

# EXPLORATION OF THE "EXPANDED ROLE" OF THE NURSE IN A PRIMARY CARE SETTING

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During the past year an interest group of the Faculty of Nursing at The University of Western Ontario has been meeting with a view to delineating our position on the nurse working in primary care. Initially, we came together to discuss the "expanded role of the nurse." However, early in our deliberations we seemed to arrive at the conclusion that although there are undoubtedly some commonalities in the functions of nurses who are working in what are termed "expanded roles," in reality, what comprises the set of functions in an expanded role depends on the setting in which the role is being practiced. Our attention then became focused on the expanded role of the nurse in primary care settings. When we felt we had raised and discussed the issues related to this role, we decided to use the Delphi Technique as a means of achieving consensus on the issues relevant to the role.

At the time of writing this article, this is the process in which we are involved.

Although the faculty as a whole has not, as yet, taken a definitive stand on the role and preparation of the nurse in primary care, during the past few years individual faculty members have been actively engaged in looking at this role. Also, we have been keeping a finger on the pulse of the local, provincial, and national scenes as they relate to the nurse in primary care and the need for this role.

As one of our faculty who has the opportunity to be involved in a local project to develop a community health centre, I have been able to explore the role of a nurse in a primary care setting, both indirectly and directly. In the remainder of this paper I will be describing our experience in this project. I would also like to share with the readers some of my personal views about the role of the nurse in primary care, and to identify some of the problems we have encountered.

Approximately three-and-one-half years ago, as a representative of our faculty, I became involved in the development of a health centre to provide health services for a medically underserved rural community which included an Indian Reserve, about twenty miles from London. Within the overall objectives of the project, the Faculty of Nursing was interested in exploring the facets and parameters of the

role of a nurse as an integral member of a primary health care team. What is an appropriate ratio of nurses to physicians on this team? Is this a setting that will afford the baccalaureate graduate the opportunity to utilize a wider range of her skills than in most traditional settings? What additional preparation does a baccalaureate graduate need to function effectively as a member of the primary health care team? These are some of the questions we hoped to answer. Although during this period of time we have worked most closely with two physicians who are members of the Department of Family Medicine, other university faculties and community health agencies have participated in the project.

I would like to interject here that the proposed centre is only now coming into being as a physical facility. Any practice to which I refer has taken place in the temporarily used facilities of the Health Centre on the Indian Reserve. The use of this Centre by personnel working with the project has strained its physical facilities, and these facilities have put some limitations on the way in which the team has functioned. These factors have in turn inhibited some of our explorations of the role.

When I began to work on the project in the spring of 1971, it was thought the centre would be built within the next year. The delays have been partly at the local level and partly at the provincial level.

In September 1971 I was assigned to work one-quarter time with the project, and from then until April 1972 the majority of this time was spent working with the other disciplines on the physical plans for the centre and in discussing with the physicians the role and functions of the primary care nurse. Early in 1972, the omens indicated construction of the centre would begin and completion was anticipated during June or July. A 1971 graduate of our basic baccalaureate programme, Ann (Harris) Bell, joined the project in April 1972 as our would-be primary care nurse. Prior to joining the project, Ann had been oriented to our current thinking related to the role she would assume. Apart from a few days spent with the Victorian Order of Nurses, with the Public Health Nurse on the Indian Reserve, and with the Public Health Nurse in the non-Indian community, Ann's orientation was predominately on-the-job. The service at the Centre was shared by the two physicians. The primary care nurse thus worked part of the week with one physician and part of the week with the other. My time with the project during this year was spent meeting weekly with Ann to discuss her activities, practice and problems, as we attempted to evolve and document the components of her role. We also met regularly with the physicians to discuss the evolvement of the role from their point of view.

The role that the Faculty of Nursing had envisioned for the primary care nurse was one that encompassed the preventive and curative functions of nursing, combining and expanding the traditional practice of office, clinic and public health nurse. She would work collaboratively with the physician and other members of the team, functioning interdependently and independently as appropriate to the needs of patients and her competence. Aspects of the role as we saw it included:

- primary contact
- health assessment, initial and ongoing, to detect deviations from normal
- management of care within her competencies, including non-threatening common illnesses
- consultation and referral to the physician for further assessment where medical diagnosis and treatment are needed
- monitoring of stable chronic diseases
- coordination of care
- health education and counselling

To facilitate coordination and continuity of care the primary care nurse should be free to move between the health centre, home and hospital as indicated by the needs of the individual patient and family.

Most aspects of the planned research could not be instituted because of the limitations of the temporary physical facilities, and because the projected service programme could not be fully implemented until the proposed centre was completed and adequately staffed. However, we did attempt to examine the practice of the primary care nurse and delineate the learning needs, using a semi-structured approach. We identified the functions and activities of the primary care nurse and compared the competencies necessary to carry these out with the competencies which Ann brought to the role. The learning needs that we identified tended to fall into three categories: (1) review of previously learned knowledge or independent study of new knowledge (2) additional knowledge and skills requiring formal instruction (3) additional clinical practice of previously learned, as well as newly learned skills. The role of the primary care nurse as we were attempting to have it evolve required a breadth of knowledge and skills. Thus Ann felt the need to review knowledge, and practice skills so that she could feel competent to carry out the activities of the primary care nurse role with confidence. The two major areas we identified where a greater depth of knowledge and new skills were needed were in physical assessment and investigation of a problem where an organized, direct approach to interviewing is needed.

In June 1973, Ann left the project when she moved with her husband to another province. When the time came to consider her replacement, it was mutually agreed by our faculty, myself, and the physicians involved that I would be the replacement. We felt we had gleaned as much information on the learning needs of a graduate of our baccalaureate programme for the primary care role as was possible within the limitations of the temporary setting. In addition, it seemed to be an auspicious time for me to gain some first-hand experience in the primary care role and to look more closely at the problems we were encountering. Some of the problems, we thought, might have been related to my lack of credibility as I had not practiced in the role, and to the fact that we were asking a neophyte to pioneer a new role.\* I was released from some of my faculty commitments so that I was, theoretically three-quarter time with the project and one-quarter time on faculty. During this past year I have spent four days a week working on the project with approximately three-and-one-half of these providing service and the remainder of the time in meetings and other matters related to organization and practice within the proposed centre.

Like Ann, I worked with each of the two physicians. The temporary facilities were the lower part of an old house with one room converted into an office-examining room, off which was the only washroom. A small sunroom had been converted into an office-examining room for the Primary Care Nurse. These two rooms were separated by a room which was shared by the secretary for Indian Health Services, the secretary for the practice, and the files and records. To wash my hands, to consult with the physician, or to have a patient collect a urine specimen necessitated a trek through the secretaries' office into the other office-examining room.

Initially, we made no attempt to differentiate which patients would be seen by the Primary Care Nurse. This was due, in part, to the fact that unless the visit was a requested return we did not know the presenting problem, and in part to the fact that I was interested in being exposed to the breadth of problems that were presented. This would enable me to look at the feasibility of the nurse being primary contact person and to see what types of problems could be most appropriately handled by the Primary Care Nurse.

The problem-oriented method was used to record a patient contact. In the majority of contacts I was able to elicit and record the patient's subjective description of his problem(s). There were, and continue to

\* My experience included one year hospital staff nursing, eight years as a staff public health nurse with both Public Health and V.O.N. agencies, and four years teaching maternal-child nursing.

be, instances when the physician required and elicited additional information. In the next step of the process, I made observations and carried out examinations which I considered relevant and which were within my competence, recording the objective findings. Throughout the year I made an effort to learn additional skills necessary to investigate common presenting problems, such as otoscopic examination of the ears, auscultation of the chest with a stethoscope to identify abnormal breath sounds, and abdominal palpation for tenderness, organ enlargement, and masses. If I were unable to collect all the objective data or if there were indications of deviations from the normal or from a previous stable condition in either the subjective or objective data, I consulted with the physician. Usually, then, the physician saw the patient and we carried out the assessment and plan together.

After the first few months I usually managed independently the common non-threatening and stable chronic problems that did not require a new prescription. However, most of the patients were seen, at least briefly, by the physician, frequently because of the close working quarters. Early in my experience I began to see antenatal patients and well infants or children independently. The physician would perform the pelvic assessment for the antenatal patient, but apart from that, he would see the patient only if I identified a problem. Most of the patients knew the physician, so there was not the need for him to establish a relationship with the antenatal patient.

From our experience to date it does not seem feasible, with the ratio of one nurse to one physician, for the primary care nurse to be primary contact person for all patients and to carry a caseload of her own. Our current thinking is that working as a team, it is more efficient and appropriate, both for the patient and for the use of the respective skills of the physician and the primary care nurse, to have the primary care nurse assume the major responsibility for a defined group of patient problems, as well as for coordinating care and for education related to other problems. The group of patient problems could include antenatal and postnatal care, well infant and child care, care of chronic stable problems, common non-threatening problems, nutrition and obesity counselling, and problems of adjustment such as aging, grief and long-term illness. We will be looking at the primary contact facet of her role when the centre is fully functioning. There will not be limitations of space there, and a nursing assistant will be added to the team to assist both the physician and the primary care nurse.

At this point, in discussing the appropriate use of the skills of the team members, I would like to relate some observations on physical assessment skills. We initially had a lengthy list of physical assess-



ment skills we thought the primary care nurse should be able to perform. After two years of experience and many discussions with the physicians, the number of skills on the list has diminished. In deciding whether a particular skill was appropriate for the primary care nurse to learn we asked ourselves the following questions:

1. What would be the purpose in performing the particular assessment skill or procedure?
2. Would the examination using the skill or procedure reveal a deviation in the absence of any subjective symptom or objective data which the nurse is already competent to elicit?
3. Would it be a skill or procedure she would use frequently enough to justify the time required to learn and to maintain competency in the skill?

To justify learning the skill, we felt that its purpose should be to determine a deviation from normal rather than to identify a specific abnormality, and that the answers to the second and third questions should be "yes".

Rather than spending a great deal of time learning to duplicate the skills of the physician, it seems to me that the time would be more appropriately spent increasing proficiency in those skills that a nurse already possesses. For example, sharpening one's powers of observation and being able to make astute general and specific observations in an organized manner can reveal important information about a patient's physical and emotional status. Precise description of observations is an essential skill, both for one's own future reference, and for communication and collaboration with other members of the team. To describe the location of a lesion, pain or injury, requires a good working knowledge of surface anatomy. These are some of the skills in which we must be proficient to be an effective and credible member of a primary care team.

There are aspects of health care that have tended to be neglected in primary care settings for which a nurse, at least one with a broad preparation such as a baccalaureate, is competent and frequently better prepared and more willing to provide than many physicians. Some of these are counselling and education to facilitate health promotion and prevention of problems, as well as coordination of care. I have been performing developmental assessments on infants and young children, utilizing the information to discuss developmental needs of the child and offering the opportunity for the mother to discuss her child and any concerns she may have. This also provides the occasion to reassure and praise the parents(s) about their childrearing. Coordinating or assisting the patient to coordinate his care as he moves

from the primary care setting to a specialist, hospital, or to other parts of the health care system, can relieve a great deal of anxiety on the part of the patient and his family as well as facilitate continuity of care. It has been a common phenomenon for the patient to miss his appointment. Physicians tend to see "follow-up" as a patient responsibility, however, my community health conscience was bothered by this, particularly as we were seeing some detrimental effects of inadequate treatment. Although the physicians were not particularly keen on the idea, at least initially, I have initiated contact with patients who did not keep appointments given for return visits. The majority of these responded to a phone contact or a letter, by returning for the "follow-up" visit. I have a concern that if there is too much time and emphasis placed on learning the skills of physical assessment, we may find the nurse in primary care emulating the role of the physician, when, in order to bridge some of the gaps in the delivery of primary care there is the need for those skills of nursing which complement the role of the physician.

These comments related to the physical assessment skills needed by the primary care nurse are based on the assumption that the nurse is working in the same physical facility and has ready access to the physician who has these skills, plus a depth of knowledge in clinical sciences and pathology.

The introduction of the Primary Care Nurse into the health care delivery system is a change in the system that will effect changes in other parts of the system. With change comes the potential for problems. The problems which we have encountered in the process of putting into practice our concept of the primary care nurse could be categorized as "intraprofessional" and "interprofessional."

From the inception of this project the physicians have demonstrated an active interest in the role of the primary care nurse. They have assisted us with the learning of new skills and have spent countless hours in discussion of the role and activities; however, we have encountered, on a continuing basis, some of the traditional problems that have existed between the professions of medicine and nursing. When there has been disagreement about an aspect of the primary care nurse role or on other matters that related to or affected nursing, we have not passed the true test of collaboration. The administrative structure of the project is such that our power is mainly that of persuasion while the final decision-making power lies with the physicians. As a result most of the compromises have been made by nursing. The only major difference between the "interprofessional" problems experienced by Ann and those experienced by myself was a pressure which she perceived to concentrate on medical activities, and

which she felt result in a compromise of some of her nursing skills. She related this to the on-the-job learning from the physicians which, combined with her sense of relative inexperience in areas such as teaching and counselling, resulted in these nursing activities being neglected, particularly in the face of a crowded waiting room. I think my experience has helped me resist this pressure. This has been reflected by the physicians' change in emphasis on physical assessment skills and therapeutics. They now see teaching and counselling as a more important aspect of the role of the Primary Care Nurse.

The "intraprofessional" problems have been related mainly to the home visiting aspect of the Primary Care Nurse's role. From the early stages of the project, nursing personnel from the community health agencies have been participating in our discussions of the proposed role. Their input based on their experience and knowledge of the community has been of great assistance to us. There seems to be, however, some discomfort on the part of the community health nurses relating to the primary care nurse visiting in the homes. We are planning to coordinate the home visiting of the public health nurse and the primary care nurse so there is not duplication. The thought is that the primary care nurse would visit in the home, when indicated, for those patients with whom she has established a relationship through her contacts in the centre and for whom it seems more appropriate for her to visit than the public health nurse. I think that we are effecting this coordination so that the central focus is the patient and that the skills of each nurse are used appropriately thereby avoiding "intraprofessional" problems.

We have encountered no problems related to patient acceptance of the primary care nurse. This may be partly related to the population with whom we are working. We have, however, always made it clear that the physician was available if the patient wished to see him.

I suspect that the long gestational period of this project, which in itself has created many frustrations, may have had heightened anxieties and thus increased the potential for problems. Hopefully, when the centre opens and begins to function, the anxieties will diminish and our problems may begin to resolve.

An additional problem area in which we have had, and continue to have problems is financial. The salary for the primary care nurse is part of a grant from the Ontario Ministry of Health. Initially we had problems convincing them that the role, as we envisaged it, required someone with baccalaureate preparation. There has been continuing reluctance to give approval for a salary which will allow us to be competitive with local health agencies for nurses with a baccalaureate preparation.



Despite the limitations of the temporary facility and the compromises we have had to make, we have gained some valuable experience and information on a *model* for the primary care nurse. The identified learning needs will be of assistance for curricular changes that will assist a graduate to move into this area of nursing. One important aspect to which I believe, based on my experience, we need to give careful consideration is the need to prepare our graduates to be "pioneers" and change agents. There would appear to be a great deal of interest in the "expanded role" for the nurse in primary care and one gets the impression that the system is waiting with welcome arms. This may be! However, I believe that there is still a great deal of pioneering to be done. To do this we need nurses who have a strong sense of identity as nurses. For, if nursing is going to make an impact on the primary health care system, I hope that it is in a role that is based firmly on nursing skills and is a role that complements, rather than emulates the role of the physician.

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I would like to acknowledge that in writing this article I have liberally used ideas and thoughts gleaned through discussion with my colleagues on the Faculty of Nursing and from Ann (Harris) Bell who worked as a Primary Care Nurse with this project from April 1972 to June 1973. The views presented, however, are based on my personal perceptions and do not necessarily represent those of my colleagues.