

Family Practice: A Nursing Perspective

As primary care providers, family practice nurses (FPN's) have the potential to utilize a broad scope of practice. A recent survey of family practice nurses in Ontario (Alsaffar, 2004) identified key practice functions as:

- Case Management including advocating, facilitating and assisting patients maneuvering the health care system
- Provision of health promotion, health education and disease prevention
- Telephone triage and monitoring within the office setting
- Provision of health education, information and counseling to patients and families across the continuum of health care including immunization, chronic disease management, well baby and family care
- Technical nursing interventions including giving injections, changing dressings, ECG's
- Assisting in the completion of health records and other necessary documentation related to insurance claims and WSIB to facilitate appropriate care and back to work initiatives.

The above functions, as well as travel health nursing, were also discussed in a literature review on the role of family practice nurses (Duaso and Cheung, 2002; Richards, Meakins, Tawfik, Godfrey, Dutton, Richardson et al., 2002; Richards et al., 2002; Chiodini, 2005; Moore, 2005).

FPN's are the first point of contact with those visiting a family physician/primary care practice. Their role begins with observations of the patient's appearance and demeanor (Nelson, 1998), and encompasses assessment and counseling for the full range of health needs. Despite their ability to provide the many functions outlined, in reality the FPN's scope of practice varies significantly, influenced by such factors as their physician or group practice employer's understanding and preferences related to scope of practice, and the size of the patient caseload. Accordingly, their practice may be as narrow as that of a receptionist, or as broad as that of a nurse practitioner (Gibson and Heartfield, 2005; News, 2001).

Literature review findings reinforced the fact that the full scope of FPN practice is not consistently realized. For example, a study in a general practice in north-east England found evidence that the frequency with which FPN's actually provided health promotion and lifestyle advice is low (Duaso and Cheung, 2002), as was their involvement in assessment and counseling for those with a mental illness (Nelson, 1998). To address the

inconsistency in scope of practice and realize the full benefit of FPN care, Britain has designated “practice nursing” as a specialty under the auspices of their primary care program (Barr, 2005). As part of this reorganization of “general medical services,” practices receive funding incentives for delivering quality care as measured through specific criteria. For example, if 70% of patients with hypertension have a blood pressure reading of 150/90 or less in the previous 9 months the practice earns 56 points, with each point being worth a given financial value. Barr (2005) suggests that skilled nursing teams are essential if practices are to achieve these performance measures and meet “their contractual obligations” (p. 22).

Family practice nursing has not traditionally ranked high in the health care hierarchy. The low status associated with the role has been attributed to a common perception that FPNs do not require many skills or that those who work in general practice may become “de-skilled and work for office hours rather than for a purposeful career” (Gibson and Heartfield, 2005, p. 55). However, the true complexity of the FPN’s practice was reflected in the observation by one of the study participants that: *“Practice nursing is so different and so varied. ...at least in a hospital ward [there is] a focus on people with particular conditions and age groups. In general practice [the FPN] deals with any condition and ages from babies to the elderly”* (p. 55).

To raise the status of family practice nursing, study respondents identified the need for family practice nursing to be included in the undergraduate nursing curriculum and in continuing education. Respondents also advocated for a role statement and standards of practice for their unique practice. The need to inform patients about the roles of various team members in a generalist practice was emphasized by Stille, Jerant, Bell, Meltzer and Elmore (2005). The authors found that in the absence of such knowledge, patients rated the communication and clinical skills of the non-physician team members as “lower than those of their physician” (p. 704). Accordingly, specific information must be provided to the patient including whom they should contact for specific questions or concerns and who is directing the overall care. In the absence of such acknowledgement of the FPN’s role, their contributions may be invisible to patients and thus undervalued and misunderstood.

Publicizing the work of FPN’s may also assist in raising their status through illustrating their contributions. The OFPN (2005) has begun to do this through their documentation of actual scenarios in which FPN’s positively influenced optimal outcomes for the patient and the system. These include:

A gentleman called complaining of leg pain. Symptoms on the phone were redness, swelling, and hot to touch. I recommended medical assessment in the office that morning. The physician ordered a Doppler of the leg which I booked for early that afternoon with the results to be called immediately to the office. The ultrasound clinic called back stating that there was a deep vein thrombosis. I then arranged for the man to be seen at the thrombosis clinic that same afternoon at 4 PM. He went to the hospital clinic and was started on treatment 7 hours after our initial telephone conversation. This reflects

appropriate prioritizing based on need which may have avoided more extensive and costly complications.

A man came into the office for his “flu shot”. He mentioned that he was having some tightness in his chest when he walked his dog and some occasional shortness of breath—nothing serious but did I think that he should see the doctor. Because of his symptoms and also my knowledge of his family history (his brother was a patient and had heart problems), I did an ECG on the man at that time. Comparing it to his previous ECG I did notice changes. Even though he did not have an appointment, I had him seen by the physician who took appropriate measures. This is an example of how immediate action was taken outside of the emergency care system, thus avoiding wait time issues and facilitating preventative care.

While no studies were found that explored the relationship of FPN scope of practice to patient satisfaction, a study of patient satisfaction with family practice nurses in England (where the health care system provides incentives for full scope of practice for FPNs), more than 99% of 61,426 respondents were highly satisfied with the care they received from the FHN (Scott, 1999).

The context of practice for the FPN is an important consideration. If employed by a single physician or a small group practice a solo FPN generally works in isolation from peers and has little or no access to professional conferences, other continuing educational activities and in-services, or clinical support. It is because of this isolation that mentoring for general practice nurses has been receiving recent attention in Australia (Gibson and Heartfield, 2005). In 2002 the authors undertook a study with the aim of recommending a “national mentoring framework to support general practice nurses” (p.51). The study found that mentoring for general practice nurses was viewed as an important strategy by which to overcome isolation through a network of peers and to influence quality of care through the sharing of information and clinical experience. The potential of mentoring to enhance the sustainability of nursing in general practice was identified.

While the literature search undertaken for this discussion of family practice nursing was extremely narrow, and limited to articles available on line, no studies were found that explored the utilization of FPN’s, their scope of practice, contributions, and outcomes in Ontario (or Canada). Consequently there appears to be a considerable knowledge gap in those areas. FPN’s’ interest in research was the focus of a study in two regions of the United Kingdom by Davies et al. (2002). 80% of the FPN respondents believed that practice nurses should be involved in research. FPN’s educated at the graduate level or those working in practices that provided nurse training (i.e. student nurse placements) and that participated in external research were more likely to desire involvement in research. The authors suggested that an increase in research by and with practice nurses would “...improve the quality of primary care, enhance the status of the profession, utilize the enthusiasm of individuals, increase job satisfaction and staff retention and answer real questions” (p. 370). The article suggested that facilitating practice nurse research will require the establishment of support networks and easy access to resources” (p. 380).

This discussion has identified the important contributions made by family practice nurses. They are integral members of the health team and make an essential contribution to the transformation of Ontario's health care system. The 52 Family Health Teams and 3 Regional Family Practice Networks (Ontario MOHLTC, 2005) recently implemented by the Ontario government have the potential to maximize the role of the FPN, to educate physicians and the public about that role, and to contribute to research capacity within the family practice teams and regional networks. The following recommendations reflect the content of this discussion and the opportunities presented by Ontario's new family health structures.

Recommendation to the JPNC

That the JPNC Work with the relevant departments or individuals to achieve the following initiatives:

1. Performance indicators for the family practice networks should: (1) reflect the contributions of the FPN to outcomes of both the individual patient(s); (2) the family health team at large; (3) the frequency and nature of practice supports made available for the family practice nurses; (4) the presence of a meaningful network amongst the FPNs in all networks including formal mentoring programs.
2. Promote consistency in the job descriptions of family practice nurses across all family health teams and monitor them for evidence of a professional role (versus clerical).
3. Require patient records to include the patient care and interactions provided by the FPN.
4. Promote the role of the FPN in MOHLTC promotional materials related to the family health teams.
5. Fund and/or support research studies into the scope of practice of the FPN, their contributions and associated practice outcomes.

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