Registered Nurse (RN)

Family Practice Setting

Preamble

The growing focus on primary health care as a means of providing proactive and coordinated care demands the attention of the primary health care system to shepherd this growth. A critical component in the strategic expansion and advancement of Nova Scotia's primary health care system is to enhance and expand inter-disciplinary collaborative care teams (see definitions p. 8) and the supports that enable those teams to design and deliver optimal care. The provincial Physician Resource Plan speaks to the need to shape the physician work force within the context of inter-disciplinary collaborative care teams that can respond most effectively to the primary care needs of the population while optimizing and sustaining health human resources in the long term.

Several provincial strategies are, at least in part, dependent on the presence of a Family Practice Nurse (FPN) working to optimal scope in a family practice setting. These strategies include but are not limited to collaborative care in primary health care, physician resource plan, chronic disease prevention and management, and public health renewal. The FPN is an essential member of collaborative primary health care team. Research evidence has demonstrated the positive impact FPNs have on chronic disease prevention and management (immunizations, diabetes, hypertension, care coordination), access to care, and work life balance for the team. Ideally, one FPN should work collaboratively with no more than 2-3 family physicians to promote therapeutic relationships with patients, efficient and effective teamwork, and optimal scope of practice for all team members.

Purpose of this Document:

A key health policy direction in Nova Scotia is the establishment of province-wide standardized roles to enable more consistent work practices at optimal scope of practice. The purpose of this document is to describe the intent of a standardized/consistent role for a ***Registered Nurse (RN)*** in a family practice setting (FPN).

It is expected that all *Registered Nurses* in Nova Scotia practice according to the standards defined by the *College of Registered Nurses of Nova Scotia* and no attempt was made to replicate these expectations in this document.

Role Summary:

The FPN partners with and complements other members of the health care team. The FPN functions as an integral member of the team for the achievement of patient and family-centred care, screening and health promotion, early detection of illness and disease, chronic disease management, continuity and coordination of care and enhanced access to programs, services and community resources. FPNs take a comprehensive, holistic approach to meeting the needs of the individual, family and /or community. The FPN develops professional relationships for the purpose of providing care in collaboration with the patient and family, other nurses and health team members throughout all stages of health and complexities of illness. The FPN independently provides safe, competent, compassionate, ethical nursing care to stable, predictable *and* unpredictable populations, and ensures the goals and needs of the patients and families are prioritized and individualized. Using the eight dimensions of patient-centred care (See definition p. 9), nursing knowledge, critical

thinking and clinical judgment, the RN engages in independent, interdependent and dependent functions to provide healthcare focusing on comprehensive assessment, patient/family education, and coordination of care.

Key Responsibilities:

I. COMPETENT PRACTICE

Assessment:

1. Determines pertinent aspects to include in assessment based on presenting health/illness issue(s), patient and family characteristics (e.g., age, culture, literacy) and timing (e.g., first visit, series of visits).
2. Performs an individualized comprehensive and focused assessment of health status, as well as risks that can affect long-term health. This may include, but is not limited to:
    - physical status,
    - psychological status,
    - spiritual status,
    - developmental stage,
    - functional ability,
    - self-care capabilities,
    - social/family interactions,
    - roles/responsibilities of the individuals/families/communities/client and caregivers,
    - learning capabilities, health literacy, education needs, and readiness to learn,
    - health beliefs and preferences,
    - health risks,
    - cultural influences,
    - patient's choice for level of involvement in their care,
    - need for advance care directives or 'do not resuscitate' documents, and
    - expectations/potential for living in the community.
3. Assesses determinants of health specific to the patient and situation (e.g., income, education, environment) and patient's strengths and assets (e.g., coping resources, family supports, community resources).
4. Assesses the unique health care needs/strengths of specific populations (e.g., chronic disease; mental health; first nations).
5. Monitors and reviews medications appropriately (i.e., medication reconciliation; OTC, prescription, alternative); and assesses adherence and access to medication (e.g., health coverage).
6. Integrates assessment data from other sources while maintaining confidentiality (e.g., patient chart, family, caregivers; lab/diagnostic results; reports from other health care providers).
7. Collaborates with individuals/families/communities and members of the healthcare team to collect, validate and expand assessment data.

Planning:

1. Analyzes assessment data to identify the individual/families/communities' needs and strengths (e.g., wellness, acuity, chronic disease).
2. Identifies factors that could adversely affect wellness and long-term health of the individual/family/community (e.g., personal preferences-lifestyle choices, non-adherence to treatment regime).

3. Uses a self-management support approach reflective of the patient's needs and strengths. Collaborates with the patient and family and other members of the healthcare team
    a. to identify and prioritize goals;
    b. to determine appropriate screening, monitoring, preventive and therapeutic interventions; and
    c. to anticipate expected outcomes.
4. Engages patient in determining capacity for patient and family involvement in plan of care.
5. Determines need for increased advocacy role during certain episodes of care (e.g., incapacity) and with different patient populations (e.g., children, patients with disabilities, etc).
6. Incorporates teaching, learning and long term health goals in the plan of care.
7. Integrates appropriate population health strategies into plan of care (e.g., family planning, sexual health teaching, immunizations).
8. Applies knowledge of pertinent nursing and related healthcare research and evidence to care planning (e.g., clinical practice guidelines); and uses current knowledge to justify plan of care.
9. Identifies resources required to support the plan of care.
10. Integrates inter-professional and multiagency factors into the care plan.
11. Negotiates with the individual, family, community, health care team, and service providers when there is a difference between the care plan and the wants, needs and strengths of the individuals / families / communities.

Implementation:

1. Engages patient as a member of the team and an active participant in care.
2. Collaborates and communicates effectively with individuals, families, communities, team member(s) and internal/external resources to implement and coordinate plan of care/services.
3. Adheres to standards, care directives, employer policies and procedures, and legal requirements during the provision of care.
4. Interacts with patients and families in a respectful, manner facilitating their growth and adaptation to their health care experience.
5. Provides culturally safe, competent and compassionate nursing care.
6. Implements identified interventions designed to achieve expected patient outcomes (e.g., screening and monitoring mechanisms; health promotion and injury/illness prevention activities; chronic disease management).
7. Uses self-management strategies and monitors patient progress with self-management plans (e.g., healthy choices, medication adherence, chronic disease) and behavior change (e.g., smoking cessation, healthy eating).
8. Practices effective aseptic technique, routine precautions, and other infection control practices as per established standards
9. Recognizes and responds effectively to urgent and emergency situations.
10. Consults other members of the healthcare team for guidance when unsure of action to take or practice requirements are beyond individual abilities and scope of practice.
11. Identifies appropriate action following consultation (e.g., provide guidance/direction to another care provider; assume care responsibility; transfer care responsibility).
12. Provides timely and accurate education that helps individuals/families/communities understand health/illness issue(s).
13. Provides education resources appropriate to client's literacy level and learning style (e.g. print materials, web sites).

14. Liaises with community resources to enhance patient education and ensures appropriate referrals to other community/provincial services and programs to achieve patient's health goals.
15. Articulates rationale for clinical decisions that are based on current theory and research
16. Uses information and communication technologies to support clinical decision making, patient education, safety, and care coordination (e.g., on-line literature and resources, database management systems of patient information, electronic information systems).
17. Maintains patient records that meet professional and legal requirements using appropriate/applicable technologies (e.g., electronic records).

Evaluation:

1. Monitors achievement of established goals and modifies plan of care in collaboration with other members of the health care team and client/family using evidence informed rationale for decisions.
2. Identifies and communicates expected and unexpected responses to care to appropriate care providers, in partnership with individuals/families/communities.
3. Regularly reassesses goals to determine relevance.
4. Responds appropriately to complications and unexpected events during provision of care.
5. Identifies need to recall patient for monitoring or change in care.
6. Recognizes patterns of health care needs within the population served, including health promotion and prevention and assesses the effectiveness of interventions over time.
7. Considers high risk trends in the community and proposes/participates in changes in patient screening, and health promotion/illness prevention activities (e.g., STI outbreaks, increased meningitis cases).
8. Discusses observations with and makes recommendations to interprofessional team and leaders to influence program development/evaluation.

Care Coordination:

The FPN supports coordination of care within the family practice team. In this role he/she:

1. Promotes and supports continuity of care by involving patient, family, and members of the health care team in all aspects of care.
2. Initiates and/or contributes to the development of an integrated interprofessional plan of care that extends within and across care settings (e.g., health promotion/illness prevention activities to diagnostic testing to hospitalizations; home care to LTC).
3. Consults with other health care professionals as needed while practicing within own scope of practice.
4. Collaborates with the family practice team to maximize efficient use of resources, energy, and time.
5. Promotes and supports continuity of care within and outside of the family practice team.
6. Identifies points in patient's care journey where continuity of care could be at risk (e.g., provision of care by different care providers, including patient/family, and/or in different care settings; patients new to practice; end of care for patients moving to a different family practice).
7. Identifies and uses established strategies to ensure accurate and timely transfer of information at transition points (e.g., transfer of care documentation/form).
8. Coordinates referrals as appropriate to care providers, services and resources based on needs.
9. Recognizes and supports the role of consultation within the health care team.

10. Works in collaboration with all team members including office support staff to enhance efficient and effective patient care flow.
11. Protects individual and family confidentiality, privacy and creates an overall environment that is safe and secure.

II. EXCELLENCE AND LEADERSHIP

1. Advocates for the rights of the patient and family and for provision of their unique care requirements.
2. Identifies system (environmental/unit) issues and offers recommendations of change.
3. Provides input into the development of employer policies/procedures and practices.
4. Participates in and supports the development and implementation of the plans, goals and objectives of the workplace.
5. Demonstrates a commitment to the values of the employer and the profession of nursing and acts in congruence with vision, value, and mission.
6. Uses human and material resources effectively and efficiently
7. Demonstrates appropriate professional and personal conduct when using information and communication technologies (e.g., confidentiality, restricted access to appropriate members of team, understands PIPEDA and PHIA requirements).
8. Fosters the development and maintenance of shared leadership through personal contribution and by supporting the contribution of colleagues in decision-making processes.
9. Maintains an acute awareness of the changes within the health care system that may affect the practice of registered nurses in Nova Scotia.
10. Functions as a change agent by thinking reflectively, questioning assumptions, assessing alternatives, and supporting change
11. Advocates for the nursing profession by contributing to an environment that supports and acknowledges other's contributions and successes
12. Provides guidance and support in a preceptor role to students, colleagues, and other personnel as appropriate, to assist in their orientation to work routines, roles and expectations.
13. Mentors colleagues in areas of expertise and seeks mentorship to achieve full potential in professional development.
14. Demonstrates a spirit of inquiry by examining current practice and uses research findings to improve outcomes of nursing care and shares in the dissemination of research finding.
15. Reflects on personal and team practice through a systematic evaluation of professional competencies; and acceptability, quality, efficiency, and effectiveness of practice.

III. SAFETY

1. Demonstrates accountability for practice using strategies such as providing rationale for decisions and actions, acknowledging errors, taking corrective action, recognizing own limitations and consulting with others as necessary.
2. Invites, expects and accepts constructive feedback from patients and families regarding the care and services the employer provides.
3. Identifies potential problem areas and participates in the collection of data for problem verification, and adverse event reporting.
4. Identify, promotes and implements a safe working environment by identifying and resolving potential risk issues
5. Implements safety measures to protect self and others from injury

6. Demonstrates ability to use equipment and supplies according to established standards and procedures.
7. Identifies trends in safety issues, reports appropriately, and participates in correction and prevention action plans
8. Participates in quality improvement activities, e.g. falls prevention and error management programs.
9. Facilitates healthy work environments that promote quality care practices.

IV. PROFESSIONAL PRACTICE

1. Assumes responsibility for clinical competence in designated area of practice consistent with current knowledge
2. Demonstrates accountability for own nursing practice by complying with Canadian Nurses Association (CNA) Code of Ethics, College of Registered Nurses of Nova Scotia (CRNNS) standards for nursing practice, the DHA/Employer standards and policies ad procedures.
3. Maintains certification in mandatory programs as required by the practice area
4. Complies with:
    - Legal requirements of licensure
    - Registered Nurses Act – including continuing competence
    - DHA/Employer Policies and Procedures
    - Freedom of Information and Protection of Privacy Act (FOIPP)
    - Other relevant legislation, e.g., PHIA
5. Maintains awareness of own values and ethical priorities and how they may impact on their own practice.
6. Develops therapeutic relationships with individuals/families/communities, displaying appropriate use of communication skills, respect, empathy and an understanding of the unique values of each individual/family.
7. Displays a collaborative attitude of mutual respect and valuing of others in interactions with individuals/families/communities and members of the inter-professional healthcare team.
8. Appropriately advocates on behalf of the individuals/families/communities including:
    - Providing access to information in consultation and collaboration with other team members
    - Consultation regarding ongoing consent for care
    - Promoting comfort and safety
    - Facilitating participation in decisions affecting care
    - Intervening effectively in situations where safety or well-being may be compromised; while respecting individual rights and diversity.
9. Recognizes and examines processes to correct unsafe practice issues or inappropriate professional conduct.
10. Identifies, achieves, and maintains own professional development needs and competencies, seeks appropriate learning opportunities and evaluates own learning.
11. Promotes and maintains effective interpersonal and inter-professional relationships by listening actively and communicating directly and seeks to resolve conflict in a respectful manner.
12. Ensures ongoing development and maintenance of own knowledge, skills and abilities through self-evaluation, feedback from colleagues, and identification of learning needs
13. Demonstrates commitment to continuous learning through participation in activities such as in-service programs, conferences, and appropriate continuing nursing and health professional education

14. Participates actively in the development of peers using methods such as sharing knowledge and resources, providing feedback, precepting, role modeling, mentoring and coaching.
15. Shares knowledge gained through attendance at conferences, in-services, etc. with peers.
16. Demonstrates a high level of skill in team building, collaboration, and conflict resolution.

V. WORKLIFE AND RELATIONSHIPS

1. Promotes a positive practice environment by:
   Respecting other's opinions, judgments and abilities
   Using proper channels of communication
   Managing conflict effectively
   Demonstrating flexibility and reliability
2. Facilitates open and meaningful communication within the health care team.
3. Recognizes the role self-care activities have on one's work performance (e.g., well-being exercises; balance work and home life).
4. Identifies system (e.g. environmental/unit) issues and offers recommendations for change.
5. Appears professionally attired with proper identification at all times
6. Guides and supports students and other personnel as appropriate.

References:

- CNA: Primary Care Toolkit, *CFPNA: Sample Role Description for Registered Nurses in Family Practice.* Retrieved September 4, 2013 from www.nurseone.ca
- CRNNS: *A Discussion Paper on Scope of Practice for Registered Nurses in Nova Scotia* (2009).
- CRNNS *Entry Level Competencies for Registered Nurses in Nova Scotia* (2009).
- CRRNS *Standards of Practice for Registered Nurses* (2012).
- CRNNS *Effective Utilization of RNs and LPNs in a Collaborative Practice Environment* (2012).
- Family Practice RN Position Description (Capital Health, 2011; GASHA, 2013)
- MOCINS: Standardized Role Descriptions, Registered Nurse (2009).
- Toronto Western Family health Team, University Health Network: *Competency Framework for Family Practice Registered Nurses.* Retrieved September 4, 2013 from http://pmh.toronto.on.ca/About_UHN/programs/MCC/Family_Community/FamilyPractice-RN/docs/Roles-Competencies-FINAL.pdf

Definitions

Collaborative Care[1]

Collaborative care is organizing and working as a team while effectively utilizing the separate and shared knowledge, skills and interests of patients, providers and office staff.

Team members identify, explore, manage and/or solve patient and population health concerns, with the best possible participation of the patients, families and communities, to improve health outcomes.

Collaboration recognizes, utilizes and respects the strengths and integrity of each team member's approach and contribution to care. The team, in collaboration with the patient, develops and utilizes a shared plan of care and establishes consistent approaches to care so that the individual patient's experience of care is consistent across the team.

The team practices in a way that optimizes scopes of practice for all team members including office staff and efficiencies in administering and delivering primary health care services.

Interdisciplinary Team

Different types of primary health care providers who collaborate and share responsibility for comprehensive and continuous primary health care for a practice population. The team consists of family physicians and at least one other provider type including, but not limited to, nurse practitioners, family practice nurses, dietitians, social workers, occupational therapists, physiotherapists, and/or community mental health workers. While office staff members are considered integral members of the team, they are not included as providers in this definition.

[1] Adapted from definitions in the following: 1) Guidelines for Collaborative Practice Teams and Employers of Nurse Practitioners: Strategies for Integrating Nurse Practitioners in Healthcare Teams (2012); 2) Collaborative Practice Incentive Program Working Group Recommendations to MASG for the 2011/12 General Practitioner Collaborative Practice Incentive Program (Dec 2011); 3) Implementation Strategies: "Collaboration in Primary Care-Family Doctors and Nurse Practitioners Delivering Shared Care" Way, Jones and Busing for Ontario College of Family Physicians (May 2000).

Patient-centred Care:

Eight Dimensions of Patient-Centered Care[2]

Respect for patients' values, preferences and expressed needs

Patients need to be recognized and treated as individuals. They are concerned with their illnesses and conditions and want to be kept informed.

- An atmosphere respectful of the individual patient should focus on quality of life.
- Involve the patient in medical decisions.
- Provide the patient with dignity, and respect a patient's autonomy.

Coordination and integration of care

Patients feel vulnerable and powerless in the face of illness. Proper coordination of care can ease those feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability:

- Coordination of clinical care;
- Coordination of ancillary and support services; and
- Coordination of front-line patient care.

Information and education

Patients fear information is being withheld from them and staff is not being completely honest about their condition and prognosis. Healthcare organizations can focus on three communication items to reduce these fears:

- Information on clinical status, progress and prognosis;
- Information on processes of care; and
- Information to facilitate autonomy, self-care and health promotion.

Physical comfort

Physical comfort has a tremendous impact on patient experience. Three areas were reported as particularly important to patients:

- Pain management;
- Assistance with activities and daily living needs; and
- Clinic surroundings and environment.

[2] http://www.nrcpicker.com/member-services/eight-dimensions-of-pcc/

Emotional support and alleviation of fear and anxiety

Fear and anxiety associated with illness can be as debilitating as the physical effects. Caregivers should pay particular attention to:

- Anxiety over physical status, treatment and prognosis;
- Anxiety over the impact of the illness on themselves and family; and
- Anxiety over the financial impact of illness.

Involvement of family and friends

Patients continually address the role of family and friends in the patient experience, and often express concern about the impact illness has on family and friends. Family dimensions of patient-centered care were identified as follows:

- Providing accommodations for family and friends;
- Involving family and close friends in decision making;
- Supporting family members as caregivers; and
- Recognizing the needs of family and friends.

Continuity and transition

Patients often express considerable anxiety about their ability to care for themselves. Meeting patient needs in this area requires staff to:

- Provide understandable, detailed information regarding medications, physical limitations, dietary needs, etc.;
- Coordinate and plan ongoing treatment and services; and
- Provide information regarding access to clinical, social, physical and financial support on a continuing basis.

Access to care

Patients need to know they can access care when it is needed. Focusing mainly on ambulatory care, the following areas were of importance to the patient:

- Access to the location of hospitals, clinics and physician offices;
- Availability of transportation;
- Ease of scheduling appointments;
- Availability of appointments when needed;
- Accessibility to specialists or specialty services when a referral is made; and
- Clear instructions provided on when and how to get referrals.

Appendix I

Practice of Nursing: Is defined in the RN Act as meaning the application of specialized and evidence based knowledge of nursing theory, health and human sciences, inclusive of principles of primary health care, in the provision of professional services to a broad array of clients ranging from stable or predictable to unstable or unpredictable, and includes:

(1) assessing the client to establish their state of health and wellness;

(2) identifying the nursing diagnosis based on the client assessment and analysis of all relevant data/information;

(3) developing and implementing of the client's plan of care;

(4) coordinating client care in collaboration with other health care disciplines;

(5) monitoring and adjusting the plan of care based on client responses;

(6) evaluating the client's outcomes;

(7) such other roles, functions, and accountabilities within the scope of practice of the profession which support client safety and quality care;

in order to

(a) promote, maintain or restore health;

(b) prevent illness and disease;

(c) manage acute illness;

(d) manage chronic disease;

(e) provide palliative care;

(f) provide rehabilitative care

(g) provide guidance and counseling; and

(h) make referrals to other health care providers and community resources;

and also includes research, education, consultation, management, administration, regulation, policy or system development relevant to the above.