Babies First! and CaCoon

Manual 2024- Chapter 2

PUBLIC HEALTH DIVISION
Maternal and Child Health

CONTENTS

COMPETENCIES OF HOME VISITING IN OREGON

Oregon Home Visiting Core Competencies

The Oregon Home Visiting Core Competency domains each have a description, attributes, knowledge and skills section.

1. Attributes are those inherent traits, values or beliefs of an individual within the home visiting field.
2. Knowledge is defined as the information needed within each domain required to effectively work within the home visiting field.
3. Skills are defined as strategies for application of knowledge within the home visiting field.

There are ten core competency domains:

1. **Cultural and Linguistic**:
   Commit to understanding individuals and families within their cultural context and providing appropriate supports.
2. **Dynamics of Family Relationships and Engagement:**
   Understand the complexity and diversity of family relationship, dynamics, and systems while working in partnership with families for the best interest of children.
3. **Family Health and Well-Being:**
   Establish and maintain environments and supports that promote children's health, safety, nutrition, physical activity and adaptations for special needs, in partnership with families.
4. **Family Self-Sufficiency:**
   Actively engage family members in identifying and working towards self-sufficiency, as defined and desired by the family.
5. **Human Growth and Development:**
   Apply the principles of development across the lifespan, including child growth and development; value each family member's unique biology, interests, needs and potential while nurturing relationships, starting with healthy infant-caregiver attachment.
6. **Professional Best Practices:**
   Work with families in a professional, reflective manner; adhere to ethical standards, regulations and laws pertaining to the home visiting field.
7. **Professional well-being:**
   Examining one's own thoughts, attitudes, feelings, actions, strengths and challenges; seek appropriate supports and engage in selfcare activities to ensure ability to effectively support families.
8. **Screening and Assessment:**
   Use appropriate tools and methods for understanding child interactions, knowledge and skills to support the child's development and make appropriate referrals for further evaluation.
9. **Service System Coordination:**
   Understand the value of partnerships and collaborations between families and agencies/organizations to meet family needs.

10. **Social Emotional Well-Being:**
    Understand supportive strategies for encouraging social emotional development and addressing challenging behaviors and recognize the influence of temperament and emotional regulation capacity on behavior.

Public Health Nurse Competencies

The Quad Council Coalition of Public Health Nursing Organizations developed the Public Health Nurse Competencies in 2018. The document describes three core functions of Public Health, which are Assessment, Policy Development, and Assurance. Within these core functions are 10 essential services (e.g., monitor health status to identify and solve community problems; inform, educate, and empower people about health issues; and link people to needed personal health services). Home visiting services encompass many of the ten essential public health nurse activities. In nurse home visiting, public health core functions and activities are carried out within the framework of the nursing process.

Nursing Diagnosis and Care Planning

The nursing process in home visiting

It is important that PHNs working in home visiting are well prepared to understand the role of the Public Health Nurse and to use the nursing process. Public health nurses use the nursing process to:

- Assess the client's strengths, risks and needs,
- Identify a nursing diagnosis,
- Create a care plan using evidence-based and evidence-informed tools and practices,
- Implement the nursing plan of care, and
- Evaluate outcomes.

Note:

CHWs provide services according to their competency validation, as determined by the implementing agency (e.g., a CHW may be assigned to educate clients on breastfeeding if they have a CLC). See Appendix D for more details.

CHWs provide support, education and case management services to families in collaboration with the PHN and following the plan developed by the PHN. Home visitors work to build therapeutic relationships that nurture the client's autonomy and confidence in parenting, decision-making, learning and navigating health and social service systems.

The five steps of the nursing process flow into a continuous loop of activities, beginning with the nursing assessment of the client's strengths and needs. Then, based on the assessment, the nursing diagnosis (or

problem statement) is chosen. The diagnosis and assessment inform care planning and the choice of interventions. After interventions are begun, and there has been time for action, progress toward goals is evaluated. From there, further assessment may be needed and adjustments to diagnosis, planning, and interventions may be made. Periodic evaluation and adjustment provide tailored support as the client reaches for their goals. Nurse home visiting interventions encompass public health interventions, and this is illustrated below (Figure 1).

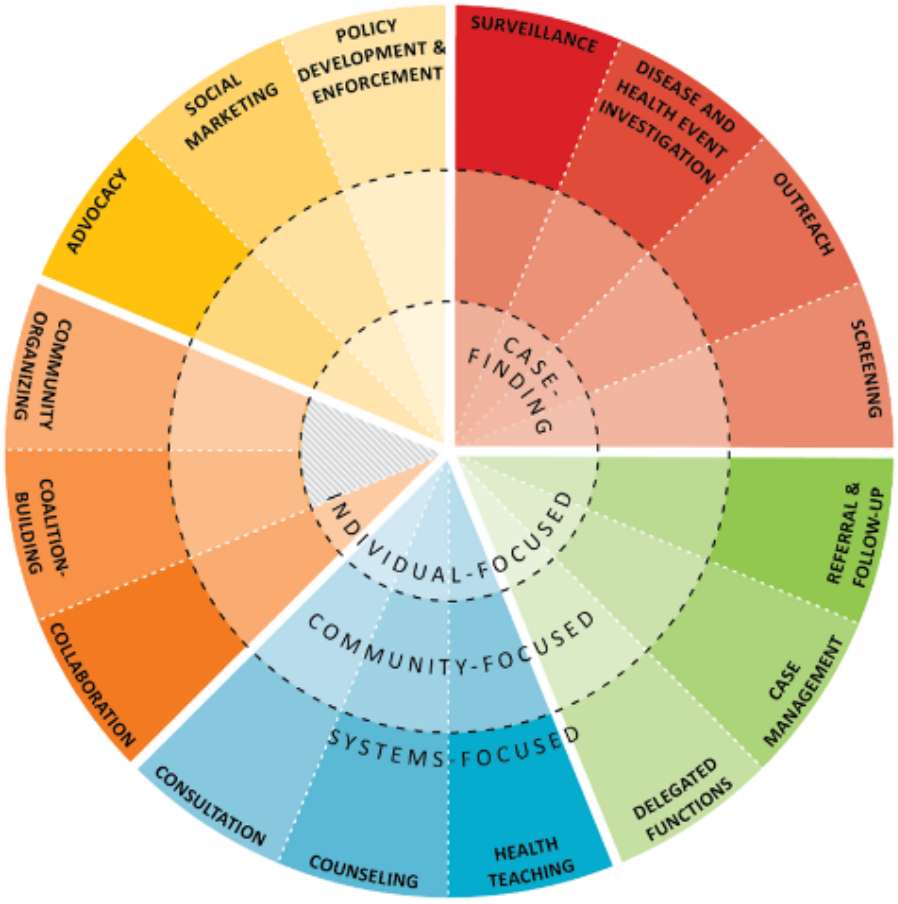

Figure 1. Minnesota Department of Health. (2019). *Public health interventions: Applications for public health nursing practice* (2nd ed.).