Nurse Coordinator Skills Checklist

To be completed by all Clinic providers prior to RN recruitment

Nurse Coordinator Role
Overview
Supports the patient with a team-based approach in the family practice setting. Supports the patient along the continuum of maintaining health, improving health, and living with illness to the end of life. This involves ○ health promotion and disease prevention ○ self-management of chronic disease ○ care planning ○ assessing patient knowledge and providing education ○ direct care skills and procedures ○ collaboration with primary care providers, MOAs, and the full PCN clinical support team (social worker, dietitian, occupational therapist, pharmacist, physiotherapist, psychologist, Indigenous health coordinators, off site hub nurse) ○ navigation of community resources and specialized community programs The Nurse Coordinator works as a team member within the clinic and strives to embed themselves into the clinic culture to support the patient and care team. The NC will start with a skillset that will build over time in response to the clinic, program, and professional development goals with the support of PCN leadership, the knowledge coordinator and peers.

Note: Items with checkmarks are an expectation of every NC in clinics	
Nurse Coordinator Skills *(For the full scope of practice of a Registered Nurse, please review the MoH RN Scope of Practice Document)* *https://www.bccnm.ca/Documents/standards_practice/rn/RN_ScopeofPractice.pdf*	Check which skills you would like the Nurse Coordinator to perform And put a *next any top priorities
Intake and Assessments	
Panel review and follow up	
New patient intake / health history/ chart review and prep	
Physical assessment/biometrics pre/post physician visit	
Specimen collection	
Point of care testing (glucose, pregnancy, urinalysis)	
Medication review, reconciliation, education	
Screening assessments: mental health, pain, cognitive (ie., MMSE, MoCA, PHQ-9)	
Lower limb/ foot assessment / education	
Assistance with driver's medical exam report	
Health promotion / prevention/disease management / follow up	
Screening with Lifetime Prevention Schedule Guide	
Immunization education / Vaccine administration	
Flu Clinic*	
Assist with complex care visit (pre or post / documentation)	

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Chronic disease care planning and follow up using clinical practice guidelines (i.e., COPD, diabetes, CKD, cardiac, frailty, obesity, mental health and substance use, high risk)	√
Coaching /education/ goal setting for health maintenance, risk factors, symptom management, lifestyle changes	√
Complete consults, laboratory requisitions, diagnostic imaging requisitions with patient specific order.	
Mental health adult and youth support and care coordination	
Coordination and referrals to PCN allied health clinicians	√
Coordination and referrals to specialized community programs (ie., MHSU, H&CC, SH&W)	√
Assistance with forms: Special authority, Disability Tax Credit, Long Term Disability forms (in collaboration with other professions)	
Pelvic Exam/STI assessment and testing *	
Contraceptive management *	
Medication adjustment with patient specific orders (i.e., INR, insulin)	
Post-hospital discharge/ED visit follow-up	√
Support transitions in care (ie., movement into AL or LTC)	
Advanced Care Planning/MOST/DNR	
Serious illness conversation and support *	
Palliative care support and coordination	
MAID education and support *	
Direct care treatment / interventions	
Ear irrigation*	
Simple skin and wound care / wound care referrals	
Complex skin and wound care (i.e., debridement)*	
Cryotherapy*	
Suture and staple removal	
ABPI (ankle brachial pressure index)*	
Medication administration / injections (ie., B12, birth control, hormone replacement)	
Obstetric Care	
New mom and well-baby assessment*	
Obstetric and maternity care*	
Other	
Long Term Care visits*	
Home visits*	
Other	

*Denote skills that require extra training or special consideration.