**Nursing Competencies for Community Assessment**

*The purpose of this checklist is to outline the expected behaviors of a school nursing as it relates to conducting a community assessment. The self-assessment can also be used to identify areas where further professional development may be needed.*

**Overall**

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| **Competency** | **Self-Assessment**D=DevelopingE=EmergingP=Proficient |
| **D** | **E** | **P** |
| Conducts community assessment using population-based, community engagement, socio-ecological/systems perspective (including multiple sources of data and remembering environmental factors). |  |  |  |
| Accepts authority, ownership, accountability, and responsibility of practice |  |  |  |
| Advocates for student and school population health: in policies, actions, appropriate staffing models, and removing individual and systemic barriers |  |  |  |
| Uses innovation and creativity to enhance school nursing practice and environment |  |  |  |
| Communicates activities, progress, and outcomes with administrators, school board, and community. |  |  |  |
| Documents each step in the nursing process |  |  |  |

# Step 1: Preparation/Gather Team

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| **Competency** | **Self-Assessment**D=DevelopingE=EmergingP=Proficient |
| **D** | **E** | **P** |
| Partners with students, families, interprofessional team members, and community partners to create, implement, and evaluate a comprehensive plan for change that leads to positive outcomes and quality care.* *Identify different stakeholders of school health to have a diverse group (this can include school and community personnel)*
* *The team can serve as an advisory group during the process.*
 |  |  |  |
| Leads efforts to establish, improve, and sustain collaborative relationships for the school community. * *Input from diverse colleagues bring insight that the others partners do not see.*
 |  |  |  |
| Leverages the expertise, unique strengths, and contributions of each team member.* *This may include who collects data or conducts interviews, as well as in developing plans.*
 |  |  |  |
| Creates a safe place for students, families, faculty, and colleagues to share and be themselves.* *Utilizes consensus building and evidence-based conflict management strategies.*
* *Allows all to speak and accepts multiple perspectives and lived experiences*
 |  |  |  |

# Step 2: Assessment

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| **Competency** | **Self-Assessment**D=DevelopingE=EmergingP=Proficient |
| **D** | **E** | **P** |
| Integrates from local, national, and global initiatives when planning community needs assessment.* *This may include data that looks at HealthyPeople 2030, state initiatives or county priorities.*
 |  |  |  |
| Uses national and regional standardized data set/systems when possible.* *Collecting and reviewing data already collected by trusted agencies helps ensure the quality and accuracy of the data.*
 |  |  |  |
| Validates data with population and/or interprofessional team.* *Multiple persons can gather the data, and then the team should look at it together, as expertise and experiences may interpret some data points differently or give important insight into the data findings.*
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# Step 3: Diagnosis

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| **Competency** | **Self-Assessment**D=DevelopingE=EmergingP=Proficient |
| **D** | **E** | **P** |
| Synthesizes population data to interpret findings of health status, health outcomes, and disparities.* *Looks for differences by populations, trends of concern*
 |  |  |  |
| Identifies strengths and abilities including resources, support system, health literacy, and engagement in self-care.* *Strengths of a community help when implementing the plan.*
 |  |  |  |
| Identifies gaps, potential risks of population including interpersonal, systemic, cultural, or environmental.* *Focus groups and key informant interviews can help understand why trends are occurring and the influence of policies, culture, environment on the trends. This information is needed to develop an appropriate plan.*
 |  |  |  |
| Utilizes assessment data when articulating the nursing/interprofessional diagnosis.* *Utilize the community diagnosis formula:*

***Risk of*** *(concern),* ***Among*** *(identify specific community),* ***Related to*** *(characteristics identified in the assessment that contribute to the risk (knowledge, motivation, skills, behaviors, environmental factors),* ***as evidenced by*** *data/measurable indicators that support the conclusion that an increased risk is present (can also use qualitative evidence).* |  |  |  |
| Prioritizes initiatives based on importance, severity, timeliness, trends, and readiness, as well as resources, impact and urgency of need.* *More than one issue may arise from the assessment-so prioritization is needed in the order things will be addressed.*
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# Step 4: Outcomes

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| **Competency** | **Self-Assessment**D=DevelopingE=EmergingP=Proficient |
| **D** | **E** | **P** |
| Engages community in developing outcomes. |  |  |  |
| Sets outcomes that are specific, measurable, attainable, realistic, time limited, inclusive, and equitable (SMARTIE)* *Think what would it look like if we were successful in our intervention, what do we want to see.*
 |  |  |  |
| Uses established benchmarks (i.e. Healthy People 2030)/promising practice to identify expected outcomes. Clearly state and document these goals (and communicate them with appropriate leaders).* *When making outcomes “measurable” there needs to be an objective number (i.e. 80% of the population will, 12% increase). The number can be hard to determine and so use the county or other goals already in place to help you determine a realistic number.*
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# Step 5: Plan & Implement

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| **Competency** | **Self-Assessment**D=DevelopingE=EmergingP=Proficient |
| **D** | **E** | **P** |
| Develops a holistic, evidence-based, innovative, population-based plan based on outcomes already established.*A nursing population-based plan includes:** *All 3 levels of prevention (1st, 2nd, 3rd) and ideally puts emphasis on primary prevention,*
* Addresses 3 different levels: student/family, groups, school, community, policy. (*A multi-tiered system of support framework should be utilized to include focusing on marginalized populations and those living in vulnerable situations, to avoid negative outcomes).*
* *Directly links back to diagnoses and outcomes that were derived by the community assessment.*

*An evidence-based plan includes interventions that are based on the best evidence or experiences available and should include multiple modes (education should NEVER be the only intervention).** *Interventions may include teaching (including evidence-based pedagogy), policy changes, advocacy, incentive programs, activities, screenings, health promotion campaigns, etc.*
* *As appropriate integrate technology, culture, and community traditions into the plan.*
* *Uses a variety of communication methods to share population-based messages.*
 |  |  |  |
| Engages community partners and alliances in plan development and execution.* *This includes not just the community stakeholders in step 1, but may include others who are experts in the field, have resources that can be leveraged, or are already addressing the issue (in the field or at the advocacy/policy level).*
 |  |  |  |
| Coordinates community efforts, systems, organization, and resources to implement plan. * *Partners with librarians, faculty, and community providers to address student, family, community health literacy needs and looks for cross-curriculum opportunities.*
* *Partners with community organizations and/or other school professionals to provide evidence-based health promotion and/or disease prevention programs to groups or entire community*.
 |  |  |  |
| Modifies plan based on continuous monitoring (see evaluation) |  |  |  |

# Step 6: Evaluation

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| **Competency** | **Self-Assessment**D=DevelopingE=EmergingP=Proficient |
| **D** | **E** | **P** |
| Evaluates process of conducting the community assessment* *Debriefs-seeking peer and community organization (step 1) input on how well the process went and what could be done differently in the future.*
* *Determines the safety, timeliness, effectiveness, efficiency, equitability of the process and plan developed.*
* *Throughout the plan evaluates the fidelity and application of interventions.*
 |  |  |  |
| Evaluates Community Plan* *Utilizes data, applicable standards (i.e. quadruple aim) to determine if outcomes have been met.*
* *Collects feedback from peers, students/family, teachers, supervisors, etc. Reviews and incorporates feedback into the plan.*
 |  |  |  |
| Reviews progress of outcomes and plan and modifies as needed. |  |  |  |
| Provides peers with formal and informal constructive feedback |  |  |  |

**Table of How Community Diagnosis Formula can help identify intervention group & evaluation:**

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| --- | --- | --- | --- |
| **Community Diagnosis Formula** | **Problem** | **Intervention** | **Evaluation** |
| **Risk of:** | Health problem | Program Goal | Outcome variables |
| **Among:** | Target population (at risk) | Target recipients | Intervention group |
| **Related to:** | Processes, conditions, factors | Interventions to address process/condition/factors | Outcome evaluation |
| **As evidenced by:** | Health indicators (rates) | Program objectives | Outcomes and impact variables |

(table from Georgetown, 2015)

**References**

Georgetown University. (2015). *Public Health Nursing Lecture: Community Assessment*.

National Association of School Nurses. (2016). Framework for 21st century school nursing practice. NASN School Nurse, 31(1), 45-53.

National Association of School Nurses (2022). School Nursing: Scope and Standards of Practice, 4th Edition. Silver Spring, MD: NASN.

**Created by the Center for School Health Innovation & Quality (2024) based on NASN’s Scope and Standards of School Nursing Practice (intentionally using wording from S&S for fidelity) with the intention of state and district leaders updating to include state or district specific laws or policies.**