Interior Health
PRIMARY CARE

Registered Nurse (RN)

Role of the Registered Nurse

Registered Nurses (RN) provide holistic, person centered, and culturally appropriate care along a continuum. They work within a team based environment, to help patients navigate through the health care system and access resources. Registered Nurses provide education and support directed at health promotion, disease prevention and management of chronic conditions.

Education and Registration

- Graduation from an approved School of Nursing with current practicing registration with the British Columbia College of Nurses and Midwives (BCCNM)
- Advance clinical skills training in the assigned practice area.

What can RNs do in Primary Care?

Within a Primary Care Network, Registered Nurses initiate, implement, and monitor health care plans in collaboration with the patient, physician and other members of the interdisciplinary team throughout the lifespan to optimize wellness. Through the Registered Nurses knowledge of community based resources, some functions may be better delivered with referrals to existing IH Specialized Community Service Programs. The list is meant to be illustrative and should not be considered exhaustive.

- Completes documentation, accurate statistical data and reports in a timely manner
- Participates in relevant meetings, committees, and network groups
- Seeks professional development opportunities consistent with current primary care practice, new and emerging issues, changing needs of patient population, and research
- Maintains and applies evidence-based knowledge to the nursing process
- Uses research findings and evidence to guide the delivery of services
- Recognizes personal attitudes, beliefs, feelings and values about health in their interactions with patients and their families
- Establishes and maintains effective professional relationships and partnerships with other organizations to benefit system integration, efficient service utilization, effective collaboration and optimal patient care.
- Follows the four levels of control on practice.
    - Regulation and legislation
    - BCCNM standards, limits & conditions
    - Organizational policies
    - Individual nurse competence

Resources

- Pathways (Includes BC Guidelines and BC Lifetime Prevention Schedule)
- Clinical Care Resources - Primary Care
- Elsevier
- Learning Plan – IH Professional Development (Learning) Plan
- Up to Date

Staying Healthy	**Indirect Care** • Health promotion and disease prevention strategies in collaboration with communities and interdisciplinary team members • Education and communication strategies to address health topics (e.g. Individual and group education, written, verbal, visual)

	Direct Care • Health care planning in collaboration with patient and interdisciplinary team • Assess immunization status and provide or refer for immunization *(additional education)* • Care coordination and health care navigation support (community resources/referrals, PCN resources (regional resources) • Plan and participate in strategy to recall patients across the lifespan for monitoring and screening, using the British Columbia Governments Lifetime Prevention Schedule, British Columbia Governments Clinical Practice Guidelineselines, and best evidence based practice guidelines for chronic disease management • Reproductive and sexual health promotion through assessment, education and/or counselling (*additional education*) • Assess patients current knowledge, education, literacy levels, social supports, learning preferences and other factors that may affect the educational approach and plan • Provide patient-centered education related but not limited to healthy living, medications, chronic disease management, care and treatment • Document completion (eg: life insurance, workplace accommodation, extended health benefits, driver's medical fitness)
Getting Better	**Indirect Care** • Collaborate with primary care provider or most appropriate member of the health care team (eg: discharge follow up, community care) • Match community resources with patient needs and facilitates access to services in a timely and supportive manner • Gather appropriate information and prep charts for appointments – consults, labs, imaging and flag abnormal results • Complete consults and referrals (eg: laboratory requisitions, diagnostic imaging requisitions, and completed as per guideline care with patient specific order) • Provide additional supports, education, appointments for higher risk patients • Complete necessary documentation to access medications or treatments that are exception to BC Pharmacare formulary **Direct Care** • Bladder scans (post residual void/assess urine retention) • Simple/superficial skin and wound care (eg: skin tears, suture or staple removal, drain removal, peripheral line removal • Ear syringing • Adult immunizations (*additional education*) • Injections (e.g. B12, birth control) • Cryotherapy (*additional education*) • Pelvic exams, annual exams, cervical cancer screening (*additional education*) • Sexually transmitted infections (*certified practice*) community needs • Contraceptive management (*certified practice*) community needs • Epistaxis treatment • Point of care testing (glucose, pregnancy, urinalysis screening) • Insulin dose adjustments (*advanced education*) community needs • Assessment for pain, cognition, drug toxicity, chronic diseases, mental health etc.
Living with Illness and Disability	**Indirect Care** Collaborate and liaise with: • Specialized Community Service Programs (SCSPs) like MSHU, Complex Medical with/without Frailty (CMF) and Acute Care • Primary Care Provider and Home and Community Care (CMF SCSPs) for home bound patients to coordinate services. • Providers to support patients in long-term care or assisted living

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	Direct Care
	• Identify and support patients with complex health conditions
	  ○ Chronic diseases
	  ○ Frailty
	  ○ Obesity
	  ○ Mental health and substance use
	  ○ High risk
	• Support illness management following clinical practice guidelines and evidence based practices
	• Complete regular medication reconciliation
	• Counsel patients on drug therapies, side-effects, and interactions
	• Counsel and guide patients on symptom management, health maintenance and rehabilitation strategies, as well as risk factors and lifestyle changes
	• Document completion support
	• Information gathering, symptom review, treatment review, chart review
	• Disability Tax Credit, Long Term Disability forms (in collaboration with other professions)
	• Teach and coach patients to participate and manage their own care (eg: education strategies and Motivational Interviewing skills to support behavioral change)

Optimizing End of Life	**Direct Care**
	• Support advanced care planning conversations for patient and family/caregivers through assessment and support in completion of:
	  ○ MOST
	  ○ DNR
	• Support patients through life transitions including palliation and death (eg: referrals to palliative care supports, navigation through palliative care benefits
	• Assist with pain and symptom management
	• Assist primary care providers as appropriate with Medical Assistance in Dying support for patient and supports

References

Canadian Family Practice Nurses Association. *Sample Role Description for Registered Nurse in Family Practice For Adaptation to your Primary Care Practice.* https://cna-aiic.ca/-/media/nurseone/files/en/sample_role_description_e.pdf?la=en&hash=07386589D135746C0C31D120BD893D998B84D8C9 . August 14, 2019

BCCNP (2019). *Scope of Practice for Registered Nurses.* https://www.bccnp.ca/Standards/RN_NP/StandardResources/RN_ScopeofPractice.pdf