Family practice registered nurses

The time has come

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ABSTRACT

OBJECTIVE To provide a picture of the unique role and competencies of family practice registered nurses (FP-RNs).

DESIGN Case-study approach using interviews and focus groups.

SETTING Ontario.

PARTICIPANTS Seven FP-RNs identified as exemplary by family medicine and nursing peers.

METHODS An e-mail was sent to 9200 health care providers from nursing and family medicine, asking them to identify names of exemplary family practice nurses. Using a purposive sampling methodology, 7 exemplary FP-RNs were selected, taking into consideration the number of years in practice as a nurse, location of practice, length of practice as an FP-RN, and type of family practice. Individual interviews were held, and focus groups were organized with colleagues. Narratives were analyzed iteratively by the project team.

MAIN FINDINGS Four main themes emerged: The first theme relates to the relationship-centred approach to care delivered by FP-RNs, founded upon trust. The second theme highlights the FP-RN's unique skills in balancing the priorities of patients, colleagues, and the clinic as a whole. The third theme capitalizes on the nurses' commitment to advancing their learning to enhance their abilities to be FP-RNs. The fourth theme illuminates the perspectives shared by FP-RNs that family practice is uniquely different from acute care in the manner in which care is delivered. We draw attention to the approach and role of FP-RNs in Ontario. The 4 themes that emerged have striking similarities to stories shared by family physicians and to the evolutionary development of the discipline of family medicine.

CONCLUSION We believe the findings from this paper can help shape the role of the FP-RN within clinical practice and that they will propagate discussion among nursing educators to consider the necessary educational preparation required to develop the FP-RNs needed in this country.

EDITOR'S KEY POINTS

- The role of the family practice registered nurse (FP-RN) has been overshadowed by the "glamour" of acute care nursing. With the advancement of primary care teams, the role of the FP-RN is gaining traction, yet it is still poorly understood. This study sought to begin to define and shape the unique role of the FP-RN.
- Interviews with exemplary FP-RNs and focus groups with their colleagues revealed 4 main themes: trusting relationships, critical priority-setting skills, commitment to learning, and recognition of specific differences between family practice and acute tertiary care approaches.
- With the advancement of interprofessional collaborative approaches to care, it might serve the health system well to consider the lessons learned in family medicine that could inform the advancement of family practice registered nursing. If Canada is moving toward an integrated approach to the provision of primary care, the system needs to articulate the roles of health care providers, understand the uniqueness of the care delivered in family practice, and describe the educational requirements essential for our primary care work force.

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Les infirmières spécialisées en médecine familiale

Le temps est venu

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RÉSUMÉ

OBJECTIF Donner un portrait du rôle et des compétences uniques des infirmières spécialisées en médecine familiale (IS-MF).

TYPE D'ÉTUDE Étude de cas à l'aide d'entrevues et de groupes de discussion.

CONTEXTE L'Ontario.

PARTICIPANTS Sept IS-MF jugées exemplaires par leurs pairs en médecine familiale et en sciences infirmières.

MÉTHODES On a adressé un courriel à 9200 intervenants en soins infirmiers et médecine familiale, leur demandant d'identifier des infirmières spécialisée en médecine familiale exemplaires. Au moyen d'un échantillonnage raisonné, on a choisi 7 IS-MF en tenant compte du nombre d'années de pratique comme infirmières, du lieu de pratique, de la durée de pratique comme IS-MF et du type de pratique familiale. On a tenu des entrevues individuelles et organisé des groupes de discussion avec des collègues. Les propos ont été analysés de façon itérative par l'équipe du projet.

PRINCIPALES OBSERVATIONS Quatre thèmes principaux ont été identifiés. Le premier a trait à l'approche axée sur la relation dans les soins dispensés par les IS-MF, qui repose sur la confiance. Le deuxième souligne l'habileté particulière des IS-MF pour établir les priorités des patients, des collègues et de la clinique dans son ensemble. Le troisième thème insiste sur les efforts déployés par les infirmières pour améliorer leurs connaissances et ainsi devenir de meilleures IS-MF. Le quatrième thème porte sur l'opinion que partagent les IS-MF voulant que la pratique familiale se distingue clairement des soins aigus dans la façon de dispenser les soins. Cela montre bien l'approche et le rôle particuliers des IS-MF en Ontario. Les 4 thèmes retenus présentent une ressemblance frappante avec des événements vécus par les médecins de famille et avec le développement de la médecine familiale.

CONCLUSION Nous estimons que les présentes observations peuvent aider à définir le rôle des IS-MF au sein des cliniques et qu'elles favoriseront la discussion chez les enseignants en nursing à propos de la préparation de l'enseignement nécessaire pour former les IS-MF dont le pays a besoin.

POINTS DE REPÈRE DU RÉDACTEUR

- Le rôle des infirmières spécialisées en médecine familiale (IS-MF) a été occulté par l'aspect prestigieux des soins infirmiers aigus. Avec l'instauration des équipes de soins primaires, ce rôle prend de l'importance, mais il demeure mal compris. Cette étude se veut un début de définition et d'encadrement du rôle unique des IS-MF.
- Des entrevues avec des IS-MF exemplaires ainsi que des groupes de discussion avec leurs collègues ont révélé 4 thèmes principaux : relation de confiance, habileté dans l'établissement des priorités critiques, motivation pour apprendre et reconnaissance des différences entre le mode de pratique familiale et celui des soins aigus tertiaires.
- Avec l'instauration d'une collaboration interprofessionnelle au niveau des soins, le système de santé aurait avantage à tenir compte des leçons tirées de la médecine familiale, lesquelles pourraient contribuer à l'avancement des IS-MF. Si le Canada se dirige vers un mode intégré de dispensation des soins primaires, il faudrait que le système précise les rôles des soignants, comprenne la nature unique des soins dispensés en pratique familiale et décrive les besoins de formation nécessaires aux intervenants de première ligne.

Cet article a fait l'objet d'une révision par des pairs.
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Family practice registered nursing has historically been perceived as less attractive than acute care nursing, which has been viewed as more glamorous and professional. There are few empirical studies that examine what the role and contributions of family practice registered nurses (FP-RNs) are in the family practice setting internationally.[1] Historically there has been a tendency to describe the role of the FP-RN according to tasks, rather than as a comprehensive role defined by a set of core competencies within a nurse's scope of practice. Alsaffar[2] noted that the roles and responsibilities of FP-RNs are often based on the local employer's understanding and wishes. The FP-RN role has therefore varied from paralleling that of a receptionist to that of a primary care nurse practitioner.[3,4]

Clear role descriptions and role understanding among health care providers has been found to be critical to successful interprofessional collaboration.[5] Qualitative research in newly formed family practice teams in Ontario revealed that poor role understanding and role ambiguity acted as barriers to building effective collaborative teams.[6-8] Recognizing that there is a health human resource shortage upon us, there is an urgent need to reflect on with whom and how collaboration should take place to advance teamwork within family practice settings.

This paper is timely in that it explores the role of FP-RNs in Ontario in order to articulate a more fulsome description that could be used by FP-RNs, nursing associations and regulatory bodies, family physicians, and policy makers in this country.

METHODS

We studied exemplary FP-RNs, identified as such by peers (nurses and other health professional colleagues) who recognized them as experienced, seasoned mentors and role models who were self-reflective and highly respected. Using a case-study approach, we interviewed the FP-RNs and their colleagues in the spring of 2009 and analyzed their narratives, searching for emerging themes. Case-study methodology is often used when the boundaries between phenomenon and context are not clearly evident and when there is an opportunity to investigate a phenomenon in its real-life context.[9,10] With this in mind, the use of case-study methodology was thought to be a good choice to begin to understand more fully the nature and role of FP-RNs. In so doing, it was the intention of this study to uncover the "phenomenon" of exemplary FP-RNs within the places they work and among the people they work with. Ethics approval to conduct this study came from the University Health Network Research Ethics Board.

Recruitment

An e-mail was sent to 9200 health care professionals in nursing and family medicine, by means of professional list servers from the Ontario College of Family Physicians, the Canadian Nurses Association, the Registered Nurses' Association of Ontario, and Ontario Family Practice Nurses. We received 58 nominations of exemplary FP-RNs from this call. Using a purposive sampling approach, we narrowed our pool to obtain a heterogeneous group of 7 exemplary FP-RNs who were distinguished by the following criteria: number of years in practice as a nurse; type of practice (eg, family health team, community health centre, group practice, solo physician); geographical location; and number of years working in a family practice setting (**Table 1**).

Data collection

Seven 1-hour, face-to-face, semistructured interviews were conducted with the exemplary FP-RNs. Each interview was audiotaped and transcribed. Five 90-minute focus groups (1 focus group in each setting) ranging in size from 3 to 9 participants were conducted with colleagues who worked with the interviewees (**Table 2**). We were not able to arrange focus groups with the colleagues of 2 of the 7 FP-RN participants.

Information gathered from the focus groups with nurses' colleagues tested the congruence of their perspectives with those of the FP-RNs themselves. Using this methodology we were able to triangulate and enhance the strength of our emergent findings.[11] Data

Table 1. Participant characteristics

CHARACTERISTIC	NURSE 1	NURSE 2	NURSE 3	NURSE 4	NURSE 5	NURSE 6	NURSE 7
No. of years in practice as a nurse	36	33	17	26	38	29	27
No. of years as a family practice registered nurse	28	7	13	17	19	10	15
Type of practice	Urban academic family health team	Rural family health team	2-physician family health group	Solo physician, shared care initiative	7-physician family health group	Solo physician practice	Solo physician practice
Geographic location	Southern Ontario	Northwestern Ontario	Northern Ontario	Southwestern Ontario	Southeastern Ontario	Southwestern Ontario	Southern Ontario

Table 2. Focus group participants

FOCUS GROUP	PARTICIPANTS
1	Team secretary 2 registered nurses Dietitian Family health team director Physician
2	Finance person Social worker Registered nurse 2 physicians Family health team director Registered practical nurse Health care assistant Receptionist
3	2 physicians Medical office assistant
4	Social worker Physician Accountant Registered nurse Administrator
5	Office administrator Registered practical nurse 6 physicians

from the interviews and focus groups were found to be congruent.

Data analysis

Data were analyzed iteratively by members of the research team: 2 family physicians, 1 nurse educator, and 3 graduate-level qualitative researchers. Each member of the research team independently read the transcribed narratives and coded the data, discussing and negotiating themes and categories until saturation was reached. NVivo software was used to assist with data management. To increase the rigour of our research process, we coded categories and found examples in participants' transcripts to check for representativeness, triangulated emergent findings across all participants, checked for explanations or theories for typical and atypical findings, and tried to discount conclusions drawn throughout the interactive analytic process, negotiating toward consensus among the independent researchers who analyzed the data.[12,13] Data were analyzed to the point of saturation (ie, until no new themes were emerging).

FINDINGS

We found that the exemplary FP-RNs in our study had a considerable effect on patient care. While the exemplary nurses' daily duties differed across the case-study settings, their functional roles were quite similar. Of critical difference among settings was the effect of funding on the roles of the FP-RNs. Some clinics that were funded on a fee-for-service model, for example, had less health education conducted by nurses because these services would not be considered billable to the practice. We biased our sample by purposively selecting exemplary FP-RNs and their very happy colleagues; therefore, the likelihood of having any contrary findings around the value and contributions of the FP-RN was very low, if not nonexistent. In addition to this, as per our conceptualization of "exemplary" across the family medicine settings, anything that might be considered contrary data was in fact included as part of the total package or range of roles and competencies. Therefore, there was no such thing as a contrary finding in the research.

We identified 4 main themes in enhancing our understanding of FP-RNs' specific approach to care: trusting relationships, critical priority-setting skills, commitment to learning, and recognition of specific differences between family practice and acute tertiary care approaches.

Trusting relationships

Our findings revealed that building strong nurse-patient relationships was critical to the role of the FP-RN. The depth of nurse-patient relationships allowed FP-RNs to obtain information that might not otherwise be disclosed. For instance, one physician said, "There are now things that the younger crowd will relay to [the nurse] in a sexual history that they don't tell me." Many of the FP-RNs acknowledged that in the family practice setting, established trust with patients intensified over time. They seemed to think that trust and relationships with patients were more easily developed within family practices that valued continuity of care. One nurse noted that "family practice nurses get to see the impact of their decisions, and the impact of their advice" over time. In acute care settings, "a nurse will make decisions, but once that patient's out, that's it."

We found that nurse participants had an important effect on patient care through the support they provided and the health education they imparted. One family physician described a successful intervention influenced by the clinical relationship between an FP-RN and an obese patient who had diabetes. He concluded his account by noting: "It's a wonderful story in terms of the bond, the trust, the relationship that exists with the nurse."

The importance of trust also emerged from narratives describing relationships between FP-RNs and their health professional colleagues. Trust was more easily garnered by the FP-RNs when they were able to demonstrate their clinical acumen. As one family physician said of the nurse he worked with: "I value her judgments with regard to patient care. If she thinks someone needs to be seen, and when, and how, I value that, I follow her advice, and if she disagrees with me then she'll say so."

Another physician described the FP-RN in their clinic as "ha[ving] an authority we can really trust."

Balancing multiple priorities in the provision of coordinated care

Exemplary FP-RNs were able to balance multiple priorities, including the simultaneous, unpredictable, and immediate needs of many patients and colleagues. Compared with the hospital setting, one participant explained, "It's a real skill in family practice nursing, identifying those red flags of who needs to be seen—that triaging function." The ability to quickly assess and prioritize those patients who needed to be seen sooner set exemplary FP-RNs apart. Oftentimes the FP-RNs' triaging competence, coupled with an expert knowledge of the patient population, resulted in better and quicker care. Being attuned to individuals and knowing when critical situations needed to be addressed was deeply important. We heard such stories about a nurse who recognized a patient was in acute heart failure by just seeing the patient in the waiting room; a nurse who convinced a stoic patient on the telephone to seek medical attention based on her conversation; and a nurse who knew that simply sitting and listening to a crying patient would provide the type of care needed. The seemingly intuitive sense of knowing the patient and knowing how to prioritize needs was an attribute seen across all the FP-RNs studied.

It became evident that FP-RNs were also skilled in prioritizing the needs of the clinic's operational flow. One nurse stated: "I usually come in early because I need to know I've got my things in order before the patients start coming." Another explained of her organizational methodologies, "I know right in the beginning who is going to be coming in, which doctors are working, and I get their stuff ready to make sure I'm ready for them." Exemplary FP-RNs were able to proactively deal with the unexpected. One physician described that if the nurse saw that the fridge was broken, "she [would] call public health and find out which vaccines we [could] use and which [were] kaput; I wouldn't have the foggiest [idea] and I just trust her to call public health and figure it out." Another counted on her nurse partner to manage the clinic flow: "[S]he will knock on my door if I'm taking too long, like with a physical exam. She keeps me on task." The awareness of the clinic system's needs, health professionals' needs, and patient care needs were skillfully balanced and prioritized.

Committed to learning the discipline of family practice nursing

The FP-RNs in this study were characterized as independent, motivated health care professionals, continuously refining and expanding their knowledge and skills. One participant explained that, for example, "clinical guidelines for things like immunization had been around for years but were not a focus in what I had to do [previously], so I needed upgrading."

Given the absence of formal family practice registered nursing programs, the FP-RNs' capacity for creating self-directed learning opportunities was critical to the optimization of their role. Many began their careers in acute care hospital settings, and entry to family practice came with a steep learning curve. The nurses created their own learning opportunities to optimize their family practice nursing roles, including volunteering at family planning clinics to gain experience or shadowing colleagues. We found an openness and flexibility toward lifelong learning, as they noted that "nothing stays the same" in family practice.

Many of the FP-RNs studied were able to skillfully, effectively, and purposefully gather information, knowing when and how to "stop and listen to people." This specific skill enabled the FP-RN to go beyond simply "listen[ing] to the words" of the patient to "really hear[ing] what [was] being said." As a result of the dialogues developed, FP-RNs demonstrated an ability to know their patients in a holistic manner, taking into account complex medical, social, and emotional needs. As another nurse reflected that the shift to family practice made "a big difference in the way you [as the nurse] look at a family as a whole." The FP-RNs in our study successfully adapted and independently fulfilled the need to broaden their knowledge and skill as they developed their communication practices with their patients.

Recognizing family practice nursing as distinct

The nurses in this study distinguished between the type of care delivered in primary care and that delivered in acute care settings. One participant described nursing in acute care as regimented, "always [addressing] orders—give them this give them that." Another explained,

> [The family practice setting] wasn't like in the hospital where you did things *to* people. It was more like these are the people, what do they want? You have to give them what they want, not what you want to give them.

The FP-RNs thus played an important role in gathering information from the patients to develop a holistic understanding, which included lifestyle, familial, and socioeconomic circumstances. As illustrated by one nurse's story, the ability to effectively gather, process, and act on patient information over the long-term is an acquired skill unique to the FP-RN and different from the acute setting:

> When I first started in [family practice] people would show up and would be having nervous breakdowns, and I didn't know what to do with that .... [S]uddenly, there are patients that are telling you their problems, and I had no clue what was wrong with them ....

> [I]t took me probably at least 2 or 3 years before I was able to look at things in a pattern recognition kind of way .... [W]hen I think about it now, I probably wasn't the best in terms of being empathetic or understanding what the family dynamic was. 'Cause all I had cared about previously was the patient in the bed.

One FP-RN highlighted the notion of the uniqueness of "family" in "family practice":

> You're in an environment where this person in front of you is sick, but that person is the dad and now he can't go to work. And because he can't go to work the kids won't get new snow boots. So [the shift to family practice] makes a big difference in the way you [as the nurse] look at a family as a whole.

DISCUSSION

We found that the exemplary FP-RNs had a considerable effect on patient care. Through their relationships with patients, they were able to intervene using their clinical acumen and supportive care. Our findings suggest that there is something unique about family practice nurses. This study paints a picture of exemplary FP-RNs, highlighting their abilities to establish deep levels of trust with patients; foster effective relationships; and see patients in a holistic manner that recognizes their complex medical, social, and emotional needs. The specialized generalist knowledge of the FP-RN distinguished FP-RNs as generalists similar to family physicians in the discipline of medicine. Gaining this knowledge of family practice required them to independently and continuously create learning opportunities for themselves. Described as "self-starters" by many of the nurses themselves and by their colleagues, there was an inherent understanding that family practice was uniquely different from tertiary care.

The similarities in the approaches of family physicians and FP-RNs is interesting. McWhinney distinguished family medicine as one of the only disciplines that is centred on continuity of care and relationship-centred care and that operates at the highest level of complexity.[14] We submit that, as seen through our study, there might be the emergence of a distinct discipline within nursing related to family practice. To that end the findings from this study have been included within a Delphi panel process to create a competency framework for FP-RNs further articulating their roles and elaborating upon the unique knowledge, skills, attitudes, and behaviour required. The Delphi process involves circulating emergent findings to a group of experts in a series of rounds, with each round incorporating feedback from previous rounds, until sufficient consensus among the experts is achieved.[15] For the purposes of this study, the experts chosen to participate were from different professions including nursing, family medicine, association and practice leadership, and other health professions in the primary care setting. The final product of the Delphi process, which took 3 rounds, was the development of a competency framework for FP-RNs.[16]

Family physicians and FP-RNs

The research team honours the distinct disciplines of nursing and medicine and acknowledges that both have unique epistemologies and ontologies. However, much necessary overlap exists, as noted by McWhinney:

> The evolving nurse-doctor relationship is the key to the future of primary care. Each profession [nursing and medicine] has its central role, but there is much overlap, and the roles should be allowed to evolve over time with minimal direction. The value of teamwork is in the diverse perspectives of the professions. From their integration emerges a new level of care, different from each of the individual perspectives.[17]

In the nursing literature, Tanner wrote the following:

> [The nursing discipline] requires an understanding of not only the pathophysiological and diagnostic aspects of a patient's clinical presentation and disease, but also the illness experience for both the patient and family and their physical, social, and emotional strengths and coping resources.[18]

Tanner further described that what is central to nurses' clinical judgment is what they refer to in their daily discourse as "knowing the patient." This aligns well with the importance of "hav[ing] an understanding and appreciation of the human condition, especially the nature of suffering and patients' response to sickness," which is noted as a central tenet of one of the principles of family medicine (ie, "The patient-physician relationship is central to the role of the family physician").[19]

As family practice nursing becomes more clearly defined as a subspecialty in nursing, it might be fruitful to look to the evolution of family medicine for key lessons learned. Common to both is the sense of a lost glamour to the specializations within the health care field.[20] The distinction of generalism as a specialty with unique competencies is only now gaining traction.[21] In particular, the launch of the CanMEDS–family medicine competency framework for family medicine[22] might provide an opportunity for family practice nursing to advance its own competency framework in Canada.

In recognition of the unique discipline of family practice nursing, a postgraduate certificate course has been launched in Australia.[23] Similarly, the Royal College of Nursing in England, in collaboration with Staffordshire

University, has developed a tool kit specifically related to the education and support of family practice nurses.[24] Our research is another step in encouraging the Canadian nursing leadership to conduct further research on FP-RNs and to consider advancing this area as distinct within the nursing profession.

There are minimal opportunities for continuing education programs in Canada that are specific to family practice nursing (personal communications, Barbour C, George Brown College Family Practice Professional Advisory and Steering Committee, 2009). Other than the proposed post-RN certificate program offered by George Brown College in Toronto, Ont, and a professional development series for FP-RNs and family physicians (personal communications; Smith P, MN, RN; PLS Consulting Inc; 2009), no other formalized teaching program could be found to formally educate FP-RNs. This lack of professional development is of concern when the imperative in Canada is to advance primary care teams[25] in which FP-RNs are key partners with family physicians.

Limitations

Owing to our small sample size, our findings might not be generalizable to all family practice settings in Ontario and beyond. Our FP-RN participants were all women older than 45 years of age. These demographics are consistent with Canadian literature.[26] Because FP-RN participants were nominated by peers and colleagues as "exemplary," it should be noted that positive working relationships between the FP-RNs and their colleagues existed before the study, and conflict within the practice setting was not addressed during our interviews and focus groups. Further studies could be conducted to test emergent findings using other research methodologies or larger cohorts to determine applicability to broader populations.

Conclusion

Despite recent attention drawn to family practice nursing by the Canadian Family Practice Nurses Association[27] and the Canadian Nurses Association,[28] more can be done to shine the light on FP-RNs. With the advancement of interprofessional collaborative approaches to care, it might serve the health system well to consider the lessons learned in family medicine that could inform the advancement of family practice registered nursing. If Canada is moving toward an integrated approach to the provision of primary care, the system needs to articulate the roles of health care providers, understand the uniqueness of the care delivered in family practice, and describe the educational requirements essential for our primary care work force.

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Contributors

Dr Oandasan participated in the conception and design of the research protocol, contributed to the analysis of the research data, drafted the article, and approved the final version of the paper. **Ms Hammond** participated in the design of research methodology, contributed to the collection and analysis of the research data, assisted in writing the article, and approved the final version of the paper. **Dr Gotlib Conn** participated in the conception and design of the research protocol, contributed to the collection and analysis of the research data, assisted in writing the article, and approved the final version of the paper. **Ms Callahan** contributed to the analysis and interpretation of the research data and provided input throughout the research process from a nursing perspective, including review of the manuscript and approval of the final version for submission. **Ms Gallinaro** contributed to the collection and analysis of the research data, assisted in ongoing editing of the article, and approved the final version of the paper. **Dr Moaveni** collaborated in the conception and design of the research protocol, contributed to the collection and analysis of the research data, contributed intellectually to the manuscript, and approved the final version of the paper.

Competing interests

None declared

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