National Competencies for Registered Nurses in Primary Care

DECEMBER 2019

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Introduction

The health needs of Canadians and on-going reforms to strengthen primary care require a registered nurse (RN) workforce that is well-defined and understood within the health care system. The absence of national competencies for this role has been a fundamental challenge to the integration of RNs in primary care (1). This foundational report, prepared by a pan-Canadian project team for the Canadian Family Practice Nurses Association (CFPNA), presents competencies for RNs who work in the primary care setting. The CFPNA is the national voice for RNs in primary care. CFPNA provides RNs in primary care with leadership, mentorship, and fosters experiences for networking and professional development. CFPNA is a full network member and a specialty interest group of the Canadian Nurses Association (CNA). This document articulates the unique contribution of RNs in primary care, who function in diverse practices across the breadth of primary care services.

PURPOSE: The competencies presented in this report will support the integration and optimization of RNs within primary care across Canada. Specifically, these competencies are intended to inform stakeholders nationally and internationally, including patients, primary care providers, employers, educators, decision-makers, and researchers. Benefits of national competencies for RNs in primary care include:

- Support further integration and optimization of RNs within primary care across Canada;
- Articulate the unique contributions of RNs who work within primary care settings;
- Contribute to a competent national workforce of RNs who work in primary care;
- Serve as a tool for facilitating interprofessional team functioning by providing role clarity and articulating scope of practice for RNs working in primary care;
- Inform stakeholders, including patients and decision-makers, about the role and/or potential role of RNs working within primary care settings;
- Support employers with recruitment and integration of RNs into primary care settings through the formation of job descriptions, credentialing mechanisms, interview guides, orientation materials, performance evaluations, and other relevant tools;
- Serve as a framework for performance evaluation to aid employers, researchers, and other stakeholders to generate evidence on the contribution of RNs in primary care to patients and the broader healthcare system;
- Guide nursing curricula across Canada regarding content related to RNs working in primary care, including undergraduate, certification, and post-graduate programs.

The Registered Nurse in Primary Care

Several terms have been used to describe RNs who work in primary care. *Family practice nurses* (also known as *primary care nurses*) are RNs who practice in primary care settings, such as clinics/offices, family health teams, and community health centres. *Primary care* represents an entry point for patients into the healthcare system and focuses on the delivery of health promotion, disease prevention, and management of episodic and chronic conditions (2). RNs are the core of interprofessional primary care teams across many jurisdictions in Canada (3,4) and have a key role within these teams, working in partnership with family physicians, nurse practitioners, and other providers. RNs in primary care function as generalists who provide a broad range of services, including but not limited to, health education, health promotion, chronic disease prevention and management, therapeutic interventions (e.g. wound care, immunizations), medication management, pediatric and women's health, referral management, care coordination, and system navigation (5). RNs in primary care can improve access to care, patient and physician satisfaction, quality of care, and cost-effectiveness (6-8).

Overview of Competencies

Competencies are the integrated knowledge, skills, judgement, and attributes required of a RN to practice safely and ethically in a distinct role or setting. Competencies define the scope and depth of practice for a nurse in a particular healthcare setting (i.e. primary care). Competencies are informed by Standards of Practice (e.g. *Community Health Nurses of Canada [CHNC] Standards of Practice*) (9).

RNs who work in primary care fall under the umbrella of "community health nursing" which also includes home care nursing and public health nursing. Competency development has been completed for these other areas of community health nursing (10,11). However, until this report, no competencies existed to guide the unique practice of RNs in primary care. CFPNA, in collaboration with its membership, adopted the *CHNC Standards of Practice* (9) as a framework for competencies for RNs in primary care.

Based on the CHNC Standards of Practice, the competencies presented in this report are organized into the following six domains:

Domain 1: Professionalism

Domain 2: Clinical Practice

Domain 3: Communication

Domain 4: Collaboration and Partnership

Domain 5: Quality Assurance, Evaluation and Research

Domain 6: Leadership

Assumptions

In developing the competencies, several assumptions were made. Understanding these assumptions is necessary to interpret and provide a better understanding as to how these competencies may be applied to the unique positions of RNs in primary care settings.

Assumptions List

1. The terms "*family practice nurse*" and "*primary care nurse*" are used interchangeably across Canada. Throughout the report, to encompass both, we refer to this role as "Registered Nurses who work in primary care".
2. "Competency" refers to integrated knowledge, skills, judgement, and attributes. Competencies represent a higher-level statement than specific roles, activities, or tasks. Specific activities and tasks are encompassed by a competency statement.
3. These competency statements build upon existing RN entry-to-practice competencies (12) to reflect the unique contribution of RNs in primary care. An effort was made in the development of the competency statements to only include distinct competencies that are not in existing competency lists of related areas, such as RN entry-to-practice, public health nursing, home health nursing, and interprofessional competencies (10-13).
4. Within the competency statements, *"patient"* refers to individual, family, and/or caregiver, as appropriate.
5. A unique contribution of RNs in primary care that is reflected throughout these competency statements is the delivery of health services *"across the life span"* and *"over time"*. That is, RNs in primary care are unique in that they serve individuals of all ages, from 'cradle-to-grave', and form long-term, continuous relationships with patients (i.e. continuity of care).
6. RNs in primary care have a key role within interprofessional teams working in partnership with physicians, nurse practitioners, and/or other providers to deliver patient-centered care.
7. The integration of RNs in primary care is essential for the development and evolution of professional practice environments that support high-quality care. RNs in primary care help improve access to care, increase both patient and physician satisfaction, and enhance overall quality of care (6-8).

To further ensure shared understanding of the competency statements, there are appendices located at the end of this document. **Appendix A** presents a glossary of terms and **Appendix B** explains the methodology used to develop the competency statements.

Competencies for RNs in Primary Care

Domain 1.0 - Professionalism

1.1 Practice in accordance with evidence-informed guidelines and policies relevant to primary care.

1.2 Maintain a professional relationship and appropriate professional boundaries with patients across the lifespan and over time.

1.3 Promote a culture of quality improvement and safety within primary care.

1.4 Participate in professional development activities relevant to primary care.

1.5 Contribute to capacity development of nursing in primary care through mentorship and teaching.

1.6 Articulate the roles and contributions of nursing within primary care.

1.7 Participate in the advancement of nursing in primary care.

1.8 Advocate for nursing role optimization within interprofessional primary care practice.

Domain 2.0 – Clinical Practice

2.1 Integrate the principles of primary health care as applied to primary care service delivery.

2.2 Identify health and social care needs, preferences, and values of patients across the lifespan and over time.

2.3 Apply strategies (e.g. motivational interviewing, stages of change) to support patient self-management.

2.4 Address key determinants of health and health inequities within the primary care practice population.

2.5 Deliver nursing care informed by the impact of colonialism and Indigenous ways of knowing within primary care practice.

2.6 Report communicable diseases to public health as appropriate.

2.7 Understand the needs of patients with complex health care conditions common in primary care.

2.8 Manage physical, psychological, and social issues across the lifespan through the development of patient-centered health care plans.

2.9 Provide anticipatory guidance and early intervention for patients across the lifespan and over time.

2.10 Conduct assessment, monitoring, and evaluation of patient health care plans across the lifespan and over time.

2.11 Integrate relevant research and evidence-informed practices into clinical decision making in primary care.

2.12 Provide case management and coordination of care for patients with complex health needs to ensure optimal utilization of services and resources.

2.13 Deliver primary care-based programs to support health promotion, disease prevention, and rehabilitation.

2.14 Facilitate patient empowering approaches in the provision of primary care across the lifespan.

2.15 Use information technology to support patient care in primary care practice.

2.16 Educate patients on resources and tools for self-management of their health and well-being.

2.17 Help patients navigate the healthcare system.

Domain 3.0 – Communication

3.1 Utilize evidence-informed communication approaches with patients, families, and the broader community to support the achievement of patient-centered health-related goals.

3.2 Build patient capacity in health literacy.

3.3 Engage in respectful and supportive communication with members of the interprofessional primary care team.

3.4 Exchange knowledge amongst interprofessional team members to promote excellence in primary care practice.

3.5 Use communication strategies and tools (e.g. information technology) in a secure and confidential manner to effectively manage patient care with the interprofessional primary care team.

Domain 4.0 – Collaboration and Partnership

4.1 Collaborate with organizations in health and non-health sectors to promote optimal health and well-being of patients in primary care.

4.2 Understand the roles and responsibilities of regulated and unregulated health care workers involved in interprofessional primary care teams.

4.3 Facilitate organizational practices that support continuity of care.

4.4 Support transitions of care within and across health care settings to enhance patient outcomes.

4.5 Engage in intra- and inter-sectoral communication and strategies that supports integrated care for patients with complex health and social needs.

Domain 5.0 – Quality Assurance, Evaluation and Research

5.1 Participate in practice quality improvement initiatives, including accreditation activities.

5.2 Collaborate with team members in primary care to address potential and/or actual risk, near misses, privacy breaches, and critical incident reviews.

5.3 Understand quality performance indicators for primary care practice.

5.4 Assist in developing policies and procedures to ensure they reflect both best practice and local context.

5.5 Engage in research and evaluation activities relevant to primary care and the nursing role in primary care practice with academic institutions, community services, and other professionals.

5.6 Participate in gathering, interpreting, and/or synthesizing of patient data to inform continuous quality improvement.

5.7 Use clinical data and literature/studies to support program development/planning and a population health approach in primary care practice.

Domain 6.0 – Leadership

6.1 Support leadership in the implementation of primary care initiatives.

6.2 Advocate for the effective use of resources within interprofessional primary care practice.

6.3 Share new knowledge with peers and colleagues to advance evidence-informed practice within primary care nursing.

6.4 Advocate for healthy public policies and social justice relevant to patients and populations in primary care.

6.5 Participate in coordination of the development and/or implementation of primary care-based programs to support health promotion, disease prevention, and rehabilitation.

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Appendix A: Glossary

Advocacy/advocate: "Advocacy involves engaging others, exercising your voice and mobilizing evidence to influence policy and practice. It means speaking out against inequity and inequality. It entails participating directly and indirectly in political processes and acknowledging the importance of evidence, power and politics in advancing policy options." (14)

Best Practice: "Systematically developed statements of recommended practice in a specific clinical or healthy work environment area that are based on best evidence and are designed to provide direction to practitioners and managers in their clinical and management decision making." (15)

Case Management: "A way to manage care that enhances the ability of people or families to care for themselves and enhances the capacity of systems and communities to coordinate and provide services." (16)

Colonialism: "Is a way to control land, people, culture and society. Colonialism refers to the beliefs, philosophies, and politics that one group uses to claim their superiority or dominance over another group." (17)

Complex Health: "The degree to which a client's condition and/or situation is characterized or influenced by a range of variables (e.g. multiple medical diagnoses, impaired decision-making ability, challenging family dynamics)." (15)

Community: "A group of people, who live, learn, work, and play in an environment at a given time. They share common characteristics and interests, and function within a larger social system such as an organization, region, province, or nation. The core of any community is its people, who are characterized by their age, sex, socioeconomic status, education, occupation, ethnicity and religion. A community can also be defined by its place or geopolitical boundaries." (18)

Culture of Safety: "A health care approach in which the provision of safe care is a core value of the organization. The culture encourages and develops the knowledge, skills and commitment of all leaders, management, health care providers, staff, and patients for the provision of safe patient care. Opportunities to proactively improve the safety of care are constantly identified and acted on. Providers and patients are appropriately and adequately supported in the pursuit of safe care. The culture encourages learning from adverse events and close calls to strengthen the system, and where appropriate, supports and educates health care providers and patients to help prevent similar events in the future. There is a shared commitment across the organization to implement improvements and to share the lessons learned. Justice is an important element. All are aware of what is expected, and when analyzing adverse events any professional accountability of health care providers is determined fairly. The interests of both patients and providers are protected." (19)

Determinants of Health: "Definable entities that cause, are associated with, or induce health outcomes. Public health is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health- not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and

social status, education, employment and working conditions, access to appropriate health services, and the physical environment. These, determinants of health, in combination, create different living conditions which impact on health." (20)

Evidence-Informed Practice: "An approach to decision-making in which the clinician conscientiously integrates critically appraised evidence, clinical practice experience, and knowledge of contextual factors in consultation with the patient, in order to decide upon the option that best suits the patient's needs. Evidence may include, but is not limited to, published research, grey literature research, clinical practice guidelines, consensus statements, clinical experts, quality assurance and patient safety data." (21)

Health: "A state of complete physical, mental [spiritual] and social well-being, and not merely the absence of disease." (21)

Health Promotion: "The process of enabling people to increase control over, and to improve their health. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental, political and economic conditions so as to alleviate their impact on public and individual health. The Ottawa Charter for Health Promotion describes five key strategies for health promotion: build healthy public policy; create supportive environments; strengthen community action; develop personal skills; and re-orient health services." (20)

Healthy Public Policies: "Characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible or easier for citizens. It makes social and physical environments health-enhancing." (22)

Indigenous Ways of Knowing: "Indigenous knowledge comprises the complex set of technologies developed and sustained by Indigenous civilizations. Often oral and symbolic, it is transmitted through the structure of Indigenous language and passed on to the next generation through modeling, practice and animation, rather than written word." (23,24)

Inter-sectoral: "Refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector. Major influences that shape the health of populations and the distribution of health inequities are located outside the health sector. The fact that most of these influences lie outside of the exclusive jurisdiction of the health sector, requires the health sector to engage with other sectors of government and society to address the determinants of health and well-being." (25)

Near Miss: "A patient safety incident that did not reach the patient and therefore no harm resulted." (26)

Population Health: "An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks

at and acts upon the broad range of factors and conditions that have a strong influence on our health.” (27)

Prevention: “An intervention or interventions that interrupts the web of causality leading to one or more aspects of ill health…It is certain that there is a web of interactions that determine the state of health, from those that are most distal to those that are most proximal. The most distal are likely to be the political context in which the determinants are operative, followed by aspects of policy (health, social, environmental), followed by the context of social as well as medical contacts in communities, followed by individual social and behavioural characteristics (such as social isolation and health behaviours), followed by physiological states such as are related to perceived stressors. When interventions are designed to prevent the occurrence of a risk state, they are known as primary prevention. In a web of determinants, several interventions might be considered “primary”. Primordial prevention occurs when there is a focus on a more antecedent primary preventive strategy. The most effective prevention focuses on the weakest part of the web and not necessarily on the most proximal.” (28)

Primary Care: “Refers to services commonly accessed at the first point of contact with the health system.” (18)

Primary Health Care (PHC): “Is based on the new Astana Declaration on Primary Health Care that has replaced the Alma-Ata Declaration. It describes ‘a commitment to health and well-being for all based on universal health coverage (UHC). UHC means that all people, including those who are marginalized or vulnerable, should have access to quality health services that put their needs at the centre, without financial hardship. PHC is the most effective, efficient and equitable approach to enhance health, making it a necessary foundation to achieve the UHC. The Declaration envisions:

a. governments and societies that prioritize, promote and protect people’s health and well-being, at both population and individual levels, through strong health systems;

b. primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;

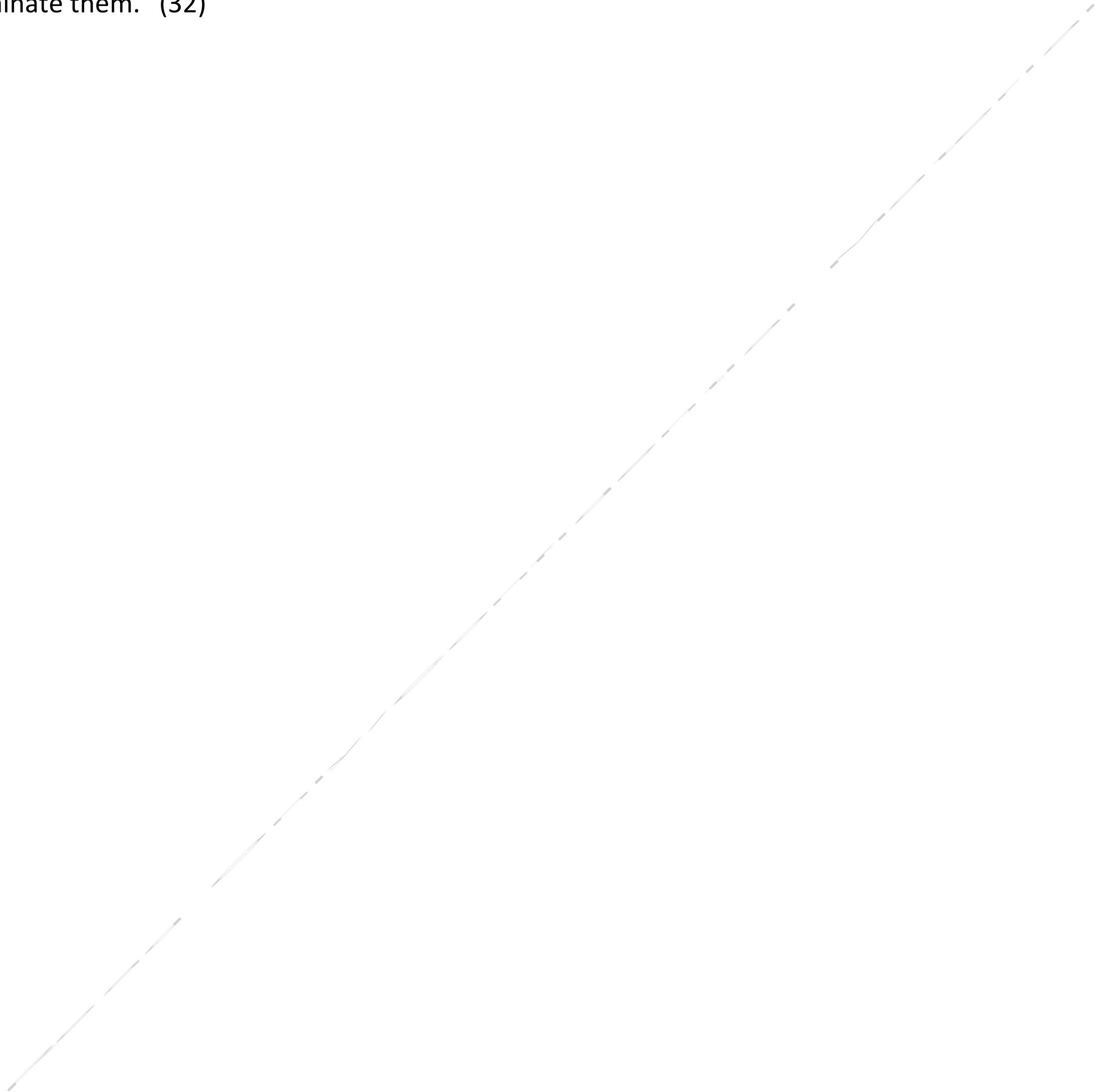
c. enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;
d. partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.’” (9,29)

Quality Improvement: “The availability of robust, coherent, defensible and credible data on healthcare system performance is an essential component of any effort to improve quality. A chart book developed by Canadian Foundation for Healthcare Improvement (CFHI) takes a multifaceted approach to assessing quality and examines international, national and provincial/territorial data. It has been designed using four guiding principles- accessibility, validity, diversity of perspectives, and

balance in presentation of data. They use six evaluation domains: effectiveness, access, capacity, safety, patient-centeredness and equity." (30)

Self-Management: "The ability of the patient to deal with all that chronic illness entails, including symptoms, treatment, physical and social consequences." (31)

Social Justice: "is the fair distribution of society's benefits, responsibilities, and their consequence. Social justice is based on the concept of human rights and equity. It focuses on the position of one social group as compared to others, as well as the root causes of disparity and what can be done to eliminate them." (32)



Appendix B: Methodology

The competencies for RNs in primary care were developed using an evidence-informed, systematic approach. The development involved a team of experienced researchers, stakeholders, and an expert panel of primary care nurses across Canada. Specifically, a modified Delphi (consensus) approach was used to reach agreement on a national set of competency statements.

Delphi Round #1: The initial draft of competencies was developed by a panel of key informants comprised of all team members and project partners with expertise and experience in primary care nursing who met in-person for a full-day, facilitated workshop in Toronto, ON (December, 2018). The competencies were also informed by an international literature review and environmental scan related to family practice nursing competencies, competencies of related practice areas (e.g. entry-to-practice competencies for baccalaureate prepared nurses, home health nursing, public health nursing, Canadian Interprofessional Health Collaborative Interprofessional Competency Framework) (10-13), and the Canadian Community Health Nursing Professional Practice Model and Standards of Practice (9). An effort was made by the panel of informants to avoid duplication or overlap with existing published competencies in similar areas. The initial draft of competencies was also informed by feedback obtained from primary care nurses who attended a workshop held at the CFPNA Biennial Conference in 2018 (Winnipeg, MB). The resulting draft of competency statements was comprised of 49 statements, organized within 6 domains (i.e. Professionalism; Clinical Practice; Communication; Collaboration and Partnership; Quality Assurance, Evaluation and Research; Leadership).

Delphi Rounds #2 and 3: Two consecutive surveys were completed to obtain consensus on the developed competency statements. Panel participants for the Delphi survey process were identified through snowball sampling and identification of eligible participants through online searches (n=137). The panel was comprised exclusively of nurses with knowledge, expertise, and/or experience related to family practice nursing representing all provinces/territories and domains of practice (e.g. clinical, education, administration, research). Participants were sent an email invitation by a research assistant, the project lead, or a member of the team. The email invitation contained information about the study and a link to the online competency development survey, which was offered in English and French. Participants were asked to report on their level of agreement with each competency statement on a 6-point Likert scale (1=not at all important; 6=extremely important) and provide comments regarding each statement and/or other general suggestions. Consensus on a competency statement was defined as at least 80% agreement (or a mean score of at least 5.0).

The majority of statements achieved agreement after the first survey. Statements that did not achieve a score of at least 5.0 were reviewed and revised by the team and included in a second survey. All individuals who completed the first survey were identified and contacted again for completion of the second (final) survey. A total of 86/137 individuals completed the first survey between April–May, 2019 and 72/86 individuals completed the second survey between June–August, 2019. The final list of competency statements for RNs in primary care consists of 47 distinct statements, organized within 6 domains. One statement was fully dropped as it did not achieve at least 80% agreement in either survey round, and another two statements were combined into one

new statement.

The final competency statements are listed in this present report. Further details are explained in a publication being prepared by the project team members.