community/<br/>Population</b>       | Collaborate with mental health promotion specialists to increase public awareness of perinatal mood disorders. | Advocate for families to have access to the right provider at the right time to support perinatal mental health | Use principles of Toward Flourishing's mental health promotion in parenting programs. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Policy and Program Planning, Implementation and Evaluation.   | Public Health and Nursing Sciences  |
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Demonstrate and discuss benefits of stress reduction strategies (ex: deep breathing) for a prenatal client.    | Promote a secure attachment relationship between primary caregiver and infant.                                  | Assess family stressors and coping abilities.   |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  | Assessment and Analysis   |

## Standard 4.1: Health Promotion

### Practice Expectations:

4.1.5 Promote healthy relationships.

| Practice Examples and PHN Competencies |   |  |   |
|--|---|--|---|
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Work with Child and Family Services to offer community support groups for pregnant adolescents.         | Address child maltreatment through the development and/or facilitation of attachment and parenting programs. | Work with community partners to establish a committee and plan for Healthy Communities. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Policy and Program Planning, Implementation and Evaluation   | Partnerships, Collaboration and Advocacy  |
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Use the Families First survey data to assess for opportunities to promote healthy family relationships. | Assist new parents to identify potential social supports.  | Invite a family to a Nobody's Perfect parenting session.                                |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Public Health and Nursing Sciences   | Diversity and Inclusiveness   |

## Standard 4.1: Health Promotion

### Practice Expectations:

4.1.6 Promote the infant/parent attachment process.

| Practice Examples and PHN Competencies |  |   |   |
|--|--|---|---|
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Community/ Population</b>           | Ensure attachment information is included in prenatal programs and resource information. | Plan for ways to include the "Serve and Return" (ex: respond to infant cues) approach in public health programming. | Partner with government and non government organizations (NGO's) to address stressors such as child poverty, which could affect attachment. |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  | Partnerships, Collaboration and Advocacy  |
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Individual/ Family</b>              | Explore childhood history and potential impact on parenting.                             | Explore how parents can respond sensitively to infant cues and needs.   | Explain attachment using the "Circle of Security", with parents during a home visit.  |
| <b>Competency</b>                      | Assessment and Analysis  | Public Health and Nursing Sciences  | Public Health and Nursing Sciences  |

## Standard 4.1: Health Promotion

### Practice Expectations:

4.1.7 Promote and support clients to create environments that facilitate healthy child development (ex: housing, income security, mental health, breastfeeding, healthy nutrition, physical literacy, school readiness).

| Practice Examples and PHN Competencies |  |   |   |
|--|--|---|---|
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Community/<br/>Population</b>       | Discuss potential consequences of alcohol use in pregnancy during high school preconception programming. | Collaborate with school division and early childhood centres to promote early literacy. | Promote universal developmental screening in early childhood. |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Policy and Program Planning, Implementation and Evaluation                              | Policy and Program Planning, Implementation and Evaluation    |
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Discuss the importance of maternal mental health on child development.                                   | Review infant milestones to help parents develop appropriate expectations.              | Complete a developmental assessment and refer as appropriate. |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  | Assessment and Analysis                                       |

## Standard 4.1: Health Promotion

### Practice Expectations:

4.1.8 Collaborate with key stake holders to create policies, programs and supportive environments that increase breastfeeding initiation and duration rates for all, with a focus on disadvantaged populations.

| Practice Examples and PHN Competencies |  |  |  |
|--|--|--|--|
|  | Prenatal   | Postpartum   | Early Childhood  |
| <b>Community/<br/>Population</b>       | Work with a First Nations community to alleviate barriers to prenatal nutrition. | Collaborate with key stake holders to create policies and programs that increase breastfeeding rates and duration across populations | Promote baby friendly initiatives for early childhood populations.                                 |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Policy and Programming, Implementation and Evaluation  | Policy and Programming, Implementation and Evaluation  |
|  | Prenatal   | Postpartum   | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Promote breastfeeding as a food security strategy with a prenatal client.        | Refer an advantaged client with breastfeeding issues to community resources.   | Assist a disadvantaged client to meet her goals of continued breastfeeding upon returning to work. |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences   | Public Health and Nursing Sciences   |

## Standard 4.1: Health Promotion

### Practice Expectations:

4.1.10 Evaluate and modify population health promotion programs in partnership with stakeholders.

| Practice Examples and PHN Competencies |   |  |   |
|--|---|--|---|
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Community/<br/>Population</b>       | Collaborate with stakeholders to introduce a program aimed at reducing rates of fetal alcohol syndrome. | Evaluate a “Back to Sleep” campaign for a Newcomers group and modify for cultural safety.      | Meet with Indigenous community members and nutritionist to culturally modify a preschool nutrition program. |
| <b>Competency</b>                      | Policy and Programming, Implementation and Evaluation   | Policy and Programming, Implementation and Evaluation  | Policy and Programming, Implementation and Evaluation   |
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Implement client’s feedback to modify a prenatal learning program.                                      | Discuss cultural norms to identify ideas for modification of breastfeeding promotion programs. | Adapt infant feeding program recommendations to be culturally appropriate.                                  |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  |

## Standard 5: Prevention and Health Protection

### Standard 5.1: Prevention and Health Protection

#### Practice Expectations:

5.1.1 Participate in prevention activities at the primary, secondary and tertiary levels (levels of prevention).

| Practice Examples and PHN Competencies |  |   |   |
|--|--|---|---|
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Community/ Population</b>           | Use media campaigns to communicate issues (ex: tobacco cessation in neighborhoods with high tobacco use). (secondary prevention) | Collaborate with EMS staff to facilitate discussion at a Healthy Baby session regarding car seat safety. (primary prevention) | Work with community groups and partners to alleviate playground hazards. (secondary prevention) |
| <b>Competency</b>                      | Communication  | Partnerships, Collaboration and Advocacy  | Public Health and Nursing Sciences  |
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Individual/ Family</b>              | Support prenatal client to self administer insulin to promote healthy blood glucose levels (tertiary prevention)                 | Enroll an eligible family on Family First home visiting program. (primary prevention)   | Offer injury prevention ideas regarding farm safety for rural families. (primary prevention)    |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  | Public Health and Nursing Sciences  |

### Standard 5.1: Prevention and Health Protection

#### Practice Expectations:

5.1.2 Work to improve prenatal, postpartum and early childhood outcomes.

| Practice Examples and PHN Competencies |   |   |   |
|--|---|---|---|
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Community/ Population</b>           | Promote populations' awareness of prenatal teratogens.  | Promote use of technologies such as Skype or Telehealth to support breastfeeding in remote communities. | Facilitate access to low cost and free recreation facilities.                                       |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Communication   | Partnerships, Collaboration and Advocacy  |
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Individual/ Family</b>              | Facilitate access to safe housing for young pregnant women (prenatal housing for youth, shelter, transition housing). | Discuss the appropriate use of infant car seats with new parents.                                       | Explore options of subsidized contraception with a mother who wants to prevent further pregnancies. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Public Health and Nursing Sciences  | Diversity and Inclusiveness   |

## Standard 5.1: Prevention and Health Protection

### Practice Expectations:

5.1.3 Incorporate principles of harm reduction.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/<br/>Population</b>       | Collaborate with community policy makers to create access to clean needles.   | Advocate for harm reduction at the policy level.                                     | Advocate for addictions treatment that allows parents and children to be housed together, with programming for all family members. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy                                      | Policy and Program Planning, Intervention and Evaluation                             | Policy and Program Planning, Intervention and Evaluation   |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Assist a prenatal client in an abusive relationship, to create a safety plan. | Work with a family to make a plan for safe infant care, when planning substance use. | Encourage parents using tobacco to smoke outdoors and away from their children.  |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Public Health and Nursing Sciences   | Public Health and Nursing Sciences   |

## Standard 5.1: Prevention and Health Protection

### Practice Expectations:

5.1.4 Complete communicable and infectious disease prevention/screening.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/<br/>Population</b>       | Partner with high school teachers to ensure students receive information on STBBIs (sexually transmitted and blood borne infections). | Participate in planning and implementation of community influenza immunization clinics.      | Provide pre kindergarten immunization and developmental screening clinics and/or remind parents to visit their routine provider. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Public Health and Nursing Sciences   | Policy and Program Planning and Evaluation   |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Discuss potential newborn risks, with a prenatal client positive for herpes simplex type II.  | Offer information to formula feeding parents regarding safe formula preparation and storage. | Provide parents with information on diseases such as hand, foot, and mouth disease.  |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Public Health and Nursing Sciences   | Public Health and Nursing Sciences   |



## Standard 5.1: Prevention and Health Protection

### Practice Expectations:

5.1.5 Increase immunization completion rates.

| Practice Examples and PHN Competencies |  |   |   |
|--|--|---|---|
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Community/<br/>Population</b>       | Track high school student's immunization records to find those who are not up to date, and offer vaccinations before high school completion. | In a community with low immunization rates, partner with community groups to identify possible solutions.                             | Work to improve access to immunizations in neighborhoods with low immunization rates.         |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Partnerships, Collaboration and Advocacy  | Diversity and Inclusiveness   |
|  | Prenatal   | Postpartum  | Early Childhood   |
| <b>Individual/<br/>Family</b>          | Provide influenza immunization information to prenatal clients during influenza season.  | Discuss and set appointment times for a disadvantaged family to see the Public Health Nurse at Child Health Clinic for immunizations. | Address immunization misinformation with a family who expresses concerns about immunizations. |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences  | Public Health and Nursing Sciences  |

*“I strongly agree with the use of PHNs for early childhood assessments and immunizations.”*

## Standard 5.1: Prevention and Health Protection

### Practice Expectations:

5.1.6 Recognize each contact as opportunity to review immunization status, and offer immunizations or facilitate referrals to alternate providers.

| Practice Examples and PHN Competencies |  |  |   |
|--|--|--|---|
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Incorporate an immunization review into reproductive health programming.   | Collaborate on a public awareness campaign regarding spread of vaccine preventable diseases to newborns. | Develop Child Health Clinics in communities with lower immunization rates and challenges to access. |
| <b>Competency</b>                      | Policy and Program Planning and Evaluation   | Public Health and Nursing Sciences   | Policy and Program Planning and Evaluation  |
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Review immunization history with a prenatal client susceptibility to rubella, and discuss opportunity and timing for immunization. | Assess for and offer immunization for all members of a postpartum family (ex: influenza and pertussis).  | Offer immunizations at a Healthy Baby program venue in communities with low immunization rates.     |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences   | Diversity and Inclusiveness   |

## Standard 5.1: Prevention and Health Protection

### Practice Expectations:

5.1.7 Evaluate the impact of public health nursing intervention, including health outcomes for clients.

| Practice Examples and PHN Competencies |   |   |   |
|--|---|---|---|
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Community/ Population</b>           | Evaluate for changes in adolescent pregnancy rates after condom promotion campaign. | Examine maternal depression rates in a community after beginning the Towards Flourishing program. | Assess effectiveness of PHN interventions during a child health fair (eg. Referrals, immunizations) |
| <b>Competency</b>                      | Policy and Program Planning and Evaluation  | Policy and Program Planning and Evaluation  | Policy and Program Planning and Evaluation  |
|  | Prenatal  | Postpartum  | Early Childhood   |
| <b>Individual/ Family</b>              | Assess client use after facilitating access to prenatal vitamins.                   | Evaluate satisfaction with a family after participating in Towards Flourishing program.           | Evaluate booster seat use after discussion with family on proper installation.                      |
| <b>Competency</b>                      | Policy and Program Planning and Evaluation  | Policy and Program Planning and Evaluation  | Policy and Program Planning and Evaluation  |

## Standard 6: Capacity Building and Community Development

### Standard 6.1: Capacity Building and Community Development

#### Practice Expectations:

6.1.1 Collaborate with communities and stakeholders to decrease inequities, address the determinants of health and improve population level outcomes for families and their children.

| Practice Examples and PHN Competencies |  |  |   |
|--|--|--|---|
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Partner with parents and recreation centres to develop accessible fitness and recreation programs for low income families. | Collaborate with faith based groups, service organizations and grocery stores to establish a neighborhood food bank. | Collaborate with school division and local Community Foundation, to implement a breakfast program for disadvantaged families. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  |
|  | Prenatal   | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Work with a pregnant newcomer to secure a culturally appropriate primary care provider.                                    | Work with HIV positive postpartum mother to access affordable infant formula.  | Assist a low income family to access opportunities for their children to participate in afterschool programming               |
| <b>Competency</b>                      | Diversity and Inclusiveness  | Partnerships, Collaboration and Advocacy   | Diversity and Inclusiveness   |

*“Populations require support to have optimal outcomes.”*

## Standard 6.1: Capacity Building and Community Development

### Practice Expectations:

6.1.2 Use community assessment and knowledge of the community to adapt programs to meet their identified needs and preferred outcomes.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/<br/>Population</b>       | Where rates of fetal alcohol syndrome are higher than average, collaborate with school division, liquor commission, social services and health practitioners to advocate for prevention programs. | In a community with rising rates of family violence, work with stakeholders underlying causes and solutions (ex: poverty, shelters). | Share and utilize epidemiological data related to injury rates, to facilitate evaluations and upgrade of playground. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Public Health and Nursing Sciences   |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/<br/>Family</b>          | In an area of high immigration, ensure the availability of language translators at a local prenatal class.  | Identify gaps in resources and services to assist in planning for needs of a postpartum family.                                      | In communities with low EDI scores, link families with early childhood development programs.                         |
| <b>Competency</b>                      | Diversity and Inclusiveness   | Public Health and Nursing Sciences   | Assessment and Analysis  |

*“We are not task driven, but community driven, and always on the lookout for how we can improve the health of our communities.”*

## Standard 6.1: Capacity Building and Community Development

### Practice Expectations:

6.1.3 Share expertise, research and best practices to assist in moving community development initiatives forward.

| Practice Examples and PHN Competencies |   |  |   |
|--|---|--|---|
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Community/ Population</b>           | Promote the benefits of community gardens and harvest of fresh produce to improve the health of prenatal women.           | Facilitate the development a community initiative for crime reduction, sharing best practices and gathering community input (ex: focus group). | Collaborate to examine the health effects of field burning on childhood asthma.                   |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  |
|  | Prenatal  | Postpartum   | Early Childhood   |
| <b>Individual/ Family</b>              | Assist a prenatal client in gathering best sleep practice information to bring forward to a community child safety group. | Present information to community working group to assist them in promoting mental health and wellness within their community.                  | Attend healthy community group with client to share ideas and resources around physical literacy. |
| <b>Competency</b>                      | Public Health and Nursing Sciences  | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  |

## Standard 6.1: Capacity Building and Community Development

### Practice Expectations:

6.1.4 Act as a catalyst to help resolve issues and concerns.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/ Population</b>           | Promote community programs that assist low income populations with income tax filing.     | Collaborate with families to develop parenting support groups.             | Work with community 4-H clubs and Municipal Council to develop an annual playground “clean up” day to reduce litter. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy                                   | Partnerships, Collaboration and Advocacy   |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/ Family</b>              | Facilitate a referral to a safe house for a woman experiencing intimate partner violence. | Work with a postpartum family to address concerns regarding food security. | Work with a family to secure financial assistance for their children to attend sports programming.                   |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy                                   | Partnerships, Collaboration and Advocacy   |

## Standard 6.1: Capacity Building and Community Development

### Practice Expectations:

6.1.5 Use a strength-based approach.

| Practice Examples and PHN Competencies |   |  |  |
|--|---|--|--|
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Community/<br/>Population</b>       | Identify and use community strengths (ex: strong volunteer base) to facilitate a community's plan to build a recreation park. | Identify potential leaders within the breastfeeding community to support and develop a peer breastfeeding network. | Build on community resources (ex: local school interest) to implement a preschool screening day.                                 |
| <b>Competency</b>                      | Assessment and Analysis   | Assessment and Analysis  | Partnerships, Collaboration and Advocacy   |
|  | Prenatal  | Postpartum   | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Assist a prenatal client to identify her strengths, to support success in achieving smoking cessation goal.                   | Assist a client in identifying their support networks.   | Use a family's problem solving, strengths to explore transportation options to Healthy Baby sessions and access to primary care. |
| <b>Competency</b>                      | Assessment and Analysis   | Public Health and Nursing Science  | Assessment and Analysis  |

## Standard 6.1: Capacity Building and Community Development

### Practice Expectations:

6.1.6 Support clients to advocate for themselves when possible, and apply principles of social justice to advocate for those who are not able to take action.

| Practice Examples and PHN Competencies |  |   |  |
|--|--|---|--|
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Community/<br/>Population</b>       | Provide demographic and epidemiological information to a community group applying for funding for a healthy prenatal lifestyles program. | Work with low income families, to advance their request to city council to address issue of accessible and affordable grocery stores. | Advocate for school readiness programs in disadvantaged communities.                                   |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   |
|  | Prenatal   | Postpartum  | Early Childhood  |
| <b>Individual/<br/>Family</b>          | Help client articulate her plan for a desired unmedicated labour to her practitioner.  | Support the client by attending a meeting with the Manitoba Housing representative to address safe housing issues.                    | Support a client to bring their concerns forward to the daycare related to their child's health needs. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy  | Partnerships, Collaboration and Advocacy   |

## Standard 6.1: Capacity Building and Community Development

### Practice Expectations:

6.1.7 Assist clients to view themselves as part of a community that influences their health.

| Practice Examples and PHN Competencies |  |  |  |
|--|--|--|--|
|  | Prenatal   | Postpartum   | Early Childhood  |
| <b>Community/ Population</b>           | Assist a community group to identify safety concerns related to criminal activity in the neighborhood. | Within parenting groups facilitate the sharing of their culturally specific infant care practices                              | Work with a Healthy Communities group to identify gaps in community resources that support early childhood development |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   | Partnerships, Collaboration and Advocacy   |
|  | Prenatal   | Postpartum   | Early Childhood  |
| <b>Individual/ Family</b>              | During a prenatal assessment link families to community resources.                                     | Explore with Hutterite mother how their traditional six week family support provided postpartum, benefits her family's health. | Explore with a family, existing community resources that can encourage activity and fitness for their children.        |
| <b>Competency</b>                      | Public Health and Nursing Sciences   | Public Health and Nursing Sciences   | Assessment and Analysis  |

## Standard 6.1: Capacity Building and Community Development

### Practice Expectations:

6.1.8 Evaluate the impact of public health nursing intervention on the health outcomes of the individual, family, group, community, population or system.

| Practice Examples and PHN Competencies |   |   |  |
|--|---|---|--|
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Community/ Population</b>           | Use a health equity impact assessment to determine if a community prenatal program is meeting the needs of low-income families. | Collect and analyze data to assess for changes in breastfeeding rates after targeted programming. | Review childhood injury data for changes, after implementation of a community safety program, in a disadvantaged neighborhood. |
| <b>Competency</b>                      | Partnerships, Collaboration and Advocacy  | Assessment and Analysis   | Assessment and Analysis  |
|  | Prenatal  | Postpartum  | Early Childhood  |
| <b>Individual/ Family</b>              | Assess for smoking cessation success in a prenatal client who requested PHN support.  | Evaluate a client's satisfaction of their public health prenatal education program.               | Reassess the developmental abilities of a child after beginning developmental enhancement activities.                          |
| <b>Competency</b>                      | Assessment and Analysis   | Assessment and Analysis   | Assessment and Analysis  |

## Standard 7: Professional Responsibility & Accountability

### Practice Expectations:

7.1 Practice according to the College of Registered Nurses of Manitoba (CRNM) Standards of Practice  
[http://cms.tng-secure.com/file\\_download.php?fFile\\_id=140](http://cms.tng-secure.com/file_download.php?fFile_id=140)

|                   |  |
|-------------------|--|
| <b>Competency</b> | Professional Responsibility and Accountability |
|-------------------|--|

7.2 Practice according to the Canadian Nurses Association (CNA) Code of Ethics  
<http://www.cna-aiic.ca/~media/cna/files/en/codeofethics.pdf>

|                   |  |
|-------------------|--|
| <b>Competency</b> | Professional Responsibility and Accountability |
|-------------------|--|

7.3 Practice according to respective regional health authority policies.

|                   |  |
|-------------------|--|
| <b>Competency</b> | Professional Responsibility and Accountability |
|-------------------|--|

7.4 Practice according to the Government of Manitoba, Public Health Act  
<http://web2.gov.mb.ca/laws/statutes/ccsm/p210e.php>

|                   |  |
|-------------------|--|
| <b>Competency</b> | Professional Responsibility and Accountability |
|-------------------|--|

7.5 Base practice on public health science and Canadian Health Nurses of Canada Discipline Specific Public Health Nursing Competencies.

|                |   |
|----------------|---|
| <b>Example</b> | Participate in holistic assessments with clients, including social determinants of health, rather than assessments based predominantly on physical needs. |
|----------------|---|

|                   |                                    |
|-------------------|------------------------------------|
| <b>Competency</b> | Public Health and Nursing Sciences |
|-------------------|------------------------------------|

7.6 Develop knowledge and expertise in influencing healthy public policy.

|                |   |
|----------------|---|
| <b>Example</b> | Identify key stakeholders in a community. |
|----------------|---|

|                   |                                    |
|-------------------|------------------------------------|
| <b>Competency</b> | Public Health and Nursing Sciences |
|-------------------|------------------------------------|

7.7 Integrate socio-political knowledge into practice.

|                |  |
|----------------|--|
| <b>Example</b> | Identify key stakeholders in a community, be aware of political influence on a community, participate in large or small policy making with groups, committees and/or government. |
|----------------|--|

|                   |                                    |
|-------------------|------------------------------------|
| <b>Competency</b> | Public Health and Nursing Sciences |
|-------------------|------------------------------------|

7.8 Develop and demonstrate leadership skills.

|                |                         |
|----------------|-------------------------|
| <b>Example</b> | Mentor a new colleague. |
|----------------|-------------------------|

|                   |            |
|-------------------|------------|
| <b>Competency</b> | Leadership |
|-------------------|------------|

7.9 Develop knowledge and expertise related to culture and integrate into practice.

|                |  |
|----------------|--|
| <b>Example</b> | Take initiative to learn about cultural groups in the Public Health Nursing practice area. |
|----------------|--|

|                   |                             |
|-------------------|-----------------------------|
| <b>Competency</b> | Diversity and Inclusiveness |
|-------------------|-----------------------------|



7.10 Promote the public health nursing profession and services to partners and clients.

|                   |  |
|-------------------|--|
| <b>Example</b>    | Take opportunities to discuss programs and services provided by Public Health Nursing. |
| <b>Competency</b> | Professional Responsibility and Accountability   |

7.11 Share knowledge regarding emerging trends, population changes, and resource requirements with key stakeholders, including colleagues and managers.

|                   |   |
|-------------------|---|
| <b>Example</b>    | Discuss increasing newcomers to a community and possible effects on Public Health nursing services with a manager who may not be aware of this trend. |
| <b>Competency</b> | Leadership  |

7.12 Participate in reflective practice as an individual and as a member of a larger organizational team.

|                   |   |
|-------------------|---|
| <b>Example</b>    | Consider the results and effects of a Public Health Nursing intervention, including assumptions and priorities on a personal and team basis, in planning for future client contact. |
| <b>Competency</b> | Professional Responsibility and Accountability  |

7.13 Engage and develop collaborative relationships with practitioners, community groups and partners who may not be aware of Public Health Nursing services and resources.

|                   |   |
|-------------------|---|
| <b>Example</b>    | Take opportunities to discuss current Public Health Nursing programs, services and resources. |
| <b>Competency</b> | Public Health and Nursing Sciences  |

*“The organization must support PHN lead initiatives and accommodate this type of work.”*

*“Regional orientation for new staff and ongoing education regarding leadership development, policy change is important.”*

*“I am excited to have provincial standards to further guide my practice.”*





