Primary Care Nursing in Alberta: A guide to the role

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Organizational Collaborators

Introduction

Primary Care Nurses are valuable team members in the Patient's Medical Home. They can provide a broad range of health services dependent on professional designation/scope of practice, that are tailored to the needs of the patient population. We encourage team members to reflect on their practice utilizing Health Quality Council of Alberta (HQCA) data, encounter records as applicable, EMR data, and subjective experiences to initiate a discussion about the key focus areas of the primary care nurse within the clinic.

Please use this document to guide conversations about each team member's role and sharing patient care within the medical home. This document may be used to guide orientation in a PCN nursing program, open discussions about shared care with the MRHP, or as a resource for currently practicing Primary Care Nurses to guide their appointment structure.

To guide orientation or shared care, select all areas that may benefit your current patient panel within your clinic, indicating priority areas in the second column of the role categories checklist below. Use the nurse appointment summary to consider areas of joint responsibility and review expectations of care in the appointment type.

The APCNA Definition

Primary Care Nurses are LPN's, RN's and NP's who work to their full scope of practice as part of a multidisciplinary team to enhance the primary care services provided in Alberta. As regulated professionals, Primary Care Nurses are accountable and liable for clinical decision-making. The Primary Care nurse typically works alongside a MRHP, clinic staff and other allied health professionals creating a healthcare team and making up the Patient's Medical Home. Primary Care Nurses act as specialty generalist in primary care, providing care to patients across the lifespan. Primary Care Nurses adjust their practice to meet the medical home and health neighborhood needs, often bridging gaps in accessibility to healthcare, and enabling positive patient experiences and outcomes. They are integral to patient management and navigation of the healthcare system. Primary care nurses also play a key role in quality improvement on a clinical, community and provincial level, supporting system linkages between primary and secondary health care.

The Vision

The APCNA wishes to have the full scope of the role of Primary Care Nurses in Alberta realized. We want medical professionals to understand the role of the Primary Care Nurse, from the educational system all the way to implementation. This will allow consistent messaging to patients and improve understanding and expectations of the Primary Care Nurse and their medical home. All Primary Care Nurses should have access to quality education and resources for nursing in this specialized field. APCNA will continue to be a source of truth for the role of the Primary Care Nurse and is ready to serve the government and the stakeholders of Alberta.

Primary Care Nurses are a valuable member of the Patient Medical Home. They can provide a broad range of health services dependent on professional designation/scope of practice, that are tailored to the needs of the patient population. These services can include but are not limited to:

Health Assessment and Promotion

- Well child assessment
- Geriatric functional and cognitive assessment
- Preventative health care and cancer screening
- Reproductive health assessment and counseling
- Pre- and postnatal care
- Urgent appointment triage

Chronic Disease Management

- Arthritis
- Congestive heart failure
- COPD/Asthma
- Dementia/Alzheimer's
- Diabetes
- Dyslipidemia
- Hypertension
- Mental Health
- Weight Management

Primary Care Interventions

- Cervical cancer screening
- Injections and immunizations
- INR management
- Medication review
- Procedure assistance
- Spirometry
- Wound care
- Cryotherapy
- Cerumen impaction removal
- ECG

Quality Improvement Initiatives

- Enhance access
- Improve clinic efficiency
- Process and policy development
- Teamwork
- Measurement and data

Nurse Appointment Summary

All assessments should include past medical history (PMHX), best possible medication history (BPMH), record of appropriate immunization status, vital signs including but not limited to height and weight, and goals of care (GOC) review as needed.

Health Assessment and Promotion	Notes

Well Child Assessment

- Pediatric health assessment and documentation based on age-appropriate Rourke Baby Record for the appropriate age
- Conduct appropriate measurements, including but not limited to length/height, weight, and head circumference
- Discuss any concerns and questions from parents
- Discuss nutritional intake, including but not limited to breastfeeding, formula feeding, introduction to solids.
- Discuss fluid intake/output, bowel health, general safety, safe sleeping habits, developmental milestones, immunization status
- Discuss well-child visit appointment intervals

Adult Physical Assessment and Driver's Medical

- Assess vision, as required
- Review any patient concerns or questions
- Conduct preventative health screening, including but not limited to, general health and well-being, cognition, sleep habits, stress, diet, exercise, contraception/STI, safety measures, living conditions, social support, substance use, and intimate partner abuse.
- Conduct any other assessment and/or screening, including but not limited to, preparing requisitions, as appropriate using ASaP Maneuvers, Choosing Wisely Recommendations, Canadian Task Force on Preventive Health Care, and Canadian Council of Motor Transport Administrators.
- Immunization counselling, including, but not limited to HPV and Pneumococcal.
- Clinic and MRHP dependant – conduct all or some portions of review of systems and head-to-toe assessment.
- Discuss any required follow-up based on information gathered in visit.

Geriatric Considerations

- Complete Functional Assessment, as required, including, but not limited to: Edmonton Frailty Scale.
- Review activities of daily living (ADL) and self- or assisted-medication administration
- Cognitive screening, as appropriate (RUDAS, SLUMS, etc.)
- Discuss home care and/or other community supports, as appropriate

Reproductive Health Assessment and Counselling:
General Women's Health Visit Considerations

- Urinary function
- Bowel function
- Pelvic pain and/or dyspareunia
- Breasts (pain, discomfort, discharge)
- Breast self-exam teaching
- Updated cervical cancer screening as per guidelines

General Men's Health Visit Considerations

- Updated prostate screening as per guidelines
- Testicular self-exam teaching
- Testosterone therapy teaching
- Obstructive urinary disease screening
- Reproductive health screening including but not limited to erectile dysfunction

Contraceptive Counseling Visit

- Can be done with all patients, of any gender
- Review patient's contraceptive goals
- Review emergency, hormonal, non-hormonal, and natural options
- Review sexual behaviors and support and/or provide STI screening, as appropriate

Menopause Counselling

- Assess for factors related to the cause of menopause, including, but not limited to increased cardiovascular risk, increased osteoporosis risk, insomnia, psychological stress, body structure and function changes, atrophic vaginitis, and urinary or other pelvic floor concerns.
- Discuss conservative management techniques.
- Discuss pharmacological treatment, as appropriate.
- Refer to other healthcare providers, as needed.

Prenatal Care

- Discuss any questions or concerns
- Nutritional counseling
- Exercise counseling
- Provide information on genetic screening available – public and private paid options
- Measure fundal height, as appropriate
- Auscultate fetal heart rate, as appropriate
- Discuss other appropriate teaching [trimester dependent] including, but not limited to, expected physiological changes, diagnostic imaging, routine bloodwork, labor and birth, postpartum recovery.
- Discuss plan of care including, but not limited to, referral, continued visit, appointment schedule

Postnatal Care considerations

- Discuss spouse/family/friend supports and transition to motherhood
- Assess lochia, vaginal or cesarean incision healing (birth-dependent) and breast/nipple health
- Assess assist with breastfeeding as needed.
- Return to physical and sexual activity counseling, as appropriate with postpartum healing
- Discuss psychological well-being and assess/screen for postpartum depression, anxiety, and psychosis, as appropriate
- Refer to Pelvic Health Physiotherapist and/or Psychologist, and other community resources, as appropriate

Urgent Appointment Triage

- Review incoming patient requests and coordinate care appropriately (Rx refills, paperwork updates, symptom deterioration, post med-change, etc.)

Arthritis

- Focused history and pain assessment
- Assessment of impact on ADL such as HAQ-11
- Discuss chronic pain- see below
- Screening for comorbid conditions (including mental health)
- Nutritional counseling (obesity avoidance, calcium vitamin D)
- Exercise such as GLA:D
- Community OT referral for home safety or mobility aid
- Preoperative assessment and postoperative self-care
- Systemic anti-inflammatory medication injection with patient teaching
- Advocate and follow the MSK Clinical Pathways for Shoulder & Soft Tissue Knee Assessment

Congestive Heart Failure

- Focused assessment with review of recent history of exacerbations and impacts on ADL
- Review daily weights
- Review diagnostics (BNP, Xray, Echo EF, ECG)
- Assess for comorbid conditions including mental health and sleep disturbances
- Discuss dietary interventions (including ETOH consumption, salt, and fluid consumption)
- Discuss healthy activity levels
- Medication teaching where appropriate
- Discuss smoking cessation
- Review heart failure action plan and RX

COPD/Asthma

- Focused assessment with review of recent history of exacerbations and impacts on ADL
- Confirm severity with a validated tool (MRC scale, CTS Asthma Class and severity)
- Inhaler usage education
- Discuss trigger avoidance
- Review preventative actions (vaccination, smoking cessation, hand hygiene, breathing techniques, allergies)
- Review or initiate COPD/Asthma action plan
- Screen for comorbid conditions including mental health
- Spirometry or peak flow coordination
- Refer to specialist link pathway COPD
- Encourage Pulmonary Rehab where appropriate

Chronic Pain

- Uses a trauma-informed and functional approach to care
- Focused pain assessment assessing for impact on ADL (Brief Pain Inventory)
- Assess for comorbid conditions including mental health and sleep disturbances
- Discuss non-pharmacological therapies to manage pain
- Initiate multidisciplinary referrals for patient
- Educate on risks of opioid therapy (opioid risk tool) facilitate informed consent prior to initiation
- Establish realistic and patient centered smart goals
- Naloxone and opioid safety teaching
- Ongoing assessment of potential side effects (cognitive decline, falls ect).
- Recommend appropriate physical activity (example GLAD hip and knee)

Diabetes

- Discuss acceptance of disease diagnosis, including, but not limited to GAD and PHQ-9, as appropriate
- Discuss diabetes as a chronic and progressive disease that needs ongoing and increased treatment over time
- Discuss aspects of vascular health and reasons why ABCDE's of diabetes are important for prevention of diabetic complications
- Review smoking cessation and Framingham risk score, as appropriate
- Review blood work results, as available
- Review of SMBG, if applicable
- Review medication, including insulin or medication adherence and adjustment, as well as proper insulin injection and site rotation techniques
- Teaching regarding nutritional intake, physical activity, safe driving, hypoglycemia, sick day protocols and emergency situations, and insulin adjustment
- Complete diabetic foot exam, as due, and provide foot care teaching

Dyslipidemia

- Conduct Framingham risk score
- Review diagnostics and update according to protocol (Ex. ECG, ALT, CK)
- Discuss dietary interventions
- Discuss healthy activity levels
- Medication teaching where appropriate
- Discuss smoking cessation

Hypertension

- Review home BP log
- Review diagnostics (last ECG, chemistry and electrolytes, urinalysis, lipid profile and blood glucose; prep requisitions if due)
- Assess for comorbid conditions including mental health (stress)
- Discuss dietary interventions (including ETOH consumption)
- Discuss healthy activity levels
- Medication teaching where appropriate
- Discuss smoking cessation

Mental Health

- Conduct appropriate mental health screening, as appropriate, including, but not limited to screening for ABBAS (A- ADHD, B- Bipolar, B-Borderline Personality Disorder, A-Anxiety, S- Substance abuse)
- Assess for imminent harm and/or danger to self and/or others
- Discuss changes in mood, sleep pattern, nutrition, physical activity and assess for barriers
- Screen for signs and symptoms of abuse, trauma, and substance misuse
- Use Cognitive Behavioral Therapy, and other clinical tools, as appropriate
- Discuss healthy coping strategies
- Prepare medication refills
- Refer to interdisciplinary team members, as appropriate
- Navigation of community resources, as necessary

Substance Misuse

- Obtain emergency contact information
- Review past and current misuse – both licit and illicit, with mode of use (ex. Injection, oral) with a trauma informed lens
- Use appropriate screening tools (CAGE, POMI, ACE's)
- Motivational interviewing with harm reduction focus
- Utilize appropriate treatment pathways, as needed (Connect MD)
- Overdose education (ensure naloxone kit education done)
- Advocate and educate on potential pharmacotherapy treatment
- Counsel and supervise induction of OAT, as appropriate
- Educate on community resources for addiction therapy (Access 24/7)

Weight Management

- BMI, and abdominal circumference
- Use tools to guide patient interaction and management, assess root causes of weight gain and disease severity, including but not limited to: 5As of Obesity Management, 4Ms framework, and Edmonton Obesity Staging System.
- Use a trauma-informed and best-practice lens to treat the root causes of obesity with the goals of obesity management being improved health and well-being, and not just weight loss.
- Assess compounding healthcare considerations, including but not limited to, mental health concerns/illness and sleep disturbances.
- Educate on dietary interventions and activity successes and assist in creating S.M.A.R.T. goals, with a broader focus than solely weight loss.
- Discuss pharmacological options, where appropriate, and titrate medications, as needed.
- Refer to interdisciplinary team members, as needed

Primary Care Interventions	Notes

INR Management

- Patient education on common drug and diet interactions and activity safety
- Patient education lab work frequency and follow up
- Collaborate with MRHP or pharmacist on maintenance dosing or adjustment algorithm
- Optimization of medication adherence emphasizing the need for same time dosing (ex bubble packs)
- Patient education about missed dose
- Document and update patient Warfarin record sheet
- Educate and assess for signs and symptoms of bleeding

Medication Review

- Patient education on common drug and diet interactions and activity safety
- Review for OTC medications or diet changes
- Assess for side effects
- Optimization of medication adherence (ex. bubble packs)

Cerumen Impaction Removal

- Assess ear canals for cerumen impaction
- Discuss hearing changes and/or pain due to cerumen impaction
- Irrigate using warm water and check often, if cerumen not removing easily
- Once cleared, assess ear canals and tympanic membranes
- Post-procedure assessment including, but not limited to, dizziness, changes to hearing, and/or pain.
- Provide post-procedure teaching, including but not limited to: relieving water in ear canal, when to return to clinic, and what to do if cerumen not removed at that visit.

Cryotherapy

- After assessment and diagnosis by MRHP, Primary Care Nurse can initiate treatment
- Primary Care Nurses cannot conduct cryotherapy on genitalia and mucous membranes
- Perform steps of cryotherapy, including pre- and post-care
- Complete patient teaching, including, but not limited to frequency and timing of follow-up treatments

Injections

- Obtain order from MRHP on injectable, including but not limited to: medication/vaccine, reason, dose, route, timing/frequency.
- Types of injections include, but are not limited to:
- Antineoplastics
- Antipsychotics
- Depot contraceptives
- Immunotherapy (allergy shots)
- Immunizations
- Iron
- Testosterone
- Vitamin B12
- Appropriate teaching including, but not limited to: pre-injection, common side effects, adverse reactions, post-injection, self-injection, and any relevant teaching if medications are listed as known or potentially hazardous.

Procedure Assistance

- Can assist with procedures including, but not limited to: skin biopsies, IUD insertion and removal, and endometrial biopsies, as well as the set-up of sterile technique.

Primary Care Interventions Cont...	Notes

Wound Care

- Provide education on prevention of wounds for at-risk patients
- Obtain history related to wound(s), including, but not limited to: comorbidities, current pharmacological treatments, nutritional status, smoking status, and body habitus
- Assess extent of injury (ex. M.E.A.S.U.R.E mnemonic)
- Assess wound for infection (ex. N.E.R.D.S. and S.T.O.N.E.E.S. mnemonics) and culture swab, if required
- Assess pressure ulcers with grading scale – stage I, II, III, IV or unstageable
- Cleanse and debride the wound, as required (Sharp debridement is considered incorporation of a restricted activity)
- Dress the wound, as required, provide patient education and clinical recommendations for products as needed
- Use strategies (DIMES) AHS Wound Care Guideline, as required
- Assess wound healing (ex. B.W.A.T. tool)
- Refer to other healthcare professionals, as required

ECG and Spirometry - if equipment available

Qualtiy Improvement and Care Coordination	Notes:

Enhance Access

- Assist with day-of appointments
- Nurse-led appointments
- Triaging phone calls

Improve Clinic Efficiency

- Leading with Team based care
- Improving Clinic processes where applicable

Home care ect

- Connect patients with community supports or other providers within their health neighborhoods such as SAGE, social workers or group health programs
- Social screening; ex. domestic abuse and reducing impact of financial strain