Public Health Nursing

Position Statement
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Background

In Ontario, public health nurses are community health nurses who, synthesizing knowledge from public health science, nursing science, and the social sciences, promote, protect, and preserve the health of populations (adapted from[1;2]). Public health nurses in their work for official public health agencies practice population health promotion in diverse settings to meet the health needs of specific populations. Although the focus of public health nursing practice is health promotion and the prevention of diseases and injury of populations, public health nurses "integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population" ([2] p. 79). That is, public health nurses recognize that a community's health is inextricably linked with the health of its constituent members and is often reflected first in individual and family health experiences.

Public health nursing in Ontario is rooted in the traditions of Nightingale, Jeanne Mance, women in religious orders, such as the Grey Nuns, and early North American public health nurses who understood the importance of social, economic, environmental, and political determinants of health. They considered social activism and collaboration with community organizations and governments to be fundamental aspects of public health nursing practice. Although developments in public health over the last century such as the biomedicalization of public health and the lifestyles approach have influenced the scope and direction of public health nursing practice, recent shifts to health promotion approaches that address broad determinants of health once again resonate with nursing's legacy of health promotion.

Public health nursing values the key principles in primary health care as described by the Declaration of Alma-Ata (1978): 1) universal access to health care services, 2) focus on the determinants of health, 3) active individual and community participation in decisions that affect their health and life, 4) partnership with other disciplines, communities and sectors for health, 5) appropriate use of knowledge, skills, strategies, technology and resources, and 6) focus on health promotion/illness prevention throughout the life experience from birth to death. 16

Public health nursing practice is a systematic process of problem prevention, risk control, health surveillance and health promotion. The nurses partner with individuals, families, and/or communities to optimize their functioning and well-being by identifying health needs and resources, planning to address the needs and strengthen the resources, implementing plans, and evaluating their success. The extent of a public health nurse's involvement in any part of the process is mutually determined by both the client and nurse. It varies with the nature and urgency of the health need and the skill of participants, and is dependent on a trusting relationship between client and nurse.

Educational Preparation

The educational preparation of a public health nurse in Ontario is a baccalaureate degree in nursing.[1] Legally, the Health Protection and Promotion Act of 1983 restricted the use of the job title of "public health nurse" in official public health agencies to Registered Nurses with a baccalaureate degree or post-RN diploma in public health nursing.[3]

In 2003 community health nursing, of which public health nursing is one area of community nursing practice, received specialty designation to become a certified area of nursing 15. Practicing nurses with advanced public health nursing knowledge and skills are essential to provide leadership in defining a public health nursing scope of practice. The recognition is hampered, however, in Ontario as elsewhere in Canada, by the unavailability of graduate programs in public health nursing.

Standards of Practice

National standards of community health nursing practice identified public health nursing as one of the two community health nursing practice areas to apply the recently developed standards.14 The standards of practice define the scope and depth of community health nursing practice and serve as a foundation in the development of the certification examination. The community health nursing standards of practices are promoting health, building individual/community capacity, building relationships, faciliting access and equity, and demonstrating professional responsibility and accountability.

Nature of Public Health Nursing

Public health nurses work in collaboration with other community service providers from a multitude of agencies, integrating and coordinating services for clients to maximize continuity of care. They work proactively and in partnership with their clients to influence the health of individuals, families, and communities. A hallmark of public health nursing has been the trust that communities and their members have placed in the nurses who can be accessed directly by the public through self-referral. Public health nurses practice in a setting without walls, providing their services in homes, schools, work places, community centres, and other community agencies/institutions where they are requested. They use a wide range of strategies including advocacy, counselling, teaching, community development, health surveillance and outbreak management working with both official and voluntary community groups to develop healthy public policies and to address broad determinants of health (Appendix I provides some examples of public health nursing work in the form of nurses' stories and Appendix II consits of a tear-off flyer that summarizes public health nurses' activities in language suitable for the general public) . Some examples of public health nursing activities are to:

- **Promote the health of young families through a variety of services, in, for example, prenatal health education; liaison with hospitals to identify families needing support; post natal and newborn assessment, health teaching, counselling, support, social marketing, policy development and media advocacy; appropriate referral to other community services; breast feeding education and support; well-baby screening clinics; and parenting groups;**

- **Promote the health of children and adolescents, in schools and other community settings through working with individual students and their families, with classes, and/or with entire school populations, using a variety of strategies such as personal counselling, health education, protective and preventative measures and program development;**

- **Evaluate health trends and identify populations at risk, participating in the identification of priorities, for example, the Healthy School Profile;**[4]

- **Promote the health of specific at-risk populations, for example, new residents to Canada, people living in poverty, and homeless people;**

- **Promotes the health of populations using the three levels of prevention (primary, secondary and tertiary) for example, communicable disease prevention and chronic disease prevention**

- **Promote the health of elders through working with groups of older adults to develop community supports such as mall walk programs; .Collaborate with communities to maximize resident participation and problem-solving in addressing complex, diverse community-wide issues such as substance use prevention or falls prevention through multisector coalitions;**

- **Facilitate the empowerment of people across the life span to gain and maintain control of their lives and health by increasing knowledge, self-care skills, and confidence using community development principles;**

- **Provide universally accessible professional nursing expertise and reliable health information regarding common health concerns; normal growth and development; available community services and resources; and disease, illness, accident, and injury prevention; and**

- **Provide service coordination, within the context of a trusting relationship, to vulnerable and marginalized community members, assisting them to access needed services.**

Health promotion is an important aspect of public health nursing. The term health promotion in this document is used in a sense that is consistent both with public health nursing's legacy in health promotion and with the widely accepted contemporary definition articulated in the Ottawa Charter:[5] "the process of enabling people to increase [and maintain] control over and improve,

their health." Public health nurses have historically included, some to a greater extent than others, all five of the Charter's health promotion strategies in their practice: creating supportive environments, strengthening community action, developing personal skills, building healthy public policy, and working to reorient health services. In summary, the hallmark of health promotion in public health nursing practice has been that it occurs within the context of a trusting relationship developed between nurse and client and involves caring and a holistic approach that is again consistent with its legacy, with the Ottawa Charter, and with contemporary nursing theorists' conceptualizations of health promotion.[6]

Outcomes of Public Health Nursing Work

Substantial research exists that documents the effectiveness of home visiting interventions for pre and postnatal women as well as for frail elderly persons.[7] More recent studies continue to document the effectiveness of nurses' postnatal home visiting for 2 years following birth in improving maternal and child health outcomes in the short term (2 years after visiting stopped), particularly in homes with the greatest economic stresses and the fewest psychological resources.[8-10]. Furthermore, significant long term effects were documented over a 15 year period and included: fewer subsequent births and greater spacing between pregnancies, less use of social assistance, fewer maternal behavioral impairments from substance use, few maternal arrests and fewer reported incidents of child abuse and neglect.[11] It is important to note that the study protocol used in these studies involved intensive interventions by nurses that have not been the case in studies that were unable to associate home visiting with positive health outcomes. Yet, the costs of these intensive interventions were recovered before the child's fourth birthday.

Outcomes research related to other aspects of public health nurses' work is less well documented because of difficulties inherent in evaluating it[12] Public health nurses, however, have identified practice outcomes such as: delayed and decreased institutionalization of elders, fewer and less frequent hospitalizations for people with mental illness, and increased functioning and improved quality of life for individuals and families. Many believed that through case finding, developing parenting skills, and providing support, they were effective in reducing incidents of child abuse and neglect in their communities.[13] In a systematic review of the effectiveness of parent training programmes for improving the maternal psychosocial health it was found that common psychosocial maternal outcomes like depression, stress, and anxiety can be improved by parenting programmes. 17 A limitation of this literature review is the lack of recognition of these practices by public health nurses even though this intervention is generally provided by them in health units.

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Appendix I: Public Health Nurses' Stories

I met this [couple from another province at our prenatal program]. They were living in an awful circumstance and so part of the initial working with them had nothing [directly] to do with pregnancy . . . . [I helped them find a place to stay], so today I went to see them at the place for the first time . . . . I said, "Show me your place" . . . . They had rented a room, a shared kitchen and shared bathroom and [it was a] big long place and they were going to meet me in their . . . . [room] and I [asked to see the whole place first] . . . . so we went to the back porch and I said, "Oh, let me just look out" . . . . At the same time the owner . . . came up the stairs and made small talk . . . . and I said, "My goodness there is a lot of space out there. Hey, you are doing a wonderful job here" and he said, "You know this year I had some time and so I am renovating a little bit" . . . I kept looking out there and he said [to the couple], "Yeah . . . that's your backyard now. Good soil, last year I grew tomatoes and they were this big but this year I am so busy." "Oh?" and then just with small talk back and forth, [I] mentioned that Shalom House down the street, a food access center, had a community garden and . . . and how I [had seen] people from Shalom House preparing a garden the size of the porch we were standing on and I said, "My God, isn't it amazing you have got enough space there for an amazing garden!" We just kept talking and back and forth slowly, easy going and he said. "Yeah, you could have a garden there." And I said, "Are you serious?" "Yeah." "Would you be interested in maybe letting Shalom House folks..?" "Yeah." And then he said, "Well it doesn't just go back here, it is over there too," . . . . I gave him my card and so the next step is calling Shalom House up and saying, "Hey, guess what!" So the interaction between . . . one-to-one health promotion and one-to-family health promotion and community development is direct in my mind.
(From: Falk Rafael AR. From rhetoric to reality: The changing face of public health nursing in Southern Ontario. Public Health Nursing.*1999. 16(1):50-9,)*

. . . . .

There was a set [prenatal] program but certainly you could assess the needs of the group and there was a lot of latitude to allow people to grow and to question and to prepare. . . . I saw the benefit was increasing their awareness and knowledge of one, the delivery process; that's important to get out of the way because at least if you have an idea of what is going to happen, you decrease fear and it's going to be a much better experience. But the whole course really helped couples prepare to be parents; it helped them to clarify and crystallize some of their issues. They weren't always resolved in the class for them. I mean, you would hope that they would go home and talk about some of the issues around abuse, for example, or stress or . . . [finances] or adjustment of even the grandparents. There are just so many life issues that you could discuss. Often it would come from the group if you had a . . . [really] aware group but if they weren't forthcoming then you would really have to try to do that with them . . . . You just got to love these people because over a seven-week period you have now formed an intimate relationship. People remember; I saw somebody the other day at the grocery store . . . and we both looked at each other and he said my name and "We had different instructors in our first class and we still talk about you and we still meet with four other couples from that class and, you know, it made such a difference in our lives" . . . . I think, if you can't build those kinds of relationships with individuals and even with groups, you just can't be effective in my mind; you are just that stranger, that expert that comes in and it's certainly not as good an experience.
(From: Falk Rafael AR. From rhetoric to reality: The changing face of public health nursing in Southern Ontario. Public Health Nursing,1999. *16(1):50-9)*

[I was notified of a new birth], a l200 gram baby . . . . [This mom] has almost a two-year-old; she has this itsy bitsy baby, having had one heart operation, needs another, has all kinds of meds, has oxygen, was still being tube-fed. I said, “Your baby sounds really sick . . . . Can I go to the hospital with you to meet your baby?” So we met there, saw the baby, left a consent on their record. Mom, [new to Canada for under four years], calls yesterday . . . Baby is coming home Monday, supposedly, with [numerous medications], inhalations, and continuous oxygen. Nobody thought about how this lady is going to manage [day-to-day]. They didn't know, [because] nobody asked her, [that] her husband's not there; he got arrested in December after he . . . hurt her. She's got a not-quite two-year-old, so how is she going to do food shopping? How's she going to do the laundry? The child won't be able to go do daycare when she needs a break; you can't just get the lady across the hall to watch over this medically compromised baby . . . . I [finally reached the social worker and] I started telling the story and the idea was, “Well, so and so is planning the discharge and I'm sure this is all thought of” and I just went through it again and again with her . . . . You have to do it very carefully and I said, “They are going to have three people landing in hospital; this little girl has [a chronic ear infection] . . . . She is being referred to [the local children’s hospital] for ventilating tubes. How in God's name is this mother ever going to manage?” The social worker says, “Well, if she can't manage we'll have to bring in Children’s Aid.” “Pardon me? . . . I will speak loud and clear. If I must call the Medical Officer of Health I will do that.”
(From: Falk Rafael AR. Running with the wolves: The power/caring dialectic revisited. *Advances in Nursing Science*, 1998:21(1))

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I remember, about four years ago as a school nurse, I had this little boy in one of my French schools, grade one. [The] principal called me in and said, “We’d like you to do a home visit. Children’s Aid has been to the home and I have been to the home. This family is still very resistive. [The] little boy comes to school with no lunch, and then he beats the other boys up and has their lunch.” So I called the family and said I was the school nurse and I would like to come out and see them. They said fine. So I pull up to this yard and there’s this great big sign that says, “Beware of dog”; it’s a big dog. Now I have been out in the country and I know that if I go easy with the dog—well, this dog was just a big suck. So I played with the dog for a minute, and then I knocked on the door. And this huge man came. It was summer time, he had shorts, bare-chested, pot belly, and he says, ”How did you get by the dog?” I said, “Well, the dog’s friendly” . . . . So I go in the house. There are 10 people in this [small] room! Because the nurse is coming, they were protecting themselves from this nurse . . . . Dad was the primary guy and so they made space for me on the couch, and he says, “Would ya like a coffee?” And I said, “Sure.” Now, I do not drink coffee, I don’t like coffee. He says, “This is good Jamaican coffee.” Well, he brought me a [giant] mug of coffee. And we started out, and I just let them talk. That was a two-and-a-half hour visit. And we eventually got around to [the reason for the visit]. I said, “My job here is to help you. Your son, why is he going to school without his lunch?” They said, “He has breakfast and we give him his lunch but he eats it at the bus stop.” So I basically found that this kid is in a growth spurt, gave them ideas on nutrition and stuff like that. And then my coffee is three-quarters full and he comes out and he pours more into it. I did not sleep for three days, honest to goodness. This is the truth. But when I left, this man said to me, “You know, ma’am, we will take your advice. The principal was here, and the Children’s Aid were here. Neither one of them took our hospitality, but you did. And we will listen to what you say.” And it worked!
((From: Falk Rafael AR. From rhetoric to reality: The changing face of public health nursing in Southern Ontario. Public Health Nursing. *1999.16(1):50-9,)*

Now when I first met Maria, (not her real name) she had undergone open heart surgery; she'd had a stroke; she was sitting in the middle of the floor of an immaculate Italian home in a walkout basement. It was a bright sunny room and [there she was], watching TV with her arm in a sling and crying. Her family was frantic; she was so depressed. Her family thought she was going to die at any minute. They wouldn't allow her to do anything. She wanted to do things, but she was afraid. Her whole life was sitting in that chair with everybody telling her, "Don't move; just stay there" and bringing her food and she was just a wreck. Because I went in and saw what was going on and was able to teach her son, her daughter, her husband, and so on about what strokes were, what she could do, she, for years now, has looked after herself, all her housework, does her cooking, manages everything. Her children are all grown up at this point in time. She was an original member of the outreach group, which is a self-support group for handicapped adults. She baby sat her grandchild when the mother and father were working. Maria is now looking after a husband who is early Alzheimer's and she still runs around with an arm in a sling. But she had been sitting there for a year in that chair. That's a change. For a whole family, not just one person, but a whole family.
(From: Falk Rafael AR. Running with the wolves: The power/caring dialectic revisited. *Advances in Nursing Science*, 1998:21(1))

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I presently chair a community-wide coalition to prevent falls in seniors. We received money about a year ago to look at better ice and snow removal and develop some strategies around that . . . . Some of [the members of the coalition] are representatives of other organizations for seniors and in some cases they're volunteers, seniors themselves. . . . I'm [also on a specific local council]. I'm on their board and chair [one of their committees]. Two years ago [our committee] put out telephone inserts--we got a corporation to sponsor it--so the seniors could read this larger print and easier format and [find] the information that they might want for their area. Now we have quarterly newsletters that go out and we're now looking at possibly a directory of some sort.
(From: Falk Rafael, AR. Every day has different music: An oral history of public health nursing in Southern Ontario, 1980-1996. [Unpublished doctoral dissertation]. University of Colorado: 1997. (Available from CNA library, Ottawa).