

Exploring the Role of RNs

in Family Practice Residency Training Programs

Until recently, there has been little interest in understanding or developing the role of the registered nurse (RN) employed in family practice/primary care (FP/PC) settings in Canada. According to the Canadian Institute for Health Information (2009), RNs who are employed in physician offices and family practice settings make up less than 13 per cent of the nursing workforce. This group provide important primary care services to patients and are considered integral members of the primary care team (Nasmith, 2006). In fact, they have been described as “unsung heroes,” who not only carry out key clinical functions but are a steady presence in family practice settings, providing stability for patients when their physician is unavailable (Nasmith, 2006).

In 2007, the College of Family Physicians of Canada (CFPC) and the Canadian Nurses Association (CNA) released a joint vision statement on interprofessional care, which stated, “All people in Canada will have access to a family practice/primary care setting that offers each person the opportunity to have his/her care provided by each of the following: a personal family doctor and a registered nurse and/or nurse practitioner.” The vision statement focuses on complementary roles rather than role substitution and on the need for health-care professionals to have a clear understanding of the skills and knowledge of those in other disciplines.

Physicians who are accepted into family practice residency training programs receive two years of additional training after they have completed undergraduate medical education. These programs provide an ideal environment for new physicians to

learn and understand the roles and responsibilities of nurses and other health professionals as well as the benefits of collaboration. It is therefore vital that all health-care professionals working in these settings are working to their full scope of practice.

In an extensive literature search, utilizing CINAHL, PubMed and Google Scholar, we found fewer than a dozen articles with reference to the roles of nurses in family practice residency training programs. Although nurses’ contributions to medical education were consistently described as being valuable (Bradley, Bond, & Bradley, 2006; Howe, Crofts, & Billingham, 2000; Solberg, Nesvacil, & Stroller, 1989), these articles focused almost exclusively on the nurse practitioner (NP) role. A recent Canadian study suggests that the RN role in family practice is ill-defined in general and even more so in the interprofessional academic family practice setting, where the role was found to be largely defined by tasks and often ambiguous (Akeroyd, Oandasan, Alsaffar, Whitehead, & Lingard, 2009).

Building on the research of Todd, Howlett, MacKay and Lawson (2007), we sought to investigate the role of nurses employed in family practice residency training programs and determine the amount of time they spent engaged in nursing and non-nursing activities, their scopes of practice and their level of job satisfaction.

STUDY DESIGN AND METHOD

We faxed a five-item questionnaire to all unit directors listed in the CFPC’s 2007 *Directory of Departments of Family Medicine* to establish whether their family practice residency training program

ABSTRACT

The authors developed a survey as part of a study to explore the role of nurses employed in Canadian family practice residency training programs, which provide physicians with two years of additional training after they have completed undergraduate medical education. Licensed practical nurses, registered nurses and nurse practitioners employed at residency training program sites have a unique opportunity to educate new physicians about nursing scopes of practice and about how to work effectively with nurses. A total of 127 nurses, including 94 RNs, from 41 program sites

across Canada completed the survey. In this article, the authors present the findings specific to this RN group. RN respondents reported performing a wide range of nursing and non-nursing activities, and only 61 per cent indicated that they felt they worked to full scope. That so many RN respondents were performing below their scope of practice may be the result of employer and organizational policies or a lack of understanding and awareness of scope of practice. The authors propose that family practice residency training programs adopt a standardized approach to the role of RNs.



MICHELLE
ALLARD
RN, BN



APRIL
FREGO
RN, CDE



ALAN
KATZ
MBChB, MSc,
CCFP, FCFP



GAYLE
HALAS
RDH, MA





site met the inclusion criterion for our study. An eligible program site was defined as a primary teaching unit where faculty physicians maintain their clinical practice and at least one nurse is employed; private physician offices or other types of primary care settings utilized by some programs to provide resident training were considered ineligible. Because there is no database of nurses employed in these programs, the questionnaire asked the unit directors to identify how many nurses worked at their program site and whether they would be willing to distribute a survey and an information package.

We developed a bilingual, cross-sectional survey for our study. Modelled on the Nova Scotia Family Practice Survey (Todd et al., 2007), it consisted of 33 items, including 16 multiple-choice questions, six Likert scale questions (each with five response levels) and one ordinal scale question. A space for comments was included at the end of the survey. The questions were divided into six broad categories: nursing roles, patient care, scope of practice, education, professional relationships and demographic characteristics.

Unit directors whose program site met the eligibility criteria were then mailed an invitation to participate in the study, along with a sufficient number of surveys and consent forms for them or their delegate to distribute among the nurses at their site. A web address was included in the print version of the survey to allow participants to fill out the survey electronically on SurveyMonkey.

All participants were required to sign a consent form. Survey data were analyzed using descriptive statistics. Ethics approval was obtained from the University of Manitoba Research Ethics Board and the St. Boniface Hospital Research Review Committee.

FINDINGS

Of the 88 programs listed in the directory and sent the

screening questionnaire, 78 responded. Of these, 49 met the inclusion criteria; 21 were French-speaking sites and 28 were English-speaking sites. All 49 unit directors and the 202 nurses they identified were invited to voluntarily participate in the study. Subsequently, 127 nurses from 41 program sites provided consent and completed the survey.

Nurse respondent profile: 119 of those who responded were female, 64 were between 31 and 50 years of age, and 68 worked full time. Seventeen respondents held a faculty appointment in the department of family medicine at an affiliated university. Thirteen respondents identified themselves as licensed practical nurses, 94 as RNs and 17 as NPs.

In this article, we report on only those findings specific to the RNs.

Non-nursing activities: RN respondents indicated they carried out various clinic activities, on a daily or weekly basis, that could be done by non-nursing support staff. Examples include booking appointments (performed by 65% of RN respondents), booking tests/procedures (53%), prepping clinic exam rooms (55%), rooming patients (51%) and restocking supplies (42%).

Nursing activities: RN respondents also performed clinic activities consistent with their role as defined by their provincial regulatory bodies. Activities done on a daily or weekly basis include providing injections (94%), telephone triage (85%), adult immunizations (85%), child immunizations (74%), glucose testing (65%), well child assessments (61%), wound care (63%) suture/staple removal (59%), medication reviews (56%) and ear syringing (56%); only 7% reported performing breast examinations, and 8% reported performing Pap tests/pelvic exams.

Scope of practice and job satisfaction: Just under two-thirds of RN respondents (63%) indicated that they had a written job description. Only 61 per cent felt they were working to full scope of practice. Interestingly, some respondents were unclear about which activities fell within regulated scope — only 47 per

cent selected Pap test/pelvic exam as such an activity. In contrast, 64 per cent reported doing anticoagulant therapy adjustment. (A delegation of function is required before RNs can undertake this activity.) A strong majority (88%) indicated a desire to participate in programs or courses to further develop their clinical nursing skills.

Survey participants were asked to consider a list of six factors that contribute to their overall job satisfaction and then rank them in order of importance. The factors were “comprehensive patient care,” “feeling valued as a team member,” “hours of work,” “broad scope of clinical practice,” “independence in role” and “educating residents.” Forty-five percent of RN respondents ranked “comprehensive patient care” as the primary contributing factor. Survey participants were also asked to rate their level of job satisfaction; 82 per cent of RN respondents reported a high level of satisfaction, and those who reported working to full scope had a significantly higher level of job satisfaction than those who did not ($p < 0.005$). We also received a number of comments from RN respondents who expressed frustration about having a limited role. For example, one wrote, “I have skills, just no opportunity to use them”; another commented, “I feel our role could change with a full scope of practice initiative. The problem is completing the role as defined right now and then finding the time to develop the role further. Nursing could help with [the] primary care practitioner shortage by absorbing some of those duties.”

DISCUSSION

RNs in family practice/primary care have a variety of clinical skills, as well as the knowledge to provide health promotion, chronic disease management and health education information to patients across the lifespan (Ontario Family Practice Nurses, 2007). However, in our survey, more than half of the RN respondents reported performing non-

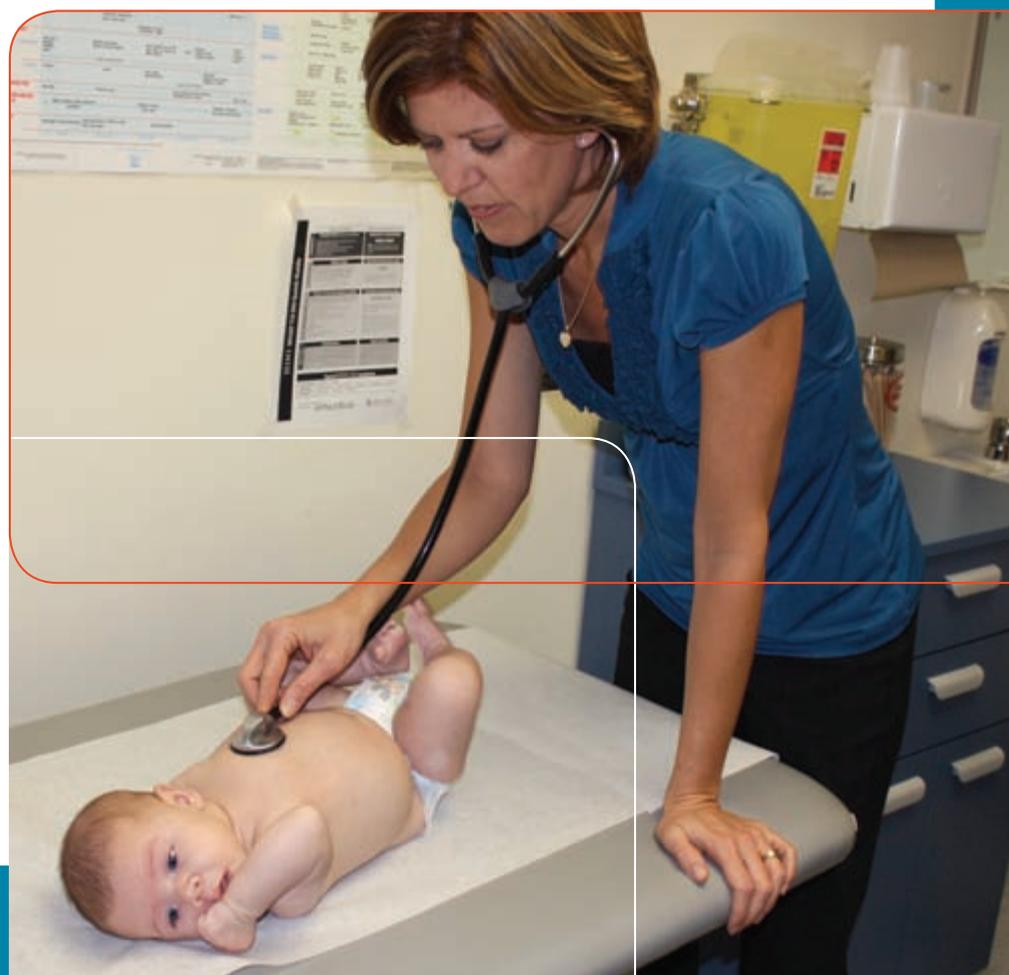
nursing activities on a daily or weekly basis, and only 61 per cent felt they worked to full scope. That so many RN respondents were performing below their scope is consistent with findings from other studies: Gibson and Heartfield (2005) found that the FP/PC nurse’s practice may be as narrow as that of a receptionist or as broad as that of a nurse practitioner; Todd et al. (2007) established that FP/PC nurses are often underutilized, making valuable but limited contributions in the provision of primary health care; and the Winnipeg Regional Health Authority (2006) stated that nurses in ambulatory primary care clinics appeared to be functioning below their full scope of practice.

Employer and organizational policies or a lack of understanding and awareness of scope of practice may be some of the possible reasons that RN respondents are performing below scope. The Canadian Nursing Advisory Committee (2002) considers role underutilization an inefficient use of limited health-care dollars, and, as we saw in our survey,

it can lead to job dissatisfaction. Job dissatisfaction has been cited as the primary predictor of intent to leave among nurses — an important point for health-care administrators, for whom minimizing turnover is a priority (Larrabee et al., 2003).

Nurses employed in family practice residency training programs generally work in isolation from the majority of their nursing peers. This reality was borne out in our study; half of the participating unit directors indicated that the number of nurses employed at their sites ranged from one to four. Isolation results in diminished access to continuing education activities, in-services or other clinical nursing support (Alsaffar, 2005), which are sources of vital networking and development opportunities. Nearly all RN respondents indicated they would like to participate in programs and courses to further develop their clinical nursing skills.

Standardizing RN practice across all program sites might help to reduce the inconsistencies in the role of RNs that we discovered through the survey responses.



Such an approach would begin with specifying the education, clinical skills and teaching experience required for RNs working in residency training programs. Further study of the challenges to standardizing RN practice is required. These challenges include the following:

- lack of knowledge in the nursing and medical professions about the actual and potential contributions of RNs in both clinical and academic roles
- lack of a formal database to identify and link RNs, limiting their ability to network, share resources, engage in appropriate continuing education activities and otherwise receive support to develop their role
- lack of specific direction in the CFPC's *Standards for Accreditation of Residency Programs* (2006) related to the RN role
- the effects of employer and organizational policies on RN roles and responsibilities.

CONCLUSION

Like many of their FP/PC nursing colleagues, RNs employed in family practice residency training programs are underutilized, are engaged in non-nursing activities, have limited support to optimize their roles and are offered few opportunities for training or continuing education (Gibson and Heartfield, 2005; Todd et al., 2007).

We suggest that there are a number of strategies that can be adopted to support RN role optimization and standardized RN practice in these programs. First, the nursing and medical professions need to recognize and embrace the wide range of knowledge, clinical skills and contributions of RNs. Second, there must be support for appropriate continuing education activities that foster networking and professional development. Finally,

employers must ensure that the amount of time RNs spend in non-nursing activities is minimized, allowing RNs to demonstrate their full potential to future family physicians.

An added benefit of successfully standardizing RN practice in residency training is the potential for raising awareness of the broad role RNs can play in providing primary health care in all FP/PC settings. ■

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MICHELLE ALLARD, RN, BN, IS A PRIMARY CARE NURSE AT THE FAMILY MEDICAL CENTRE IN WINNIPEG, MANITOBA. SHE HOLDS A NIL-APPOINTMENT WITH THE DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF MANITOBA, A NIL-APPOINTMENT WITH THE FACULTY OF NURSING, UNIVERSITY OF MANITOBA, AN EXECUTIVE POSITION AS MEMBERSHIP SECRETARY FOR THE CANADIAN FAMILY PRACTICE NURSES ASSOCIATION AND IS CO-CHAIR OF THE MANITOBA PRIMARY CARE NURSING ASSOCIATION.

APRIL FREGO, RN, CDE, IS A CLINICAL RESOURCE NURSE AT THE KILDONAN MEDICAL CENTRE IN WINNIPEG, MANITOBA. SHE HOLDS A NIL-APPOINTMENT WITH THE DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF MANITOBA, A NIL-APPOINTMENT WITH THE FACULTY OF NURSING, UNIVERSITY OF MANITOBA, AN EXECUTIVE POSITION AS EDUCATION CHAIR FOR THE CANADIAN FAMILY PRACTICE NURSES ASSOCIATION AND IS CO-CHAIR OF THE MANITOBA PRIMARY CARE NURSING ASSOCIATION.

ALAN KATZ, MBChB, MSc, CCFP, FCFP, IS THE RESEARCH DIRECTOR, DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF MANITOBA, ASSOCIATE DIRECTOR FOR RESEARCH, MANITOBA CENTRE FOR HEALTH POLICY, AND ASSOCIATE PROFESSOR, DEPARTMENTS OF FAMILY MEDICINE AND COMMUNITY HEALTH SCIENCES, UNIVERSITY OF MANITOBA.

GAYLE HALAS, RDH, MA, IS A RESEARCH ASSOCIATE, DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF MANITOBA.

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