

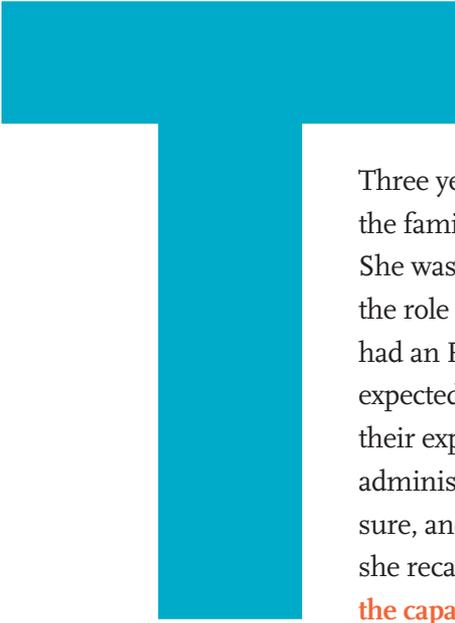


Primary care nurses have the skills – and desire – to provide more comprehensive care that will benefit patients.

BY MELISSA DI COSTANZO



Kathleen Boyd is a primary care RN at Southlake Regional Health Centre.



Three years ago, Newmarket RN **Kathleen Boyd** started working on the family health team (FHT) at Southlake Regional Health Centre. She was the team's first RN, and wanted to gain more insight into the role of a primary care nurse by visiting other FHTs that already had an RN on board. She was surprised by what she found. Boyd expected to see nurses practising autonomously in roles that demand their expertise. Instead, she saw RNs spending most of their day administering needles, triaging patients by phone, taking blood pressure, and recording heights and weights. **"It was very discouraging,"** she recalls. **"I was not expecting to see fully trained RNs working in the capacity of an RPN or administrative staff."**

Boyd's concern was that these nurses were not practising to full scope. They were not performing physicals or leading health-counseling appointments with patients. These nurses, she says, may not have understood the extent of their scope of practice.

"We are autonomous professionals who can work on our own appointments and see patients separately from the doctors," Boyd says, noting that for the sake of the profession and patients, "it's important...for us to develop our knowledge and use it."

After three visits to other FHTs over a three-week period, Boyd returned to Southlake, determined to work to her full scope. As her role developed, she began to take on quarterly diabetes visits. As she became more comfortable, she began doing well-baby visits, pre-operative assessments, and cognitive assessments for the elderly. "I took it step-by-step, (and) tried to identify where the gaps in care were, and where (I) could take some of the workload off the doctors."

The response was mixed, she admits.

Half of the physicians on the team embraced her contribution. Others did not. At times, Boyd says she would be in the middle of a diabetes assessment or counseling with a patient, and would be asked to administer a shot to a baby or call a patient with their x-ray results. It was disruptive to the therapeutic relationships she was developing with her patients, and

didn't take into account her desire and capacity to work independently.

Boyd politely – but firmly – talked to her physician colleagues. That conversation made all the difference in the world, she says. Now, they have a better sense of her professional capacity.

It's intimidating to initiate that kind of conversation, but Boyd recommends any RN who isn't practising to full scope, but would like to – and has the knowledge and skills – express themselves. "They are realizing how much we can do...and the power of a nurse," she says of most physicians.

This increased awareness can be linked, in part, to the spotlight RNAO is shining on primary care nursing and the vast

knowledge and clinical skill these nurses bring to community health centres, nurse practitioner-led clinics (NPLCs), FHTs, and other family practice settings. There are almost 4,300 primary care nurses (over 2,800 RNs and 1,400 RPNs) working in Ontario. However, the unfortunate truth is that thousands across Canada are not practising to their full scope. Nationally, it's estimated only 61 per cent of nurses who practise in primary care are actually doing what they've been trained to do despite being ready, eager and willing to take on additional responsibilities.

IN February 2012, RNAO launched the *Primary Care Nursing Task Force*, charged with responding to this issue. In June, the task force – comprised of a number of partners including the Association of Ontario Health Centres, the Association of Family Health Teams of Ontario, the Ontario Medical Association and RNAO interest group Ontario Family Practice Nurses – released a groundbreaking report called *Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario*. The report's 20 recommendations are targeted towards three main outcomes: improving timely access to quality primary care in the province; system integration and effectiveness; and cost savings for both the government and taxpayers. RNAO

It is wonderful to see RNAO engage so thoughtfully with proposals to improve the effectiveness, efficiency, and quality of health care. The focus on scope of practice, including an expanded role for nurses, addresses an area the Commission believed holds considerable promise."

DON DRUMMOND,
CHAIR, COMMISSION ON THE REFORM
OF ONTARIO'S PUBLIC SERVICES

Enhancing the role of primary care RN

The goal of every primary care organization must be to reach the highest current level of scope of practice (right) by the end of 2013.

Record presenting concern	Leads holistic assessments Implements nursing interventions based on direction	Leads and interprets comprehensive holistic assessments	Assists patients navigating through the health-care system
Prepare exam rooms	Supports care plan with interprofessional team	Identifies, plans and prioritizes nursing interventions	Provides comprehensive clinical procedures, health screening, and treatment
Clinic operation	Provides clinical services	Develops, implements and refines care plan with team	Leads chronic disease prevention, management and self-care
	Supports chronic disease management	Provides in-person and telephone counseling, triage and follow-up	Leads community analysis and planning
	Supports operation of clinic	Acts as an evidence-based champion in delivering care	Actively leads quality improvement initiatives
	Provides patient education		

sees this as the first step towards maximizing the role of all health professionals.

The report categorizes its recommendations in two phases. Phase 1 is geared towards ensuring the adoption of new role descriptions for RNs and RPNs – descriptions that were developed as a resource for primary care organizations to promote full scope of practice. These descriptions, which include key elements of practice taken from existing primary care nurse roles across Ontario, will maximize the role.

Recommendations for this first phase are targeted towards the Ministry of Health, RNAO, Local Health Integration Networks, and primary care organizations. They include: appointing a government committee that will convene for six months to ensure the suggestions in the report are implemented; designating a nurse lead at primary care organizations; and supporting primary care nurses to practise to full scope within interprofessional teams. All of the recommendations in Phase 1 have immediate deadlines.

The recommendations for implementation in the second phase were developed in an effort to expand the role of primary care nurses. They focus on amendments to key pieces of legislation, including authorizing RNs – within their level of competency, knowledge and skill – to prescribe, compound and sell medication, order diagnostic imaging, and communicate a diagnosis. The task force also wants to see support for RPNs

in executing clinical and educational programs that focus on health promotion and disease prevention; and support and funding strategies that allow at least 70 per cent of primary care nurses to work full time. Deadlines for the second phase span from 2013 to 2015.

Once implemented, these recommendations are expected to stretch beyond the primary care sector. Long-term care and home care will also reap positive spinoff, says RNAO CEO Doris Grinspun, co-chair of the task force. “This report will produce whole system change,” she says. “We focused on primary care initially because that’s where patients first have access to the system, and that’s where system change should begin. But it will extend way beyond that.”

The Association of Ontario Health Centres (AOHC) shares this view. In fact, the association’s 73 community health centres, 10 aboriginal health access centres and 15 community FHTs share a common goal: to ensure all health providers work to their full scope of practice within three years, says Executive Director Adrianna Tetley. Many CHCs, she adds, do use RNs and RPNs to full scope and most of the others are committed to getting there.

Tetley says the task force report is a pivotal first step in transforming Ontario’s primary care landscape because it clearly defines the roles of the RN and RPN in this sector.

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DORIS GRINSUN,
RNAO CEO and CO-CHAIR,
PRIMARY CARE NURSING TASK FORCE

Distinguishing these roles will have implications on other health-care professionals such as dietitians and pharmacists, she adds. “Their roles are going to shift (when nurses are working to full scope),” she says. RNAO’s report “becomes a starting point to have that conversation.”

Judie Surridge, president of RNAO’s Ontario Family Practice Nurses (OFPN) interest group, and a family practice RN at Toronto’s Women’s College Hospital, co-chaired the task force alongside Grinspun. She thinks one of the key reasons primary care nurses are not working to full scope is because health-care professionals – nurses included – are not fully aware of the spectrum of care RNs and RPNs can provide. RNs have valuable expertise in chronic disease management, health promotion and disease prevention. This is in addition to traditional skills such as administering needles and taking a patient’s blood pressure.

Surridge believes one of the root causes of the role confusion is the fact that many primary care nurses have an acute care background, and have not been exposed to primary care workplaces during their undergraduate placements. Working in primary care is attractive because the hours are typically nine to five, Monday to Friday. But Surridge asks: “if you haven’t worked in some kind of a primary care clinical setting (before) you graduate, then how do you know what that looks like?”

Learning about the full extent of the primary care nursing role as students will give the next generation of nurses a better grasp of their scope. They will be in a better position to communicate clearly to other members of the interprofessional team exactly what they’re capable of doing, says Surridge. This is why the report contains a recommendation to Ontario’s nursing schools to immediately secure clinical placements in primary care for RN and RPN students.

Surridge further points out that educational opportunities should not stop at the post-secondary level. They must continue into the workplace, she says. Courses and nurse-to-nurse mentorship help primary care RNs and RPNs feel skilled and comfortable in their roles, and ensure patients are receiving the best care possible.

The task force report directly addresses this, calling on the Ministry of Health to provide immediate funding for RNAO to develop a primary care nursing-focused learning institute for both RNs and RPNs. The institute, which is expected to take place in the summer of 2013, is a key step to help nurses strengthen their knowledge, skills and confidence. “If there’s nobody to show you how you can maximize your role, figuring it out yourself...can be a huge drawback,” says Surridge, noting that some nurses may find themselves battling with physicians or NPs because there’s inconsistency in how the role is visualized.

We welcome RNAO’s report and...appreciate the importance of a focus on primary care as an underpinning of a high performing health system.”

PAT CAMPBELL
PRESIDENT AND CEO, ONTARIO
HOSPITAL ASSOCIATION

Funding models for primary care can also create a barrier to nurses’ scope of practice. Currently, physicians are compensated when they carry out duties that can fall into primary care nurses’ capabilities, such as assessments. This means nurses’ responsibilities are often determined by the doctor, explains Nicole Nitti, a family physician and medical director at Toronto’s Access Alliance Multicultural Health and Community Services.

She thinks nurses can help speed up patients’ access to primary care by taking certain responsibilities off physicians’ plates. A diabetes assessment is one example. “Nurses practise nursing and doctors practise medicine,” Nitti says. “There is significant overlap (between the roles), which is nothing to be afraid of, but the thing to remember is that nurses bring a whole other piece that has been under-emphasized in primary care for so many years – a holistic, health promotion approach.”

An avid and vocal supporter of allowing nurses to practise to full scope, Nitti attended the launch of *Primary Solutions for Primary Care* at Queen’s Park in June. She advocates for the empowerment of nurses because “they are a key piece in a sustainable health-care system in Canada.” But she acknowledges not all physicians are on board.

“Traditionally, primary care was the family doctor in the family doctor’s office with the nurse sitting at the front desk,” she says. “Our health-care culture is really steeped in that. (Focusing on) team-based care (requires) a real shift in thinking.”

Nitti says she realized early into her career that nurses are allies on the health-care team. “I can think of a number of cases where if a nurse hadn’t stepped in and said ‘what about this?’ or ‘what do you think of this?’ I would have made an error.”

When Nitti was practising as an emergency room physician at a Toronto hospital, she was called in to examine a patient who had blood in her urine. She diagnosed the patient with vaginal bleeding, arranged for a consultation with a gynecologist, and left her shift. An RN on duty would later discover the patient had a rectal bleed, and arranged to have the patient transferred to receive rapid care from an on-call ER physician. “We need to listen to nurses,” says Nitti, recalling the experience. “Especially in primary care, when, sometimes, they have closer and more frequent contact with the patients than we (doctors) do. They might

Nurses and all health professionals must be supported to deliver the best value possible to Ontario’s patients. AFHTO was a proud member of this task force, and we commend RNAO for assembling a wide group of stakeholders to examine the evidence and explore how our health system can reap the full benefit of the competencies, knowledge, and skills of our primary care nurses.”

ANGIE HEYDON
EXECUTIVE DIRECTOR, ASSOCIATION OF
FAMILY HEALTH TEAMS OF ONTARIO

pick up on something we’ve missed.”

The task force report speaks to the issue of physician compensation through a recommendation that challenges the Ministry of Health and the Ontario Medical Association to revamp physician payment models. This will ensure all health professionals are working to their full scope, while ensuring fair compensation for physicians.

Another recommendation urges the ministry to “develop a uniform and streamlined process to apply for additional funding to increase health human resources for primary care organizations when patient enrollment targets are met, and infrastructure capacity exists.” Thunder Bay’s Lakehead NPLC is one example, says Grinspun, who hand-delivered a request to Health Minister Deb Matthews last February. “Lakehead NPLC met its targets long ago. It has two exam rooms fully equipped and is still waiting for the government to approve its funding to add staff,” she says. “Meanwhile, patients without a primary care provider are waiting to enroll.”

Recruitment of nurses into primary care is a challenge recognized by many in the sector, including Judith Manson, executive director for the Sunnybrook FHT in Toronto. She represents the Association of Family Health Teams of Ontario on the task force. “If we want to recruit good people, we’ve got to make sure they’re being paid appropriately,” she says. “We’ve got to get the message out that these are good jobs.” This will lead to higher job satisfaction

and retention, the task force argues. It will also mean stronger continuity of care for patients, and will help to expel the image of a primary care nurse “putting people in rooms, giving shots and not doing much else,” says Manson. “That old paradigm... is not true, but it’s still out there, even within the nursing group,” she says, adding: “We’ve got to educate our own.” This includes relaying real-life stories of nurses who have been working in primary care environments for years, says Manson. Some nurses have provided care to generations of families, which can be a very rewarding experience, she explains.

Building a strong rapport with patients is gratifying for RN Karen Lue-Kim, who works to her full scope at Lakehead’s NPLC. She says her patients appreciate her experience and knowledge, and the amount of time she spends with them. Many comment that they like discussing more than one health concern with her. In other health-care settings, patients are often booked to talk about one health issue. They are sometimes more willing to come back to the clinic, if necessary, because “they know there’s going to be that interaction,” Lue-Kim says. As a result, they want to take better care of their health.

NPs at the Lakehead clinic developed the RN and RPN roles in concert with Lue-Kim and RPN Michele Grace, who has taken on diabetes teaching because that’s her area of expertise. This frees up time for the NPs to focus on more complex cases, explains Pam Delgaty, clinical director. “We went over what jobs might be designated to them, keeping in mind their scope, their level of comfort and experience,” the NP explains. “We’re all nurses, and we all contribute together to meet the patient’s needs. We’re a team and collectively, we all have value.”

The Lakehead clinic opened in November 2010 and hit its capacity of 3,200 patients in less than one year. Lue-Kim helps to meet the demand, often offering same-day primary care for patients. In addition to taking pressure off NPs in the clinic, working to her full scope puts less stress on emergency departments and walk-in clinics in the community, she says.

Her schedule is always bustling. She’ll see anywhere from four to 11 patients daily. Typically, she’ll perform baby exams and physicals, administer immunizations, or look after patients with sore throats. She

triages patients over the telephone, speaking with clients who have medication concerns or providing advice to those who are ill. The clinic is also developing a medical directive for an RN to prescribe medication for a urinary tract infection.

One of the second phase recommendations set out by the task force urges the College of Nurses of Ontario to implement regulatory changes that authorize RNs (in the general class) and RPNs to dispense medications. The document also advocates for RNs to be sanctioned to identify and communicate a diagnosis (within their level of competency), and suggests a shift away from medical directives, enabling RNs to

consistent, in-depth care to patients. “I get tremendous satisfaction from my role here,” she says. “The job satisfaction, the personal fulfillment of being able to provide that care and build that rapport with the patient is amazing.”

The task force shares Lue-Kim’s wish, which is why its co-chairs Grinspun and Surridge have said they will continue to hold stakeholders’ and politicians’ feet to the fire to adopt all the recommendations by 2015. Doing so will lead to a brighter future for primary care in Ontario, Grinspun says. Phase I of *Primary Solutions for Primary Care* is currently in progress, and the report has already been adopted by



(L to R) RN Karen Lue-Kim, RPN Michele Grace and NP Pam Delgaty practice side-by-side at Thunder Bay’s Lakehead Nurse Practitioner-Led Clinic. Each works to their full scope thanks to their dedication to defining nursing roles, and an appreciation for the expertise each brings to the table.

take on the full responsibilities of prescribing and dispensing. Implementing these changes would mean the number of patient visits could be kept at bay, and doctors and NPs would be free to see complex clients.

For example, nurses often review all birth control options with their patients. If a client chooses to use birth control pills, and there is a supply on hand, only an NP, doctor or pharmacist (or, in Lue-Kim’s case, an RN under a medical directive) can dispense the medication. If none are available, the RN completes the assessment and the patient has to make a follow-up appointment with a physician in order to fill the prescription.

Lue-Kim hopes in the future, all primary care nurses enjoy the satisfaction of working to full scope and providing timely,

the Joint Provincial Nursing Committee, which is comprised of leading government civil servants and nursing stakeholders. “It’s RNAO’s duty to be a leader in shaping the health system,” says Grinspun. “Our role now, as nurses and as members of our community, is to mobilize everybody for speedy uptake of all the recommendations in this report, so the vision can become a reality, sooner rather than later.” **RN**

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In October, RNAO released *Enhancing Community Care for Ontarians (ECCO)*, which builds on some of the recommendations contained in *Primary Solutions for Primary Care*. To read about ECCO, turn to *Policy at Work* (pg. 24).